Developing patient rapport, trust and therapeutic relationships

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Abstract
Rapport is established at the first meeting between the patient and nurse, and is developed throughout the therapeutic relationship. However, challenges can arise during this process. Initially, nurses can establish trust with the patient through the questions they ask, however, as care progresses, the nurse will be required to demonstrate a commitment to maintaining the patient’s psychological well-being. When the therapeutic relationship ends, the nurse should assist the patient to assess progress and plan the next stage of recovery. This article provides three reflective exercises using case study examples to demonstrate how rapport is developed and sustained. Evidence is provided to identify why challenges arise in the therapeutic relationship and how the nurse can ensure they provide care that the patient regards as genuine.

Keywords
partnership working, patient support, person-centred care, rapport, therapeutic relationships, trust, vulnerability

Aims and intended learning outcomes
This article aims to assist the nurse in developing rapport and trust with the patient throughout the therapeutic relationship. The article presents three reflective exercises using case study examples to demonstrate how the nurse can sustain rapport with the patient. The author focuses on three main areas: establishing a relationship; sustaining the relationship while patients receive treatment or assistance with rehabilitation; and bringing the therapeutic relationship to a close. After reading this article and completing the time out activities you should be able to:

- Define and explain rapport, trust and the therapeutic relationship.
- Summarise how rapport, trust and the therapeutic relationship relate to each other.
- Outline the main challenges involved in developing rapport with patients.
- Understand what is required of the nurse to ensure the care provided is person-centred and professional.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

- It emphasises that a therapeutic relationship involves developing trust through effective communication, honesty and respect. The theme of prioritising people in The Code states that nurses must treat people with kindness, respect and compassion.
- The Code states that nurses should work in partnership with people to make sure they deliver care effectively. This article emphasises that the therapeutic relationship represents a partnership between the nurse and the patient.
- It outlines the importance of recognising that the patient may be vulnerable.
because of their health circumstances and that the nurse’s actions must focus solely on the healthcare needs of the patient. As part of the theme of preserving safety, The Code states that nurses must take all reasonable steps to protect people who are vulnerable.

» As part of the theme of promoting professionalism and trust, The Code states that nurses should act with honesty and integrity at all times. This article emphasises that honesty is a central element of genuine regard for patients and their experiences.

Introduction
The literature outlines the importance of developing rapport with patients (Hallldorsdottir 2008). Rapport is defined as the ability to establish and sustain a working partnership, and is considered critical to developing trust (Godsell et al 2013, Workman 2013). If vulnerable patients are to trust nurses, the relationship must begin with rapport. Rapport supports trust and, in turn, trust is vital to the maintenance of a therapeutic relationship. If patient care is to be centred on the patient’s needs, it is necessary for the nurse to become familiar with the patient (Harding et al 2015). Care that centres only on treatment, skills and information-sharing is insufficient. Instead, best practice must incorporate the patient’s experience of illness and any support provided (Harding et al 2015).

Evidence suggests that, for doctors, establishing rapport with patients is challenging, partly because medicine provides less opportunity for patient contact than nursing (Lelorain et al 2014, Dang et al 2017). It is often assumed that the nurse’s ability to develop rapport with a patient is dependent on their personality (Van den Heever et al 2015), and that the empathetic nurse has a natural affinity with patients. However, in practice, establishing rapport can also be challenging for nurses.

Patients often feel vulnerable and there can be an imbalance of power between the nurse and the patient; similarly, patients who are receiving treatment in hospital can find themselves in an unfamiliar environment (Angel and Vatne 2017). The nurse has to establish a professional relationship that functions within controlled limits. While personal friendships can be sustained through the sharing of personal information, this is not a basis for rapport in healthcare. Professional standards require that nurses share limited information about themselves with patients (Griffith 2013).

Recently, patients have come to be regarded as consumers of healthcare services, and their expectations have increased while resources remain finite (Sagarra 2015). Also, the length of time that patients spend in hospital has decreased, which means there is less time to form therapeutic relationships. Similarly, patients periodically return to healthcare settings and the nurse may have to re-establish rapport with patients whose needs have changed.

