

# **Managing the Emotional Aspects of the Patient - Nurse Relationship**

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## **Why examine this topic?**

I think it is worthwhile to think about why this topic: "Managing the Emotional Aspects of the Patient - Nurse Relationship" has attracted much interest. Traditionally helping professionals – especially those in the medical and nursing fields - have been trained to be dispassionate or detached, and to not be affected by the emotional pain that patients might be experiencing. Additionally, I think there has also been a belief that the emotional pain from their *own* lives which health professionals might bring to their work should either be non-existent or kept out of their professional lives. Thirdly, it has, I think, also been believed that the impact on the professional of working with emotional pain should be eliminated (or at least it is often disregarded).

The reality of working with people who are very distressed or who are in great emotional pain because of illness or impending death is that such pain not only can but also does affect us. And further, because (like our patients) we are human and feel emotional pain too, we not only bring our own past painful experiences with us into our work, but our own past painful experiences can be stirred up by our patients' pain.

On this basis, *I am questioning the assumption that health professionals should be detached; that they should exclude their own feelings from their work; and that they should not be emotionally affected by their work.* However, I am also asserting that we should **not** simply give free reign to our own emotional lives. To do that might inhibit our patients' freedom to express their pain; it would burden patients with our problems; and it would handicap our capacity to work effectively. What I mean, instead, is that we need to *experience, attend to, harness and utilize* what we feel and experience in order to work effectively in emotionally painful environments. There are a number of aspects to this which I plan to explore with you this morning: firstly, how do we *protect* ourselves against the impact of emotional pain in a way that is *useful*; secondly, how do the organisations in which we work support or obstruct our doing this; thirdly how might we mobilize our capacity to understand and to draw on our own feelings and experiences to enhance the care, health and quality of life of patients?

The last aspect focuses firstly on how we can pay attention to our intuition and to our thoughts and feelings to help us to understand better our patients' experiences and to intervene more helpfully. It also focuses on a new way of thinking about the role of the health professional – nurses in particular. In this regard I will later explore with you what I describe as the "executive" and the "caring" dimensions of the role.

However, let me begin by talking about the ways we usefully protect or defend ourselves against the pain of nursing ill people, but also the destructive and unhelpful ways we can defend ourselves.

## **WHAT DO WE MEAN BY DEFENCES?**

For over a century the notion of psychological defences or “defence mechanisms” has been part of our common understanding of emotional functioning. Indeed so common has it been that the phrase “defence mechanism” has become part of popular cultural usage – often inaccurately. Probably at the core of this is the idea that the mind has ways of protecting itself against pain. But the common usage does not go nearly far enough because it only addresses the *conscious* aspects, while defence mechanisms usually fall into the realm of *unconscious processes*, rather than conscious ones. We do not make **choices** to use a particular defence mechanism in the way we might choose to defend ourselves with this or that weapon against an invader. A deeper understanding of the concept of psychological defences sees them as *unconscious* mental mechanisms which are mobilised to prevent unbearable, disturbing, unwelcome or painful anxieties, experiences, thoughts and phantasies from *entering* consciousness. The term “anxieties” refers to some of the more fundamental sources of human pain – like our own death, and the loss or threatened loss of those we love.

As we gain deeper insights into our mental functioning we can begin to recognise when a particular defence has kicked in and whether it is a help or a hindrance.

### **DEFENCE OR DEFENSIVENESS?**

Defences are frequently regarded as the opposite of coping. This is an unfortunately superficial view. It is like suggesting that the mobilisation **of** the body’s immune system to fight infection is only a pathological response! We all employ defence mechanisms – we *must* in order to protect ourselves against unbearable pain. However, here a distinction must be made between defence and defensiveness. Defence is about *protection* while defensiveness is about suspicion, guilt, self-interest etc.

The key question is not *whether* psychological defences are used, but *how* they are employed – in the service of defence or defensiveness.

### **COMMON PSYCHOLOGICAL DEFENCES.**

So that we can share a mutual understanding I want to broadly identify some basic primary common psychological defences before going on to look at how these and others might operate in workers in this specific field, who after all are only using common human psychological defences themselves, just as their patients might.

However a crucial feature that I want also to address is the presence in *workplaces* of collective psychological defences.

