The future of the Theory of Interpersonal Relations? A personal reflection on Peplau’s legacy

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The work of Hildegard Peplau represents the most significant influence, worldwide, on the development of psychiatric nursing practice. Her use of the Theory of Interpersonal Relations created the basis for defining the potential significance of the psychiatric nurse’s role as a therapeutic agent. Forty years later she has indicated the means by which nurses might sharpen their focus on the person often overshadowed by the ‘patient’ label. Peplau’s writings have, over this 40-year period, helped clarify the broad range of roles required of the nurse in general and in particular, within psychotherapeutic nursing.

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The legacy

In formal terms, psychiatric nursing has been the beneficiary of Peplau’s interpretation of the theory of interpersonal relations for more than 45 years (e.g. Peplau 1952, 1962, 1963, 1964, 1969, 1987, 1990, 1992, 1996). For those nurses who were her colleagues, or her early students, the legacy of her understanding of the significance of that theory, and of the proper focus of nursing, is even longer. As someone whose encounter with Peplau’s work was serendipitous, and occurred relatively late in my career, my appetite for her theoretical, professional and practical writing derives, in part, from an appreciation of what I might have missed. That said, I hope that this paper will be read neither as an apologia for Peplau’s position on psychiatric–mental health nursing (PMHN) nor a hagiography. Whichever perspective one takes, Peplau’s exploration and clarification of the theory, and her examination of its relevance to various practice contexts, has significance. However, the greatest compliment anyone might pay to this pioneer, in the professional and academic development of PMHN, would be to submit her work to continuing critical appreciation and appraisal.

A significant dimension of Peplau’s work involves its focus on human issues. It is that aspect of Peplau’s oeuvre that I shall emphasize, in this estimate of her value for future generations of PMH nurses (cf. Peplau 1995).

Peplau’s humanity has been acknowledged by her colleagues, who recognize the ‘mother of psychiatric nursing’ (Lego 1996) as a:

wise, caring and gentle person (who) is one of the finest and best scholars the profession has known . . . for over 60 years her scholarship has been evocative, informative, and provocative (Sills 1989, p. viii).

This suggests the complex dimensions of true leadership, and connotes the benefits accrued by the field during her tenure as one of its leaders. Today, PMHN is under threat in most of the countries in the developed world, either in terms of its presumed function or its substantive focus (cf. Barker 1995, Dawson 1997). During the writing of this
Peplau is, unarguably, the most widely acclaimed psychiatric nursing theorist. However, McKenna (1993) discovered that, at least at the level of implementation in practice, she had only limited popularity. It is not altogether clear what this might mean for nursing theory or practice. Given the academic significance of Peplau’s exposition of the theory of interpersonal relations in nursing, no obvious acceptable explanation exists for the disinterest or apparent hostility towards her work (Gournay 1995). These conditions may be a function of cultural differences. The North American nursing tradition, within which Peplau’s work is embedded, characteristically differs from that of other countries. There exists a well-established graduate tradition within PMHN, including a 40-year history of Master’s level education. These twin traditions also have enjoyed a theoretical and practical understanding of psychotherapeutic nursing which, arguably, is to be found in no other part of the world. In 1994 the American Psychiatric Nurses Association hosted a conference based upon a critical appraisal of psychiatric nursing spanning almost five decades (1947–94). No other nation could enjoy a theoretical and practical understanding of psychotherapeutic nursing which, arguably, is to be found in no other part of the world. In 1994 the American Psychiatric Nurses Association hosted a conference based upon a critical appraisal of psychiatric nursing spanning almost five decades (1947–94). No other nation could match the sheer quantity of literature published since the end of World War Two, far less the quality of its academic standing. In that sense most, if not all, other nations are ‘underdeveloped’ by comparison with the USA. Nurses in other countries who have tried to ‘implement’ Peplau’s theory may, in a professional sense, simply not be ready for the challenges associated with Interpersonal Theory.

