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FEATURE ARTICLE

'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship

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ABSTRACT: *The purpose of this study was to describe mental health service recipients' experience of the therapeutic relationship. The research question was 'what is therapeutic about the therapeutic relationship?' This study was a secondary analysis of qualitative interviews conducted with persons with mental illness as part of a study of the experience of being understood. This secondary analysis used data from 20 interviews with community-dwelling adults with mental illness, who were asked to talk about the experience of being understood by a health-care provider. Data were analysed using an existential phenomenological approach. Individuals experienced therapeutic relationships against a backdrop of challenges, including mental illness, domestic violence, substance abuse, and homelessness. They had therapeutic relationships with nurses (psychiatric/mental health nurses and dialysis nurses), physicians (psychiatrists and general practitioners), psychologists, social workers, and counsellors. Experiences of the therapeutic relationship were expressed in three figural themes, titled using participants' own words: 'relate to me', 'know me as a person', and 'get to the solution'. The ways in which these participants described therapeutic relationships challenge some long-held beliefs, such as the use of touch, self-disclosure, and blunt feedback. A therapeutic relationship for persons with mental illness requires in-depth personal knowledge, which is acquired only with time, understanding, and skill. Knowing the whole person, rather than knowing the person only as a service recipient, is key for practising nurses and nurse educators interested in enhancing the therapeutic potential of relationships.*

KEY WORDS: *nurse–patient relationship, phenomenology, qualitative methods, therapeutic relationship.*

INTRODUCTION

Therapeutic relationships are central to the practice of psychiatric/mental health nursing. Classical theories and research from nursing and psychology have contributed to our knowledge of these relationships; yet still, we know little about what recipients of psychiatric/mental health nursing care believe is therapeutic. For recipients of mental health care, what is therapeutic about therapeutic relationships? The purpose of this paper is to describe mental health service recipients' experience of the therapeutic relationship.

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THEORETICAL BACKGROUND

Clinicians aiming to establish therapeutic relationships should be guided by theory: 'If you have no theory, you have no tools' (Hedges 2006). Any discussion of theories of therapeutic relationships must begin with Freud's (1915, 1935) psychoanalytic theory. Drawing from his clinical cases, Freud formulated the concepts of the unconscious, repression and other defence mechanisms, free association, transference, and countertransference. With regard to the therapist–patient relationship, Freud took an authoritarian stance. For example, he told one patient that she had 24 hours to change her beliefs or she would have to leave the hospital (Freud 1895/1964). In the psychoanalytic approach, patient improvement was attributed to the therapist's hypnotic suggestions or sage interpretations of dreams and symptoms. Rejected interpretations were seen as resistance. Much of Freud's theory is still influential (Stuart 2005), but his fatal error was his 'abiding reluctance to test his own theories – to stand them up against competing explanations – then revise them to accommodate controverting facts' (Wilson 1999; p. 81).

Jung (1967) differed significantly from Freud, adopting a more egalitarian approach to working with his analysands. Rather than having the patient lie on a couch, with the analyst seated behind, as was customary among Freudians, Jung preferred to have the patient sitting directly across from him. He even disliked the word 'patient', speaking instead of 'persons working with him' (van der Post 1977; p. 59). Today's Jungian therapists retain his view of the therapeutic relationship as a dialectical process which transforms both parties and his metaphor of the *temenos* as the space in which the therapeutic relationship takes place (temenos in ancient Greece being a sacred, protected place dedicated to the gods) (Sedgwick 2001).

In contemporary psychiatry, most clinicians rely on object relations theory, following Winnicott and Klein, or self-psychology theory, derived from the work of Sullivan and Kohut (Gabbard 1994). In brief, these theories guide the therapist to enter the service recipient's world of depression or chaos and engage in an empathic investigatory process, enabling the service recipient to relinquish maladaptive defensive structures and envision new ways of being and relating. To the object relations theorists, we owe insights into primitive defences such as splitting, projective identification, introjection, and denial; to the self-psychology theorists, we owe the recognition that attachment, trust, and security are vital issues throughout our lives (Gabbard 1994).

Still another theoretical orientation is existential psychotherapy, in which the clinician assists the client to deal with the four ultimate concerns of existence: freedom, isolation, meaninglessness, and death (Yalom 1980). In this approach, the therapeutic relationship is considered beneficial because it provides the client a 'dress rehearsal' for new ways of relating to significant others, as well as the experience of a genuine relationship with someone whose caring is indestructible (Yalom 1980). While agreeing with the need for the clinician to exhibit empathy, genuineness, and positive regard (as delineated earlier by Rogers (1942), Yalom deplored the textbook emphasis on techniques for conveying these characteristics. Authenticity is lost when one is focused on technique rather than 'turning toward another with one's whole being' (Yalom 1980; p. 410).