Rapport, trust and the therapeutic relationship
Rapport
Rapport refers to the ability to open and sustain a relationship. It entails attending quickly and accurately to what the other person says or does, as well as interpreting this in a way that respects their motives, concerns and needs (Bryant 2009). Rapport can be developed with patients who have different values and beliefs to those of the nurse, and involves empathy and interpersonal skills such as listening and communicating (Mercieca et al 2014). Rapport is associated with enabling patients to feel at ease during stressful circumstances (Belcher and Jones 2009). While some nurses may not regard themselves as having a natural aptitude for establishing therapeutic relationships with patients, they can nonetheless develop this skill through effective communication (Mercieca et al 2014).

Trust
Belcher and Jones (2009) defined trust as an attitude in which the individual has the confidence to rely on someone or something. Belcher and Jones (2009) observed that trust is a vital component...
Segaric and Hall (2015) described the therapeutic relationship as a process of developing engagement. Instead of care being provided as a standard package or a routine that the nurse and patient follow, it should represent a series of reviewed interventions, re-evaluated needs and mutually agreed plans.

Therapeutic relationships
Where rapport and trust are successfully established, a therapeutic relationship can develop. Segaric and Hall (2015) described the therapeutic relationship as a process of developing engagement. Instead of care being provided as a standard package or a routine that the nurse and patient follow, it should represent a series of reviewed interventions, re-evaluated needs and mutually agreed plans. The nurse should determine whether the care provided involves the patient fully in the treatment process. For a therapeutic relationship to function effectively, it is necessary that the nurse understands the patient’s attitude towards nursing care and the role of the nurse.

Harding et al (2015) drew on Bowlby’s (1969) attachment theory to explore the therapeutic relationship. Patients may be predisposed to assume that nurses will undertake specific tasks. The therapeutic relationship has to be based on the nurse’s understanding of the patient’s attachments, or the ways in which the patient expects to relate to the nurse. If these expectations are ignored, the nurse may find it challenging to achieve rapport with the patient and to sustain their trust. For example, the patient may expect the nurse to inform them about which rehabilitation exercises to perform; however, if the nurse insists on patient responsibility and consults with the patient on a range of exercise options, the patient may become frustrated by their expectations not being met.

As well as engaging with the patient in a therapeutic relationship, the nurse is also required to maintain professional distance. Griffith (2013) reported on NMC rulings where nurses breached professional boundaries by sharing excessive personal information with patients, or developing sustained relationships that exceed the requirements of a therapeutic relationship. For example, in a 2011 case, one nurse who maintained email contact with a patient after a care episode had ended received a three-year caution from the NMC. In 2011-2012, 247 cases where professional boundaries were breached were confirmed (Griffiths 2013).

The premise of all therapeutic relationships should be that the patient is vulnerable because of their health circumstances. It then follows that the nurse’s actions must focus solely on the healthcare needs of the patient.

TIME OUT 1
Reflect on a patient with whom you found it challenging to establish a therapeutic relationship. What aspects of the relationship were challenging? At the outset of the therapeutic relationship, were you able to understand the patient’s expectations of your care? Were their expectations of care different to your own and if so, in what way?

Reflective exercises
The author used three reflective exercises in telephone tutorial workshops to assist nurses in exploring the challenges involved in developing rapport, trust and therapeutic relationships. The nurses were studying the nature of expert practice as part of an MSc in Advancing Healthcare Practice at the Royal College of Nursing Institute, London. Each of the exercises involved requesting small groups of nurses (three to five nurses in each group) to respond to previously supplied case study examples, indicating how they might establish, develop, sustain and successfully conclude a therapeutic relationship. The case study examples are reproduced in this article, and readers are invited to respond using the time out activities. After
each of the case study examples, extracts of the responses provided by the nurses are outlined, as well as the supporting literature.

