**Why you should read this article:**

- To learn more about the therapeutic relationship and its central role in mental health nursing practice
- To find out how nurses can use themselves as an instrument of care in the therapeutic relationship
- To count towards revalidation as part of your 35 hours of CPD, or you may wish to write a reflective account (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

# Exploring the therapeutic relationship in nursing theory and practice

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## Abstract

The therapeutic relationship is widely regarded as central to nursing practice, yet the concept is so familiar that it is easily taken for granted. However, like any relationship, a therapeutic relationship cannot be assumed, and to be therapeutic it requires investment from both nurse and service user. This article outlines the theoretical background and fundamental components of the therapeutic relationship, such as self-awareness, reflection and professionalism. The author also describes the skills required to develop therapeutic relationships with service users and introduces a new mnemonic – ATTACH – which encapsulates some of these qualities and skills.

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## Keywords

communication, interpersonal skills, mental health, mental health therapies, nurse-patient relations, nursing models and theories, professional, professional issues, therapeutic relationships

## Aims and intended learning outcomes

The aim of this article is to provide an overview of the therapeutic relationship in nursing theory and practice, detailing its importance in mental health nursing and the essential qualities and skills required of mental health nurses. After reading this article and completing the time out activities you should be able to:

- Explain the concept of the therapeutic relationship, its theoretical background and the associated contemporary theories.
- Recognise how the therapeutic relationship is linked to a person-centred approach.
- Understand how mental health nurses can use themselves as an instrument of care in the therapeutic relationship.
- Describe some of the essential qualities and skills required to develop optimal therapeutic relationships with service users.

## Introduction

More than any other field of nursing, mental health nursing relies on the way in which mental health nurses connect with those who seek support and care – that is, mental health nursing relies on the development of an optimal therapeutic relationship. The term 'therapeutic relationship' is found in most care plans and nursing textbooks, although other terms with the same meaning are used as well, such as 'working alliance', 'nurse-patient relationship' and 'helping alliance'. For the service user, the experience of working with a mental health nurse who connects with them in such a way that they feel valued and heard is vital, since it creates the optimal environment for the development of a therapeutic intervention. Yalom stated that an optimal therapeutic relationship represented healing 'in its own right' (Yalom 1980), since the relationship is the conduit for the therapy.

The therapeutic relationship forms the 'backbone of nursing practice' (Moreno-Poyato and Rodríguez-Nogueira 2020), yet it is so familiar that it is easily taken for granted. However, like any relationship, the

therapeutic relationship cannot be assumed, and to be therapeutic it requires investment from both parties.

This article considers how nurses can recognise their part in the development of a therapeutic relationship, which involves a conscious and deliberate attempt to create a safe space where nurses can become a catalyst for the service user's recovery. The article outlines the theoretical background and fundamental components of the therapeutic relationship. The author also describes the essential qualities and skills required to develop optimal therapeutic relationships with service users and introduces a new mnemonic, proposed by the author, which encapsulates some of these qualities and skills.

## Theoretical background

Freud is considered to have established the concept that the relationship between patient and therapist is central to the therapy itself. He is also credited with being the first to use the term 'therapeutic relationship', which he defined as a 'friendly affectionate feeling' (Freud 1912). Freud also recognised that perspectives can be distorted within the therapeutic relationship because of unconscious and emotional factors (Breuer and Freud 1885, Freud 1936). Freud also introduced the term 'psychodynamics' (Freud 1936). According to the psychodynamic approach, people's behaviour and the mental health issues they experience can be traced beyond the conscious self to the subconscious mind and have their roots in conflicts between the different elements of the self.