In more specific terms, it is clear that many of the nurses who have tried to accommodate the Theory of Interpersonal Relations in their work have only limited opportunity to experience, at first hand, the experiential teaching dimension (Peplau 1957) of education in practice, for practice. In the UK, for example, many generations of nurses have been taught in classrooms by nurse teachers, both of which are remote from the everyday clinical practice context to which Peplau referred (cf. Reynolds 1982). By contrast, many North American nursing students will have been exposed to ‘clinically focused learning’ by their teachers – up to and including the Professor of Nursing – in the clinical milieu.

If there are any grounds for accepting this professional–cultural hypothesis, it may be that the nature of their educational preparation generates, unwittingly, a contextual threat when nurses are required to ‘experience directly’ and ‘reflect upon the experience’ of relating to their patients, far less (how they experience) themselves. Such anxieties may encourage nurses to elect to employ ‘models’ of nursing (as opposed to a theory) that provide them with the security they desire: structures that will contain their interactions with patients. Such ‘containment’ may also serve as a buffer against too close an engagement with people in severe mental distress. A handful of authors have, within recent history, expressed overtly critical views of Peplau and her theorizing, wishing to consign them both to the dustbin of history, or to write them off as mere footnotes to nursing history. Such criticisms may have a critical subtext. They may merely be extreme examples of the ‘continuing critical appreciation and appraisal’ of Peplau’s contribution. They may, alternatively, be illustrations of the experiences of nurses who have not been acculturated in the experiential tradition that underpins Peplau’s theorizing. Such criticisms may even be interpreted as indicative of a lack of understanding of Peplau’s work, or a failure to appreciate its significance. In Leggo’s view, some critics – such as Gournay (1995) – may even be harbouring competing ambitions for the future of PMHN (cf. Leggo 1997). What is not in dispute, and is remarkable, is that the first theory to be applied rigorously within nursing, and its advocate, should still be at the heart of an academic controversy almost 50 years after its first publication.

Despite having been in retirement for more than two decades Peplau continues to contribute to debates about nursing, mental illness and health, and the role of the nurse in describing and responding to such phenomena. However, her recent re-emphasis of the personal dimension of interpersonal theory presents some nurses with a conundrum. As Rolfe (1996) has observed, Peplau is proposing that everyone should be treated as individuals, emphasizing how people differ from one another. However, this may mean that (Rolfe 1996, p. 332):

She is saying, in effect: my model, which applies to everyone, is that there are no models which apply to everyone. Thus, if the proper focus of nursing is the unique and individual therapeutic relationship, then neither models nor theories (nor indeed, research-based practice) have a primary role to play in the planning and implementation of nursing care.

Rolfe’s view presents an intriguing challenge: does the
mysterious of the brain through which our beliefs and intentions are expressed.

The emerging consensus is that we might mean to be the person. Indeed, her recent interest in ‘persons’ (Peplau 1995) suggested the almost infinite possibilities afforded by the exploration of interpersonal dialogue. As Oatley (1990, p. 83) observed:

Freud’s striking proposal is that in a dialogue, that can be retold in a story form, about abuses of power, about imperfections and evasions, we can take a few steps towards truths that may be transformative. It was this idea that Freud glimpsed; even if not quite clearly enough to transform himself.

Peplau had earlier remarked that: ‘language influences thought, thought then influences action; thought & action together evoke feelings in relation to a situation or context’ (Peplau 1969, p. 267). The interest in the role of language extends to contemporary cognitive scientists. Fodor (1983, p. 56) has acknowledged that:

Our privileged access to thoughts is, to a considerable extent, a matter of the contents of our beliefs and intentions being available for verbal report [emphasis added].

Common sense logic decrees that we could hardly overstate the importance of such ‘verbal reports’, as contributions towards our understanding of what it means to be a person, in any given situation – including that of health or illness. Yet, increasingly the examination and exploration of the state of being – on an existential level – has been marginalized. The emerging consensus is that we might understand what it means to be human, by unravelling the mysteries of the brain through which our beliefs and intentions are expressed.