The participants were notified that the case studies and exercises might form the basis of a subsequently published article and were assured that no individual would be identified or their direct quotations published. Permission to use the material for this purpose was secured from the participants.

**Exercise one: questioning and listening**

At the outset of a therapeutic relationship, the patient is not known to the nurse. The way in which the patient’s condition has developed, their feelings about it, and the way they expect healthcare professionals to assist them is also unknown (Halldorsdottir 2008). Consequently, the nurse is required to ascertain the patient’s attitudes to their condition and its treatment. However, unlike the patient, the nurse possesses the relevant healthcare resources, expertise and facilities, resulting in a power imbalance. Therefore, during the initial consultation, the nurse should explore the patient’s thoughts and attitudes to the treatment process by asking questions and listening attentively to their answers. In this way, the therapeutic relationship will proceed from a position of established empathy. The case study in Box 1 explores this issue.

**TIME OUT 2**

Consider the case study example in Box 1. Imagine that you are tasked with recording Michael’s patient history and orienting him to the ward. If an effective therapeutic relationship is to be established at the outset, you will be required to ask Michael some questions as part of your assessment, while listening attentively to his answers. Ask yourself the following questions:

» What elements should characterise your questioning?

» How do you assure Michael that you are listening to him?

» What information would you provide to Michael about his treatment at this stage?

**Tutorial group discussion**

The tutorial group discussion regarding Michael’s case study focused on three areas:

» The nurse’s obligation to secure accurate information from Michael so that any risks could be managed.

» The necessity to assist Michael in managing any confusion associated with admission to hospital, for example the initial shock, as well as the possible challenge of comprehending the change in circumstances.

» The requirement to justify care measures, which would mean that Michael benefited from his stay in hospital. Nurse A conceded that, in practice, competing requirements meant that it was challenging to plan the questions that would be used with Michael. Some lines of questioning were focused on assessing his neurological state. However, other questions focused on assessing Michael’s emotional state. It was considered that nurses know relatively little about new patients’ impressions of hospital transfers, for example whether they have been in hospital before and how they think nurses might assist them. Therefore, questioning concerned fact-gathering as well as expressing interest and concern for the patient.

All of the nurses in the group discussion emphasised the requirement for nurses to appear warm and appreciative of the patient’s concerns; while there may be competing pressures on the nurse’s time, it is important to personalise any discussions so that Michael feels he is being treated as an individual. The nurse should listen attentively to what Michael

**BOX 1. Case study example: Michael**

Michael is a 53-year-old man who finds it challenging to remember day-to-day details about his work and home life. The exact details he finds it challenging to recall vary from day to day, but he has noticed that the issue is occurring with increasing frequency. There have been occasions when he has visited a place and forgotten why he went there. This worries him because he lives alone. Friends have told Michael that he seems to lose focus during conversations and is sometimes unable to complete his account of what has happened.

Cooking for himself has become challenging and he struggles to follow a recipe. Recently, Michael developed a chest infection and took several days off work to recover. He is dyspnoeic (experiences problems with breathing) and also pyrexial (feverish). During the previous night, Michael got up to use the toilet and fell down the stairs. He fractured his wrist and also has a suspected head injury. Michael has been admitted to your ward and, when you are introduced, you have to attempt to understand what Michael feels about his hospital admission and the issues that have led to it.
KEY POINT
Assessing patients in terms of their experiences and anxieties, as well as demonstrating interest and allocating sufficient time to talk to patients, demonstrates respect and is likely to signal that the nurse cares about the patient personally (Bryant 2009).

says, even though some of his questions might not be relevant to his care plan. Nurse B observed that it was important to ask questions that were not necessarily required for the patient’s records, such as asking how Michael felt about particular interventions. In Nurse B’s experience, these supplementary questions assisted the development of the therapeutic relationship.