Yalom's words (1980) provide a segue to the multidisciplinary relational movement in psychotherapy (Hedges 1997; Mitchell 1988). This approach asserts that the therapist and the service recipient co-create and co-interpret intersubjective realities as the therapeutic relationship unfolds (Hedges 1997). While paying homage to founding fathers such as Freud and Sullivan, relational theorists also embrace postmodern, social constructionist, and feminist perspectives.

Within the discipline of nursing, the theoretical literature on the therapeutic relationship is dominated by Peplau (1952, 1992, 1997) and Travelbee (1966, 1969). Unquestionably, Peplau's work has been most influential. Across five decades, the preponderance of published work on the nurse–patient relationship has been based on the theoretical concepts of Peplau (Horsfall *et al*. 2001). Nurses across the globe are familiar with the phases of the nurse–patient relationship outlined by Peplau (1952, 1997). She was a fierce advocate for humane and respectful treatment of hospitalized patients and was known to have physically blocked seclusion room doors (Horsfall *et al*. 2001). Her interpersonal relations theory included Sullivan's (1953) concepts such as 'security operations' and 'parataxic distortion', as well as concepts of her own, such as 'empathic linkages', or the ability to feel the emotions being experienced by the patient (Peplau 1997; p. 163). Her guidance to clinicians is straightforward and succinct. For example, when discussing the collaborative working phase of the therapeutic relationship, she advised: 'The general principle is to struggle with the problem and not with the patient' (Peplau 1997; p. 164).

In her last paper, Peplau (1997) acknowledged that the trend towards shorter hospital stays and brief psychotherapies challenged the relevance of her theory.

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However, other writers have noted its continuing relevance. Beeber *et al.* (1990) pointed out that every interaction with a client can have educative potential. Moreover, the phases of the nurse–patient relationship are 'not time-anchored and can occur over brief or lengthy relationships' (Beeber *et al*. 1990; p. 6). Reed (1996) contends that Peplau's theory can bridge nursing's modernist past with current postmodern trends. Hrabe (2005) even proposes that Peplau's theory is applicable to computer-mediated communication.

Perhaps because Travelbee died at age 47, her theoretical work is not well known. Travelbee (1966, 1969) critically examined unwritten laws about 'appropriate' nurse behaviour, disputing the old admonition to eschew emotional involvement with service recipients. The tenets of her theory of one-to-one relationships include: (i) a relationship with a patient is deliberately and consciously planned for by the nurse; (ii) emotional involvement is necessary if the nurse is to establish a relationship; and (iii) complete objectivity is not possible (objectivity is a barrier to a meaningful relationship). Travelbee was particularly insightful in helping patients find meaning in suffering and in dealing with problematic aspects of the nurse–patient relationship.

LITERATURE REVIEW

Service recipients' perceptions of the therapeutic relationship have been highlighted in several studies of therapist–client relationships (Bedi 2006; Bedi *et al*. 2005; Littauer *et al*. 2005). According to these studies, clients desire therapists to be warm, calm and responsive, and prepared for each session. They want therapists to: listen attentively; show acceptance, confidence, and understanding; and balance specific questions and comments with listening (Littauer *et al*. 2005). Service recipients also want validation of their experiences, emotional support and care, and appropriate education and referrals. Honesty in the therapist is important, as are positive non-verbal gestures and personal presentation (Bedi 2006; Bedi *et al*. 2005).

Service recipients and nurse perspectives on the factors influencing the nurse–client relationship have also been reported (Horberg *et al*. 2004; Hostick & McClelland 2002; Lowenberg 2003). The studies report that clients and nurses deem trust, being comfortable with each other, being sensitive to 'vibes', and respect as important to the relationship (Hostick & McClelland 2002). Compassion, caring, empathy, concern, sensitivity, and support are important, as well as confidence or trust in the nurse's competence, confidentiality, and non-judgementalism (Lowenberg 2003). Horberg *et al*. (2004) report that clients see security, trust, and genuineness in the relationship as important. Companionship, including friendship, mutual understanding and confirmation, feeling respected, and being understood, is also reported as important (Horberg *et al*. 2004).

Empirical testing of Hildegard Peplau's interpersonal theory of nursing (1952) has been reported by Forchuk (1994) and Forchuk *et al*. (1998), who looked at factors influencing the orientation phase of the relationship. Because this initial phase is predictive of the outcome of psychotherapy with clients with chronic mental illnesses, they wanted to see what was related to the positive development of the orientation phase of the relationship. Preconceptions of both nurses and clients were found to be strongly related to the development of the therapeutic relationship.

