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LIVED EXPERIENCE NARRATIVE

WILEY

# All I missed in the therapeutic relationship: The lived experience narrative of a mental health nurse receiving mental healthcare

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## Accessible Summary

**What Is Known on the Subject?**

- The therapeutic relationship is crucial for mental health practice, especially to practice that is recovery-orientated.

**What the Paper Adds to Existing Knowledge?**

- This lived experience suggests that mental health professionals can be a long way from knowing the service users' feelings and their precise needs.
- The narrative reveals how mental health professionals maintain stereotypes and prejudices against people with mental health conditions and how these are reflected in their practice through lack of respect and users' dignity.

**What Are the Implications for Mental Health Nursing?**

- This lived experience narrative highlights the need to humanize care.

## Abstract

**Introduction:** The therapeutic relationship is not always functional in clinical practice due to various factors, such as lack of time, lack of job motivation, exhaustion and rejection towards the person cared for.

**Aim:** The aim of this study is to illustrate to professionals the needs of the persons they care for and how they see the world.

**Method:** The aim was achieved through the development of a lived experience narrative.

**Results:** This lived experience narrative describes the experience of a mental health nurse since her first psychotic symptoms and her perceptions of the therapeutic relationship with mental health staff in her trajectory from the first psychiatric appointment until her last contact with the community mental health services.

**Discussion:** This narrative suggests that mental health professionals are sometimes far from discovering what service users are feeling and their precise needs. This highlights the need to humanize mental healthcare.

KEYWORDS
dehumanization, personal narrative, therapeutic alliance

## 1 | INTRODUCTION

The therapeutic relationship has been defined as the cornerstone of mental health practice and pivotal to recovery-oriented mental healthcare (McCluskey et al., 2022). The views of the therapeutic relationship seem to be similar both for nurses and mental health service users, framed as one-party wishing to help and the other to be helped, and resting on trust and respect (Moreno-Poyato et al., 2016). Service users believe that the most desirable qualities of mental health nurses are those essential for the development of a therapeutic relationship: active listening, showing empathy and understanding the service user's unique experience (McCluskey et al., 2022).

The therapeutic relationship is not always functional in clinical practice, and there is some discrepancy between the ideals of mental health nursing and actual practice in the form of reduced availability and accessibility. The therapeutic relationship may be negatively influenced by various factors, such as lack of time, lack of job motivation, exhaustion and rejection towards the person cared for (Hem & Heggen, 2004, Moreno-Poyato et al., 2016, McCluskey et al., 2022). Rejection is reflected in clinical practice as distance, which can be helpful in maintaining the service user's dignity, but it could also appear as a result of personal dislike (Hem & Heggen, 2004).

The aim of sharing this personal experience is to illustrate to professionals the needs of the persons they care for and how they see the world. It is not always necessary to go through an experience to be able to empathize with those going through that precise situation, and that is what we have tried to reflect in this narrative.

## 2 | MY FIRST SYMPTOMS

I want to share my story, of how psychotic symptoms are experienced in the first person, in the hope that this narrative might help mental health professionals understand what we think and feel at those times, enabling them to offer efficient and helpful healthcare to the person who is suffering. I am convinced that if the staff working at the mental health unit where I was admitted, and many others I have met in my professional nursing history, knew the effects their verbal and non-verbal language has on us, they would change how they behave.

A different treatment from the beginning might have helped me to reduce my fears and to feel safer, with less uncertainty and anxiety. Receiving information would have helped me not to suffer from the adverse effects of antipsychotic drugs. Not being told that anxiety and fear can cause or increase psychotic symptoms led me to fear a potential relapse, to believe I was psychotic and approaching schizophrenia, a diagnosis I dreaded, overnight, without realizing. What the doctor said, "you can't fight against drugs; you will end up complying," made me think that every day could be the last I would feel something, because when I was treated with antipsychotics, I felt utterly anesthetized, I obviously did not suffer, but I could not enjoy the nice things in life, either.

