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LETTER TO THE EDITOR

WILEY

Covid 19: Transcending social distance

Before 2020, the term "social distancing," while not new, was barely known. The concept was promoted by the World Health Organization in 2008 as a public health measure to prevent transmission of influenza, and in various forms, it can be identified in reference to epidemics going back hundreds of years. However, in common parlance social distancing is more likely to have been associated with stigma or social class, something with negative connotations, something to be avoided. Since COVID-19, however, social distancing has become a mainstream concept, associated with personal safety and the safety of others. For nurses, social distancing has become a professional obligation and a clinical imperative. This is a strange and unusual situation. The idea of maintaining two metres distance between ourselves and the people we care for seems antithetical to the notion of a therapeutic relationship. Therapeutic relationships require acute awareness of boundaries, physical and emotional, but it is hard to imagine maintaining such relationships without the freedom to negotiate the space between nurse and patient. COVID-19 does not permit a reassuring touch or the polite social ritual of a handshake, much less the warmth of a hug. We regard therapeutic relationships as fundamental to our practice, and ourselves, our bodies, emotions, thoughts and behaviours as fundamental tools. When we talk about a nurse being "distant," we do not mean safe and respectful; we mean non-engaged, uninvolved and detached. Enforced distance is not something that sits easily with the imperative to close the space between ourselves and those we care for. For people inpatient settings, there may be the alienating experience of nurses in uniform, behind masks, and insisting on two metres of space.

But mental health nursing has been here before. In the 1970s, we learnt, as a profession, to take skills developed in the restrictive physical environment of psychiatric hospitals and apply them in the unfamiliar environment of the outside community and people's homes. For many of us, that was an uncomfortable experience. But we have adapted our practice to general hospitals, prison settings, emergency departments, police patrols, courtrooms, schools, primary care and other unfamiliar contexts. We have even claimed, not without justification, that therapeutic relationships can survive coercive interventions, compulsory care and restrictions on personal freedoms. Can the distancing strategies necessitated by the pandemic be similarly negotiated, providing opportunities to protect the health of those we care for and ourselves, while maintaining therapeutic engagement? The stakes are high. COVID-19 is not a benign disease. There is no precedent to fall back on. In the absence of any literature, guidelines or clinical protocols, nurses have begun to discuss experiences on social media, sharing examples of helpful practices. These include substituting online communication for home visits, adapting ward environments to provide alternative social activities, supporting staff to take breaks when the pressures of work become intense and ensuring clear information is available to guide practice. Compassionate leadership that is responsive to staff has been recognized as critical. What these practices have in common is the attempt to transcend the limitations of social distance and to retain the therapeutic relationship at the heart of mental health nursing. Social distance does not have to be emotional distance.

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