Forchuk *et al*. (1998, 2000) also looked at factors involved in the progress of the therapeutic relationship from orientation to the working phase. Clients felt that availability, consistency, and trust in the nurse facilitated the progression of the relationship. They frequently mentioned needs for mutual trust and respect, which were met through listening, consistency, and follow-through. Nurses identified consistency, pacing (slow approach, at clients' pace), and listening as factors encouraging progress from the orientation phase to the working phase. They mentioned initial impressions (preconceptions), comfort, and control and client factors.

Positive outcomes of interventions and interactions in the therapeutic relationship have been reported by Beeber (1989) and Beeber and Charlie (1998) in their work with clients with depression. In 1989, Beeber used Peplau's interpersonal model (1952) to demonstrate how theoretically driven corrective interpersonal experiences successfully promoted growth and change in a depressed client. To quantify the effects of therapeutic interpersonal interventions, Beeber and Charlie (1998) tested a depressive symptom screening and intervention programme. Lower depression scores on the Beck Depression Inventory and an increase in efficacy self-esteem were found, but no improvement was noted in social self-esteem or satisfaction with interpersonal relations.

The therapeutic relationship is foundational to the delivery of mental health nursing care (O'Brien 1999). However, understanding the service recipient's perspective on the therapeutic relationship is vital if appropriate interventions are to be developed and implemented. Therefore, this study examined mental health service recipients' experience of the therapeutic relationship.

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MATERIALS AND METHODS

Design

The study was a secondary analysis of qualitative interviews (Szabo & Strang 1997) conducted with persons with mental illness in a larger study of the experience of being understood. The larger study used an existential phenomenological approach in the tradition of Husserl (1913/1931) and Merleau-Ponty (1962), as described by Thomas and Pollio (2002). The sample in that study included 20 English-speaking individuals who self-identified as having a mental illness and having experienced understanding by a health-care professional. Participants were aged between 21 and 65 years (mean 39.6). Fifteen participants were Euro-American (75%), 4 African American (20%), and 1 Native American (5%). Eight patients were male (40%), and 12 female (60%). One patient had less than a high school education (5%), 3 were high school graduates (15%), 6 reported some college (35%), 6 were college graduates (30%), 3 had a master's degree (15%), and 1 held a doctoral degree (5%). The number of previous psychiatric hospitalizations ranged from 0 to 33 (mode = 0; median = 0.5); the majority of the sample ($n = 11$; 55%) had never been hospitalized for mental illness. Participants reported past and present psychiatric diagnoses, including depression ($n = 10$), anxiety ($n = 3$), generalized anxiety disorder ($n = 1$), bipolar disorder ($n = 9$), postpartum depression ($n = 1$), panic attacks ($n = 1$), post-traumatic stress disorder ($n = 1$), attention deficit hyperactivity disorder ($n = 1$), antisocial personality disorder ($n = 1$), schizoaffective disorder ($n = 1$), and schizophrenia ($n = 1$). Seven participants reported more than one psychiatric diagnosis (mode = 2). Six (4 women and 2 men) were homeless at the time of the interview. Names and references to places were changed to protect the identity of participants. Interviews, which were audiotaped and transcribed verbatim, were conducted between February 2005 and April 2005. Individuals were compensated $20 to participate in the study. The original study has been reported elsewhere (Shattell *et al.* 2006).

Secondary data analysis

This secondary analysis was conducted after approval by the university's institutional review board. Interview transcripts were reread and re-analysed, and were examined for the experience of the therapeutic relationship. The question we asked of the texts was 'what is therapeutic about the therapeutic relationship?' The data were analysed using the systematic method described by Thomas and Pollio (2002), facilitated by ATLAS.ti 5.0 (Scientific Software Development, Berlin, Germany), a qualitative data analysis software package. The researchers analysed each transcript for meaning units. Transcripts also were read from the part (meaning units) to the whole (entire transcript). Meaning units were eventually aggregated into themes (recurring patterns that constituted important aspects of participants' descriptions of their experiences). The major outcome of these readings was development of a thematic description for each transcript. Eight transcripts were analysed in an interpretive research group; the remaining 12 were analysed individually, by the first and second authors. An overall structure of the experience was then developed and presented to a research group to enhance rigour, and interpretations from the group were considered, in addition to the rereading of all transcripts, to finalize the thematic structure. This thematic structure was then presented to one participant for validation.

FINDINGS

In existential phenomenology, each phenomenal experience has a figure that is noticed or stands out and a ground, that is, the context or background of the experience. In this study, the ground of the experience of the therapeutic relationship was living with challenges. Individuals experienced therapeutic relationships against the backdrop of living with a mental illness, domestic violence, substance abuse, and homelessness. This ground or context of their experience, as described below, forms the basis for understanding the significance of the therapeutic relationship from the perspective of those with mental illness.