I could not place the precise moment when I started interpreting reality in a delusional way. My first memories are isolated moments when I thought one of my neighbours was a detective and he was following me, or that the person who came to repair a window was installing cameras. I experienced small amnesias, such as forgetting to have put something important in a safe place and accusing the cleaning staff of having stolen it. I could not understand anything happening around me; everything was confusing and difficult. Those moments were surrounded by others of complete clarity, when I thought I was able to understand what those around me were thinking. I could not take part in conversations with relatives. I interpreted their laughs in a self-referential way; they were laughing at my new haircut, and I was convinced of it. I cannot remember it, but I could not sleep. That is what my partner says, and I would not let him sleep, with the consequent tiredness. My family finally took me to a see a psychiatrist. I had had a miscarriage 20 days earlier, and the lady beside me in the waiting room explained that she had been through the same as me. Too much of a coincidence: I interpreted that she was a detective following me. That same day, I started a therapeutic regime: antidepressants and vitamins to treat depression with psychotic symptoms. *First diagnosis*.

My family waited for the time the drugs needed to start working, as they had been told. We followed all the therapeutic recommendations, but I was getting worse. I was increasingly getting lost in a delusional world I barely left a while a day, and this led me to lose the memories of several whole days of my life.

The delusions were increasingly more consistent and faultless; all the pieces fitted together. They wanted to take my house from me, my husband had a lover and was going to leave me, and I was going to lose my job and be ruined. My life was collapsing. I heard my colleagues laugh at my job on the radio, and once I thought that my family, who were sleeping in my house, were dead, they had killed themselves, all because of me! I saw numbers on my mobile phone that were not real. I thought my life was made public on social media, and I had secrets for anyone. All of this led to my admission to a psychiatric inpatient unit.

They injected me with a sedative at the emergency room because of my anxiety level. When I woke up, I did not know in what city I was, where I was staying, or what month, day or time it was. Was it a place for people who have nothing?

My first thought was that my family had grown tired of me and had abandoned me. I got up, looked out the door and heard: "she has woken up" and went back to bed, frightened. No one approached me then; no one talked to me. Later, two people came, left my shoes on the bed and took my bed out into the corridor; they were talking about a transfer. I was terrified, mutist, motionless, I did not even know where I was, and they were talking about transferring me somewhere else. I clung to the bed rails. I could not speak. "It seems this one wants to stay," is all they said. After what seemed hours to me, I was finally taken to another room.

When my parents found out that they wanted to transfer me from that hospital to a psychiatric hospital, they broke down. They did not know what was happening to me either, so they sorted it

out so that I could stay admitted to the hospital I had been taken to. My admission lasted seven days. It has been my only hospitalization.

## 3 | EXPERIENCE DURING MY ADMISSION

*Where was I*? I still did not know it. Nobody told me. Did they expect me to know? I do not know when I was conscious that I was admitted to a psychiatric unit, but I instead began to sense it when my head became less busy with finding relationships and meanings, and those millions of thoughts and reasoning left space for reality.

How many days did my admission last? I found out when I read my discharge report. I never knew what day or time it was during my admission. How could you have time for that if your roommate, who was the Queen of the World, had named you (*you!*) the Queen of Water to fight evil? Everything else was trivial.

What could I do? What were the rules? Why did I not have a relative accompanying me? Why were visits so short, and we could not leave the hospital? Where were my things? I had enough of a mess in my head, so I adapted to what I saw the others doing, and that is how I was going unnoticed.