### Peplau's and Bordin's models

Hildegard Peplau (1909-1999), an American nurse and nursing theorist, was influenced by the psychodynamic approach theorised by Freud and his followers. In her 'nurse-patient relationship' model, Peplau emphasised the unique and individual experience of the nurse and the patient. She described different roles nurses have in the relationship, including the 'mother-surrogate', the 'technician', the 'manager', the 'socialising agent', the 'health teacher' and the 'counsellor or psychotherapist' (Peplau 1952, 1988). Later, Peplau developed her 'interpersonal relations model', which comprises four phases, experienced sequentially as the therapeutic relationship develops (Peplau 1988):

- Orientation phase – this is the introductory phase when the service user and nurse first meet and each one determines their part in the relationship. This is when the connection is made and trust is established. However, as McCormack and McCance (2017) pointed out, trust is not immediate; first you must develop a rapport, which requires considerable skill.
- Identification phase – this refers to the identification of the service user's needs and how these can be addressed by establishing a care plan and determining who needs to be involved. At this stage, the nurse needs to create a sense of hope and optimism enabling the service user to recognise the potential for recovery.
- Exploitation phase – although the term 'exploitation' may sound inappropriate when discussing a therapeutic relationship, it is used by Peplau to refer to the use of the resources available to address the service user's issues and to support the service user to develop independence.
- Resolution phase – this is a period of evaluation, when the goal of therapy is revisited and the nurse prepares the service user for the end of the relationship.

**TIME OUT 1**

Reflect on a therapeutic relationship that you have developed with a service user and which led to their recovery. How did you establish, develop and sustain a bond with that person? How did you work with them to identify and agree the goal of the therapeutic relationship? How did you negotiate the tasks required to reach that goal?

While Peplau (1952, 1988) focused on the various roles that nurses have in the nurse-patient relationship, Bordin (1979, 1994) focused on three interdependent components of the working alliance (another term for therapeutic relationship):

- Goal – identifying and agreeing a therapeutic goal.
- Task – negotiating the tasks required to reach that goal.
- Bond – sustaining a bond as the relationship progresses.

The bond in Bordin's model is the equivalent to the concept of secure attachment first described by Bowlby (1980) and more recently by Skourteli and Lennie (2011). Bordin's model may appear simplistic, but it integrates the fact that relationships do not necessarily develop in 'straight lines'. They are constantly renegotiated as the individuals involved develop rapport, establish trustworthiness and try to understand the service user's narrative. Additionally, the nurse and service user will not always 'see eye to eye', so the process of working together to negotiate an acceptable

## Key points

- Effective mental health nursing relies on the nurse's ability to develop an optimal therapeutic relationship with service users
- Freud established the concept that the relationship between patient and therapist is central to the therapy itself
- Contemporary theory challenges the concept of the nurse as 'problem solver', instead regarding the therapeutic relationship as one founded on collaboration, partnership and mutuality
- The mnemonic ATTACH encapsulates the qualities required by any nurse seeking to develop an effective therapeutic relationship – authenticity, trustworthiness, time-making, approachability, consistent communicator and honesty

care plan may produce a breakdown in the relationship, sometimes referred to as an 'alliance rupture'. Bordin (1979, 1994) believed that it was the subsequent healing of the relationship that enabled change.

### Contemporary theories

Contemporary theories about mental health nursing challenge the concept of the nurse as 'problem solver', as described by Morgan (1996), instead adopting a position where the therapeutic relationship is founded on collaboration, partnership and mutuality, and where there is shared ownership of care planning (McKeown et al 2017). The concept of the therapeutic relationship has also been enhanced by the application of evidence-based practice and shared decision-making in clinical practice (Barker and Williams 2018, Moreno-Poyato and Rodríguez-Nogueira 2020).

It has been postulated that engagement is the precursor of the therapeutic relationship since a relationship cannot develop until a connection has been made. For example, Ryan and Morgan (2004) described engagement as 'a separate and distinct function, the foundation of all aspects of the therapeutic process. It is an attempt to develop an on-going constructive partnership and will most usually be facilitated by a series of unstructured, informal and shared encounters, that take place at the beginning of the process of relationship building. It is a therapeutic activity within its own right, needing to be positively monitored and sustained throughout the duration of the helping process.' Ryan and Morgan's (2004) reference to a 'constructive partnership' is worth noting since, in contemporary nursing practice, nurses aim to build a therapeutic relationship based on equality, respect and co-production of care, where the service user and nurse negotiate the care plan together and agree on the appropriate interventions and approaches (Rippon and Hopkins 2015).