Remember that these are primarily unconscious processes:

**Splitting:** This is one of the primary defences we employ from very early in our lives. You will recognise – as I expand on it – its centrality in human functioning. Splitting is essentially the internal or mental separation of “good” feelings from “bad” feelings. By keeping them separate (or more accurately by maintaining the psychological phantasy that they are separate), we prevent our good feelings from being contaminated by the bad ones. We then might only feel the good feelings and not the bad ones.

**Projection:** projection and projective identification are used in close association with splitting. At its core, **projection** means getting rid of bad feelings by displacing them onto someone or something outside of us.

**Projective identification** occurs when the person onto or into whom they are displaced becomes – in various ways - identified with the feeling or phantasy that is projected. For example: A worker might feel helpless and therefore angry with a dying client. But to feel angry in such a situation may seem heartless. So instead, for example, the worker may project his or her feelings onto the management of his or her organisation who is then felt to be angry and heartless and may actually become angry and heartless. The worker is then temporarily freed of his or her own difficult feelings.

#### **INDIVIDUAL AND COLLECTIVE DEFENCES AGAINST PAIN.**

I am going to make a beginning reference here to something with which you may not be familiar and which I want to expand on later. I have so far been talking about *individual* forms of psychological defence in workers. I want to introduce you to the idea that there are also *collective forms* of psychological defence against pain. Later I will try to show how groups of people – teams and organisations in which we work – can develop common collective defences to manage the pain of their work.

I would expect that the audience here today are people who *offer support* to or work with those who are *experiencing* emotional pain. ***It is primarily against the fear of death or of disintegration, and the pain of loss – all of which can take diverse forms – which professionals must and do defend themselves.*** However loss and grief as major sources of emotional pain extend well beyond the most obvious forms to do with death and dying. We may also work with patients in diverse areas: people who are dying; very ill people; the elderly; damaged or abused babies and children; damaged and injured people; and disabled people.

Professionals need to defend themselves against the pain arising *from the work itself*. *Sometimes this is done by splitting oneself off.*

There are factors in the work itself and the closeness to others' intense experience of loss and grief that can and usually do re-ignite past losses that the worker has sustained. We tend more often to locate the pain "there" in the patient where we can care for it, rather than "here" where I must experience and deal with it in me.

Another factor is that such work also stimulates potential **anxieties** in the worker. These too may be about the worker's own vulnerabilities ("What if I got breast cancer?", "What if *my* child died?") These are frightening thoughts which the worker needs to defend against. If one were to remain in touch with these sorts of thoughts constantly, one might go mad.

When the worker becomes too strongly identified with the patient (the opposite of splitting off) such a loss of boundaries means that the worker's capacity to think and have some space and distance in order to work is compromised. In over-identifying with the patient, the worker also becomes more vulnerable to the stimulation of past losses and of potential anxieties.

Bearing in mind these risk factors: stimulation of past loss; activation of potential anxieties and over-identification we can examine the common psychological defences workers use either to protect themselves (appropriately) or defensively.

## **SOME DEFENCES AGAINST THE FEAR OF DEATH & THE PAIN OF LOSS <sup>1</sup>**

### **Avoidance (& avoidance of thinking)**

Avoidance may take a number of forms: not talking about death or referring to it euphemistically so as not to experience the pain it evokes personally; distancing oneself from the reality by addressing the issues in intellectualised terms (eg she is in the "protest" stage of grief"); or by being over-concerned with statistics; or by dealing with the ill person or relatives by "telling and running". Workers can easily become absorbed in institutionalised cultures of work which promote the avoidance of thinking and feeling. But I will address this shortly.

### **Task-centredness & aggressive intervention**

One version of this split is by workers becoming over-involved with the *technical* aspects of their role; eg prayer rituals replace or help to avoid personal contact; medical intervention replaces personal contact. Another is by aggressive intervention: eg radical surgery or heavy medical regimes which help the physician feel omnipotent and split off the personal engagement with pain, into other professionals.

### **Chronic niceness**

This may involve excessive concern with making death a "nice" experience, and denying the negative aspects of caring for the dying. Workers may wish to be the perfect carer making impending death or loss

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<sup>1</sup> Obholzer A & Roberts V Z (eds) (1994) **The Unconscious at Work** Routledge, London

palatable, but in so doing creating excessive stress for themselves and not allowing the patient to feel angry or in a mess.

Survivor guilt & the need for gratitude: Workers may find themselves feeling guilty for their own good health and fortune or even guiltily triumphant about their own survival. These are painful feelings in the face of someone else's tragedy. However, tolerating these contradictory feelings helps ultimately to manage them.