Context

Participants in this study lived unique and challenging lives because of their mental illnesses. As one participant said, 'Well, depression and panic attacks are both unique things in themselves, until you've been there you have no idea what it is like . . . most people don't realize how debilitating it can be'. Another participant, who was dealing with depression, substance abuse, attention deficit hyperactivity disorder, and the loss of her children, described life like this: 'I'm screaming but nobody can hear me . . . I don't feel worthy of love . . . I'm hurting all the time'. For these participants, dealing with common, everyday issues, superimposed upon living with a mental illness, was a challenge.

Participants in the study lived with various psychiatric diagnoses, including addictions, affective disorders, and anxiety disorders, as well as schizoaffective disorders.

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Many had to deal with stigma-related behaviour from lay persons as well as health-care professionals. Stigmas included a psychiatric diagnosis, homosexuality, race, ethnicity, education, and poverty. Being the recipient of prejudicial behaviour was reported by one participant, Suzanne, who was a middle-aged college professor with bipolar disorder. She had experienced stigma from health-care professionals as well as lay persons in regard to her mental illness and her homosexuality. Suzanne reported that she had to provide her professional resume to health-care professionals to prove she was educated and successful, while at the same time having a diagnosis of a mental illness. She related this about not being seen as a whole person.

> Everything about you starts being attributed either to the mental illness diagnosis that you have, even though it's stabilized, or the medication that you're on for the mental illness. And you know, then other things get ignored; you're not seen as a whole person.

A diagnosis of severe medical illness was delayed because Suzanne's symptoms were attributed to her diagnosis of bipolar disorder. While hospitalized, support from her life partner was temporarily denied due to a lack of understanding of the relationship by health-care professionals. She lived in fear of relapse with the subsequent loss of time in her life and the inability to maintain her professional endeavours.

Many participants were dealing with issues of homelessness, abuse (physical, emotional, and sexual), rape, divorce, loss of children, and estrangement from family. One participant, Mary, a 59-year-old disabled, homeless, divorced woman with bipolar disorder and chronic obstructive pulmonary disease, reported being abducted, brutally raped, losing her house in a fire, losing her husband when her children were preschool age, and having her personal information stolen while in a shelter. She reported being a 'rapid cycler' and described manic states as, 'It's almost like I was possessed by demons. That's frightening'.

Interference with life experiences was related by some participants. Eric, a 56-year-old African American man and college graduate, disabled with schizoaffective disorder and mania, reported interference with college plans. He had had a psychotic break after his first 2 years of college and had to change his study major due to electroconvulsive treatments that made him lose his 'background'. Another participant, Tim, had a master's degree but had to stop medical school studies due to anxiety and panic attacks. Interference with interpersonal relationships was described by Bob:

TABLE 1: *Themes and subthemes*

Relate to me	Know me as a person	Get to the solution
Special	Understanding	Skill
Touch	Time	Honesty
Self-disclosure		

> I'll have friends call and want to do something and I'll be in the beginning or middle of an attack and I can't do it . . . most of them don't understand that it's not that I don't want to spend time with them . . . panic and anxiety attacks almost immobilize me. It just seems like everything is spinning out of control and I can't go out and have a good time when that's going on.

Most of the participants reported negative experiences with the health-care system and health-care professionals. Physical disorders, such as kidney stones, were overlooked when symptoms were attributed to the psychiatric diagnosis. Many participants related inattention and misunderstanding from the health-care professional whom they trusted to care for them. Despite these problems and difficulties, most participants had great insight into their diseases and into life in general. They articulated clearly their experiences of the therapeutic relationship.

Figural themes in the experience of the therapeutic relationship

Participants had experienced therapeutic relationships with nurses (psychiatric/mental health nurses and dialysis nurses), physicians (psychiatrists and general practitioners), psychologists, social workers, counsellors, and nutritionists. Experiences of the therapeutic relationship were expressed in three figural themes, titled using participants' own words: 'relate to me', 'know me as a person', and 'get to the solution'. (See Table 1 for themes and subthemes.)

'Relate to me'

Relating or interpersonally connecting to an individual living with challenges is especially important in the beginning of an emerging therapeutic relationship. When participants perceive that a health-care provider relates to them, they feel connected to and understood by the provider. Participants reported that health-care professionals related to them through their personal attributes, mutual investment, particular communication techniques, and self-disclosure. Personal attributes of the health-care professional included being non-judgemental, patient, soft-spoken, open, genuine, calm, and stable.