Supporting literature
The importance of regarding the patient as an individual is reflected in the literature. Cappell (2009), writing about a patient who was deaf and mute, explained how treatment could be affected by an inadequate understanding of the patient’s concerns. In this study, the staff underestimated the patient’s anxiety, which led to the patient panicking during a rectal investigation and the subsequent need for corrective surgery. Workman (2013) emphasised the value of asking questions from the outset that focus on the patient’s experience and perception of events. If the nurse assumes the patient’s attitude to, for example, a head injury or a chest infection, the nurse may find it challenging to convey sufficient concern. Workman (2013) recommended the nurse ask questions such as, ‘How do you feel about what is happening?’ and ‘What are your expectations of treatment?’.

Writing about how to support patients who have the human immunodeficiency virus, Dang et al (2017) stated that the nurse should focus on:

- Providing clarity on any treatment the patient will receive.
- Reminding the patient that questions are welcome at any point during the care process.
- Sharing test results with the patient and explaining what they mean.
- Avoiding judgemental language.
- Asking the patient what they want.

At the outset of a care episode, one of the first tasks is to assist patients to make sense of events; however, it is also necessary to commence treatment. Consequently, for Michael (Box 1), as well as the patients that Dang et al (2017) discussed, the nurse is required to enquire about the patient’s experience, at the same time as providing the recommended interventions. While Michael is an individual, the nurse will probably have experience of other patients with memory loss, chest infections and unplanned admissions to hospital; therefore, questioning and listening should be combined with any interventions that the nurse believes may be beneficial.

Bryant (2009) summarised the factors that should guide the initial conversations with a patient. The nurse has to be ‘present’, which means they should be concerned with the variety of issues that a patient may have. Michael does not simply represent several challenges associated with his head injury, memory loss, chest infection and orthopaedic injury. Instead, the nurse should focus on the combination of Michael’s physical health, any concerns he has about his health and treatment, and his living circumstances. For example, Michael’s memory loss must be considered within the context of living alone and his chest infection should be evaluated in terms of his personal coping skills. Assessing patients in terms of their experiences and anxieties, as well as demonstrating interest and allocating sufficient time to talk to patients, demonstrates respect and is likely to signal that the nurse cares about the patient personally (Bryant 2009).

In the case study example of Michael, the nurse should aim to gather the relevant information to manage any future risks. The extent to which this is possible depends on how the nurse focuses their questioning. For example, questions should be person-centred to address any anxieties the patient may have as well as facilitating an accurate diagnosis. If the nurse’s questions are not person-centred or do not express interest in the patient’s concerns, the patient may not share any further information (Nakash et al 2009). In Michael’s case, experiencing a fall, developing memory loss and being unable to overcome a chest infection might prompt anxiety that he is becoming prematurely dependent. Rapport is developed when the nurse listens to the patient’s perceptions of events before forming any judgements.
Exercise two: providing patient support
At the outset of treatment, rapport can be developed by the nurse asking the patient appropriate questions and by listening attentively (Workman 2013). Following up any concerns the patient may have, for example alerting a medical colleague to a patient’s pain, signals to the patient that the nurse respects their concerns. Sustaining a therapeutic relationship as treatment progresses, however, requires additional consideration. There may be a series of developments, for example diagnostic tests may reveal additional health issues, the patient may discover that medications have side effects or may have to contemplate an extended period of rehabilitation following surgery. Each new insight will test the therapeutic relationship between the nurse and patient, the role that the nurse plays and what the patient feels about any support received.

The case study example in Box 2 demonstrates the type of changes that can occur as treatment progresses, and prompts examination of the type of therapeutic relationship that nurses should provide if the patient is to feel reassured.

TIME OUT 3
Consider the case study example in Box 2 and answer the following questions:

» How do Raymet’s changing circumstances reshape the therapeutic relationship that you established with her before her first hip operation?

» Given the new challenges involved in Raymet’s treatment, which has developed from post-surgical care to lifestyle advice, what factors would you consider important in maintaining a therapeutic relationship?