This raises the question, what is the proper focus of nursing? (Barker & Reynolds 1996). More specifically, we might ask is nursing concerned with the ‘mind’ or its brain? Almost 20 years ago the US government pledged its support for a portfolio of neuroscientific research earning the 1980s the title ‘Decade of the Brain’. Although the impetus for that paradigm shift has grown exponentially, it remains unclear to what extent laboratory-based research will explain, far less resolve, human problems that may derive from a complex of person–environment interactions in the organized chaos of the everyday world (Barker 1996a). The influence of the ascendancy of neuroscience is now being felt within PMHN. It has been advocated that psychiatric nurses should accommodate various biomedical models of understanding human problems (e.g. Torrance & Jordan 1995) and should employ biological or psychopharmacological models as a means of understanding their patients (cf. Gournay 1995). Whether or not such approaches will help us understand those patients as persons (cf. Rolfe 1996) remains unclear. These views appear closely aligned to the contemporary drive towards ‘clinical effectiveness’ and ‘evidence-based practice’ (e.g. NHSE 1993), both of which appear to favour the perceived ‘gold standard’ of randomized control trials (RCTs) and the virtue of quantifying human experience.

At the risk of stereotyping, these latter-day representations of the ‘old (Cartesian–Newtonian) paradigm’ (cf. Capra 1976) appear to represent an overtly ‘masculine’ psychiatric world view: focused on the negative attributes of people; their conflicts and past traumas, or their contemporary consequences. That paradigm adopts an essentially rational, analytic, linear, objectifying, fragmenting, dismantling, disempowering and distancing approach to human distress; assuming the presence of a subject-object duality that neither fits with everyday experience nor with the propositions of contemporary physics, far less psychology and sociology. Ultimately, its conjoint aims may be the control of such psychiatric phenomena, through the refinement of its techniques. The ‘old paradigm’ may represent the patriarchal imbalance in post-modern society, one that fails to acknowledge – far less approve of – its ‘feminine’ side. Dawson (1997, p. 70) has argued that:

the language of nursing, of meaning, of care, of subjectivity and of spirituality has been suborned by the one-dimensional language of the technocratic society, which purchases a spurious exactness at the cost of meaning.

In healthcare that ‘old paradigm’ technocracy finds expression in materialism and managerialism, both of which implicitly challenge the principles upon which many nurses believe that nursing is founded, and is (Dawson 1997 p. 70):

revealed in the tortured vocabulary that attempts to reconstitute the whole from the pieces left strewn on the battlefield of rational investigation: ‘biopsychosociocultural’, ‘psychosocial’ mantras that are repeated ad nauseam in psychiatric nursing texts. The words them-
selves indicate the essentially divided and atomistic nature of the constructed reality that their enforced unity parodies; the mode of reasoning being employed is still, in essence, analytic rather than holistic, and the praxis is instrumental and objectifying.

In its ambition to ‘treat’ people, albeit compassionately, approaches derived from the ‘old paradigms’ largely eschew attempts at understanding. Despite its continued celebration of the value and relevance of post-positivist methodology (cf. Guba 1991), Western culture has been flooded with proposals for a ‘new paradigm’ of science; one that suggests the inherent wisdom of balancing ‘masculine’ and ‘feminine’ world views. Borrowing the Oriental metaphor of Yin and Yang, this new paradigm recognizes that science and the arts are complementary and, more importantly, emphasize the need to view human experience in terms of contexts and wholes, rather than isolated parts (cf. Barker 1998). Within the context of mental distress and health the new paradigm emphasizes the value: in research, of co-operative inquiry (Heron 1996); in practice, of working alliances (Anderson 1991); in mental health, of valuing personal experience (Chamberlin 1984, Fisher 1992); and, generally, of tolerating paradox and uncertainty (Ikehara 1995). Given these assumptions, the ‘new paradigm’ honours people’s feelings and intuition, recognizing that in deciding upon and enacting life change a person must first reclaim her (sic) inner wisdom and power.