An example of a therapist who related to her client through skill and personal attributes was described by

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Theresa, who reported a powerful therapeutic relationship with her therapist at the student counselling centre. Theresa, who was a graduate student at the time of the interview, was in therapy for depression and anxiety stemming from childhood psychological (and perhaps sexual and physical) abuse. Theresa drew images of her abuse on paper, and then together with her therapist, attached words and meaning to them, none of which would have been possible without their interpersonal connection. In Theresa's words:

> I'm very, very visual, and I've had these visions . . . since I was a little girl, and we [Theresa and therapist] worked out all . . . that this meant, but she was open to exploring that with me, and I didn't feel crazy when I talked to her about those images. There were lots more images. Not only talking about it with her . . . but one time, when I couldn't verbally say what I was feeling – this stuff happened over 10 to 12 years [ago] . . . a long time. So I drew. I mean, I'm not an artist . . . so I just drew what I felt was happening to me. and she was very, very open to that. She said, 'Wow! Okay, this is good. We can work with this.' And she said, 'What does this mean?' And I said, 'That's all the people . . . that is my mother that I felt getting into my most tender parts, you know. I had a bird, like, pecking in between my legs, and into my stomach, and into the softest parts of my body', and so I gave her two pictures like that, and she said, 'Well does this mean that?' That really made us connect. It really made me feel like she understood.

In Theresa's description of this, the therapist was able to relate to the client and skilfully work through the client's issues. In the following quotation, Theresa noted more specifically the importance of her therapist's personal attributes and how they supported the relationship and outcomes of therapy:

> She gave me hope. And . . . somehow she let me know that she was happy. You know, I wasn't one crazy person talking to another crazy person. Maybe we have a sense of what's healthy. Or I did, maybe. Which is that she was calm and patient . . . I think she was the most normal, healthy person I knew. And I felt safe in her office, eventually. Oh, and she would tell me, 'When you get through all this, eventually, however long it takes you, this is what it's going to be like. Your two sides will integrate . . . it will be natural to you; you won't have to think about it. It will be natural, everything will be together.' I said, 'really, really?' And now I'm starting to believe her, because it's happening.

In addition to personal attributes, communication techniques, such as restating, summarizing, clarifying, questioning (such as 'why did you do that?'), reflection, reassurance (such as 'it'll be all right'), and sympathy ('I'm sorry'), contributed to relating to participants. Open-ended beginnings to conversations, such as 'tell me about that', were also helpful in allowing individuals to feel like the other person related to them. Eye contact, full attention, and expression of emotion (such as tearfulness) were other aspects of communication that facilitated the therapeutic relationship.

Special Feeling special grew out of relating to, or connecting with, health-care professionals. If participants perceived that the health-care professional related to them, they felt special by their connection. Although the definition of the word special means 'surpassing what is common or usual' (American Heritage Dictionary 1983; p. 656), our participants reported feeling special even though they thought everyone was treated like they were special. Feeling special is especially important in the lives of people living in a society that stigmatizes them because of their mental illness. Eric, an older African American man with a long history of serious and persistent mental illness, said this of his perception of being special, among all the other service recipients, in his community mental health nurse's caseload:

> There was a sense of rapport, you came out to my house one time to see me, and that meant a whole lot, because I know – and this is the important thing I want you to get – you didn't do it just for me, but I have a sense you did that for all your patients. You treated me special and I think you treated all your patients that way.

Touch Participants wanted people to relate and connect to them both physically and metaphorically. Physical connection such as a hug or touch on the hand helped participants feel like the helping person related to them. As said by one participant,

> I think that one of the big things that helped me a lot . . . was just touching. Simple touching. Putting a hand on your shoulder, telling you, 'It's going to be okay', and, 'we're going to do our best here.' It seemed like the good doctors, or at least the doctors that I got the sense were being understanding of me, did use physical contact as a reassuring method of reaching out to the patient.

Suzanne, the college professor with bipolar disorder, described the struggles she had to endure and the hurdles she had to overcome to obtain health care for a medical problem. Suzanne had to make several trips to local emergency rooms and physicians' offices before her medical problem was diagnosed (and treated), because initially it was attributed to her mental illness or her psychotropic

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medications. Suzanne described how she used touch strategically to connect with potentially stigmatizing health-care providers:

> I try to shake hands with as many people as I can because I believe that once you touch that person, you're making a commitment that goes on as they touch you . . . you have a connection. You got something stigmatizing? Try to get in touch physically with the person because the mental and social barriers are kind of big.