Raymet’s case study illustrates how a therapeutic relationship can develop over time. In circumstances where a patient is transferred between healthcare environments, for example from an intensive care unit to a medical ward, regular adjustments to the patient’s treatment will be necessary. Nurses may have to adopt new clinical roles while maintaining a therapeutic relationship with the patient (Eichhorn-Kissel et al 2012). For example, in the case study outlined in Box 2, while the nurse’s role was initially focused on supporting Raymet through hip surgery, it subsequently became concerned with her ongoing lifestyle issues, which might have involved the nurse challenging Raymet’s health beliefs.

Tutorial group discussion
Nurses in the group discussion quickly identified the issue outlined in Raymet’s case study. Although the nurse’s initial role had been as a ‘helper’, supporting Raymet through her original surgery, this developed into the nurse becoming the ‘questioner’, and asking Raymet to focus on her lifestyle. Nurse J observed that despite the role change, the nurse had to ensure that their interest in Raymet and their concern for her well-being did not diminish. Similarly, where the initial surgery and recovery was primarily the responsibility of the healthcare team, it was now Raymet’s responsibility to focus on her lifestyle issues. Another nurse found the word ‘work’ useful, suggesting that this could be used to support Raymet who had already made extensive efforts to lose weight before her first operation. The clinical focus, or work, had to take a new direction, that is, managing the side effects of any medications and making optimal use of prosthetics to exercise and sustain a healthy body weight. Overall, Raymet’s case study raised questions about the intrinsic qualities of the therapeutic relationship and how it can support patients and nurses as new clinical challenges arise.

BOX 2. Case study example: Raymet
Raymet recently retired from her sedentary job in a telephone call centre. Eating out and socialising have always been important to Raymet. However, her weight gain over the past 10 years has contributed to osteoarthritic wear on her hip joints. While Raymet concedes that she is a ‘bit overweight’, her weight places her in the clinically obese category. Raymet was scheduled for a total hip replacement of her right hip and advised of the need to prepare for surgery by losing weight. Raymet successfully reduced her weight by more than one stone and underwent a successful hip operation. However, she has been advised that the weight loss will need to continue before surgery can be scheduled on her other hip. Failing to make the necessary lifestyle adjustments will undermine the benefits of the surgery on the right hip and the planned surgery on the left hip. Further clinical tests reveal that Raymet has moderate hypertension and that her high cholesterol levels might be treated successfully with statins. You are assigned to work with Raymet to assist her to re-examine how her diet, mobility and drug treatment can be combined to optimise her health and reduce the risk of heart disease in the future.
Supporting literature
Segaric and Hall (2015) stated that after rapport has been established with a patient, the nurse must continue to engage with them. Nurses should not expect to continue a formal relationship with patients that simply involves undertaking a list of clinical tasks. According to Segaric and Hall (2015), care has to be psychological as well as physical; sensitive as well as skilful. They described how care involves ‘doing the job with solicitude’, that is, attempting to imagine how the patient views any clinical developments and undertaking the role of nursing with ‘heart’. This involves the nurse engaging in a reciprocal therapeutic relationship with the patient to address any health challenges. However, for the nurse, expressing interest in the patient’s experience, as well as experiencing pleasure or concern when the patient’s recovery progresses or stalls, can be challenging. This level of involvement requires the nurse to accept that, as well as the patient being vulnerable, they themselves are also potentially vulnerable (Angel and Vatne 2017).

The role of caring can have a psychological cost to nurses, often referred to as stress or emotional labour, which can develop as a result of nurses viewing the patient as more than simply a recipient of treatment, skills and information (Segaric and Hall 2015). However, Van den Heever et al (2015) explained that a quality of genuineness can sustain the nurse-patient relationship through changes. This level of involvement requires the nurse to accept that, as well as the patient being vulnerable, they themselves are also potentially vulnerable (Angel and Vatne 2017).

Van den Heever et al (2015) explained that a quality of genuineness can sustain the nurse-patient relationship through changes. Nurses appear genuine when they behave in a manner that implies that they care about what is happening to patients, beyond what is required by their professionalism. For Van den Heever et al (2015), honesty is a central element of genuine regard for patients and their experiences. Van den Heever et al (2015) defined honesty as the nurse expressing genuine pleasure or disappointment in events that affect the patient, for example ‘I am so pleased that your results have come back clear’, or ‘I’m really sorry that the surgery hasn’t achieved all that you hoped’.