**TIME OUT 2**

Think about the qualities and skills you use when you meet a service user for the first time. What would you do or say to make them feel safe and to gain their trust? Similarly, how do you prompt them to engage in the therapeutic relationship?

## Acting as an instrument of care

In any therapeutic relationship, the nurse acts as their own instrument of care, using themselves in their practice, and thereby developing person-centred care on a human level (Wright 2010). Rowan and Jacobs (2002) described the ability to become a 'therapeutic instrument' at will, reflecting Barker and William's (2018) view of compassionate communication as requiring awareness of oneself as well as of the needs of the other person.

Benner (1984) discussed the skills nurses require to increase their self-awareness and reflect on their practice. Along with Schön (1983), Benner (1984) suggested that nurses' actions are often intuitive rather than considered. This led Schön (1983) and Benner (1984) to recommend that nurses should reflect more on their practice, the rationale for their decisions and their effect on others. It was theorised that this would enable nurses to practise in an evidence-based way that was informed by their experience, thereby achieving enhanced outcomes. The inference was that nurses who are not self-aware will be less able to recognise the effect they have on others and may therefore develop an unprofessional or ineffective therapeutic relationship with service users.

Freshwater (2002) reinforced this concept of self-awareness, arguing that when a person is unwell, they perceive themselves differently and that it is the nurse's responsibility to assist the person to achieve a '(re)emergence of the self'. However, this can only happen if the nurse is self-aware, and holds an optimistic view of the person's potential to recover. This humanistic approach resonates with the work of Rogers (1961), who explained how the therapist needs to take a person-centred approach and view the person with 'unconditional positive regard'.

## Measuring the therapeutic relationship

There are several scales used to measure the therapeutic relationship. To a large extent, they are used in psychotherapy practice, rather than mental health nursing – which is why they employ the term 'therapist', for example. Probably the most well-known of these scales is the 12-item Working Alliance Inventory (WAI) (Bordin 1994). The 12 WAI items comprise some general questions about the person's demographics and health, as well as statements where they are asked to mark their response on a continuum; for example, between 'I did not feel heard, understood, and respected' and 'I felt heard, understood and respected.' The items are rated on a Likert-type scale and assess the three components of Bordin's (1994) model (goal, task and bond) (Hatcher and Gillaspy 2006).

Kim et al (2001) developed the Kim Alliance Scale to measure the effectiveness of the 'alliance' (another term for therapeutic relationship), which has four components – collaboration, communication, integration and empowerment – which are measured using

a 16-item scale. The term empowerment is controversial, however, since it implies that the therapist holds some form of power that they 'gift' to the patient so that they are able to act independently and exercise self-determination (Wright 2015).

While not a measure of the therapeutic relationship as such, the Interpersonal Reactivity Index (IRI) developed by Davis (1983) measures a person's empathy, which Davis (1983) defined as the 'reactions of one individual to the observed experiences of another'. The IRI contains 28 items divided into four subscales (Davies 1983):

- Perspective taking – an individual's tendency to spontaneously adopt the psychological point of view of others.
- Fantasy – an individual's tendency to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies and plays.
- Empathic concern – an individual's 'other-oriented' feelings of sympathy and concern for 'unfortunate others'.
- Personal distress – an individual's 'self-oriented' feelings of personal anxiety and unease in tense interpersonal settings.

### TIME OUT 3

Consider a therapeutic relationship with a service user that you have developed recently. In this relationship, did you manage to find an optimal balance between authenticity and professional distance, and between showing empathy and demonstrating clinical expertise? To assist in establishing the relationship, did you use any of the following techniques?

- Active listening – to demonstrate that you acknowledge and respect the service user's concerns
- Paraphrasing and summarising – to explore in more depth their circumstances, experiences and concerns

## Essential qualities and skills

If it is accepted that the therapeutic relationship is fundamental to person-centred care, it is important to recognise the essential qualities and skills that are required to ensure that any relationship is useful. A new mnemonic designed by the author encapsulates some of these qualities and skills. The mnemonic spells the word ATTACH (authentic, trustworthy, time-maker, approachable, consistent communicator, honest), which reflects Bordin's (1994) focus on the bond between the therapist and the service user. Table 1 provides a rationale for each element of the ATTACH mnemonic.