Qualitative research methods are integral to this paradigm shift and nursing has, perhaps, embraced such approaches to human inquiry, more so than other health care disciplines. Several studies have suggested that the ‘value’ attributed to psychiatric nursing, by people receiving nursing, is predicated on the form and function of the interpersonal relationship (Barker 1995, Barker et al. 1997, Beech & Norman 1995, Hellzen et al. 1995, Wray 1994). These studies echo the dictum of the ANA (1980) that nursing is focused on human responses to health care problems rather than on the problems themselves. Of particular note, in this context, was the English national survey of over 500 former ‘patients’ which not only reported greater value attached to nurses over any other discipline, but a preference for the ‘soft focus’ of relationships over formal methods of counselling or therapy (Rogers, Pilgrim & Lacey 1993).

Even some psychiatrists have challenged the potential confusion between what might be happening in the brain as opposed to what might be happening within the person (cf. Thomas 1997). Given the importance of psychopharmacology in contemporary psychiatry, Healy (1990) proposed the need to re-establish a phenomenological approach to drug treatment: how do drugs affect the mind or the individual consciousness? These examples suggest that reflective psychiatrists also recognize the interpersonal importance of the psychiatric experience: persons may have as much of a relationship with their brains as they do with other aspects of their experiential world.

Relationships, partnerships and alliances

These contemporary developments carry discrete implications for the role of the PMH nurse. As awareness of the interdependent, or reflexive, nature of the interpersonal relationship grows, it has been recognized that ‘consumers’ of mental health services need (or perhaps rather deserve) a voice to determine their own affairs. This has led, indirectly, to greater emphasis being put upon the potential for, or desirability of, a more collaborative style of relationship; one guided more by co-operative inquiry than the objective style of inquisition often favoured by the ‘old paradigm’. Contemporaneously, the value (and virtue) of psychotherapy in general has been attacked (Masson 1988), and many mental health service consumers appear openly antagonistic to any form of ‘systematic’ therapy (Rogers, Pilgrim & Lacey 1993). Although representing differing perspectives, these critiques invite us to consider the potential of concepts such as ‘working in partnership’ (cf. DoH 1994).

Given that partnerships are predicated on equality, conspicuously absent from most, if not all, care and treatment settings, it might be more appropriate to consider a future established on alliances (cf. Bordin 1976). Such a concept might form the basis for exploring the interpersonal relationship between nurse and patient (sic). This concept might also represent a new dimension for the supervisory and mentoring relationship which, despite widespread popularity, is still misunderstood (Barker 1990). More than 30 years ago Peplau began to identify some of the issues involved (O’Toole & Welt 1989, p. 165):

(what would it [clinical supervision] be like?), e.g. a systematic study of instances of clinical data in one case or several cases; relevant literature; and a beginning formulation of an explanation of the data.

The kind of supervisory relationship which Peplau was discussing appeared to be predicated on a power relationship: where the supervisor and supervisees were defined, at least in part, by their respective qualifications, experience, etc. Currently, I am a member of a peer supervision group where, despite my professional status as ‘the Professor’ I am re-defined – by my colleagues – as being on the same level as the most ‘junior’ staff nurse member. The agenda for all meetings of the group are mutually negotiated and, despite the differentials in length of experience and social status, my contribution is (in principle) of no greater value.
than that of any other member. Such developments in the structure of clinical supervision suggest the potentially limitless range of ways in which nurses might come to know their professional practice (cf. Reynolds 1982). Such developments might even reflect one way in which the basic tenets of Interpersonal Theory might be used in contemporary practice to cover the processes governing the relationship with self and others, of both patients & nurses.

**The focus on the person: a future for human inquiry?**

In her keynote address to the second ‘State of the Art in Psychiatric Nursing’ conference, held in Columbus, Ohio in 1974, Peplau returned to one of her prevailing interests – people in schizophrenia. Perhaps, of equal significance to her consideration of how nurses might address the human responses associated with schizophrenia (cf. ANA 1980), was her assertion that nurses needed to emphasize the ‘personhood’ of patients. Two decades earlier, at the first ‘State of the Art’ conference, she urged her colleagues to recognize that (Peplau 1995):

> It is not enough to preach commitment to nursing or to patients. The commitment of a professional requires thinking deeply about unanswered questions, doing something to clarify them, and reporting results of actions to colleagues in the profession at large.