At no point did I have a conversation with a nurse. They talked about me in the third person, as if I was not there. For example, as I walked along the corridor, they said, "she seems a bit nervous; I am going to take her blood pressure." The staff also thought it was odd that my relatives preferred to come to the door of my room with me when we came back from a walk outside the ward, instead of leaving me at the entrance to the unit. They judged us and expressed their opinions in a loud voice as if we could not listen to what they were saying. *Where is the respect?*

One day I had to go for a scan, and they gave me a gown. I kept it on when I arrived back at the unit because I felt more comfortable than using my hospital pyjamas, which were far too big. The staff said that they would take it from me because I looked like a princess. For them, it was better if I wore the pyjamas tied with tape not to show my breasts so that I was no different to the rest. *Where is our dignity?*

Other people admitted told me that I could smoke in the unit. The staff gave you several cigarettes a day, and you or your family could buy the rest. As I did not know what to do and everyone was smoking, I went and asked for a cigarette. The nurse looked at me, smiled ironically and gave me a dark tobacco cigarette instead of a blonde one. *Was that about superiority? Humiliation?*

I felt I was controlled by the nursing staff. I remember I had a book on my bedside table, and one day, I could not find it. I asked the nurse, and she said they had taken it from me and left it with my other belongings without my permission. *Where is respect for privacy?*

The nurses' job was only to administer drugs. They never asked me how I was or if I needed anything. When they offered me "an extra," a hypnotic drug, of course I always said yes, as I only wanted to get away from that world as soon as possible. Nobody told me about the potential adverse effects of what they gave me. As an example, I discovered that my vision was blurred one month after taking my prescribed drugs; until then, I believed the world had become blurred. Another side effect I had was akathisia, an internal sense of motor restlessness with inability to resist the urge to move; I was exhausted. At home, I could not stop doing things so as not to stand still, and I volunteered to do the washing up, I went to buy the dessert, I did handicrafts, and I walked and walked. If I was sitting down, I could not stop moving my legs. When I explained this, the psychiatrist denied it could be a side effect of the drugs I was taking, but both blurred vision and akathisia disappeared when he changed the active ingredient I had been prescribed.

When you are on your own for so long and with so many worries on your mind, you need to talk to somebody, but nobody was available. When you have an appointment with the psychiatrist, you think you will be allowed to speak, and you will understand what is happening. During the first of my only two psychiatrist appointments during my admission (the second was to be discharged), I remember I wanted to talk about something that had happened to me before I was admitted. The psychiatrist started to be afraid of me, and I did not know why she was trying to leave the office if all I wanted was to explain what had happened to me. I simply could not find the proper words; it seemed extremely complicated because even I could not understand it. I was overwhelmed and confused at not having an explanation, but I was not upset or violent, and my tone of voice was low, although I imagine my language was incoherent. She left the office. I went back to my room in astonishment and stared out of the window, not understanding anything and in greater need of saying what was in my heart and knowing why the psychiatrist had been afraid of me. While I was thinking about this, she came to the door of my room and stood in the doorway, I looked back at her, and we stared at each other for a few seconds. She left without asking anything, and I felt even lonelier.

## 4 | DISCHARGE. MY RELATIONSHIP WITH COMMUNITY MENTAL HEALTH STAFF

Finally, I was discharged, and I got a new drug regime and a second diagnosis, a brief psychotic disorder. At this point, my journey through community mental health units began. During my first visit to the outpatient mental health clinic, the nurse asked me very general questions, and some years later, he took my blood for a test. That was all the contact I had with a nurse in the four years I was a patient at that centre.

From the very first visit, the psychiatrist I was assigned to only asked my husband about my symptoms. My husband said I ate and smoked too much, so without even checking or trying to find what was leading me to behave like that; I was prescribed paroxetine, an antidepressant drug. *Hello? Am I here? I am experiencing the symptoms, but I am being totally ignored.*

So, after several visits in which my husband came to the appointments with me, and I was only listening to their conversations, I had two options: to let my partner attend the appointments on his own, or to attend them alone. I chose the second. I asked my husband

not to come with me anymore, but the doctor always sent him his regards. Would it have been the same if I had chosen the first option? I will never know, but I do not think so. He was not the only one. Another psychiatrist kept in touch only with my husband to see how I was.

During the four years of treatment, I was never told my diagnosis. My psychiatrist and I agreed to suppress the antipsychotics on several occasions, but if any destabilizing situation at work arose, he prescribed them to me again, despite me not having shown new psychotic symptoms. He suggested I take antipsychotics on a chronic basis at an infra-therapeutic dose in order to protect me from a psychotic relapse. After his suggestion, I asked if I had any disorder that made me need those drugs, and he said that I was borderline. *Third diagnosis*.