Theresa described how her therapist metaphorically touched her by helping her out of a lonely, dark existence:

> When I went into her office, when I first met her, I felt like I was in a dark room by myself, and she's the one – lots of people look into me – but she's the one that kind of knocked on the window, and I eventually opened the door which was one way of trusting her. She took my hand. She helped me out. And I didn't go back in.

Self-disclosure Self-disclosure by health-care professionals of similar struggles or experiences facilitated relating to participants. Wayne, a 60-year-old African American homeless man living with end-stage renal disease, described therapeutic relationships with his dialysis nurses. When he was asked to change to another dialysis centre because his doctor was changing centres, he declined, preferring to stay with his nurses (and be assigned a new doctor). One way his nurses related to him was through their self-disclosure. As noted by Eric,

> They share their problems with me. I share my problems with them . . . We talk . . . They tell me about their problems, we share this here, and the main thing is, when a person comes to me as a person. Instead of, 'I'm your nurse.'

'Know me as a person'

Knowing the individual as a person, not as a patient, number, diagnosis, or set of diagnoses, is significant to the experience of the therapeutic relationship. Abby, a 21-year-old Caucasian woman with a history of child abuse who went to the student health centre at her college for treatment of anxiety and 'hypermania', wanted to be known as a person and to have her problems taken seriously. Abby described a positive therapeutic relationship with a physician at the student health centre:

> He took the time to get to know me as a person as opposed to just a case or number or somebody who's a little bit stressed out . . . He actually treated me like an adult, or like I had a real opinion, or it was valued. And that I wasn't crazy. Because while they call it 'mental illness', I don't feel crazy or ill necessarily, I just feel like I have something that a lot of people necessarily don't have to deal with. I'm still going to have a nightmare about my dad coming in and beating me or something. That, I'm always going to have to deal with and just to kind of pat me on the back and say, 'Go on, you're going to be fine', when I'm not going to be fine, without some kind of treatment, you know, just doesn't work.

As Wayne said, 'I've been going there for a long time. I got communication with my doctor, with my nurse . . . They know me personally'.

The therapeutic relationship was evident when a health-care professional showed in-depth personal knowledge of an individual, beyond that expected of the professional. Participants commented that they (health care providers) 'see me as a fellow human being', and 'come to me as a person'. 'More than just the actual physical health of the person . . . questions like "are you married?" and "where do you go to school?" or just more questions about them [the service recipient]', rather than just questions related to the mental or physical health-care issue, were deemed important to knowing the person. Wayne described his perception of an interaction with one of his doctors:

> When I go to her, we go through the little ritual and then she'll ask me, now this means a lot to me, 'Well, what's happening with you now?' She says, 'tell me what's happening with you now? Are you working?' You know, get off into my personal things, which means a lot to me. I don't know if she really knows it means a lot to me, but when she does it, she does it sincerely.

Understanding Part of getting to know the individual as a person requires certain behaviours or ways of being on the part of the health-care provider. Genuine concern, care, sincerity, and understanding are requisites to knowing. Good listening skills are necessary to get to know the help-seeking person. Advice from one participant was just to 'sit and listen, without thinking about what you are going to say next'.

In-depth personal knowledge (or knowing) requires time, understanding, and skill. For the therapeutic relationship to develop through personal knowledge, the health-care provider needs each of these. If the provider has time but limited understanding or skill, personal knowledge will not be gained and the therapeutic relationship will not develop. Similarly, if the health-care provider has understanding but little time or skill, the therapeutic relationship will not be present. Finally, if the health-care provider has skill but little time or understanding, the therapeutic relationship will be absent.

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Time, understanding, and skill were evident in Abby's words:

> It's incredibly beneficial to have somebody in health care that can take out the time individually, and understand what you're going through, and see what they can do to help you on a one-on-one basis, because nobody else can do that.

Time As noted above, time is not the only aspect of knowing a person, but time is required. Taking time, investing time and energy, and not looking rushed (like a beehive of activity) were figural in the experience of the therapeutic relationship. For example, participants commented that 'he took the time to get to know me', and 'she takes the time to make sure she understands me'. Again, Abby described the difference time can make:

> He actually took out the time to sit down and talk with me about the things I was going through and dealing with, for an extended period of time. Doctors in particular, can be in a hurry to rush through things and want to get in and out as quick as possible. But he sat down for a long period of time and talked to me about the things that have gone on and why I was feeling the way I was . . . an extra 5 or 10 minutes can make all the difference in the world.

Participants wanted to understand their life experiences or mental illness, and believed that health-care providers needed knowledge of them as an individual, as a person, not just as a service recipient. This was perceived as necessary in order to get to the solution of the problem. For example, 'Get to the person. Figure that person out.' Wayne, who had been on dialysis for more than 10 years, likened his caregivers' personal knowledge of him to his lifeline. He described the therapeutic relationship with his dialysis nurses as the most important to his continued survival; the renal physicians and dialysis machines seemed secondary.