Peplau’s concern to explore the ‘personal’ and ‘human’ context of the expression of mental distress echoed the early writing of Harry Stack Sullivan, with whom Peplau worked early in her career at Chestnut Lodge (Barker 1993). Sullivan had observed that even the ‘most peculiar behaviour’ of the acutely schizophrenic patient was intelligible, since it comprised interpersonal processes ‘with which each one of us is or historically has been familiar’ (Sullivan 1947). In Sullivan’s view people were ‘all much more simply human than otherwise’, leading him to conclude that it was possible to understand psychotic phenomena, since we are all more alike than different. Sullivan represented a radical stance in post-war psychiatry that most of his contemporaries found too uncomfortable. His emphasis of the interpersonal and human nature of psychiatric care and treatment was revived 20 years later when Laing paid homage to Sullivan’s respect for the ‘patient’, repeating the apocryphal story that Sullivan told all young psychiatrists who came to work with him (Laing 1967):

> I want you to remember that in the present state of our society the patient is right and you are wrong.

It was not surprising that Sullivan’s views found an echo in the psychiatric counterculture of the 1960s. Given her history, neither is it surprising that Peplau should appear to be advocating a more inductive approach to gaining real understanding of the human experience of what is designated mental illness – through an acknowledgement of the personal nature of such experience. What is, perhaps, surprising is that in the late 1990s some psychiatric nurses advocate that we should return to the method of approaching patients (sic) against which Sullivan cautioned more than 50 years ago: treating people designated patients as if they were all likely to present the same phenomena (cf. Gournay 1995). There is room for all manner of inquiry in PMHN. However, attempting to understand the experience of human distress associated with mental illness (sic) may well be the ‘proper focus of nursing’ (Barker & Reynolds 1996; Barker, Reynolds & Stevenson 1997). The furtherance of an ‘existential epistemology of mental health’ may be one of the threads of human inquiry that will link tomorrow’s psychiatric nurses with Peplau’s original theory and may, in practice terms, be the royal road to care.

**Psychiatric nursing practice research: grounded inquiry**

As Peplau observed, nursing has for at least a generation espoused the virtues of person-centredness or holism or both (Peplau 1995). In keeping with such an attitude it may be appropriate for nurses to approach the person (sic) in much the same way that a student approaches any ‘subject’; with the expectation of learning something of interest or value. In my own clinical work and research I have attempted to extend the basic Peplau method (if there is such a thing) to integrate the twin philosophies of ‘personhood’ and ‘holism’ (Barker 1996b).

Almost a decade ago I counselled a young woman who had been described as having a depressive illness, in association with an ‘interpersonal relationship problem’, involving ‘especially men’. Her problems were attributed to her experience of rape in her early teens. When I first met her she was reluctant to discuss anything at all, and mumbled inaudibly in response to my question: ‘What have you brought along that you would like to talk about?’ (cf. Robinson 1983). Wholly intuitively I found myself saying:

> OK, maybe there is nothing that you would like to talk about. Maybe there is something that you need to talk about but don’t want to talk about. Talk about that then, but don’t tell me what it is.

When she appeared perplexed by this suggestion, again intuitively, I said: ‘well . . . just call it “X” or the “blue banana”!’ (at which point she laughed, incredulously). After a pause, I returned to the tried-and-tested interviewing technique that I had derived from Peplau’s writings:

> OK, tell me . . . when did you first notice that X (or are
The rest was, as they say, history. I saw the young woman only twice: the second time when she came back to report that 'things are much better' and that she had 'got my life back on track'. From that single clinical experience, I developed a method for teaching nurses how to interview people without knowing what (exactly) was the patient’s problem. This allows the exploration of at least eight dimensions of any anonymized problems: from its ‘origins in time’ to its holistic context (Barker 1997). A delimited study (Barker 1996b) suggested that nurses can explore the person’s problem without becoming overly concerned with the detail of the story, and in the process appear, by the patient’s account, to develop considerable rapport. More importantly, the approach affords the person qua patient a degree of security that might prove helpful in the early stages of the development of therapeutic relationship. Although nurses could apply this method in any clinical situation, it may have special applications in contexts where the patient is reluctant to discuss the focal phenomenon, for fear of negative evaluation by the nurse or others: experience of sexual abuse or hallucinations.