### Being authentic

Authenticity is characterised by trustworthiness, honesty, reliability, openness, compassion and genuine hope for service users' recovery. However, authenticity needs to be underpinned by evidence-based practice (Bugental 1987). In the author's clinical experience, humanness, compassion, reliability, hope and optimism enable nurses to be authentic, while evidence-based practice enables them to provide care from an informed position. The combination of authenticity and evidence-based practice enables nurses to be regarded as dependable and reliable professionals.

Daniel (1998) identified vulnerability as a vital element in authenticity, explaining that 'vulnerability gives nurses the opportunity to be authentic'. Daniel urged nurses to recognise their own vulnerability so that they could recognise vulnerability in others, enter 'mutual vulnerability' and develop a relationship which acknowledged their shared humanity with the service user.

When nurses are authentic, they become believable provided that they remain focused on each individual service user. As Christiansen (2009) explained, 'it is not enough to "be yourself" when caring for patients; one has to be able to use one's personality in a flexible way that is adapted to each individual patient and each situation'. It is possible – and vital – for nurses to be authentic without crossing professional boundaries; professional boundaries create a safe space in which trust can develop. For this reason, the Nursing and Midwifery Council (NMC) expects its registrants to 'stay objective and have clear professional boundaries at all times with people in [their] care' (NMC 2018a).

### Being trustworthy

Trust is fundamental to the therapeutic relationship (Peplau 1952, 1988, Travelbee

**Table 1. Rationale for each element of the ATTACH mnemonic**

| | | |
|---|---|---|
| A | Authentic | Displaying authenticity with service users is crucial, since the mental health nurse is their own instrument of care and uses themselves in their practice |
| T | Trustworthy | Being a reliable and well-informed professional encourages service users to trust the mental health nurse, their judgement and practice |
| T | Time-maker | Making time to 'be with' service users encourages them to feel cared for and listened to, and enables the nurse to discuss the timeframe of care, including the potential end of the therapeutic relationship |
| A | Approachable | Being approachable enables the nurse to demonstrate that they are accessible and visible, can act as a good listener and provide empathic responses |
| C | Consistent communicator | Demonstrating effective communication is crucial and nurses also need to provide consistent messages |
| H | Honest | Being honest is a fundamental value for nurses and enables them to have open and realistic conversations with service users |

1971, Forchuk 1994, Clarkson 2003, Wright and McKeown 2018), since confidential disclosure is impossible without it (Bond 2015). It would be easy for nurses to believe that if they are compassionate and caring, service users will automatically trust them. Rather, nurses need to recognise that certain features of service users' experience – for example, the paranoia and suspicion that can accompany psychosis; adverse childhood events; or anxiety about the treatment itself such as can be seen in anorexia nervosa – may interfere with their ability or willingness to trust. Whether service users feel able to trust also depends on their previous and current relationships, including with mental health professionals and services. Nurses need to support service users to feel safe and confident in their treatment, since many may feel misunderstood and anxious (Wright and Hacking 2012).

Dickinson (2011) suggested that people are constantly striving to achieve authenticity and their capacity to trust others is one of the important factors in this endeavour. Using themselves in their practice means that nurses have to access fundamental human qualities such as trustworthiness, honesty and openness (Peterson and Seligman 2004, NMC 2018a). However, the primary role entrusted to nurses by service users is to provide evidence-based care; therefore, simply using themselves in their practice is not sufficient for nurses to gain service users' trust. In their participatory action study, Moreno-Poyato et al (2021) found that nurses who demonstrated an optimal knowledge of evidence-based practice and who demonstrated a professional attitude were better able to engage in shared decision-making with service users, compared with nurses who had a suboptimal knowledge of evidence-based practice.

### TIME OUT 4

Identify any barriers to developing optimal therapeutic relationships that exist in your practice setting and discuss them with your colleagues and/or with your clinical supervisor. Can these barriers be overcome and if so, how?