### **NEED FOR SUPPORT & CONTAINMENT**

Workers need their own sources of nurturance to help manage painful feelings that arise from this work. Often shame prevents them from sharing their ambivalent feelings with supportive colleagues, leading to splitting and denial. But being *understood* may be the first major step to managing painful feelings – just as it is for patients.

At the heart of the matter, the most unhelpful defences are those which *maintain excessive* splitting between thinking and feeling, and which lead to feeling detached, omnipotent, ashamed of not being good enough, excessively diligent or perfectionistic, leading to burn-out; or becoming excessively matter-of-fact. A degree of denial and avoidance may temporarily ease the pain but ultimately psychological defences that rely heavily on splitting are very stressful. There is no easy answer to managing this individually, but ultimately it is in the recognition, understanding and acceptance of ambivalent feelings that make relief possible: so one may be able to resent the pain of the dying or grieving person while simultaneously empathising closely with their distress.

I want to turn now to look also at the common psychological defences that can develop **collectively**. I mentioned previously that workers can become institutionalised in their delivery of care, working in ways that try to eliminate or minimise thinking and feeling.

I will try to comment on *how* they are usefully or destructively employed.

### **ORGANISATIONS AS CONSCIOUS AND UNCONSCIOUS SYSTEMS**

We all live and work constantly in groups of various sizes and configurations. Yet our attention is mostly focused on the *individual*. It can be disturbing to discover that the group we belong to often powerfully influences our experiences. It is disturbing because it threatens our sense of being in control of ourselves. Study of the dynamics of groups and organisations over many years has demonstrated clearly that our experiences are a function of *both* our individual characteristics, as well as of the group. Groups often influence us in ways of which we are aware. But we are mostly *unaware* of how we are powerfully affected by the groups in which we function, and that groups have a life of their own, so to speak. I want to look briefly at how groups or organisations establish collective psychological defences against the pain evoked by the work in which they are engaged.

### **ORGANISATIONAL DEFENCES AGAINST PAIN**

Studies of organisations that deal with people in emotional pain have demonstrated ways in which their culture and organisation establish collective defences against pain. One of the most well-known studies is

that of the nursing system in a hospital by Isobel Menzies-Lyth. She demonstrated how the organisation of nursing services in the hospital *prevented* nurses from developing close relationships with patients. In so doing they rarely had to deal with emotional pain. However the destructive element was that they also experienced very low morale, poor job satisfaction and high staff turnover. By *avoiding* the pain of the work and of the nurse-patient relationship the staff were also denied the experiences of emotional *repair*, which are necessary in such painful environments. Other studies have described organisations such as hospices, schools for disabled children, nursing homes, wards for at-risk babies, AIDS organisations, psychiatric hospitals etc. All deal with loss, grief and associated emotional pain. It is in the collective ways of working, relating to each other, thinking together and the structure of tasks that organisational psychological defences are apparent.

#### **THE NATURE OF ORGANISATIONAL PAIN/ANXIETY**

All organisations exist to perform a particular key task - such as nursing the dying, for example. The *very nature of this task* is a source of the pain that workers have to face: nurses and doctors deal with pain, illness and dying; mental health professionals deal with madness and disintegration and so on. You can determine from this that people working in many human services are constantly exposed to and have to manage, suffering of this kind.

Frequently the *task* in which people are engaged also influences the type of collective defences which develop.

## COMMON ORGANISATIONAL DEFENCES

Interestingly some of the psychological defences in groups are very similar to those in the individual: however the power of numbers increases the pressure to conform to these ways of managing. This often results in institutionalised ways of functioning. There are also processes in which individuals or groups take up or are endowed with a special role, in order that those at the coalface be spared the pain. Frequently, however, these processes also contribute to serious dysfunction in organisations and are therefore destructive defences.

**Splitting and projective identification** are extremely common mechanisms in organisations. However, painful or disturbing feelings are usually projected onto a group or person who seems to draw these feelings onto themselves. Earlier I gave the example of a worker feeling angry and helpless towards a dying patient. Imagine groups of workers feeling this way. Such feelings might – for example - be projected into the organization's management who are then felt to be heartless and aggressive - and they often act this out - as expressed by meanness of wages or withholding resources etc.