Van den Heever et al (2015) suggested that there are five ascending levels of genuineness, as shown in Table 1, that can demonstrate empathy with the patient even though uncomfortable information has to be shared. In Raymet’s case study, as well as emphasising the lifestyle interventions required to manage her weight, the nurse could identify potential benefits, such as the opportunity to try new foods. A sense of genuineness in the therapeutic relationship between Raymet and the nurse could also be fostered by the nurse ensuring Raymet that they are personally interested in her progress.

Exercise three: promoting patient independence
The therapeutic relationship can be considered in terms of a journey, where rapport is renewed and recommitted to under changing circumstances. Halldorsdottir (2008) described the therapeutic relationship in terms of reaching out, removing anonymity, making a connection, being truthful, achieving some form of agreement of what the relationship should do and negotiating about what to do next.

The factors that sustain the therapeutic relationship include an appreciation of vulnerability and why patients feel disempowered, a genuine regard for the patient’s emotions, and a willingness on behalf of the nurse to engage with any challenges. The nurse cannot guarantee success or progress, which means that the patient is required to assess whether elements in the treatment pathway have been resolved or remain a challenge.

Boyle et al (2005) described the optimum elements in a nurse’s communication technique as:

» Invite – ask the patient how they feel about their condition.
» Listen – demonstrate interest in the patient’s experiences.
» Summarise – assist the patient to reflect back to themselves what a particular experience has taught them.

The ability of the patient to summarise their experiences, and reflect on them, becomes increasingly important when the therapeutic relationship reaches its close and the patient no longer requires the
nurse’s input. The case study example in Box 3 explores this issue.

**TIME OUT 4**
Read the case study example in Box 3 and imagine that you are assisting Martha with the psychological issues that may affect her when she is discharged from hospital. Answer the following questions:

» How will Martha’s discharge from hospital either facilitate or challenge the successful closure of the therapeutic relationship you have formed with her?

» What are some of the important issues to consider when concluding the therapeutic relationship you have developed with Martha?

**Tutorial group discussion**
The nurses in the group discussion found it challenging to identify the issues involved in concluding or interrupting a therapeutic relationship, or in referring the patient to another healthcare professional. While there were several suggestions about the practical measures that Martha could adopt to ensure that she received continued support with her stoma, there were fewer suggestions about how to draw the therapeutic relationship to a close.

Nurse G stated that this reflected the empathy felt by nurses for patients with cancer, resulting in increased concern about their future, compared with that of other patients. Nurse L suggested that there might also be ambiguity around the closure of a therapeutic relationship, for example where the patient’s perception changes over time. Baruch (1981) detailed the phenomena known as ‘atrocity stories’, where treatment episodes that were regarded by patients as positive are later viewed negatively because they did not anticipate the long-term outcomes.

However timely and effective a treatment episode has been, it is not certain how a patient with cancer might eventually evaluate their care. If the treatment episode reaches a definitive conclusion – for example, involves a routine curative operation – finalising the therapeutic relationship may be easier. In this case, the patient is not necessarily being discharged with the prospect of complete recovery even though they may be offered guidance on what to do if any complications subsequently arise.

**Supporting literature**
The literature confirms the challenges identified by the nurses in the group discussion. While Halldorsdottir (2008) outlined the features and stages of the therapeutic relationship, the study provided little information on how the therapeutic relationship should be concluded. Tai-Seale et al (2007) explained that with biomedical issues, for example correcting an insulin imbalance, the healthcare professional’s remit is