## Being a time-maker

For nurses, finding time to 'be with' service users can seem an impossible task, considering the many other priorities that require nurses' attention. Taking the appropriate approach in the time available to them and making the most valuable and realistic use of that time is paramount. Being aware of the elements that may impede the therapeutic relationship, such as a lack of time, is the first step in overcoming such barriers. According to Harris and Panozzo (2019), 'if the nurse is not aware of how he or she responds to time pressure, frustration or lack of clarity of practice policy … there is a risk that the patient may perceive the nurse's actions as lacking in care, presence or involvement'.

Such is the emphasis on developing a therapeutic relationship that it can be easy for the nurse to forget that the ultimate goal is for the service user to reach a position of independence where separation from the nurse and mental health services is possible, and where the service user can be safely discharged. This stage of the therapeutic relationship is referred to as the 'resolution phase' by Peplau (1988) and the 'termination phase' by Mann (1973) and Macneil et al (2010). Nurses need to ensure that during the course of the therapeutic relationship they make frequent reference to this ultimate goal in preparation for discharge; this will prevent service users from feeling abandoned or betrayed (Ryle 1995). If undertaken effectively and within professional boundaries, the resolution phase will occur incrementally as the goals of treatment are being met, and the service user will feel safe and secure about the impending separation.

### TIME OUT 5

As part of the celebrations for its 100th anniversary, the Royal College of Nursing asked healthcare support workers to share their expertise and contributions to patient care. This resulted in '100 top tips,' many of which relate to communication and empathy. Visit rcn.org.uk/centenary/projects/100-top-tips/communication-and-empathy to read these 'top tips.' Consider whether you find any of them useful in relation to the therapeutic relationship. What are your 'top tips' for developing optimal therapeutic relationships with service users?

## Being approachable

In general, being approachable usually means being friendly and kind, but for mental health nurses there are more elements involved; for example, being accessible and visible, being a good listener and providing empathic responses. Nurses can develop approachability by demonstrating compassion and kindness. Being approachable also means being accessible and open to listening to other people's perspectives. Since mental health nurses are often seen as being in a position of authority, creating approachability enables partnership working and co-production of care with service users.

Very few studies have considered approachability in the healthcare professions and none has explored it in relation to mental

health nursing. A recent study by Petronio-Coia and Schwartz-Barcott (2020) researched approachability in children's nursing. The authors concluded that it was the responsibility of the children's nurse to ensure that those in their care were heard, understood and respected with 'unprecedented dignity' – a position that is transferable to mental health nursing.

### Being a consistent communicator

Service users rely on consistent communication from all members of the multidisciplinary team, since inconsistency causes confusion and mistrust. McCarthy (2011) described the importance of optimal communication in vivid terms, stating that 'communication is the food of relationships. Good communication is nourishing, delightful and memorable. It creates intimacy, enriches us and we become better people. Poor communication is like bad food – poisonous and harmful.' McCarthy (2011) discussed communication in the context of dementia care, outlining person-centred approaches for families and carers of people living with dementia; however, the quality of communication is paramount in all care settings and has profound effects on the therapeutic relationship.

In its standards of proficiency for registered nurses, the NMC clearly states that 'effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges' (NMC 2018b). Furthermore, the standards of proficiency for registered nurses outline a wide range of communication and relationship management skills that nurses need to be able to demonstrate such as making appropriate use of open and closed questioning and employing clarification techniques (NMC 2018b).

### Being honest

The NMC states that, to uphold the reputation of the nursing profession, nurses must 'act with honesty and integrity at all times' (NMC 2018a). Honesty is required in many aspects of the therapeutic relationship. For example, honesty means being open and realistic about treatment options and possible outcomes; being clear about how service users' information may be shared with others; and nurses being honest with themselves in the evaluation of their practice (Oliver 2017, Price 2019). Being honest and open requires nurses to demonstrate sensitivity and the ability to perceive how service users are receiving their messages.