Other areas of practice that offer fertile conditions for the further examination of Peplau’s theory in its original form, or as part of some wider research brief include:

- the assessment of the patient’s interpersonal world (Barker et al. 1997);
- mutual assessment of the nurse–patient relationship;
- the outcomes of focused relationships – e.g. on the experience of discrete phenomena such as hearing voices;
- the experience of long-term drug therapy; and
- invisible forces and subconscious crises.

I was honoured to be asked to give the first keynote address to the inaugural conference of the nursing section of the Association of Psychoanalytic Psychotherapists in the NHS (APP) at the Tavistock Clinic in London in 1996. In my paper I discussed the respective contributions made by Peplau – and her British counterpart, Annie T. Altschul – to the development of interests and expertise in the therapeutic use of the nurse-patient relationship (Barker 1997, Winship 1997). I was struck by the number of participants – many of them sophisticated nurse psychotherapists – who knew little of Peplau’s work, or the huge literature associated with her Theory of Interpersonal Relations. I was similarly intrigued by the relative absence of references to the nursing literature in some of the clinical papers that followed. This experience echoed Peplau’s observation, made in her Preface to the report on the first state of the art conference (Huey 1975; Peplau 1995, p. ix):

Psychiatric nurses need to judge what has been done in the light of such questions as: How adequate is the published theory? Is it all borrowed from other basic or applied sciences or have psychiatric nurses suggested new concepts or practices or expanded existing ones? In the light of changing nurse practice acts and other social and health care trends, what are the weak, unexplored, untouched areas that should capture the interest of psychiatric nurses in theory scholarly and research efforts in the years ahead?


- most psychiatric nursing textbooks, while emphasising the nurse-patient relationship, base nursing actions on non-nursing theory, particularly psychoanalytic or sociocultural theory.

Twenty years later, Peplau echoed that observation, when she commented on ‘seven recently published books on PMHN’:

I expected to find a psychiatric nursing approach to the care of persons diagnosed as schizophrenic that would be complementary to but different from the prevailing biomedical model of psychiatric treatment. The DSMIII-R … was presented in whole or in part in virtually all chapters. In several texts, schizophrenia was described with pessimistic words such as ‘irreversible’, ‘chronic’ and life-long, rather than as a persistent enigma for which the health professionals have not yet found reliable explanatory theories and effective remedial measures…. Most of the bibliographic references cited were non-nursing psychiatric ones; only two authors used quite a few nursing publications; one author did not use any nursing references (emphasis added).

I was struck by the fact that, 20 years into her retirement, Peplau retained a sense of purpose, concerning the clarification of nursing theory and practice. She also exhibited a concern for the human condition, which appeared to be missing from my generation, who were still young children when Peplau first published her seminal text (Peplau 1952). One might argue that, in her advocacy for ‘persons’ in schizophrenia (or indeed any other category of human distress), Peplau is still holding the baton of human inquiry (and compassion) that may have been held by Sullivan, and was held briefly by Laing and others. Clara Thompson, a long-time colleague of Sullivan’s, suggested that his principal contribution to psychiatry was a very simple idea (Hausdorff 1985):

… ever present awareness of the need to convey respect for the patient and to maintain the patient’s own self-esteem.
Sills’ appreciation of Peplau (Sills 1989) clearly indicates that she perceived her in a similar light. If psychiatric nurses could continue to explore, collaboratively – with the people in their care – the experience of human distress, then they might honestly be said to be ‘working in partnership’ (DoH 1994) or involved in the development of ‘mental health nursing’, predicated on human growth and development, derived from the logic of their own experience (Barker 1996b).

Notes

1 Where I am making ‘personal’ observations it seems appropriate to employ the first person.
2 I use this conjoint title to convey the mutual interdependence that I believe Peplau intended.
3 My speculations about the future are, like most such thoughts, woven through my past and present experiences.

References