Another example is an organisation dealing with people with AIDS, a disease which evokes much anxiety and grief. HIV transmission essentially involves a virus breaching a boundary and entering the body. Prevention of infection involves establishing barriers to transmission, sexually as well as in patient care. A particular organisation was so fraught with anxiety - its director being a particularly anxious person - that much of its energy was spent in defending and mending breaches to its own organisational boundaries - between teams, between the clinic and its stakeholders etc,

and also in managing the anxieties of the director. In so doing the anxiety, pain, and grief of dealing with very ill and potentially ill young people, was apparently avoided; but so was the helpful engagement with these concerns. Even breaches to the structure of the building became a preoccupation! These examples demonstrate how the *actual work* shapes the *particular defences*.

### **Role suction**

Individuals and groups also often have characteristics or qualities - valencies - which draw split-off feelings onto themselves. The anxiety of the clinic director described above resulted in her being the recipient of much additional anxiety. This is because her *valency* for anxiety made her vulnerable to what may be called "role-suction" - that is attracting projected feelings of anxiety in the organisation to her, which then coalesce like iron filings to a magnet. Once she is fixed in a role, the rest of the system can then *seem* to function relatively free from these feelings, but in so doing valuable opportunities for dealing with pain are missed.

### **Loss of thinking capacity**

Organisational defences tend not only to relieve susceptible workers from feeling, but also prevent them from thinking. One organisation managing a deluge of distressed families functioned in such a way that there was no space or time to *think* about the work or to plan and implement decisions. The families with whom they worked were overwhelmed by disruptive behaviour such that they too could not make space to think about their difficulties but acted out impulsively. Thinking would have meant recognising many painful issues and then having the difficult task of

working through them. Instead, acting out may prevail, just as the adolescent children in these families did.

### **Organisational denial**

An organisation having to deal with the grief and loss evoked by working with injured and disabled adolescents continued to insist on a policy of "normalisation" as a desirable standard for the young people. Their students were seriously disadvantaged by their disabilities and to treat them as if they were "normal" in the sense of being *able* to compete with able-bodied peers, effectively denied the grief and loss and actually *disadvantaged* the students further. The denial was extensive. It also, however, artificially relieved the staff of the distress of working with severely disabled children.

The examples I have given of ordinary individual and organisational psychological defences against the emotional pain of working with illness and death have some common features. They can be helpful and they can be destructive. In effect they do so by impairing thinking and eliminating pain from feeling. Ultimately, the actions that ensue from destructive defences unexpectedly cause more problems than they solve. At the core of many of these defences is the splitting off of thought from feeling, and vice versa, as well as from effective action.

What constructive action is needed? Essentially, it involves creating space, time and containment for reflection (i.e. thinking) and emotion (i.e. feeling), to be *engaged* with. The shoring up of splits like these means finding ways of *tolerating conflicting feelings* - love and hate, care and

anger, grief and hope and so on - for the individual as well as for the organisation. Or, in other words, of bearing the unbearable. We want people working with emotional pain to protect themselves *constructively* in the face of this pain. But the capacity to sustain concern and reparative support requires acknowledgment, affirmation as well as tolerating the co-existence of these unbearably conflicting feelings.

This requires us firstly to be aware of and to pay close attention to our own feelings, thoughts, experiences and intuitions. When we can think about these, we can try to find appropriate ways to act on them. Here I would like to give just a few short examples of these. These examples are drawn from my own experience as a psychotherapist. After the break I hope we can spend time exploring your own similar experiences.

I once worked in my private practice with a young man with AIDS. His partner was extremely abusive and denied him access to even the basic money he needed for his medication. I felt so sorry for him that I reduced his fee to almost nothing. Within weeks he terminated therapy. I had allowed my own feelings to intrude and by reducing his fee, unwittingly made him feel guilty and unworthy – exactly what his partner did. Instead I should have paid closer attention to my need to help him and rather referred him to an agency where he could get help without feeling guilty that he could not pay. This is an example where instead of understanding my own guilt and sympathy with him which could have aided me in understanding HIS guilt, I had split off my feelings and acted out the role of “saviour” to his detriment.