'Get to the solution'

Getting to the solution or helping to solve a problem is central to the therapeutic relationship. Nurses, counsellors, psychiatrists, and other health-care providers help individuals get to the solution by offering advice, information, medications, diagnoses, suggestions, feedback, information, and resources. Participants in this study needed solutions for problems and issues such as dealing with child abuse, symptoms of mental illness (e.g. depression, anxiety, and mania), and financial and economic issues such as joblessness and homelessness. Compassion and interest, while essential, were clearly not enough. Without investment, action, or help to accomplish some stated or implied goal, the relationship was not perceived as therapeutic. Doing for, or with, the individual was crucial to the experience of the therapeutic relationship. For example, one participant said: 'get to the root of the problem and solve it'. Productivity of the relationship was evident in the words of Amber, a 27-year-old Caucasian woman being treated for depression and anxiety by a psychiatric nurse at an outpatient counselling centre:

> If a professional in this sort of capacity is really trying to guide you to particular solutions to your problems, you should know what the problems are. Pinpoint them. I mean, not necessarily pigeonhole, but to be able to have some idea of what's going on. 'How are we going to solve this?' Not to just talk about it, talk about it, like venting. That's not necessarily going to solve it.

Amber juxtaposed a positive experience with a psychiatric nurse with a negative experience with a counsellor:

> I had spoken with, like a counselor and that wasn't . . . I don't think that was nearly as productive. I felt like I was just kind of kept talking and I don't really know if there was a particular point, even. It's one thing to kind of let things happen, and let a flow happen, but it's another to let it flow in such a way that it makes no sense. The difference was focus . . . If I was having particular, like a particular frustration, the counselor would want me to speak more about that frustration. That's not going to help me to understand it. But maybe speaking about the reasons behind it or how to kind of cope with that is more helpful to me I think. Kind of the reality of why I was feeling that way, or I mean, helping me to understand that myself, in my own way, because, I mean, one frustration for one person is not going to be the same for another . . . To help me to understand why that was causing frustration to me . . . And the nurse did that. The counselor did not.

Skill Getting to the solution involves helping people verbally work through problems or issues, requiring skill on the part of the health-care professional to focus the interaction as a 'guide, not a director'. In this study, the health-care professional was experienced as equal, as a guide or facilitator of interaction. Participants said, 'we were a team'; 'whether it was true or not, he made me feel like I was the one that was driving what was happening in the sessions'; 'he was there to help me . . . facilitate me helping myself;' and 'she let me design the forum'.

Guiding and focusing interactions to get to the solution requires skills such as: helping individuals articulate feelings; asking questions, asking for clarification, and 'asking questions that need to be asked'; going in depth into life experiences; and drawing parallels and making

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connections to behaviours, emotions, and other life events. Superficial or 'free-flowing' talk and encouragement to ventilate feelings alone were not considered therapeutic or helpful by participants in this study. Getting to the solution required focus to 'get down to the real problem, not just the symptoms'.

Theresa, the participant who described how her therapist used her drawings, provided another example of the skill required of a health-care professional to get to the solution:

> Eventually I didn't mind asking her [the therapist] the simplest of things, like you'd ask a mom. Like, 'How do I do this, emotionally?' 'Or how do I . . .' I forgot what it was but I remember her saying at one point, 'You know, Theresa, this is something a mom would usually tell a daughter.' She said, 'This thing . . .', I forgot what it was, but she said, 'This is so simple that I would think I wouldn't', She didn't make me feel bad or crazy, but she said, 'This is a very simple thing that I think I need to tell you, because healthy people do this; and it's so simple I wouldn't have thought to mention it, but I think I need to tell you because you're under-developed in one sense, because of stuff that happened.' So, she worked at my level. And she didn't berate me because this happened. She just said, 'Okay, you're like a ten-year-old in one sense, and we'll take it from there.'

Honesty Working on the real problem often required health-care providers to provide direct, truthful, honest, and sometimes blunt feedback. The participants wanted straight talk and did not appreciate talk that was inauthentic, or too nice. In the words of one participant, 'Don't gloss it over, making it look like it came out of a candy wrapper'. Participants perceived relationships to be therapeutic when health-care providers 'said it like it was', 'are real', 'straight-up', and 'honest.' One participant said, 'If I tell her something she doesn't agree with, she'll tell me'. Participants wanted to be 'called on the carpet', but in a caring way. Bob, a 35-year-old Caucasian man who had been treated for depression, anxiety, panic attacks, and substance abuse since childhood, described how a psychiatrist at a student health centre confronted him after learning he drank alcohol after a long period of abstinence. In Bob's words:

> I did something grievous, bad, in the past week [between sessions]. She'd look at me funny for a second and then she'd be like, 'well, why did you do that?' And most of the people I've dealt with don't ask those kinds of questions. They're like, 'oh', and they write it down that I've done this but don't want to know why.