It can be tempting for nurses to attempt to make the therapeutic relationship more honest and open by using self-disclosure – that is, the sharing of the nurse's own experiences with service users – because this can create a sense of shared experience and identification. A degree of self-disclosure has been shown to enable nurses to connect with service users because they share certain interests (Wright and Jones 2012); or simply because it allows them to talk about 'normal stuff' (Jones and Wright 2017). Unhjem et al (2018) found that the common reason for nurses to share their experiences with patients was because it felt natural to respond to service users' questions. However, Unhjem et al (2018) also stated that the outcomes obtained from nurse self-disclosure vary and are not consistent. Also, self-disclosure can create confusion, where 'friendliness' is mistaken for 'being a friend', thereby blurring professional boundaries and creating tensions (Hem and Heggen 2003). If the nurse finds themselves sharing details of their own experiences with a service user, it is advisable for them to stop and think whether this is of any benefit to the therapeutic relationship, remembering that the service user must always be the focus of the interaction.

## Conclusion

Developing optimal therapeutic relationships with service users is crucial at all levels of mental health nursing practice. The therapeutic relationship places nurses in a prime position to become a catalyst for change and to work with service users towards their recovery. When engaging in therapeutic relationships, nurses should demonstrate self-awareness, empathy and professionalism, and support their practice with evidence-based approaches. The mnemonic ATTACH encapsulates some of the essential qualities and skills required to develop optimal therapeutic relationships with service users.

**TIME OUT 6**

Consider how developing optimal therapeutic relationships with service users relates to The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC 2018a) or, for non-UK readers, the requirements of your regulatory body

**TIME OUT 7**

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: **rcni.com/reflective-account**

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# Therapeutic relationship

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

**1. Which of the following is not another term for therapeutic relationship?**

a) Working alliance ☐
b) Socialising relationship ☐
c) Nurse-patient relationship ☐
d) Helping alliance ☐

**2. The 'mother-surrogate' is a role of the nurse in which model?**

a) Therapeutic-relationship model ☐
b) Cognitive behavioural therapy model ☐
c) Mindfulness model ☐
d) Nurse-patient relationship model ☐

**3. What is the identification phase in Peplau's 'interpersonal relations model'?**

a) The introductory phase, when a connection is made and trust established ☐
b) A phase when the nurse uses self-disclosure to create a sense of identification in the service user ☐
c) The phase involving identification of the service user's needs and how these can be addressed ☐
d) A phase when the nurse identifies whether the service user has reached independence ☐

**4. What are the three components of Bordin's 'working alliance'?**

a) Goal, task and attachment ☐
b) Aim, task and bond ☐
c) Goal, task and bond ☐
d) Goal, task and rapport ☐

**5. For nurses, acting as an instrument of care in the therapeutic relationship involves:**

a) Using themselves in their practice ☐
b) Using service users in their practice ☐
c) Ignoring a service user's viewpoint ☐
d) Holding a pessimistic view of the service user's potential for recovery ☐

**6. Who said that the therapist needs to view the patient with 'unconditional positive regard'?**

a) Rogers ☐
b) Freud ☐
c) Breuer ☐
d) Peplau ☐

**7. Integration is a component of which scale?**

a) Psychometric Properties Scale ☐
b) Kim Alliance Scale ☐
c) Waterlow Scale ☐
d) Therapeutic Engagement Questionnaire ☐

**8. Which of the following are subscales of the Interpersonal Reactivity Index?**

a) Perspective taking ☐
b) Fantasy ☐
c) Personal distress ☐
d) All of the above ☐

**9. For Daniel, the key to authenticity is:**

a) Openness ☐
b) Honesty ☐
c) Vulnerability ☐
d) Compassion ☐

**10. Which of the following statements is correct?**

a) To demonstrate authenticity the nurse must cross professional boundaries ☐
b) Professional boundaries create a safe space in which trust can develop ☐
c) Professional boundaries confine the nurse to a position of authority ☐
d) Optimal professional boundaries are created through self-disclosure ☐

## How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

**You may want to write a reflective account. Visit rcni.com/reflective-account**

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to **rcni.com/cpd/test-your-knowledge**

This multiple-choice quiz was compiled by **Anne-Claire Bouzanne**

**The answers to this quiz are:**

1. b 2. d 3. c 4. c 5. a 6. a
7. b 8. d 9. c 10. b

**This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:**

Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor ☐

As a result of this I intend to: _____

_____

_____

_____