**TABLE 1. Levels of genuineness**

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<td>1 (lowest)</td>
<td>Responses are unrelated to what the patient is feeling at that moment. The nurse has not ascertained the patient’s emotions regarding an event</td>
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<td>2</td>
<td>False or superficial reassurance is provided to the patient, which may involve the nurse relating the experiences of other patients</td>
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<tr>
<td>3</td>
<td>Neither positive nor negative responses concerning events are provided to the patient. The patient does not know how the nurse feels about an event</td>
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<td>4</td>
<td>The nurse ventures some personal feelings about an event, which are broadly congruent with the feelings of the patient</td>
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<td>5 (highest)</td>
<td>The nurse’s expression of feelings at an event is spontaneous and congruent with those of the patient. Therefore, any delight or disappointment is mirrored. However, the nurse remains ready to explore what might be more efficient subsequent responses, think of ways to re-evaluate the event, or formulate an alternative plan of action. The patient’s emotional response is not the sole arbiter of the nurse’s response. Some of the patient’s emotional responses might not be beneficial, for example if they unrealistically blame others for a disappointing outcome, without considering their own responsibilities</td>
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(Adapted from Van den Heever et al 2015)

**BOX 3. Case study example: Martha**
Martha is a 50-year-old woman who has undergone a bowel resection and colostomy formation after being diagnosed with bowel cancer. She admits that the experience has been transformative: from feeling like a healthy woman, to feeling vulnerable; from managing to use the toilet normally, to experiencing issues using the toilet; from relying on ‘just being healthy’, to consciously having to manage her health. Martha feels that she is less of a person and it has taken time for her to come to terms with her stoma. While she now cleans the stoma appliance and attaches the stoma bags herself, she admits that this only represents the ‘practical management’ of her stoma. Her psychological needs, including how she would like to be seen by others and the stoma’s effect on her sexual relations, have yet to be addressed. Now that Martha’s acute care has ended, her discharge has been finalised and you are assisting her as she prepares to go home. While she has friends to support her, they are not medical experts and she is daunted by the prospect of having to care for herself.
The nurse’s role in a therapeutic relationship is not necessarily to resolve every issue or threat to the patient’s well-being. For example, in many chronic illnesses, the patient’s prospects may remain uncertain. In these circumstances, Haugan (2014) described the function of the therapeutic relationship as focusing on promoting hope and enabling the patient to address any challenges they may encounter in the future.

In many instances a therapeutic relationship closes because of external forces beyond the nurse’s control. For example, patients may be discharged from hospital before they are psychologically prepared because services have been rationed. A patient may also die, bringing the therapeutic relationship to an end; in this case, the nature and circumstances of the patient’s death can also influence the way the therapeutic relationship will be perceived in the future (Roe and Leslie 2010).

There are, however, some recommendations that can be made regarding how nurses might conclude a therapeutic relationship, including:

- Return to the aims that were initially agreed between the patient and the nurse. Relationship closure is concerned with evaluating whether the patient has any issues that still need to be addressed, in which case the nurse can recommend other agencies that might provide further support.

- The nurse’s role in a therapeutic relationship is not necessarily to resolve every issue or threat to the patient’s well-being. For example, in many chronic illnesses, the patient’s prospects may remain uncertain. In these circumstances, Haugan (2014) described the function of the therapeutic relationship as focusing on promoting hope and enabling the patient to address any challenges they may encounter in the future. For example, the nurse might assist a patient such as Martha (Box 3) to evaluate her treatment episode in terms of the new insights she has gained into her well-being, as well as preparing her for any threats to her health that may arise in the future.

- It is important to remember that the therapeutic relationship represents a partnership (Gallant et al 2002). While the nurse may feel that their support of the patient has not been satisfactorily concluded (Korhonen and Kangasiemi 2014), the aim of the partnership is empowerment. Patients and nurses should negotiate what they can achieve and priorities should be identified for each stage of care. If the nurse has been honest with the patient about the resources and services available, for example physiotherapy for how long and how often, then the process of identifying what the nurse and patient agree deserves priority is easier.

**TIME OUT 5**

Return to the patient that you reflected on in Time out 1. Do you think the patient’s experience might have been improved by an understanding of what the therapeutic relationship was meant to achieve? Did you simply respond to the patient’s expectations as care progressed, attempting to manage the patient’s needs as they arose? With increased knowledge of the therapeutic relationship, what changes might you have made to the patient’s care?