Here is an example of how by paying closer attention to my feelings and experiences I was able to be more helpful to a patient. A woman I once

worked with told me over a few sessions in a very dramatic and manipulative way that she intended to kill herself. Naturally I was very worried by this, but instead found myself feeling very angry with her with thoughts which made me feel ashamed, like “Well go on – stop threatening and do it already!” Of course it would have been both dangerous and irresponsible to act on these thoughts and feelings. Unless I really thought about my feelings, I might easily have become angry with her, so strong were the feelings. Instead I was able to understand how angry she was and how ashamed she was of her life failures. By attending to my own feelings of anger and shame I became able to help her talk about HER feelings of anger and shame that led to her wanting to die; the result was considerable relief for her, the diminution of her suicidal feelings and an opportunity for emotional growth.

One final comment on the role of intuition. Intuition has often been dismissed as unscientific, fanciful and “New Age-y”. However there is considerable understanding nowadays that intuition can arise from unconscious communication between people, in ways that are not yet fully understood. It is my firm conviction that intuitions should be attended to and it is my experience that when they are, they are a rich source of emotional communication which can provide a basis for seeking out more information and data. While intuition should be respected, other confirming information should also be sought. A brief example from the suicidal patient I just described. During her suicidal period I received a blank message on my messagebank. I had the strong intuition that this was a message from my patient and a call for help. I am very careful about breaching boundaries – as you will have gathered – so I would not normally make an unsolicited call to a patient. However, so strong was the intuition that I felt I should. When I called her, she was in the process of

gathering a large dose of pills. I was able to persuade her to desist. Had I not called, I suspect the outcome would have been very different.

I mentioned earlier that a new way of thinking about the role of the health professional – nurses in particular is also helpful in this context. I have observed and recognised that there are two complementary aspects to the role of “health professional”. I have called these aspects the “Caring function” and the “Executive function”. I define the Caring function as the “soft-edged” or sensitive function which provides deep empathically based responsive intervention. The Executive function is a form of conduct drawing on one’s professional authority that is intended to help one to remain on-task. I also think of it as a “boundary regulating function”. The “hard-edged” or tougher “executive” function involves regulating or managing certain boundary conditions essential for good professional practice. Usually we think of this executive function as something that “managers” do. As is becoming evident, I am trying to demonstrate that the caring function of the **nurse-patient relationship** operates in tandem with an executive function to manage the boundaries of that relationship. What I have found though, is that many health professionals hold this Executive function in low regard while placing very high value on the Caring function.

I will describe what I mean by “boundary conditions” because I place great importance on this activity. Managing boundary conditions is critically important to managing all aspects of the nurse-patient relationship. It is the proper management of boundaries that enables the human and emotional dimensions of the nurse-patient relationship to emerge and to be properly worked with. It allows real human emotions to

be present and experienced without them becoming an obstruction to or intrusion on the patient, the nurse or the nurse-patient relationship.

I could spend a whole seminar talking only about boundary management but because I have to manage the resource of time right now, I will have to limit what I say about this. Simply by doing that, I have enacted an example of boundary management, because if I breeched this boundary right now, much as I would love to give you a long talk on the subject, you would be swamped with information, unable to concentrate, become tired and distracted and that would be a hindrance to your learning today rather than a help.

Similarly we have to manage the emotional boundaries of our relationships with our patients. A more clinical example would be one where we allow feelings of our own to intrude on or override those of a patient, rather than *having and thinking about* our feelings in a way that helps the patient. An example of this was a Hospice nurse who consulted me many years ago, feeling completely burnt out. She was excessively zealous in looking after her dying patients to the point of invading their emotional space and their family lives; bringing patients flowers, gifts etc. What emerged was that she was driven to making these dying patients feel "good" because of her guilt about her neglect of her own elderly parents before they died. In other words, instead of recognising the pain *she* was in and *managing* it, she tried excessively to manage her patients' emotional pain.

Some of the key boundaries we need to manage (without denying or ignoring our own emotional responses) are:

Time – carefully managing the amount of time we spend with a patient; not spending excessive personal time thinking about or doing things for patients; not allowing the work to excessively impinge on our personal lives.

Territory – managing where and how we work with patients; controlling patients access to our personal lives or families; keeping our “personal” space somewhat uninvaded by our work

Task – this one is critical: being quite clear what the key purpose or task is of our work with patients: defining accurately what this involves – for example, does caring for a patient involve doing their shopping for them? Does supporting a patient emotionally mean trying to be a therapist to them and going into their deeper personal issues? The more carefully we both define and adhere to the task, the more effectively we manage this vital boundary.

There are other boundary conditions but again I have to limit myself within the time boundary of this workshop.

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