When health-care providers said what they thought about a situation or provided blunt feedback or questioning, participants experienced this as helpful to finding solutions to their problems or issues.

Sometimes the real problem was not an issue that was best served through talk or interaction. Assistance that is not verbal but is action-orientated, was experienced as helpful to individuals who had a specific need – for example, help finding a job, financial aid, housing, and medications. In these situations, finding a solution meant help in finding resources.

DISCUSSION

The ways in which these participants described therapeutic relationships challenge some long-held beliefs, such as the use of touch, self-disclosure, and blunt feedback. The personal attributes of health-care providers described by these participants are similar to those in other studies (Bedi 2006; Hostick & McClelland 2002; Littauer *et al.* 2005; Lowenberg 2003; Rydon 2005). Generally, clients wanted health-care providers to provide emotional support and validation of their situations. Consistent with Rogers's (1942) work, trust and respect were deemed important qualities by most clients, as were empathy, calmness, and professionalism. Individualizing care and taking time with clients were essential to the formation of a therapeutic relationship.

Participants in the study expressed the need to 'get to the solution'. Those in Bedi's (2006) study expressed similar needs. Education, appropriate referrals, and recommended reference materials were considered important in the therapeutic relationship. Similarly, a participant in Littauer *et al.*'s (2005) study felt that therapists should be prepared and have a plan, 'She must show me the way to go' (p. 29).

The concept of authenticity encompasses many of the personal attributes and concerns considered important by participants in this study, a finding consistent with Yalom's (1980) approach. Authentic nurses have been described as 'down to earth' (Falk-Rafael 2001; p. 7). They share power in a relationship and allow the client to be an individual (Daniel 1998). They are willing to approach a therapeutic relationship with a spirit of unknowingness in order to interact fully in the client's life and get to know the client as an individual instead of a diagnosis or stereotype (Munhall 2004). Authentic nurses encourage authenticity in clients by helping them to face problems and to generate viable solutions to the problems (Porr 2005).

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As noted by our participants, the time to establish a therapeutic relationship is a concern. Littauer *et al.* (2005) reported that two client–therapist sessions were needed before a connection was made. Hostick and McClelland (2002) reported nurses' concerns that paperwork and the rotation of nurses between caseloads interfered with the time needed for a therapeutic relationship to form. A client expressed the need for time with the nurse with this statement, 'I can survive but not progress without support. Going my own way has ultimately tripped me up. The amount of time spent with the psychiatrist is not enough to form a proper relationship' (p. 114). Clients said they sometimes felt guilty asking for help when they sensed the nurse did not have time to be with them.

Participants in this study also alluded to the need for caring behaviours like those described by Swanson (1991) in her middle-range theory of caring. Participants wanted health-care providers to know them in the way Swanson described knowing: avoiding assumptions and centring on the one cared for. They also wanted health-care providers to offer action-orientated assistance, which Swanson termed enabling – in which information and explanations are provided along with support. Finally, participants desired time with health-care providers. Swanson termed this 'being with' – health-care providers are emotionally present with clients and share their own feelings.

This study supports the classical theories of therapeutic relationships reported here, such as Jung (1967), Yalom (1980), and Rogers (1942). For example, a therapeutic relationship in which power is shared between service recipients and health-care providers is consistent with Jungian theory (1967). More contemporary relational theories (e.g. Hedges 1997; Mitchell 1988) are also supported by our findings (i.e. the 'relate to me' theme). Clearly, study participants disliked the distant, authoritarian, clinician, as exemplified by Freud.

CONCLUSION

Clients desire therapeutic relationships with nurses and other health-care providers. They want nurses to really know them and to incorporate time, understanding, and skill in their care. The rich descriptions of therapeutic relationships in this study can serve as a guidepost for nurses when developing relationships and planning interpersonal interventions. Needs expressed by the participants in the study are basic and do not require sophisticated technology or large amounts of money. They require nurses to be cognizant of clients' needs and to treat clients as unique individuals worthy of quality care. Understanding the client, being honest, using touch, and relating by self-disclosing require the nurse to value clients and take the time to get to know them on a meaningful level. Helping clients get to the solution requires nurses to be skillful as well as knowledgeable about available resources. Listening and heeding client needs are vital if the therapeutic relationship is to reach its potential.

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