My relationship with psychiatrists has always been complicated. I have had four (two men and two women), but I never felt comfortable with any of them. That is not a pleasant feeling, because they ask about your personal issues, but when you open up and start telling them intimate things, you feel they do not care about the content, and sometimes it is hard for them to hide their yawning. They want to find out how much you react to their comments or how you face problems. That is why sometimes they stop showing interest when they have enough information to decide if there is a need to change the treatment regime based on the symptoms you describe. Obviously, when you are aware of what is happening, you systematically shut up, and do not explain all your concerns. You learn the lesson quickly and answer their questions briefly: *why should I bother giving you details if you do not care what I say?*

You have the feeling that they do not care about you. For you, the most important thing is the content of your speech, so you do not feel listened to. *It is we who adapt to the professionals' needs. Could this be the reason why so many professionals believe mental health service users always lie? What is the root of the problem?*

## 5 | DISCUSSION AND IMPLICATIONS FOR CLINICAL PRACTICE

This lived experience narrative of a person with a healthcare professional background who then worked as a mental health nurse is consistent with previous research describing opinions of people who have come into contact with various mental health services (Hansson et al., 2013; Ross & Goldner, 2009).

This lived experience narrative suggests that mental health professionals are a long way from discovering what service users are feeling and their precise needs. The users are diluted and unseen when the professionals believe they are alienated, they have lost their minds and are not conscious of what is happening to them or to others around them, and dehumanization of healthcare occurs (Tidefors & Olin, 2011). These beliefs also lead to people being treated disrespectfully, their dignity not been taken into account and no need to communicate with them being considered. The psychotic experience is difficult to explain.

The humanization of care is an aim of healthcare services (White et al., 2018). However, when a person's capacity for action is diminished, no attention is paid to their personal history or their future possibilities. If healthcare only covers the physical side, the humanizing vision of care is compromised (Todres et al., 2009). This is reflected in this story when Anonymous expressed she felt she had no one to share her experience with, and the staff were only concerned about the psychiatric diagnosis in order to prescribe and administer the proper drug (Wang, 2019).

The professionals have a different perspective after experiencing illness themselves and identify changes in their interactions with other health professionals (Hahn, 1995). Some things not accessible from the professional's perspective can only be learnt from the patient's role. The illness can teach things that books cannot (Bradley, 2009; Klitzman, 2006; Woolf et al., 2007). Oates et al. (2017) found in their qualitative study of 27 mental health nurses that personal experience of mental disorders created understanding and empathy for the people they cared for and provided them with credibility when interacting with those they cared about. Mental health nurses use their personal lived experiences to build therapeutic connections (Hurley et al., 2022). Acting as participant observers, they also provided a critical view of the rules for communication between professionals and patients, the information they offer, and how they provide it. The lack of sensitivity and compassion when communicating was a recurring theme (Klitzman, 2006; Tuffrey-Wijne & Williams, 2015; Woolf et al., 2007).

Emotions are crucial in connecting with other people, but it is hard to be empathetic with someone who is going through such different experiences. Professionals have to make a greater effort to try to understand what the person is feeling (Galvin, 2010). However, not only can there be a lack of connection. What is worse, malpractice occurs when nurses do not offer a supportive relationship or communicate with the people they are caring for, as these are competencies of nursing.

This narrative highlights the need to humanize care. The story reflects how mental health professionals maintain stereotypes and prejudices against people with mental health conditions. Potential dangerousness and altered cognitive capacity are myths that are still present (Martínez-Martínez et al., 2021). These beliefs may justify why professionals show paternalistic attitudes towards the people they care for, such as deciding what is best for them (Ljungberg et al., 2016).

### DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

### ETHICAL APPROVAL

The study was conducted following the ethical principles for medical research involving human subjects described in the Declaration of Helsinki.

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