Shirley Goodwin and Meg Bond

Nursing Humans

Think little and feel less. This was the message when we trained as nurses ten years ago. Do as the doctors say. Don't get too involved. Never let anyone see you weep. The patients depend on you; so you have to be strong (1).

We are a couple of community nurses who have been thinking a lot lately about where we are in relation to the people we help.

These thoughts have been influenced by our experiences with humanistic psychology, and we would like to share some of them with you. We offer them from the viewpoints of firstly, a health visitor, and secondly, a district nurse.

Health Visiting

Health visiting is a profession which grew up in the latter part of the last century as a response to the high infant mortality rate and the poor health, in particular, of the "lower classes". From the beginning, the emphasis was on improving health and hygiene practices, particularly in the care of babies and children, in order to promote good health and prevent illness.

Today, the health visitor comes from a nursing background, undergoes a training which has much in common with that of social workers, and then works in the community, visiting all families with children under five years of age, in her "area", as well as other age-groups (in her "area").

Visiting is essentially non-selective (at least, in areas where the staffing levels are up to what they should be) and contact with clients is usually initiated by the health visitor him/herself, but sometimes by clients themselves, or general practitioner, social worker etc. Health visiting is non-stigmatising, because all young families have an HV who calls on a routine basis to offer appropriate health advice and support. She does not usually carry out crisis intervention work, since her work is essentially preventive in nature, and must be a continuous "screening" process, which hopes to identify potential needs and assist clients to mobilise personal and social resources in the hope of avoiding or alleviating the effects of breakdown, whether of physical or emotional health, or of social circumstances.

Relevance of Humanistic Psychology

This brief outline of health visiting may suggest some obvious ways in which the humanistic psychological approach has relevance to its practice. This is not to say that at the present time there is much input into the profession from humanistic psychology, although I begin to detect influences in some

health visitor training centres, and articles are appearing in the professional journals on client-centred counselling, (2) and group work (3) etc. Also, I am encountering fellow health visitors who have met humanistic psychology methods and ideas on courses, and are finding them - as I do -exciting, and relevant to their work.

Therefore what I write here is not so much about the effect of humanistic psychology on health visiting practice now, but concerned with the future, since I believe there is an increasing acceptance of these ideas and methods in a profession to which they have such direct relevance.

Personal Potential

To start with, it seems important to me that as a health visitor, I develop my personal potential in working with clients because I am the most important resource I have to offer.

"Success" in health visiting is a very difficult thing to measure, but to me it means something like developing the sort of relationship with my clients which will enable them to ask for and use the advice I can give about their health. Unless they feel I am open and accepting of them, they may not be able to approach me. I need to be more aware of myself and my own needs, prejudices, attitudes, expectations etc., not only so that they don't get in the way inappropriately and prevent me from truly encountering the client, but also so that I can look after myself too.

Professional Role

The "professional" role poses some difficulties for me here. I am the "expert"; clients should ask for advice and expect to be told the "right" thing to do. To some extent that is what happens much of the time; for example;, when I am asked for factual information such as how many scoops of milk power to put in the baby's bottle; there is no way I should avoid giving a straight answer to that sort of question!

However, health visitors are in a situation where they are asked for advice about less clearly defined issues, and this brings me to another areas where I believe humanistic psychology can benefit health visiting. One often described function of health visitors is that of being a "listening ear", which is generally understood to mean that HV is there as a shoulder to cry on, but that she also has appropriate practical suggestions to offer in dealing with whatever problem the client has presented. I have been learning recently what the "counselling approach" really is, and it is not what I practised for at least my first five years as a health visitor, except possibly intuitively when, on occasions (feeling somewhat guilty about laying down the cloak of "professionalism") I allowed myself to feel *with* a client and "took it from there".

It is still difficult for me to behave like this as a health visitor, partly because

it feels "unprofessional" - my invisible nurse's cap is still firmly pinned on much of the time!

Self-help

Something else which relates to my feelings about being a professional occurs to me as I write, and it is about self-help. HVs acknowledge that one of their most important functions is that of facilitating community and neighbourhood mutual support. They have always put lonely mothers in contact with each other by setting up mothers' clubs, or by passing on information about existing local groups.

However, there exists still, in many of my fellow HVs and in a little corner of me also, the fear of using "lay" people, "enthusiastic amateurs", and voluntary helpers - a good example being the post-natal support groups set up by the National Childbirth Trust. After all, we are the experts, and if mother-to-mother help really got off the ground perhaps they won't need us anymore!

There is the preoccupation with confidentiality and also the risk that putting people in touch with each other could ricochet back on the HV if they don't get along.

Bringing the concept of self-help down to a more individual level, I think about enabling clients to help themselves, to achieve their health potential by taking responsibility for their own health, illness or handicap. Having been a nurse, I still retain involuntarily a sense of a degree of responsibility for my clients' health and well-being, which is not perhaps the best way to allow them to achieve responsibility for themselves! I have yet to learn, deep down in my "health visiting soul", that clients are not patients - they are well.

Furthermore, they can even move on from there.

A quotation from Katherine Mansfield (4) which has been used to define health in one or two recent publications concerning health visiting is relevant here:-

> *"By health I mean the power to live a full adult, living, breathing life, in close contact with what I love - I want to become all that I am capable of becoming".*

Becoming!

District Nursing

The dividing line between health and disease has been a subject of philosophical debate for centuries. Explaining the difference between the health visitor's and the district nurse's work is almost as difficult.

However, I will try to explain by pinpointing the main difference as being that the district nurse usually helps those people who require specific practical nursing procedure in their own homes. These people usually have some identifiable physical illness or disability.

To the patient and family, this illness involves a loss. Something has been taken away from their lives. This might be for instance, energy, mobility, roles in the family and other groups, control over bodily functions etc.

In my experience, this loss causes a grief-type reaction, and also a degree of regression.

District nursing has always been involved with rehabilitation in the physical sense, but I feel that my training did not equip me to help the rehabilitation of the whole person. I was aware to a certain extent of the patient as a person, but did not quite know what to do about it. Like Shirley, I felt I was muddling through, hiding behind a stereotype which my uniform personified, and only occasionally taking the risk of allowing myself and the patient to be free of the constraints of predetermined roles.

I am now no longer working in direct contact with patients, thus my view of humanistic psychology related to district nursing is related mainly with optimism about the future, rather than from experience.

The Changing Catalyst

In order to help patients work through grief and develop from regression to progression, I feel district nurses must develop their skills in cathartic and catalytic intervention. (as per John Heron's Six-Category Intervention Analysis (5).

In chemistry, a catalyst is defined as something which effects change without undergoing change itself. However, in human relationships this is not so. I believe the change in the nurse who is to be the catalyst is the starting point.

I came to be interested in humanistic psychology after a spell of developing my own physical health. The process of growth had started and I was looking for the next step. Physical health as a starting point is a particularly relevant one for nurses.

In looking after my own body, I developed an increasing respect for it as the external representation of me as a person. With this came greater respect for the bodies of my patients. Nurses often have to carry out very personal procedures, and awareness of the assault on the personal dignity of the patient will affect the way a nurse carries out these procedures.

We have the ideal opportunity to develop sensitivity and communication

by touch: we are one of the few groups of people allowed to do this in our touch-taboo society.

In my own experience, the few times when I have really allowed myself to concentrate on the way I was communicating by touching, it has been very enriching experience for both the patient and myself.

Unfortunately, I left the field before I started to become aware of the potential I have for my own personal development. I can now see how I could have better enableed patients to grow. Those who were adjusting to a handicap could have discovered new facets of themselves which would make the future full of possibilities, rather than the same as before but with minuses. Those who were dying I might have helped more by allowing them to express feelings, and to develop more of the insights which such a stage of life can bring.

The Nursing Process

One of the most exciting possibilities of humanistic psychological principles being applied, lies in the application of "The nursing process". (6)

This is a system which involves the patient and family and friends in the assessment, planning, implementing and evaluating of nursing care. The patient and the nurse are seen as equals in the process of nursing, right from the start. Realistic goals are set, and the patient can see his/her growth by acknowledgement of the achievement of each stage of development.

This takes away from the nurse her traditional "parent" role of taking control of the patient's care, colluding in his regression, encouraging dependence and possessiveness, and being unwilling to let go when the patient no longer is in need of nursing. It is this 'taking away' feeling which causes insecurity and resistance against the widespread introduction of the Nursing Process.

However, when the philosophy of development of personal potential and self-help becomes more widespread in district nursing education, this will provide a satisfying replacement for the old roles. I hope to play my part in this.

Conclusion - The Future of Community Nursing.

1. **Education** - We feel that nurse education has to change by moving towards awareness of patients and nurses as human beings, each having their own potential to grow, and by teaching the skills which enable this to happen.

2. **Management** - The N.H.S. administrative structure is highly institutionalised but has built into it an ideal opportunity for personal development of staff, by the staff appraisal system. Nurse managers could apply humanistic psychology principles in their staff counselling.

3. **Patient/Client-Centred Approach.** We would like to see less emphasis on role distinctions when distributing patient/client care amongst members of the Primary Health Care Team. (G.P's, district nurses, health visitors, social workers, midwives etc.) Professional roles should not be allowed to shape recognition of patients needs.

4. **Personal Responsibility for Health.** Once we stop perceiving needs in the light of preconceived ideas of resources available, we will discover that these needs are infinite. We can never satisfy them by trying to take responsibility away from the patient/client. We should aim at facilitating individual and group self-help.

References

(1). **Menzies, I.** *'Functioning of social systems as a defence against anxiety'.* University Quarterly. Vol. 24, Spring 1970.
(2). **Price** and **Johnson,** *'Integrated client centering in community health planning'.* Health Visitor. Oct. 1976.
(3). *With a little help from my friends'.* Community Outlook section of Nursing Times, 13. 6.78.
(4). **Katherine Mansfield** quoted in *'An investigation into the principles of health visiting'.* Council for the Education and Training of Health Visitors. 1977.
(5). **Hargreaves, I.** *The Nursing Process.* Nursing Times Occasional paper. Nursing Times 28.8.75.

Stephen Paul

The Laisteridge Centre.

A catalyst for mental health?

Before we look at true 'mental health' we must look at its shadow 'mental illness', which is seen as "dirty", "incurable", "dangerous", etc. in our present day society.

So what is "mental illness"?

Firstly, a seemingly vast area of psychoses and neuroses caused by the individual's inability to cope with 'normal' society. Secondly - or a chronic illness of organic origin which can be maintained by regular drug treatment. Thirdly - or a laspe in behaviour traits which can be modified.

Or is it, in fact, a point to the fact that something is very wrong with society and that society needs to change to accomodate this? Coupled with this is the possibility that mental trauma are, in fact, the upheavels of a new awakening of awareness in which old mental frameworks can no longer work - hence the "break-down" and "freak-out" of the ego.

It is very much the premise we take which determines the treatment and potential 'cure' of "mental illness".