**Conclusion**

Rapport, trust and therapeutic relationships are important to nursing care. Patients’ experience of care can depend on the way in which nurses engage with them, enquire about their concerns and needs, and celebrate any successful treatment. The therapeutic relationship requires the nurse to maintain professional distance and the focus must remain on the patient’s clinical needs. However, understanding how to relate to the patient’s experience is a significant advantage for the nurse, who through developing rapport and trust with the patient will be better placed to identify their ongoing care needs.

Reviewing case studies enables nurses to examine their experience of relating to patients. Discussion often prompts differences of opinion or recognition of challenging issues, which can then be
Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how promoting the development of therapeutic relationships in your area of practice could relate to the themes of The Code.

Now that you have completed the article you might like to write a reflective account as part of your revalidation.

References


resolved. Evidence from the literature is also important in explaining why therapeutic relationships benefit patients and nurses, but also how they can be challenging. However, while the literature provides evidence on the formation of therapeutic relationships, there is less evidence on how nurses should conclude these relationships.
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For further details and to register, visit the workshop websites

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Developing patient rapport

TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 906

1. Rapport is defined as:
   a) A series of reviewed interventions, re-evaluated needs and mutually agreed plans
   b) An attitude in which an individual has the confidence to rely on someone or something
   c) The ability to establish and sustain a working partnership
   d) The ability to undertake a task successfully or efficiently

6. Optimum communication involves which of the following elements?
   a) Invite
   b) Listen
   c) Summarise
   d) All of the above

2. Establishing patient rapport may be challenging for nurses because:
   a) Patients are always in a position of power
   b) The length of time patients spend in hospital has shortened so there is less time to form therapeutic relationships
   c) All patients are difficult to manage
   d) Sharing personal information is the basis for developing rapport in healthcare

7. During an initial consultation with a patient, the nurse should:
   a) Dictate treatment goals
   b) Focus on physical issues only
   c) Explore the patient’s thoughts and attitudes to the treatment process by asking questions and listening attentively to their answers
   d) Avoid discussing future risks

3. Nurses can develop therapeutic relationships with patients by:
   a) Employing effective communication skills
   b) Sharing personal information
   c) Focusing on improving their technical skills
   d) Using electronic devices

8. Level 2 of the levels for genuineness model involves:
   a) Responses unrelated to the patient’s feelings
   b) Providing the patient with false reassurance
   c) Mirroring of the patient’s disappointment
   d) Formulating an alternative plan of action

4. Why is trust a vital component of nursing?
   a) It allows the nurse to undertake procedures without patient consent
   b) It enables the patient to provide information to support diagnosis and care plans
   c) It enables the nurse to form a personal friendship with the patient
   d) It enables the nurse to make assumptions about the patient’s attitude and behaviour

9. Which of the following is not a factor that sustains the therapeutic relationship?
   a) Genuine regard for the patient’s emotions
   b) Willingness of the nurse to engage with any challenges
   c) Appreciation of vulnerability and why patients feel disempowered
   d) The undertaking of clinical tasks only

5. Which statement is true?
   a) Trust does not rely on consistent and transparent reasoning
   b) For a therapeutic relationship to function effectively, it is necessary for the nurse to understand the patient’s attitude to nursing care and the role of the nurse
   c) All nurses have a natural aptitude for establishing therapeutic relationships
   d) Therapeutic relationships remain unchanged over time

8. How might a nurse conclude a therapeutic relationship?
   a) Return to and evaluate the aims that were initially agreed between the patient and the nurse
   b) Promote hope and enable the patient to address future challenges
   c) Recommend other agencies for additional support
   d) All of the above

This self-assessment questionnaire was compiled by Alex Bainbridge

The answers to this questionnaire will be published on 23 August

Answers to SAQ 904 on depression in children and young people, which appeared in the 26 July issue, are: