Module to Increase Communication Skills of Nurses

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MODULE TO INCREASE COMMUNICATION SKILLS OF NURSES

by

Mary Kay Schultz

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A special thanks to my parents, Francis and Mary for instilling in me their attitudes and beliefs about people and education.
VITA

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>VITA</td>
<td>iii</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Need for Study</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Summary</td>
<td>6</td>
</tr>
<tr>
<td>II. REVIEW OF HISTORICAL AND SOCIO-PSYCHOLOGICAL PERSPECTIVES AND COMMUNICATION DEFICITS OF NURSING</td>
<td>7</td>
</tr>
<tr>
<td>Historical Perspective of Nursing</td>
<td>7</td>
</tr>
<tr>
<td>Socio-Psychological Perspective of Nursing</td>
<td>11</td>
</tr>
<tr>
<td>Communication Deficits in Nursing</td>
<td>17</td>
</tr>
<tr>
<td>Summary</td>
<td>21</td>
</tr>
<tr>
<td>III. BACKGROUND CONCERNING SPECIFIC COMPONENTS OF MODULE</td>
<td>22</td>
</tr>
<tr>
<td>Values Clarification</td>
<td>24</td>
</tr>
<tr>
<td>Active Listening</td>
<td>28</td>
</tr>
<tr>
<td>Assertiveness Training</td>
<td>31</td>
</tr>
<tr>
<td>Summary</td>
<td>39</td>
</tr>
<tr>
<td>IV. MODULE TO INCREASE COMMUNICATION SKILLS OF NURSES</td>
<td>40</td>
</tr>
<tr>
<td>Values Clarification</td>
<td>43</td>
</tr>
<tr>
<td>Active Listening</td>
<td>66</td>
</tr>
<tr>
<td>Assertiveness Training</td>
<td>86</td>
</tr>
<tr>
<td>Summary</td>
<td>132</td>
</tr>
<tr>
<td>V. SUMMARY</td>
<td>133</td>
</tr>
<tr>
<td>Restatement of the Purpose of the Study</td>
<td>133</td>
</tr>
<tr>
<td>Discussion and Conclusions</td>
<td>135</td>
</tr>
<tr>
<td>Limitations of Study and Recommendations</td>
<td>139</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>141</td>
</tr>
</tbody>
</table>

iv
CHAPTER I

INTRODUCTION

Need for Study

The increasing shortage of hospital based nursing personnel has reached critical proportions. This problem is most predominant in the Midwest and is particularly evident in large hospitals. There is much greater nurse resistance to employment in metropolitan areas which results in a serious nurse supply problem in these areas. A study performed by the Illinois Hospital Association in January, 1980, showed that 15 percent of budgeted staff registered nurse positions in Chicago hospitals were vacant. This represents 2,580 positions. The inclusion of other than staff nurse vacancies results in a yield of 2,758 vacant registered nurse positions (Illinois Hospital Association, 1980).

This shortage has affected patient care in a variety of ways. Forty-eight hospitals in Illinois reported temporary or permanent closure of 891 beds or 1.5 percent of the total bed compliment in 1979 because of nursing staff vacancies. This indicates that persons requiring hospitalization had to wait a longer time to be admitted. This delay can result in increasing severity of the disease process, can postpone treatment, and may lengthen the time required to treat the ailment. Prolongation of physical and psychological discomfort for the patient and significant others may also accompany delayed hospitalization.
Another result has been the use of temporary nursing personnel services. These services provide nursing personnel on an on-call basis and charge the hospital a per diem rate based on the type of personnel and the length of service supplied. Use of these services results in concern by nursing management for the quality and consistency of patient care delivery. Nurses not familiar with patients or policies and procedures of a particular institution may be responsible for rendering care. Orientation for these nurses varies and may result in the nurse not even knowing location of life-saving equipment. Evaluation and training of these nurses is difficult as their stay in a particular hospital is many times very limited. This limited commitment also may result in patients being cared for by many different nurses. The Illinois Hospital Association (1980) study showed 68 percent of the hospitals reporting from Chicago utilized temporary nursing services in 1979.

While health care technology, including nursing, is advancing, there are not enough nurses available to successfully implement these new methods. Increasing sophistication in medical care frequently results in prolongation of life which subsequently results in increased need for nursing skills. A few decades ago premature infants usually died, now many survive through use of newly developed techniques and equipment. The same can be said for every area of health care. The increasing life expectancy also speaks to this issue. In essence, there are more people requiring the benefits of medical advances, and not enough working nurses to supply them. Although health care facilities are expending great sums of money to recruit and retain
registered nurses, the shortage places more physical and mental stress upon those nurses who are working which frequently causes them to leave their jobs and possibly the profession. The American Nurses Association estimated in 1980 that 30 percent of today's 1.4 million qualified, nonretired nurses are currently not working in the field, by choice. It also estimates that 40 percent of the nurses currently active are only working part time (Donovan, 1980). According to a survey done by RN magazine of nurse career patterns, 40 percent of the nation's licensed registered nurses drop out of active nursing at some point in their professional lives (Donovan). The Nurses Almanac of 1978 lists a variety of miscellaneous positions in which nurses are sometimes employed. These include: airline hostess, assistant to mortician, camp counselor, demonstrator of appliances and food, executive secretary, kindergarten worker and lobbyist. This same publication compared job satisfaction of nurses with the average United States worker and reported 44 percent of nurses were dissatisfied with their job compared to 11 percent of the average U.S. work force (Rowland & Rowland, 1978, p. 101). It should be noted that the conditions regarding this national survey were not specified but there certainly seems to be a definitive trend present.

Reasons given for nurses leaving jobs or ultimately the profession vary according to the source. Review of these sources (Benner & Benner, 1979; Donovan, 1980; Hallas, 1980; Hedberg, 1980; Houtz, 1975; Illinois Hospital Association, 1980; Kramer, 1974; Rowland & Rowland, 1978; Sandroff, 1980; Seybolt, 1978; Wandelt, Pierce & Widdowson, 1981) results in the emergence of four themes which contribute to the nursing
shortage. These are: 1) lack of job satisfaction, 2) lack of respect from administration including nursing administration, physicians and the public, 3) poor working conditions such as understaffing, undesirable hours, and lack of flexibility, and 4) poor salaries, not commensurate with the responsibility registered nurses assume each time they take a tour of duty.

The need to address possible resolutions to the problems in nursing is apparent. Many studies have been directed toward specific groups of nurses or isolated issues within nursing. Marlene Kramer (1974) and Kramer and Schmalenberg (1978) concentrate their efforts on the new graduate nurse entering the work setting and define reality shock and bicultural training. Benner and Benner (1970) also discuss the new nurse's difficulty in entering the work role. Nurse (1975) describes counseling needs of the community nurse. Davitz and Davitz (1981) document nurses' behaviors in response to patients' pain, and Lore (1981) addresses therapeutic communication needs of student nurses. The problems of self-esteem of nurses are discussed by Aroskar (1980), Christman (1967), Katz, Mathews, Pepe, and White (1976) and Sleeper (1976). Many of these examples are directed toward a specific group or isolated issue. Most have been done with student nurses, new graduates or nurses working in a specific area of interest.

The four themes which contribute to the nursing shortage, lack of job satisfaction, lack of respect, poor working conditions, and poor salaries have emerged over the years. Nurses have allowed the continued existence of these problems. Communication deficits within nursing may directly relate to these themes. Nurses' perceptions of
themselves and their colleagues, ability to relate to administrative persons, ability to communicate with others and themselves, the self-image of the profession and the image projected to others may all be a result of nurses' inability to effectively communicate.

**Purpose of the Study**

The purpose of this study is to develop a practical module to increase communication skills of nurses to assist them in dealing not only with colleagues, supervisors, the public and patients, but also to assist them in recognizing some of their own needs and values. This module will integrate a variety of approaches to be applied to nurses regardless of experiential background, clinical area of interest, or time in the work setting. The study will review some of the historical and socio-psychological perspectives in nursing as contributing factors to conflict for the present day nurse and will integrate aspects of nursing and counseling in the development of an experiential teaching module.

Chapter I has stated the need and purpose of the study. Chapter II will be a review of the historical and socio-psychological perspectives of nursing as well as communication deficits. Chapter III will address the background of three communication skills emphasized in the teaching module; values clarification, active listening and assertiveness training. Chapter IV will contain the teaching module and Chapter V will be a summary which will restate the purpose of the study and contain suggestions, limitations and recommendations.

**Summary**

In summary, there is an alarming shortage of nurses working in
health care settings which not only jeopardizes the quality of patient care, increases hospital expenditures for recruitment and retention but adds to the frustration of those remaining active in the profession. The causes of this shortage are many including: lack of job satisfaction; lack of respect; lack of appropriate working conditions; and lack of commensurate financial compensation. These concerns are not new but have evolved over time. The advances in medical technology require more nursing personnel at a time when more and more nurses are leaving the profession. Most of the studies involving nursing are concentrated on the student or the new graduate nurse. The nurse who has been in practice over the years has seen a variety of changes in technology and attitudes. Communication as a means of resolving some of the conflicts is the concern of this study. Teaching nurses, regardless of their years of experience, to recognize and communicate their needs and concerns will be a measure to increase job satisfaction, gain respect and improve self-image, all of which may decrease attrition rates.
CHAPTER II

REVIEW OF HISTORICAL AND SOCIO-PSYCHOLOGICAL PERSPECTIVES
AND COMMUNICATION DEFICITS OF NURSING

The purpose of this chapter is to review the historical and the socio-psychological perspectives of nursing and the communication deficits resulting from these issues. Three sections are included in this chapter. Part one presents an overview of the history of nursing. Part two discusses the socio-psychological developments in nursing including the images and roles of nurses and their relationship to the field of medicine. Part three focuses on the communication deficits observed within nursing, many of which result from historical and socio-psychological developments.

Historical Perspectives of Nursing

Although the nursing profession includes mostly females, it is not exclusively so. Many professional nurses in the past were men. The priests in the Greek temples of Aesculapius who gave nursing care were male. One of the reasons the Romans were able to extend their conquests so far, was that they were able to minimize losses on the battlefield by setting up first aid procedures and care for their wounded in movable tent hospitals rather than leaving them to die as many other ancient armies did (Bullough, 1978).

During the medieval period there were several male monastic nursing orders such as the Knights Templars and Lazarists (Ellis &
Female orders became more numerous and the occupation of nursing more female dominated in the later Middle Ages (Bullough, 1978). Bullough reports that as women entered the field the status of the occupation fell. She also indicates that two groups of nurses emerged: religious sisters who were respected for their vows of poverty, chastity and obedience; and, secular nurses whose position was comparable to servants. With the emergence of the Christian era in the fourth century, religious orders developed whose primary concern was with the care of the sick, the poor, orphans, widows, the aged, slaves, and prisoners, all done in the name of charity and Christian love (Ellis & Hartley, 1980).

Of particular significance in the history of nursing are the deaconesses in the Eastern churches. The rich and influential who became Christians served the poor and ailing in the name of Christ as did individuals in lower stations in life. Dolan (1978) describes these deaconesses as women who practiced acts of mercy that included caring for the sick, feeding the hungry, clothing the naked and burying the dead. She compares these deaconesses as early counterparts of today's community health nurses. As they made their rounds distributing food and medicine, they carried a basket which would later become the visiting nurse bag used today. The first deaconess and first visiting nurse, Phoebe, carried the letters of St. Paul and cared for him and others. In the Epistle to the Romans, dated about 58 A.D., reference is made to Phoebe and her work (Ellis & Hartley).

Not clearly distinguished from the deaconesses was another group comprised of widows and virgins, whose title and role was similar
to the deaconesses. Because they often visited the ill in their homes, they are sometimes referred to as the earliest organized public health nurses (Bullough, 1978).

The one person who influenced the course of nursing the most was Florence Nightingale. Her work at Scutari, Turkey, during the Crimean War was reported in great detail by the British press, making her a heroine to the people. According to Bullough, Miss Nightingale never worked directly but was able to "manipulate men to speak for her while she pretended helplessness" (p. 50). In Scutari, although she came with significant power delegated to her by the Secretary of War, she refused to allow the nurses under her command to give any care to the suffering men until the surgeon ordered them to do so (Bullough). This gained her the support of the physicians who had been very suspicious of her, but according to Bullough it also helped to establish the physician as superior to the nurse. Dr. Cope (1958) in his book, Florence Nightingale and the Doctors, reports that "she knew the power of the medical profession and in her public pronouncements always tried to conciliate the doctors and tried to make others do the same" (p. 21). Cope further indicates that while Miss Nightingale was not a public politician, she worked to influence statesmen who were in a position to get things done.

In the United States, schools of nursing as they are now known did not come into existence until 1873 in Massachusetts, Connecticut and New York (Dolan, 1978). Florence Nightingale was involved by correspondence in the establishment of these schools. Between 1873 and 1926, the number of hospital sponsored schools grew from three to
1000 (Olesen & Wittaker, 1968). This growth was encouraged by hospitals since nursing schools were the answer to problems of staffing, for until the 1950's the majority of its graduates practiced private duty nursing. To ensure an adequate supply of students to provide the bulk of nursing care, hospitals established their own schools. Traditionally, the hospital based program provided a diploma (Dip.) after two to three years of training. To keep pace with the changing educational patterns and needs, the baccalaureate nursing program in the university setting was established as far back as 1909 requiring four to five years to obtain a degree (B.S.N.-Bachelor of Science in Nursing). In 1952, the associate degree program for nursing began. This preparation provides a degree (A.D.) after two years in a junior college program.

It was only in the 1970's that the baccalaureate education program began to assert itself as a result of the 1966 American Nurses Association position paper, which seemingly altered nursing education patterns. The essence of this position paper involves five ideas: 1) education for those who work in nursing should take place in institutions of learning, within the general system of education; 2) education for all who are licensed to practice nursing should take place in institutions of higher education; 3) minimum preparation for beginning professional nursing practice should be at the baccalaureate level; 4) minimum preparation for technical nursing practice should be at the associate degree level; and 5) nursing assistants should be educated in the vocational setting (American Nurses Association, 1965). The intent of the A.N.A. position paper is the current educational model for nursing and
nursing education. Graduates of all three programs (B.S.N., Diploma and A.D.) are eligible to take state board examinations, successful completion of which results in the title of registered nurse. Advanced education at the master and doctoral level is increasingly available and encouraged. Further effects of the variety of educational programs available will be discussed in the next section of this chapter, *Socio-Psychological Perspective of Nursing.*

**Socio-Psychological Perspective of Nursing**

The historical events leading to the predominance of women in nursing has affected the image of the profession. Historically doctoring and nursing arose as complementary functions (Bullough, 1978; Cohen, 1981; Dolan, 1978; and Katz, Mathews, Pepe & White, 1976). Several authors (Bakdash, 1978; Bower & Bevis, 1979; Broverman, 1970; Cleland, 1971; Cohen, 1981; Donnelly, 1978; Fagin, 1978; Friedan, 1963; Herman, 1978; Messer, 1980; Rosaldo & Lamphere, 1978; Sleeper, 1976; and Smith, 1978) report that women have historically been thought of as lesser than, if not inferior to, men. These authors also describe typical characteristics of women and men. Characteristics typically ascribed to women such as caring, being tender, compassionate, intuitive about people, supportive and nurturing became the dominant qualities of the nurse. Characteristics ascribed to men such as being decisive, able to take initiative, objective, persistent, intelligent, rational, brave and dominant resulted in an attitude that physicians (males) were superior to nurses (females). In 1920, Father Spalding summarized this sentiment in his *Talks to Nurses:*
There may be members of the medical profession who have slight defects in methods and manners, and who nevertheless, are men of real worth. In this case, it is your duty to overlook the defects. There are physicians who are punctilious in prescribing the most minute details, who insist that their cases be handled in strict accordance with their wishes. It is your duty to carry out the wishes of such doctors. Even if you should think that you are capable of improving on their method, it is not for you to decide. You may be mistaken in your judgement about the matter; but even if you are right and the physician is wrong, he is to be the judge in the case (p. 112).

Bowers and Bevis (1979) report that "professional sabotage occurs when nurses, through a commitment to culturally accepted behavioral norms for women, use nursing as a vehicle for maintaining the subservient, dependent, nonassertive, restrictive, stereotyped female roles" (p. 29).

Florence Nightingale greatly contributed to the image of the nurse. She insisted that nurses be clean, chaste, quiet and religious and she also agreed with hospital authorities that nurses should work long hours, never complain, and be obedient to physicians and their superiors (Bullough, 1978). She was against any self-determination on the part of the nurses and fought against the organization of the British Nurses Association (Cope, 1958). Bullough reports that Miss Nightingale argued that good character was more important than knowledge in producing a good nurse, so the Nightingale model in nursing education stressed apprenticeship training in the simple procedures, with long hours and stringent rules to help students avoid temptation.

The public view of the nurse can be influenced by a variety of images, from Nurse Ratchet in "One Flew Over the Cuckoo's Nest," Hot Lips on M*A*S*H, and Linda Lovelace as a visiting nurse in "Deep Throat" (National League for Nursing, 1980; Wheelock, 1976). Nurses are often depicted as tyrants, angels of mercy or sex objects. The
themes of obedience to higher authority, dull wittedness and sexual fantasy are frequently depicted by the media (Iskowitz, 1980; Wheelock, 1976).

Advertisements in nursing journals recruiting nurses often promise romance and play without emphasis on being an intelligent decision maker. Cleland (1971) reports that instead of offering money for professional services, recruitment techniques frequently confuse the sex role with the professional role. Smith (1978) states that book learning and intellectual development have been purposefully limited in nursing education by the influence of administrators and physicians. She also indicated that in 1904, the Journal of the American Medical Association printed that educating nurses/women, "interfered with their ability to produce children and was a cause of infertility" (p. 83). This statement of the A.M.A. regarding nursing education further demonstrates the traditional dependent link between medicine and nursing.

There is varying and ongoing pressure by nurses to separate from the dependency on physicians and to achieve recognition and independence. Efforts are being made to demonstrate the value of independent nursing function. As medical care has changed in response to advanced scientific and technological discoveries, nursing tasks have changed with increased emphasis on nurses taking over tasks delegated by physicians (Dolan, 1978; Fagin, 1978; Katz, et.al., 1976).

While nurses are placing emphasis on establishing an identifiable nursing profession (Christman, 1978; DeChow, 1976; Roy, 1978), the acceptance of these delegated tasks makes the distinctive contribution of nurses less clearly identifiable. The link between nurses and
physicians contributes to the difficulty in defining nursing professionalism. The high status and power of physicians compound the difficulty of the predominately female profession to attain recognition and autonomy (Cleland, 1971; Cohen, 1981; Smith, 1978). The delegation of portions of patient care to other health professionals (e.g., social workers, physical therapists, psychologists, dieticians), also diffuse the nurse's distinct contribution.

In addition to the influences from outside nursing, there is much controversy within nursing regarding image, status, and role. Considerable confusion exists concerning the nature of nursing and the particular contribution that nursing has to make to the health care system. Schlotfeldt (1977) reports that confusion stems from inadequate conceptualization concerning the roles of nurse-professionals and their assistants, and faulty communication on the part of nurses themselves. She further states that some definitions of nursing practice have been vague and without focus, and distinctions between professionals and their assistants have not been clearly explicated.

Cohen (1981) in reviewing data on 800 diploma nurses and the literature on personality characteristics of nursing students, determined that it is apparent that nursing students have problems with autonomy and are more passive than other college students. She also reports that faculty and administrators in nursing have trouble with their own autonomy within the health care system. Her study, reported in 1981, also supports the Nightingale view of personality factors of the nurse. Cohen reports that nursing students as a group, tend to be higher on deference, nurturance and endurance, and lower on dominance.
and autonomy than a comparison sample of college women. This helps explain the continuation of the subservient view of nurses.

Another area of internal conflict in nursing is the previously described three preparatory programs. Christman (1978) expands on this area:

Unlike all other major professional groups, nurses are splintered into opposing camps from the onset of their preparatory programs. The discord which emanates from having such varied educational entries into the field greatly inhibits the development of unity. Cooperation is unlikely when "turf protection" is a primary concern. It becomes more important to win internal battles than to promote the advancement of the profession. An esprit de corps is impossible when an atmosphere of petty jealousies dominates our deliberations and when the battles in nursing follow the pattern made famous by Pogo, "We have met the enemy and they are us" (p. 24).

The role of the nurse is also an area of controversy. New roles are developed including primary care, clinical specialist, private practice and nurse practitioner. Primary nursing, in the hospital setting, represents a method of assignment for responsibility for total patient care around the clock. Bowers and Bevis (1979) indicate that since a primary nurse position may be filled by graduates of any preparatory program this may add to the confusion regarding the role. The clinical specialist in the hospital is a nurse who demonstrates a high degree of professional competence in a specialized field of nursing and may or may not, have an advanced degree in nursing (Roy, 1978). Roy defines nurse practitioner as a nurse who has acquired additional knowledge and skills, provides direct patient care, while consulting with a physician. Another new role, one which has caused much controversy (Bowers & Bevis, 1979), is that of the private practitioner. The functions and preparation for this role are even more unclear than
that of the other roles (Roy, 1978).

Entrance into the work setting by new graduate nurses adds to role conflict. Marlene Kramer (1974) has made a significant contribution by her research on reality shock and biculturalism. She describes reality shock as the startling discovery and the reaction to the discovery that school-bred values conflict with work-world values. She defines biculturalism as the ability to get along in two cultures or subcultures without fusing with, or being absorbed by, either of them. Kramer maintains that the new graduate is shocked upon entering the work world and has to learn to resolve inherent differences between the educational and patient care setting. Cohen (1981) questions this concept. She questions how a new graduate, after spending at least two years on various units in a hospital, does not know about the hospital as a system and the authoritarianism associated with the bureaucracy of the health care delivery. Cohen feels the shock comes from finding out that the total system reflects the same problems inherent in education. The health care system demands that they produce as professionals and take responsibility for their judgments while maintaining subservient attitudes.

Nursing is fraught with a variety of conflicts. The view of the nurse varies not only from the media, the public, and health professionals but also among nurses themselves. The educational preparation is not standardized nor are the roles of the nurse. One might conclude that the only apparent consistency in nursing is lack of autonomy and dominance.
Communication Deficits in Nursing

The previous two sections of this chapter delineated a variety of changes in nursing from its inception. One might contend that physicians have had a major effect on the role of the nurse and maintenance of a subservient position. This deference of nursing to medicine leads to discord. Brown (1978) contends that a large segment of the nursing profession lives within a culture of denial, including the denial of self-worth and self-importance as a professional. She further states:

This culture of denial not only tends to reduce its constituency to a feeling of impatience that almost precludes positive action, but also erects a psychological barrier that must be slowly and painfully scaled by the remainder of the profession that is intent on producing change. Among many and varied explanations that have been given for the existence of this culture of denial are the following:

1. Since the profession is composed mainly of women, nursing is vulnerable to the hazards of sexual stereotypes. They are perceived as passive personalities who dislike decision making and hesitate to be involved in action programs.

2. Society views nursing as a semi-profession, hence nurses should be content with their status.

3. The medical profession has impeded the efforts of nurses toward greater independence and has failed to recognize their accomplishments (p. 10).

Bowers and Bevis (1979) also report that "power is not taken from nurses by physicians; it is surrendered by nurses. The blaming of male physicians is part of the victim-persecutor-rescuer game. Nurses must find their own level of autonomy, professionalism and identity and begin to enact the roles they choose" (p. 32). Virginia Satir (1976) identifies "Blaming" as one type of communication that often accompanies people who have low opinions of themselves. She also
indicates this type of communication as limiting an individual's resources and increasing dependency.

Fagin (1978) also agrees that nurses are blaming others for their situation. In her article on Nurse's Rights, she expands on this premise:

Rather than face this misery openly and honestly we have found it much easier to focus on the responsibilities we ought to have and have not. We are more likely to blame others for the fact that we are not able to carry out the responsibilities we describe in our own nursing literature. Unfortunately, in this blaming of others we contribute to the alienation of professionals from each other and towards an ever-expanding gulf of hostility and noncommunication (p. 58).

Several authors (Bowers & Bevis, 1979; Christman, 1978; Cohen, 1981; DeChow, 1976; Roy, 1978; Schlotfeldt, 1977; and Skaggs, 1977) also discuss the artificial divisiveness nurses have created for themselves: the technical against the professional; the two-three- and four-year against one another and graduate school against all the rest; the educators and service oriented; the public health nurse against the hospital nurse and vice versa.

The lack of open communication among nurses and between nurses and others has contributed greatly to the problems and conflicts within nursing (Bowers & Bevis, 1979; Clark, 1978; Cohen, 1981; Edwards & Brilhart, 1981; Healey, 1980; Herman, 1978; Munn, 1980; Patrick, 1981; Simms & Lindberg, 1978 and Woodward, 1980). Edwards and Brilhart (1981) report "... far too few nurses have had courses in their basic education on face-to-face communication itself. Study of not only the written and spoken language but of the arts and all human behavior is relevant to the nurse in promoting effective
communication with the tremendous variety of people with whom he or she must interact" (pp. 8-9).

Edwards and Brilhart (1981) determined that there are nearly 100 different definitions for the term "communication", presently in the literature. One of the simplest definitions of communication was given by communication theorist, Lee Thayer (1968): "in its broadest perspective, communication occurs whenever an individual assigns significance or meaning to an internal or external stimulus" (p. 15). O'Brien (1978) views communication as a process whereby an individual shares his ideas, values, opinions, and feelings with others. Edwards and Brilhart define communication as "a transactional process of energy exchange, perception, and interpretation through which people form images of themselves, others and the world around them" (p. 26). Thus communication is not the simple mechanical process of transmitting words but is aimed toward presenting one's self and one's ideas. Goldsmith (1977) reports that:

Whenever communication is attempted between two people at least six messages, each somewhat different, are involved in the communication:

1. What one means to communicate
2. What one actually communicates
3. What communication the other person receives
4. What communication the other person thinks he receives
5. What the other person says
6. What one thinks the other person says (p. 30).

Kramer and Schmalenberg (1977) declare that interpersonal competence is the key to achieving biculturalism. They further define this competence as the ability to "accurately define the situation as the other person sees it, and then to be able to influence, motivate, or
work with the other person to achieve some desired goal" (p. 4). They further describe the person possessing interpersonal competence as one who 1) can define the cultural differences between her/himself and others clearly, 2) possesses a repertoire of strategies that are potentially useful in situations when representative norms and behaviors might conflict and 3) can select and implement those strategies that are useful and appropriate to a given situation.

Kramer and Schmalenberg also define a concept of empathy as "in which a person imaginatively takes the role of another and can understand and accurately predict that person's thoughts, feelings, and actions" (p. 75). They also conclude that empathy is an important factor in interpersonal competence, nurses do not generally rate high on empathy and that empathy increases effectiveness and speed of communication.

Paterson and Zderad (1976) define communication in nursing in terms of "call and response" (p. 26) rather than sending and receiving messages. They also state that in the complex health care system, nurses frequently follow the line of least resistance by responding to the loudest or most important demands.

Lore (1981) indicates that how one sends and perceives messages is based to a large extent on one's past experiences, socio-cultural background, attitudes, communication skills and knowledge of subject matter. She further indicates that the number and complexity of variables in communication result in a fluid, ever changing, and often unpredictable process. Munn (1981) in The Nurse's Communication Handbook declares that "nurses are constantly exchanging information via
communication, but they may have only limited knowledge of interpersonal or small group communication process" (p. ix).

Summary

It seems apparent that what and/or how nurses are communicating is less than beneficial to them. Changes in nurses' roles, as well as changes in society as a whole demand a greater understanding of interpersonal relationships. Instead of working principally with the physician, the nurse now works in a multidisciplinary atmosphere. She/he is portrayed to the public in a variety of ways through the media. She/he belongs to one of the largest and most neglected groups in the voting population. According to Kalisch and Kalisch (1978) she/he lacks the confidence and assertiveness to move into active roles in government. Her/his deficits in communicating have played a role in her/his present status.

The manner in which one communicates is based to a large extent on past experiences, socio-cultural background, attitudes, skills, and knowledge of the subject. Nurses through their historical and socio-psychological perspectives and lack of knowledge have deficits in communication. The inability of nurses to recognize and utilize appropriate means of communicating with themselves and others greatly contribute to the existing problems. Improving communication skills of nurses along with appropriate utilization of these skills is a means to begin resolving some of these conflicts. Subservience, blaming others, passivity, and divisiveness can be reduced through increased communication skills.
CHAPTER III

BACKGROUND CONCERNING SPECIFIC COMPONENTS OF MODULE

As indicated in Chapter II, the nurse's historical and socio-psychological backgrounds have resulted in a variety of conflicts and communication deficits. This module has been developed to assist nurses to develop communication skills to enable them to reduce conflict and enhance growth. This personal growth aligns with what Jourard (1971) terms a "rehumanizing process, growth as a person among persons" (p. 178).

The focus in nursing on helping or nurturing others may result in the nurse's sole concentration on values, needs and rights of others. This module is designed to assist the nurse in adapting skills used to assist others, to the care of self. The tendency toward subservience, blaming others, passivity, and divisiveness in nursing can be reduced through increased communication skills.

The purpose of this chapter is to review the three components of the proposed teaching module. The three communication skills, values clarification, active listening and assertiveness training were selected for a variety of reasons and the module is designed to build on strengths usually present in the nurse.

The assessment of patient values is a basic aspect of planning patient care but rarely does the nurse assess her/his own values. Values clarification will assist the nurse to examine her/his own
personal and professional values, understand and identify areas of potential conflict between these values, and to assist one in understanding how values effect behavior. The skills which the nurse uses in assessing patients' values and consequent behaviors can be utilized to help assess personal values and behavior.

Active listening will establish the concept that the nurse needs to listen to her/himself and become aware of how and what she/he communicates. While this ability will assist one in relating with others, the emphasis will be on increasing self-awareness. The active listening component will aid the nurse in recognizing her/his style of communication, understanding the benefit of and conditions for active listening, and in recognizing feelings associated with communication.

The assertiveness training component of the module will help the nurse to 1) distinguish between nonassertive, assertive and aggressive behaviors, 2) identify one's own style of communicating and how it may differ depending on the situation or person(s) involved, 3) identify verbal and nonverbal components of communication, 4) demonstrate some assertive behaviors, and 5) to assume responsibility for her/his behaviors. This component will also assist the nurse in determining her/his personal and professional rights.

The use of these three communication skills will enable the nurse to develop self-awareness, self-esteem, self-care, direct and honest communication, and assertion of rights. The development of these attributes are directed to combat the subservience, blaming of others, passivity and divisiveness present in nursing. It is the aim of this module to assist nurses to change communication patterns and concepts of
nursing.

The chapter will be divided into three sections. The first section discusses values clarification. Active listening is the topic of the second section and section three focuses on assertiveness training.

Values Clarification

Values represent a way of life (Steele & Harman, 1979). They are the "shoulds" and "should nots" which give a direction to life and which make a difference in living. Carl Rogers (1961) and Louis Raths (1966), while viewing values from different conceptual frameworks, agree that a value is learned, arises out of personal experiences, forms a basis for behavior having an internal locus of control, is held over a period of time, and is evident in a pattern of behavior. Raths defines a value as a belief which an individual chooses on his/her own,cherishes, and consistently uses as a determinant of behavior.

Values are dependent on, and influenced by parents, peers, religion and culture. Most of the learning about values occurs as children and adolescents, but learning about values as adults can certainly occur. Besides learning about values themselves, one learns relative importance of values, or establishes a hierarchy or value system (Hart, 1978; Simon, 1974). This value system is formed by learning from significant others plus one's experience in daily living which confirm or disconfirm the appropriate value ranking.

In defining values two parts are mentioned by Gordan Hart (1978), a specific mode of conduct and end-state of existence. Values such as
independence, responsibility and self-control refer to modes of conduct and are called instrumental values. These instrumental values have a direct bearing on how one lives each day and affect every day decisions. Values such as freedom, salvation, equality, and world peace refer to an end-state of existence and are called terminal values. These represent long range beliefs, that one hopes for, anticipates or works toward.

Values are subjective and individual as no two people experience the world in identical ways (Lowe, 1976). Since humans are social beings, each value system is uniquely individual, and each choice of values orientation is limited by circumstances of time and place. One must derive his/her values from the ideologies of one's particular cultural heritage. Lowe differentiates between values and morals by indicating that values are created by individuals, while morals are created by culture and provide the social standard for differentiating between good and bad. He further points out that when a particular culture is extremely directive, the individual has minimal freedom to construct his/her own values. Simon (1974) contends that while values don't transmit, and cannot be taught, they can be learned.

Values clarification is a learning process which helps persons explore and clarify their values and examine the relative importance of these values, i.e., the value system. Values clarification is an outgrowth of the Third Force in psychology, which developed from the Freud/Adler split early in the century (Simon). Values clarification is more concerned with the present and future and less concerned with exploring the past. Unlike counseling and psychotherapy theories,
which are designed to change personality, attitudes and behaviors, the purpose of values clarification is educational.

The three main stages of values clarification consist of choosing, prizing and acting (Simon). Hart (1978) also refers to these as representations of a process of identification, refinement and application. Seven processes evolve from these three stages. These processes as related to their specific stage are listed in different order by different authors (Hart, 1978; Simon, 1974; Steele & Harman, 1979) but the concept remains as follows:

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing (Identification)</td>
<td>Chosen freely</td>
</tr>
<tr>
<td></td>
<td>Chosen from alternatives</td>
</tr>
<tr>
<td></td>
<td>Chosen after due reflection, or consideration of consequences</td>
</tr>
<tr>
<td>Prizing (Refinement)</td>
<td>Prized and cherished</td>
</tr>
<tr>
<td></td>
<td>Publicly affirmed when appropriate</td>
</tr>
<tr>
<td>Acting (Application)</td>
<td>Acted upon</td>
</tr>
<tr>
<td></td>
<td>Part of a pattern that is consistent and repeated</td>
</tr>
</tbody>
</table>

For something to be a full value, it must meet the above criteria. Simon maintains that anything that does not meet all seven standards is a value-indicator. Value-indicators include goals or purposes, aspirations, attitudes, interests, feelings, beliefs and convictions, activities and worries, problems, or obstacles.

The choosing stage of values clarification is where one examines sources of influence, makes finer distinctions and analyzes consequences (Simon). Choosing freely deals with independence and
helps make one aware of influences on him/her and helps to evaluate the strength of these influences. Choosing from alternatives indicates to persons that alternatives do exist and that skills for developing alternatives can be learned. When one is reacting emotionally or is being pressured to act in a certain manner, it may be difficult seeing alternatives. Examining the consequence or cost of each alternative course of action occurs through reflection. Selection of the alternative with the most positive and the least negative consequences is the goal of this step.

The prizing stage identifies or labels values (Simon). Public affirmation may help one who has definite values but has not stated them aloud, and thus has not inspected them or allowed others to inspect them. This inspection may lead to changing one's values or may reconfirm maintaining values.

The acting stage relates to one acting upon his/her choice which may require support and direction for such implementation (Simon). The consistency aspect of the acting stage is not to imply rigidity or inflexibility. Acting with consistency does not mean that one always relates in the same manner but allows for the differential cues that occur from situation to situation and deals with reality and spontaneity.

Nursing, as described in Chapters I and II, has demonstrated problems with values and values clarification. Lack of determination of values seems apparent by the internal conflict and communication which occurs within nursing. The very value of nursing and nurses is questioned as demonstrated by high attrition rate, the shortage of nurses,
the high lack of work satisfaction, the internal conflict in nursing regarding educational preparation, specific roles, job descriptions, and the conflicting image of the nurse by the public, physicians and peers. Thus questions develop in regard to what is valued in the field and what alternatives are explored. Simms and Lindberg (1978) in The Nurse Person recognize that while there are "no magic solutions to discrepant personal and professional values, examining personal values can lead to greater congruence between personal values and actions" (p. 175). They also believe that this is the first step toward resolving discordant personal and professional values, since professional values are based on personal values.

Active Listening

It has been estimated by Munn (1977), that most persons spend 70% of their work day communicating and that 45% of that time is spent listening. Carkhuff (1969) estimates that 40% of a person's daily verbal interaction is spent in listening. It is the listening side of the communicative act where one gathers the necessary data to solve a problem, settles a grievance, becomes more efficient, builds a supportive climate or makes a person feel special. Listening is not only a physiological process of hearing but includes the process of attaching significance to what one hears. Real listening requires an expenditure of energy to obtain and retain the spoken discourse of others. Active listening involves becoming immersed in another's frame of reference and listening to feeling as well as content. When active listening occurs attention is paid to choice of words, rhythms of speech, pitch and tone of voice, themes of repetition, silences,
omissions and nonverbal messages (Lore, 1981). In order to practice active listening, one must concentrate and care about what the other person has to say.

Active listening is not a static or "cookbook" process but includes adaptability. Use of reflective techniques helps others know that another is interested in them and also helps clarify and verify what is being communicated. There was a recent pattern in communication which encouraged "reflecting" by repeating all or part of another's statement. Lore refers to this as parroting and is a poor imitation of Carl Roger's (1951) non-directive counseling. Roger's idea was to put in one's own words the feeling of the other's conversation. This paraphrasing conveys interest and provides an opportunity for clarification.

Use of silence (Gordon, 1974; Munn, 1980; Rogers & Farson, 1974; Simms & Lindberg, 1978) also plays a large role in active listening. This provides time for both participants to get in touch with their feelings and thoughts. Nonverbal messages and attentiveness during these silences can enhance the communication process by conveying continued interest and encouragement. Minimal responses such as "um huh" can also be encouraging to the speaker without breaking his/her train of thought or feelings. Open ended questions or "door openers" such as "tell me a little more about..." can also be utilized (Gordon).

In essence then, active listening involves listening with understanding, being involved with the speaker and his/her thoughts, feelings, hopes, fears and perceptions. The speaker receives feedback from the listener for verification after the message has been decoded.
Conditions (Gordon, 1974; Munn, 1980; Rogers & Farson, 1974) which ideally should be present for active listening to occur include:

1. The person must have a concern.
2. There must be time enough to listen.
3. The setting is comfortable and free of interruption.
4. Care must exist for the person.
5. One must believe the person is capable of solving the problem with help.
6. One must respect the person.
7. One should have some degree of separateness from the other person.

Active listening is obviously not always appropriate in the communication process. These inappropriate times include: when the listener has a problem, when attempting to change someone else's values, when information is called for without verbal empathy, and when information is sought.

Adler and Towne (1978) discuss seven barriers to active listening. These are as follows: 1) pseudolistening, an imitation of the real thing while giving the impression of being attentive; 2) stage hogging when one is only interested in expressing one's own ideas and doesn't care about what anyone else has to say; 3) selective listening when one responds only to the parts of the remarks that interest him/her; 4) insulated listening or failure to hear or acknowledge certain topics; 5) defensive listening or taking innocent comments as personal attacks; 6) ambushing to collect information to use to attack another's; and 7) insensitive listening, taking a speaker's remarks
at face value. These are all examples of people who don't receive another person's messages clearly.

The benefits of active listening can be personal and professional for the nurse who utilizes it. Some of these benefits are showing interest, indicating the other person has been heard, preventing mindreading, checking accuracy of messages, opportunity to ventilate feelings, communicating acceptance, fosters movement from superficial to deeper feelings, promotion of honesty, openness, intimate and warm relationships, and helping one become responsible for his/her problem. The nurse who communicates with interest and concern will convey this to all those with whom she/he interacts.

The conflicts which exist within nursing, have inhibited open communication. Nurses from different educational backgrounds frequently are limited in communicating effectively with one another. The diversity in preparatory programs may prevent them from actively listening to one another. The accuracy of messages received by nurses from different backgrounds (educationally and experientially), clinical interests and roles may be less than accurate. The apparent lack of acceptance between members of the profession, as well as the varied acceptance of nurses by the public and physicians, require improved communication. By promoting open, honest communication with her colleagues, supervisors, physicians, and the public, she could reduce some of the problems which presently exist.

**Assertiveness Training**

While the birth of assertiveness training dates back to the 1949 publication of Andrew Salter's *Conditioned Reflex Therapy*, the
definition of assertiveness training varies with different sources. Salter urged development of an assertive personality structure to counteract shyness and avoidance behavior. He described assertive behavior in terms of "feeling talk" (saying what one feels); "facial talk" (the non-verbal expression of feelings); the ability to make "contradict and attack" statements when one disagrees with someone; frequent use of "I" messages; the ability to accept compliments and praise; the ability to praise one's self; and the ability to be spontaneous and to live for the present. Salter referred to these six rules as "excitatory reflexes" and applied them almost universally to his patients.

Joseph Wolpe (1958) referred to these procedures as "assertive" rather than "excitatory" and found them of value only for overcoming unadaptive anxiety that occurs in the course of interpersonal relationships. He recommended self-assertion for those who exhibited passivity and anxiety in the presence of others. He believed fears were the reason a person behaves ineffectively with others, and in turn, feels at their mercy.

Wolpe and Lazarus (1966) pointed out that persons have certain basic (assertive) rights which they are not only entitled to exercise, but which they should exercise in order to achieve a healthy adjustment (this view was also supported by Alberti and Emmons, 1974). Wolpe and Lazarus defined assertive behavior rather vaguely as "all socially acceptable expressions of rights and feelings" (p. 39). Lazarus (1973) classified the main components of assertive behavior into four response patterns: 1) the ability to say "No"; 2) the
ability to ask for favors or make requests; 3) the ability to express positive and negative feelings; and 4) the ability to initiate, continue and terminate general conversations.

Alberti and Emmons presented a more behavioral definition for assertiveness as "behavior which enables a person to act in his own best interest, stand up for himself without undue anxiety, to express his rights without destroying the rights of others" (p. 2). Hersen, Eisler, and Miller (1973), teachers and researchers of assertion, found that not all people behave nonassertively because anxiety inhibits them, but rather because they never learned to assert themselves. This leads to the conclusion that assertiveness is a learned skill. Adler (1977) supports that "assertiveness training is based on the idea that verbal and nonverbal self-expression are skills, similar in many ways to other skills, such as playing a musical instrument. The ability to communicate can be learned" (p. 4).

Rich and Schroeder (1976) offer the following functional definition of assertive behavior: "assertive behavior is the skill to seek, maintain or enhance reinforcement in an interpersonal situation through an expression of feeling or wants when such expression risks loss of reinforcement or even punishment" (p. 1082). This definition does not specify the content of an assertive response but indicates that the behavior is goal oriented, dependent on an individual's values.

An issue related to the definition of assertive behavior is whether assertiveness is a generalized or situational response. Salter (1949) viewed it as generalized, while Cattell (1965) declared
that assertiveness had a hereditary basis. Wolpe (1958) also viewed assertiveness as a generalized trait. However, none of these three provided research to support their views. Rich and Schroeder cite studies which provide research evidence to support the concept of assertiveness as situational in nature. These cited studies include: factor analysis of various assertiveness inventories which failed to indicate a generalized trait; a study which showed variations in assertive response dependent on the stimulus person; and studies which indicated a lack of generalization of assertive behavior from one response class to another after training. The authors, therefore, conclude that assertiveness is best defined as "a group of partially independent situation-specific response classes" (p. 1083). Alberti and Emmons (1974) also differentiate between generalized and situational and indicate that "situational" problems can usually be treated by a non-professional who has received some assertion training, whereas the person displaying "generalized" unassertive or aggressive behavior might best be treated over an extended period of time by an experienced therapist.

Before continuing it is important that nonassertiveness and aggression also be defined. Nonassertive behavior, according to Herman (1978) is that type of interpersonal behavior which enables the person's rights to be violated in one of two ways: 1) the person violates her or his own rights when she or he permits herself or himself to ignore personal rights that are actually very important to her or him, or, 2) the person permits others to infringe on her or his rights. Nonassertive behavior pays off by enabling the individual to avoid potentially unpleasant conflicts with others; however, various unpleasant internal consequences such as hurt feelings and lowered self-esteem are likely to occur (pp. 55-56).
Nonassertive people have either not learned (have not been taught) to assert themselves or have been conditioned not to assert themselves by being taught that assertive behavior is undesirable. Efforts at self assertion thus become sources of fears, anxiety and guilt (Adler, 1977; Dawley & Wenrich, 1976). Several authors contend that women/nurses frequently utilize nonassertive behavior for a variety of reasons: lack of assertive skills; conditioning; maintenance of femininity; and victims of the "compassion trap" (Bush & Kjervil, 1979; Dawley & Wenrich, 1976; Donnelly, 1978; Herman, 1978; Jakubowski-Spector, 1973; Simms & Lindberg, 1978).

Aggressive behavior, on the other hand, is at the opposite end of the spectrum from nonassertive behavior. Aggressive behavior as defined by Jakubowski-Spector (1973) is that type of interpersonal behavior in which a person stands up for her own rights in such a way that the rights of others are violated. The purpose of the aggressive behavior is to humiliate, dominate, or put the other person down rather than to simply express one's honest emotions or thoughts. It is an attack on the person rather than on the person's behavior. Aggressive behavior is quite frequently a hostile over-reaction or outburst which results from past pent-up anger (p. 77).

It is important to distinguish between nonassertive, assertive and aggressive behaviors. Herman indicates that perhaps the main reason nursing has been reluctant to support assertiveness is that the concept of assertiveness has often been misunderstood and confused with aggression. For example, berating the Director of Nursing after being refused a raise or yelling at a doctor because he put you down, illustrates belligerence and antagonism-in other words, aggressive behavior. This behavior not only is inappropriate and self-defeating, but it is not compatible with nursing-whose concerns are the nurturance and caring of others (p. 17).

Figure I depicts the distinctions between nonassertive, assertive and
Figure 1. A Comparison of Non-Assertive, Assertive, and Aggressive Behavior

<table>
<thead>
<tr>
<th><strong>Characteristics of the behavior:</strong></th>
<th><strong>NON-ASSERTIVE BEHAVIOR</strong></th>
<th><strong>ASSERTIVE BEHAVIOR</strong></th>
<th><strong>AGGRESSIVE BEHAVIOR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally dishonest, indirect, self-denying, inhibited, ignores own needs.</td>
<td>(Appropriately) emotionally honest, direct, self-enhancing expressive, caring, clear, expresses and asserts own rights, needs, and desires.</td>
<td>(Inappropriately) emotionally honest, direct, self-enhancing at expense of another, expressive intent to &quot;get even&quot;, humiliate, to put down the other person.</td>
<td></td>
</tr>
<tr>
<td>Your feelings when you engage in this behavior:</td>
<td>Hurt, anxious, disappointed in self at the time and possibly angry later.</td>
<td>Confident, self-respecting, feels good about self at time and later.</td>
<td>Righteous, superior depreciatory at time and possibly angry and guilty later.</td>
</tr>
<tr>
<td>The other person's feelings about self when you engage in this behavior:</td>
<td>Guilty, angry, or superior.</td>
<td>Valued, respected.</td>
<td>Hurt, humiliated.</td>
</tr>
<tr>
<td>The other person's feelings about you when you engage in this behavior:</td>
<td>Irritated, pity, disgusted.</td>
<td>Generally respect.</td>
<td>Angry, vengeful.</td>
</tr>
<tr>
<td>Outcome:</td>
<td>NON-ASSERTIVE BEHAVIOR</td>
<td>ASSERTIVE BEHAVIOR</td>
<td>AGGRESSIVE BEHAVIOR</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Does not achieve desired goals.</td>
<td>May achieve desired goals.</td>
<td>Achieves desired goals at expense of others.</td>
</tr>
<tr>
<td>Pay-off:</td>
<td>Avoids unpleasant and risky situations.</td>
<td>Feels good, valued by self and others.</td>
<td>Saving up anger resentment justifies a &quot;blow-up&quot;, an emotional outburst, &quot;to get even&quot;.</td>
</tr>
<tr>
<td></td>
<td>Avoids tension.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoids confrontation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needs not met.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accumulates anger.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Feels non-valued.</td>
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</table>

aggressive behaviors and further demonstrates how assertive behavior is compatible with the concerns of nursing.

Assertiveness training utilizes a variety of methods dependent on the source. Rich and Schroeder (1976) discuss several methods used in assertiveness training based on behavioral theory. They include: operant shaping; hierarchical stimulus presentation; role-playing; role reversal; homework assignments; modeling; relaxation; instruments; coaching; external reinforcement; and self-reinforcement. Lange and Jakubowski-Spector (1976) describe assertiveness training as a semi-structured training approach which includes four components. These are: differentiating among assertion, aggression, nonassertion, and politeness; discovering and accepting one's own personal rights and the rights of others; surmounting cognitive and emotional blocks which prevent assertive behavior; and developing assertive skills through actual practice. Rathus (1975) delineates ten types of assertive behaviors. These are: 1) assertive talk; 2) expression of feelings; 3) greeting others; 4) disagreement; 5) asking why; 6) talking about oneself; 7) rewarding others for compliments; 8) refusing to justify opinions to habitually disputatious persons; 9) looking people in the eye; and 10) the anti-phobic response. Herman (1978) developed an 11 step model for assertiveness training. These are: 1) learn background for assertive behavior; 2) differentiate assertive, nonassertive and aggressive behavior; 3) identify interpersonal rights; 4) review assertive behavior ideas; 5) cope with anxiety; 6) build a positive belief system; 7) refuse requests; 8) make requests; 9) ask for change in behavior; 10) self-affirmation assertions; and 11) group- and self-
reinforcement.

In review, many approaches to assertiveness training are being utilized. The different models, regardless of how their approaches are described all include the following: increasing awareness; improvement of verbal skills; modeling; behavior rehearsal and reinforcement.

Summary

In summary, assertiveness has received much attention since Salter introduced the concept in 1949. Assertive behavior is an interpersonal skill which allows an individual to act in his/her own best interest, to stand up for his/her rights without anxiety and to exercise his/her rights without denying the rights of others. The assertive person is outgoing but not overbearing, spontaneous without being exhibitionistic. Assertiveness, as well as values clarification and active listening have a place in nursing. Nurses who believe in self-respect, respect for others, self-power and authenticity can be assisted by all three of these techniques. Frustration and conflict of nurses as described in Chapters I and II result in lack of fulfillment and lack of a sense of control, and in general, a feeling of interpersonal exploitation. It is the contention of this proposed teaching module that examining one's values, learning to actively listen and learning to be assertive will assist the nurse to cope with the conflict in which she/he finds her/himself, while maintaining and enhancing her/his concern for others.
Qualities associated with interpersonal relationships were initially nonspecific and global (e.g., empathy, genuineness, positive regard) (Rogers, 1951) but have increasingly become more specific and objective as personal qualities and attitudes have been translated into behavioral terms. These qualities have become operationalized and transformed into teachable skills. While originally developed in the formal training programs of counselors and psychotherapists, interpersonal skills training has been extended to others who need to develop personalized and trusting relationships. Greenburg (1980) identifies that health care professionals clearly fall into this category.

The purpose of this chapter is to describe the proposed teaching module to increase communication skills of nurses. The module is designed to be adapted to the variety of needs of the nurses to whom it will be presented. It is desired that this module will be presented to a varied spectrum of participants including: 1) those of different educational backgrounds; 2) those working in a variety of health care settings (e.g., large teaching hospitals, small community hospitals, out-patient facilities); 3) those with different lengths of time in the health care field (e.g., experienced practitioner, new graduate or student); 4) those with varied responsibilities (e.g., staff nurse,
nurse manager, clinical specialist); and 5) those working in a variety of clinical areas (e.g., medicine, surgery, pediatrics, intensive care areas).

It is proposed that the teaching module might best be offered to settings in which nurses are working, rather than have the nurses leave their institution for classes. The difficulty nurses have in getting relief for their responsibilities, along with economic concerns of the institutions in arranging for this relief contribute to this decision. Using existing facilities in the institution will also reduce costs. The cost of the presentations would then be limited to the fee for the presenter.

Due to the time and facility constraints placed upon many nurses, the presentations can be made in any appropriate physical facility which might range from a conference room on a patient care unit to a lecture facility. It would be most desirable to be in a comfortable setting without interruptions (e.g., from patients and physicians). Time allocated for presentations may vary depending on the constraints and needs of the participants. One or two hour blocks of time on a weekly basis may be allocated or half or all day sessions may be planned. Voluntary or mandatory attendance may be emphasized. These variables would have to be negotiated with the sponsoring institution and would depend on its goals, needs and constraints, as well as those of the presenter. The size of the group would also be dependent on the constraints present but desirably would consist of no more than 20 participants in order to facilitate participation (Cartwright & Zander, 1968; Edwards & Brilhart, 1981; Gibb, 1951; Indik, 1965; Shaw, 1976).
The initial meeting of each group will include discussion of the behavioral goals of the group as well as what types of procedures will be used in order to help each individual meet her/his goals. The following guidelines of Cotler (1975) will be used:

1. It is explained that the group is designed to keep stress, anxiety, and embarrassment at a minimum.
2. It will not be an "encounter" or "sensitivity" group.
3. The participants are asked to honor the confidentiality of information discussed by others.

All sessions will encourage group participation. Utilization of specific areas of concern and examples from the group will be encouraged and incorporated. It should be noted that not all materials would necessarily be presented to all groups and that individualized examples would be used (e.g., examples of relating to resident physicians would be used for groups interacting with house staff and not attending physicians).

Readings will be suggested and/or provided depending on the resources of the facility. Role-playing, modeling, and feedback will be integral parts of the sessions. The individual will be encouraged to self-evaluate performance and positive reinforcement will also be encouraged. The trainer(s) will model appropriate behaviors. Maintainence of individual logs or diaries will be fostered to assist the participant to gain insight. Revelation of this written material will be entirely on a voluntary basis. Audio-visual devices may be used to provide further information or for feedback purposes. Opportunity will be provided at the beginning of each session for questions, comments,
and follow-up from the previous week(s) if the group is an on-going one. This time can also be used for discussion of suggested homework assignments.

This chapter will consist of three sections. Section one will focus on values clarification. Part two will present active listening. The third part will present assertiveness training. Each section will include background information to be presented, objectives for the participant, suggested readings, and exercises for the participant. Each exercise will be accompanied by outcome goals and homework suggestions. Exercises included in each section may be done during the presentation, prior to the presentation or as homework depending on time available and goals of a particular situation.

Values Clarification

Values represent a way of life. They are the "shoulds" and "should nots" which give direction to life and which made a difference in living. They might be compared to the policies and procedures of one's life. Raths (1966) defines a value as a belief which individuals choose on their own, cherish, and consistently use as a determinant of their behavior. Steele and Harman (1979) report that:

Values are almost never isolated entities. Consequently when a question occurs, more than one value may be used in resolving the conflict. There is never a final answer to a question of values. Even the traditions which sustain certain values over long periods of time are difficult to understand. Why some values are sustained while others are discarded is hard to comprehend. What is clear, however, is that each value held is but one among many (p. 4).

While values are chosen individually, they are dependent on, and influenced by others. Parents, peers, religion, instructors, bosses
and society may influence one's choice. Most of the learning about values occurs as children and adolescents, but learning about values as adults also occurs. Many of a nurse's professional values develop during her/his educational process and first work experiences (Kramer, 1974). It is not uncommon for a nurse to be influenced positively or negatively by a particular instructor, head nurse or peer. Most nurses have opinions about what constitutes a good or bad nurse. Many nurses prefer to work with certain peers versus others. Many nurses have definite ideas how, and in what priority, patient care should be delivered; what meetings should be attended; how evaluations should be done; and how to manage a patient care unit. All of these may reflect one's values.

The importance of values results in establishing a hierarchy or value system. This value system is formed by learning from significant others plus one's experience which confirms or disconfirms the appropriate value ranking. If one ranks listening to a distressed patient as an important value, but the head nurse demands that meds be passed on time and evaluates the staff on this behavior, the nurse may change her/his ranking of providing emotional support at a particular time.

Values clarification is a learning process which helps persons explore and clarify their values and examine the relative importance of these values, i.e., the value system (Simon, 1974). Values clarification is more concerned with the present and future rather than exploring the past. The three main stages of values clarification according to Simon consist of choosing, prizing and acting. Hart (1978) also refers to them as identification, refinement and application.
Seven processes evolve from these stages. Simon describes them as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing</td>
<td>Chosen freely&lt;br&gt;Chosen from alternatives&lt;br&gt;Chosen after due reflection or consideration of consequences</td>
</tr>
<tr>
<td>Prizing</td>
<td>Prized and cherished&lt;br&gt;Publicly affirmed when appropriate</td>
</tr>
<tr>
<td>Acting</td>
<td>Acted upon&lt;br&gt;Part of a pattern that is consistent and repeated</td>
</tr>
</tbody>
</table>

The choosing stage of values clarification is where one examines sources of influence, makes finer distinctions and analyzes consequences. Choosing freely deals with independence and helps make one aware of influences and helps to evaluate the strength of these influences. Choosing from alternatives indicates to persons that alternatives do exist and that skills for developing alternatives can be learned. When one is reacting emotionally or is being pressured to act in a certain manner, it may be difficult seeing alternatives. Examining the consequences or costs of each alternative course of action occurs through reflection. Selection of the alternative with the most positive and the least negative consequences is the goal of this step.

The prizing stage identifies or labels values (Simon). Public affirmation may help one who has definite values but has not stated them aloud, and thus has not inspected them or allowed others to inspect them. This inspection may lead to changing one's values or may reconfirm maintaining values (Hart, 1978; Simon, 1974).
The acting stage relates to one acting upon his/her choice which may require support and direction for such implementation. The consistency aspect of the acting stage is not to imply rigidity or inflexibility. Acting with consistency does not mean that one always relates in the same manner but allows for the differential cues that occur from situation to situation and deals with reality and spontaneity.

The previously stated criteria must be satisfied for something to qualify as a full value. Simon maintains that anything that does not meet all seven standards is a value-indicator. Value indicators include goals or purposes, attitudes, aspirations, interests, feelings, beliefs, and convictions, activities and worries, problems or obstacles.

All persons have values, needs, feelings and opinions which affect the way they react to and communicate with others. Emphasis on patient's needs in nursing is a reflection of these. In planning a teaching program for the newly diagnosed diabetic attention is given to all of these areas. Issues to be considered might include: 1) Does the patient value good health? Is it important to him/her to eat anything he/she wants? What does food represent to him/her? Does he/she perceive him/herself different or lesser than others because of his/her diagnosis? How does he/she feel about being dependent on medication? 2) What does the person need regarding this condition, how much information and teaching is required? Can he/she read and understand English? How will he/she pay for his supplies? Does he/she have the physical dexterity for self-injecting his/her insulin? Does he/she work different shifts? Does he/she have significant others for physical and emotional support? Are there rewards for compliance
or for noncompliance? 3) Is he/she frightened? Does he/she feel guilty for having this condition? Is he/she depressed about the diagnosis and management of the diabetes? Is he/she concerned about his/her children's tendency to inherit the condition? Is he/she scared of needles? Is he/she angry about the diagnosis? Is he/she confused as to what is going to happen to him/her? Is he/she surprised at the diagnosis or did he/she suspect it? 4) Does he/she think urine testing is a waste of time or distasteful? Does he/she think doctors and nurses are knowledgable or does he/she think health care is a waste of time? Does he/she think he/she can cure himself? Does he/she think he/she will be an invalid? Does he/she believe in the use of medications?

These values, needs, feelings and opinions of patients are assessed by the nurse when planning patient care. One's understanding of these will enable one to be more empathetic with the patient. These skills can be transmitted to one's self for the nurse to assess and evaluate her/his own values, needs, feelings, and opinions, to increase understanding of self and how one communicates with others.

Basic needs are those considered common for all people, are at the base of Maslow’s hierarchy of needs and are considered shared values. These needs of patients are frequently met by the nurse in maintaining comfort, nutrition, adequate rest and cleanliness for the patient. The care plan frequently addresses these issues as well as providing for emotional and teaching needs. What about the nurse's physical, emotional and teaching needs and values?

Personal and professional values may not be consistently congruent.
It is difficult to hold a personal value in high regard while under pressure to assume a conflicting professional value (Steele & Harman, 1979). Steele and Harman declare that personal and professional values must be compatible to allow for an accountable practitioner. Without examining value systems consciously, it is possible to have inconsistencies which are not immediately obvious. These inconsistencies may not be problematic until a situation occurs which involves the conflicting values in the decision making process. Values clarification is a means to examine these areas of inconsistency in a growth producing manner.
VALUES CLARIFICATION

Objectives

The objectives for the participant of this section are that the participant will:

1. Be able to define values and values clarification.
2. Understand how values affect behavior.
3. Understand the possibility of conflict between personal and professional values.
4. Begin to examine her/his personal values.
5. Begin to examine her/his professional values.
6. Identify areas of conflict between personal and professional values.

The title of this section is "Who Am I and What Do I Want?".
VALUES CLARIFICATION

Suggested Readings


Values Clarification Exercise

Nurse's Care Plan

Outcome Goal

The objective of this exercise is to assist the nurse in transferring her/his ability to plan for patients' needs to planning care for her/himself. It will help her/him identify what she/he values and how to attain compliance with that value in a comfortable, realistic fashion, using her/his patient care planning skills.

Instructions

If the institution uses Problem Oriented Medical Records (P.O.M.R.) format, adapt this to individual nurse's problems or needs. Have nurse write a care plan for her/himself utilizing the patient care plan and . format.
<table>
<thead>
<tr>
<th>Potential/Actual Problem</th>
<th>Desired Outcome</th>
<th>Target Dates</th>
<th>Nursing Orders</th>
</tr>
</thead>
</table>
| Fatigue resulting from working overtime | Nurse will get 8 hrs. sleep at least 5 nights per week. | Two weeks from now | 1. Will not accept any overtime work.  
2. Will leave duty no later than ½ hour past end of shift time.  
3. Will leave unit for 30 minute lunch break at least 3 times per week.  
4. Will request assistance to accomplish above p.r.n. |
Homework Suggestion

Attempt to achieve the desired outcome by your target date. Were you able to accomplish this? If not, why not? What were the costs and/or benefits in attempting this goal? Do you need to modify your "nursing orders"?
Values Clarification Exercise

Life Line - Personal and Professional

Outcome Goal

The participant is to identify potential or actual areas of conflict between personal and professional values. This should assist her/him in gaining insight into why she/he may be experiencing conflict, and in eliminating some further conflict. Discussion of the discoveries may be helpful in a supportive group (e.g., If the participant desires a further degree in nursing but lives in a small community without access to further educational opportunities, conflicting values may result. If she/he values a peaceful death for all people, but works in a teaching-research hospital which encourages life-support devices, conflict may result.).

Instructions

1. Take a piece of paper and draw a line across the face of it. Place dots at either end of the line. The dot at the left represents your birth date, write the actual date under it. The dot at the other end of the line signifies the date of your death. Over this dot write the number, your best guess, of the estimated date of your death.

2. Place a dot that represents where you are now on the line between your birth and your death. Then write today's date under this dot.

3. To the left of today's date, above the line, write down a few simple words that represent what you believe are your personal accomplishments up to this point.

4. To the right of today's date, indicate in a few words some things you would like to get done or experience before your death.

5. Take another piece of paper and repeat steps 1. and 2.
6. To the left of today's date, above the line, write down a few simple words that represent what you believe are your professional accomplishments up to this time.

7. To the right of today's date, indicate in a few words some things you would like to get done or experience before you end your career.

8. Compare the two lines. Do you detect any areas of conflict between your personal and professional goals? Do you plan on working most of your life? Are your future or past accomplishments concentrated more in your personal life line, professional life line, or both?

Modified from Sidney Simon, Meeting Yourself Halfway, Niles, Illinois, Argus Communications, 1974.

Homework Suggestion

In the next week, be aware of any conflict between personal and professional values and record them in your log. Did your work interfere with your personal life and vice versa? How often did this occur? How did you feel about these instances? What did it cost you? Does this occur frequently or rarely? Are there measures you can take to reduce these happenings?
Values Clarification Exercise

Clarifying Values About Nursing

Outcome Goal

The participant will gain some perspective about her/his value of nursing and reflect on the values others have of nursing. This may result in the nurse establishing or reestablishing some esteem about her/his chosen profession. This may also result in some embarrassment from being a nurse and a desire not to align oneself with the profession.

Instructions

1. List all the things you value in relation to the profession of nursing.

2. List all the things you think society values in relation to the profession of nursing.

3. After finishing the exercise, note the discrepancies in the two lists. Discuss the lists with another nurse. Attempt to clarify what effect the discrepancies have on how you feel about being a nurse.


Homework Suggestion

Reflect upon and write in your log how you feel about being a nurse. If you have the opportunity to meet new people this week, how do you feel when they ask you what kind of work you do? Do you answer honestly, are you proud or ashamed? What kind of responses do you get from others (family, friends, new acquaintances) about being a nurse? Do they relate you to bedpans and giving shots? Are they impressed? Do they wonder
"how can anyone do that kind of work"? Do they immediately tell you about a family member, former girlfriend or friend who is/was a nurse? Do they have an accurate idea of what a nurse does? How do you respond to the view others have of nursing? What do you do about it?
Values Clarification Exercise

I Am Someone Who...

Outcome Goal

The participant will begin to identify how behavior reflects one's values. This will assist one in identifying her/his own values, both personal and professional and assist her/him in understanding the stages of values clarification. The values that are chosen, prized and acted upon will become more defined for the individual. Discussion of the choices with others will assist the person in knowing which values are prized.

Instructions

1. Write Y for yes, N for no, and M for maybe after each of the statements.

2. Use the Maybes cautiously. One of the purposes of this exercise is to encourage definite stands. Unless you feel Maybe quite strongly, answer all questions as they might apply to you.

3. After completing the answers, you might want to give the questions (but not your answers) to someone who knows you fairly well. Have that person do two things. First, have him/her code the answers. Then start over, this time guessing the answers you think the other person gave. After, sit and discuss each other's messages, the messages we send, and how they are received by others.

Modified from Sidney Simon, Meeting Yourself Halfway, Niles, Illinois, Argus Communications, 1974.
I Am Someone Who... Exercise

I Am Someone Who...

1. Blushes at a compliment.
2. Talks loudly when nervous.
3. Has faced death.
4. Enjoys intimacy with another person.
5. Will insist on traveling first class.
6. Is capable of handling opinions different from my own.
7. Enjoys leisure time for creative development.
8. Experiences boredom and lacks motivation.
9. Responds with compassion when others suffer misfortune.
10. Likes to take over leadership responsibilities.
11. Thinks interracial marriage is a good thing.
12. Works diligently on every project undertaken.
13. Will travel extensively during my lifetime.
14. Reads the comics in the newspaper first.
15. Has high ethical standards.
16. Could get hooked on drugs or alcohol.
17. Works for racial equality.
18. Would die for my beliefs and values.
20. Considers a savings account very important.

Modified from Sidney Simon, Meeting Yourself Halfway, Niles, Illinois, Argus Communications, 1974.
I Am Someone Who...

1. Is willing to pay a lot to have a good time.
2. Needs several cocktails before dinner every night.
3. Is easily swayed by the latest fads and gimmicks.
4. Goes out and impulsively buys because I am easily influenced by ads on TV.
5. Spends a great deal of time reading the latest best sellers.
7. Thinks that most politicians are dishonest.
8. Thinks the Ku Klux Klan has its good points.
9. Volunteers for jobs that are necessary but unpleasant.
10. Would want to design and build my own home.
11. Has an ambition to become a well-known author.
12. Always looks up an unknown word in the dictionary.
13. Enjoys working crossword puzzles.
14. Frowns on gambling.
15. Would marry for money and prestige.
17. Would like to become a well-known sports athlete.
18. Enjoys playing games rather than watching them on TV.
19. Would compromise personal principles for a promotion and higher salary.
20. Smokes three packs of cigarettes a day.

I Am Someone Who...

1. Would like to have different parents.
2. Has seen someone die.
3. Would like to take karate lessons.
4. Would not want to be president of a company that produces napalm.
5. Would like to have a secret lover.
6. Would like my body to be cremated when I die.
7. Could invite someone I couldn't stand to my home.
8. Is fully satisfied with what I have accomplished in life so far.
9. Thinks marijuana should be legalized.
10. Would turn in someone for using drugs, if he/she were my friend.
11. Has written a "Dear John" letter.
12. Has wanted to really hurt someone for something he/she did to me.
14. Goes to a movie alone.
15. Enjoys talking on the telephone.
16. Has few good friends.
17. Enjoys caring for plants.
18. Enjoys going to the zoo.
19. Would like to take a cruise on a luxury liner.
20. Enjoys making things with my hands.

I Am Someone Who...

1. Spends a lot of time worrying about things without doing something about them.

2. Tries to do everything as perfectly as possible.

3. Values friendship more than money.

4. Would like a flashy sports car.

5. Goes to as many X-rated movies as possible.

6. Would like to be a famous movie or TV star.

7. Might seriously consider joining a radical, revolutionary-type organization.

8. Would place a parent in a nursing home without considering other options.

9. Often drives over the speed limit.

10. Wouldn't drive without fastening my seat belt.


12. Is concerned about corruption in business and politics.

13. Would enjoy serving as a juror trying a criminal case.

14. Likes to cook gourmet food.

15. Finds it difficult to praise someone for a job well done.

16. Likes to work with other people rather than alone.

17. Is conscientious about saving fuel and energy.

18. Yearns to become a very successful business person.

19. Gets an annual physical checkup.

20. Might cheat a little on my federal income tax.

From Sidney Simon, Meeting Yourself Halfway, Niles, Illinois, Argus Communications, 1974.
I Am Someone Who...

I Am Someone Who...

1. Considers loyalty to a friend or cause more important than honesty.
2. Keeps a daily journal of events, reflections, and experiences.
3. Is able to take personal risks without too much anxiety.
4. Considers failure a bad thing.
5. Tries to understand and respect other opinions.
7. Respects the lessons to be learned from a study of history.
8. Would like to be a community organizer.
9. Sets realistic life goals.
10. Thinks being a street gang leader is cool.
11. Makes important decisions without consulting others.
12. Is inclined to blame others when experiencing failure.
13. Sends greeting cards for each and every occasion.
14. Carries on extensive correspondence with friends.
15. Would rather fight than quit.
16. Would enjoy owning a large sailboat.
17. Is afraid of flying.
18. Would like to hitchhike through Europe.
20. Is usually late for appointments.

From Sidney Simon, Meeting Yourself Halfway, Niles, Illinois, Argus Communications, 1974.
I Am Someone Who...

I Am Someone Who...

1. Would donate my body to science research.
2. Might rush into marriage.
3. Falls in love right away.
4. Has felt lonely, even in a crowd of people.
5. Has a close friend of another race.
6. Has had someone of another race home for dinner.
7. Plans to vote for the same political party as my parents.
8. Has had such bad problems that I wished I could die so I wouldn't have to face them.
9. Thinks that women should stay home and be wives and mothers.
10. Has been hurt by a friend.
11. Thinks people should limit the size of their families to two children.
12. Favors a law to limit families to two children.
13. Would like to make some changes in my life.
14. Thinks it is all right for older brothers and sisters to discipline younger ones.
15. Would rather be older or younger than I am now.
17. Knows someone who has fought in a war.
18. Has seen a dead body.
19. Would like to jump from a plane with a parachute.
20. Thinks I will be only too happy to retire when the time comes.

Values Clarification Exercise

I Am Someone Who...

Homework Suggestion

You might want to give the "I Am Someone Who..." questions (but NOT your answers) to someone who knows you fairly well. Have that person do two things. First, have her/him code the answers. Then start over, this time guessing the answers YOU made. Then you might want to guess the answers you think the other person gave. After, sit and discuss each other's messages, the messages we send and how they are received by others.

Record in your log any impressions of the interaction. Were you surprised about how the other person perceived you? What contributed to their perception? Did you perceive the other person accurately? What did you learn about yourself and the other person?
Active Listening

The purpose of presenting material on active listening is not only to assist the nurse in relating with others, but also to establish the concept that one needs to listen to oneself and become aware of how and what she/he communicates. As discussed in previous chapters, the nurse is portrayed in a variety of images, frequently is subservient, and may question her/his role in society and the health care field. Lore (1981) indicates that to be an effective communicator one must be aware of how and what one communicates, become adept at putting feeling tones into words, and learn how to clarify and verify what one thinks one hears. Much of the literature concerning nursing and communication centers on the relationship with the patient or client. While it is not the purpose of this module to minimize the importance of the nurse-patient relationship, it will not be emphasized. Rather the focus will be on the other relationships in which the nurse participates and how and what is communicated.

Active listening requires that one must concentrate and care about what the other person has to say (Lore). It requires involvement with the speaker, with her/his thoughts, feelings, hopes, fears, and perceptions (Gordon, 1974). Richard Weaver (1978) suggests:

To listen effectively we have to pay attention to facial expressions and eye contact, gestures and body movements, posture and dress, as well as the quality of the other person's voice, vocabulary, rhythm, rate, tone, and volume... listening with our third ear helps us to understand the whole message (p. 99).

Gordon indicates that active listening provides feedback to the speaker and decodes the message given for verification of the message.

For active listening to occur certain conditions or prerequisites
are necessary. These conditions, according to Gordon, Munn (1980), and Rogers and Farson (1974), include:

1. The other person has a concern or problem.

2. There must be enough time to listen. This is frequently a constraint for nurses who usually have limitations on their time. Frequently problems are brought to a nurse when in the midst of something she/he feels cannot be interrupted. Depending on the nature of the problem it may be appropriate to postpone the discussion. (Example: "I can see you're concerned about this issue. Why don't we meet in the conference room in 30 minutes after I finish passing my meds?")

3. The setting should be comfortable and free of interruption. This also may require some planning on the nurse's part. Active listening is difficult to do in the middle of the hallway with other staff and patients interrupting. Conference rooms, lounges, offices, empty patient rooms and even washrooms can provide the freedom from interruption required to actively listen to another.

4. Care for the person must be present. If the listener does not care for the person, she/he may not be concerned about the problem. The caring nature of nursing usually results in concern for others.

5. One must believe the other person is capable of solving the problem with help. Nurses may have some difficulty with this condition based on the tendency to attempt to meet needs of others. By acknowledging and respecting the capabilities of the person, the nurse is more likely to want to assist them in solving the problem, rather than solving it her/himself.

6. Some degree of separateness must be present. Gordon
describes this separateness "as allowing each to grow and develop his uniqueness, creativity, and individuality (p. 24).

Gordon describes twelve typical response to problems. These are:

1. Commanding-Example: "You better stop wasting time and get your work done!"

2. Issuing a warning or threat-Example: "If you're not going to complete your assignment, I'm going to report you."

3. Preaching-Example: "You're here to work, you should leave your personal problems at home."

4. Giving advice-Example: "You should prioritize your patients' needs and meet them in that order."

5. Using logical persuasion-Example: "You have five patients assigned to you today, so give each one one-fifth of your time."

6. Agreeing or praising-Example: "You're a good nurse so I know you can handle the work."

7. Judging, criticizing, or blaming-Example: "Doctor, if you cared about your patients, you'd have made early rounds."

8. Analyzing or diagnosing-Example: "You're just behaving this way to gain my sympathy."

9. Comforting-Example: "There, there, everything will be okay."

10. Probing-Example: "Who and what are involved in this problem? How and when did it start?"

11. Humoring-Example: "Things could be worse, all of the staff might have called in, not just three nurses."

12. Name Calling-Example: "You're acting like a first year student, not an experienced staff nurse."
Nurses frequently utilize many of these typical responses when problems are brought to their attention. This is not to imply that the above responses are not sometimes appropriate, and that active listening should always be used. There are times when active listening is not appropriate (Gordon). These include:

1. When you (the listener) have a problem. Example: If your favorite patient has just died and someone confronts you with a problem, you may not have the energy, time or concern for active listening.

2. When you want to change someone's values. Example: If you demand that a team member demonstrate a particular behavior at all times, you may not be concerned with why she/he is not conforming to your values.

3. When information is solicited without need for verbal empathy. Example: When asking where the bathroom is located, one does not usually need empathy, but merely directions.

4. When you need information. Example: When an error has occurred and you need information for reporting the incident.

Other factors which may impede effective, or active listening have been set forth by O'Brien (1974) as "barriers to hearing". He states that:

You have difficulty hearing the words of another when

- the person's views are different from yours
- the person's culture, education, or work experience deviates from yours
- it is not easy to follow the thoughts expressed because the vocabulary is not known to you
- the person speaks with a dialect or accent
- the attire or appearance of the speaker is extreme in some way
- you have heard the discourse before by the speaker or someone else
- the thoughts or feelings being expressed shock you or cause you to feel anxious
- you realize you are out of your depth in trying to converse with another
- the person is telling something you do not want to hear
- the environment is noisy, or frequent interruptions occur
- you are experiencing stress or discomfort to any degree (physical, emotional, social)
- the words of the speaker belie his or her actions or true feelings
- your emotions influence your rational approach to the discourse
- you will have to admit an error
- you realize an apology from you should be forthcoming
- the values you support are under attack
- you are self-centered and hear only your own voice
- the news or outcome of a situation is not good
- the needs of another will demand a commitment or involvement by you
- a physical condition develops and the sense of hearing is impaired or lost permanently
- you decide you dislike the person with insufficient information or evidence (pp. 33-34).

There are alternative responses available to replace the previously mentioned typical responses. These alternatives facilitate active listening (Gordon, 1974; Lore, 1981; Munn, 1980; Rogers & Farson, 1974; Simms & Lindberg, 1978) and include:

1. Use of silence - this not only is to encourage the speaker to continue but also affords time for the listener to think about what is being said.

2. Use of minimal responses - "uh-huh" - can be encouraging without breaking the train of thought or feelings.

3. Use of door openers such as "tell me a little more about..." encourages the speaker and provides more information about the concern.

4. Use of reflective listening transmits empathy to the speaker. Reflective listening is not merely repeating or parroting what the other says but rather reflects the essence of the message and feelings being communicated.
Learning the skills of active listening is like the learning of any new skill, it improves with practice. Poor listening habits can be corrected. A few guidelines for listening as developed by Brammer (1973, pp. 81-87) include:

1. Attending
   a. Establishing contact through looking at the speaker when he talks.
   b. Maintain a natural relaxed posture which indicates your interest.
   c. Use natural gestures which communicate your intended messages.
   d. Use verbal statements which relate to his statements without interruptions, questions, or new topics.

2. Paraphrasing
   a. Listen for the basic message of the speaker.
   b. Restate to the speaker a concise and simple summary of his basic message.
   c. Observe cues or ask for a response from the speaker which confirms or denies the accuracy and helpfulness of the paraphrase for promoting his understanding.

3. Clarifying
   a. Admit confusion about speaker's meaning.
   b. Try a restatement or ask for clarification, repetition, or illustration.

4. Perception Checking
   a. Paraphrase what you think you heard.
   b. Ask for confirmation directly from the speaker about the accuracy of your perception of what he said.
   c. Allow the speaker to correct your perception if it was inaccurate.
Munn (1980) indicates that one can avoid miscommunicating if the following points are remembered:

Words have no meaning.
Meaning is in the person.
People should not be word-minded.
They should be person-minded.
Messages should be questioned and paraphrased.
People should seek feedback.

The benefits of active listening (Gordon, 1974; Lore, 1981, Munn, 1980; Rogers & Farson, 1974) include the following:

1. It shows interest.
2. It proves the person has been heard and prevents mindreading.
3. It checks the accuracy of the message.
4. It is a chance to ventilate feelings.
5. It communicates acceptance.
6. It fosters movement from superficial to deeper communication.
7. It fosters openness, insights, and honesty.
8. It promotes intimate and warm relationships.
9. It helps people to become responsible for their problems.

Active listening is a skill in which attention is paid to choice of words, rhythms of speech, pitch and tone of voice, themes of repetition, silences, omissions and nonverbal messages (Gordon, 1974; Lore, 1981). It requires time, concentration, energy and concern. Like all skills it can be learned and improves with practice. Just as learning to give injections is initially awkward and time consuming but becomes second nature with experience, so can active listening.
Nurses have several advantages in learning active listening techniques. The concern nurses have for others is a prime ingredient for learning active listening. The experience of observing and assessing nonverbal messages of patients can easily be transmitted to observation of others.
ACTIVE LISTENING

Objectives

The objectives for the participant for this section are that the participant will:

1. Begin to recognize her/his style of communicating.
2. Understand the importance of active listening.
3. Understand the prerequisites or conditions for active listening.
4. Begin to actively listen for feeling.
5. Develop an awareness of active listening and when it is appropriate.

The title of these presentations will be Stop, Look and Listen!
ACTIVE LISTENING

Suggested Readings


Active Listening Exercise

First Names, First Impressions

Outcome Goal

The participant will learn to determine the accuracy of first impression data, the effects of first impressions and her/his reaction to this experience.

Instructions

1. At the first meeting of the group, the facilitator directs that each person give her/his first name and one or two significant facts about her/himself.

2. Participants are then instructed to turn their chairs around, away from the circle, so that they cannot see the other group members. They are told to write down as many of the first names as they can remember.

3. After about three minutes, they turn their chairs back toward the group and find out whose names they forgot. They may ask for additional information to attach to the names that they found difficult to remember.

4. The group discusses names, feelings attached to them, difficulties experienced in remembering them, and reactions of those whose names were not remembered.

5. The facilitator hands out additional sheets of paper, and participants are directed to write a group roster (names in the same order on each). Then they are asked to note briefly their first impressions of each group member.

6. These first-impressions papers are collected by the facilitator. Without revealing the identity of the writers, the facilitator reads all impressions of the first participant, who is then asked to comment on the accuracy of the impressions, her/his feelings while hearing them, and surprising items. Then all impressions of the second participant are read aloud, she/he reacts, and so on.
7. The group members discuss the accuracy of first impression data, the effects of first impressions, and their reactions to this experience.


Homework Suggestion

If you have the opportunity to meet new people this week, assess your first impression of them. Did it change when you learned their name or spent time conversing with them? If your impression changed, what do you think caused it to change? Record these thoughts in your log.
Outcome Goal

The participant will become aware of her/his ability to listen and will be able to determine specific areas for improvement.

Instructions

Complete Listening Power Quiz by marking the most appropriate answer to each question. After completing the quiz refer to the scoring directions to determine Listening Power.

Scoring

Questions 1, 2, 4, 5, 6, 8 and 10.

Usually: 10 points
Sometimes: 5 points
Seldom: 0 points

Questions 3, 7 and 9.

Usually: 10 points
Sometimes: 5 points
Seldom: 0 points

Below 70 listening skills can be improved, have some undesirable listening habits.

70-85 listen well but still can improve.

90 or above have listening power and are an excellent listener.
Listening Power Quiz

<table>
<thead>
<tr>
<th>Question</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Seldom</th>
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<tbody>
<tr>
<td>When speaking interpersonally or in a small group, do you:</td>
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<tr>
<td>1. Prepare yourself physically by sitting facing the speaker and making sure that you can hear?</td>
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<td>2. Watch the speaker for the non-verbal as well as the verbal messages?</td>
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<td>3. Decide from the speaker's appearance and delivery whether or not what she or he has to say is worthwhile?</td>
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<td>4. Listen primarily for ideas and underlying feelings?</td>
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<td>5. Determine your own bias, if any, and try to allow for it?</td>
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<tr>
<td>6. Keep your mind on what the speaker is saying?</td>
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<td>7. Interrupt immediately if you hear a statement you feel is wrong?</td>
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<td>8. Try to see the situation from the other person's point of view?</td>
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<td>9. Try to have the last word?</td>
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<tr>
<td>10. Make a conscientious effort to evaluate the logic and creditability of what you hear?</td>
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Active Listening Exercise

Listening Power Quiz

Homework Suggestion

Observe, and record in your log, interpersonal communication in dyads or small groups over the next week. What do you observe? Do certain persons relate differently with certain people? At work, do you listen differently to staff in different positions (e.g., your head nurse, an attending physician, an aide, an intern)? Do you listen differently to certain friends, patients or acquaintances? What differences have you noted and why do you think these exist?
Active Listening Exercise
Nonverbal Cues

Outcome Goal

The participant will explore how much information is available without words and how valid the interpretation of this data may be.

Instructions

A. Divide group into pairs, preferably those who are not acquainted or at least do not know each other well. Each dyad should find a place where they can carry out the exercise with as little distraction as possible.

B. Sit facing each other, then silently observe each other for about 2 minutes.

C. Now write down your best guesses (inferences) to each of the following items:

1. I am ____ years old.
   My partner is ____ years old.

2. I have a (good, fair, poor) sense of humor.
   My partner has a (good, fair, poor) sense of humor.

3. I feel (tired, energetic) right now.
   My partner feels (tired, energetic) now.

4. I am (comfortable, uncomfortable) doing this exercise.
   My partner is (comfortable, uncomfortable) doing this exercise.

5. I am (married, not married).
   My partner is (married, not married).

6. I am relatively (introverted, extroverted).
   My partner is relatively (introverted, extroverted).

7. I consider myself (passive, assertive, aggressive).
   My partner is (passive, assertive, aggressive).
8. I am a (smoker, nonsmoker).
My partner is a (smoker, nonsmoker).

9. I tend to be (calm, nervous).
My partner tends to be (calm, nervous).

D. Keep your answers covered while you engage in a conversation for about 3-4 minutes about anything unrelated to the preceding items (such as the weather, important news, a movie or television program).

E. Working alone, make any changes you think are needed in your answers about your partner.

F. Compare your answers with those your partner wrote down. Then answer the following questions:

1. What did you guess correctly? What did you miss?

2. From what nonverbal cues that you are aware of did you infer your answer to each question?

3. Did you change any answer after conversing? If so, what? Why?

4. What kind of information is available to us in nonverbal cues?

5. How did you feel while making inferences about your partner from strictly nonverbal cues?

Modified from Barbara Jean Edwards and John Brilhart, Communication in Nursing Practice, St. Louis, C.V. Mosby Co., 1981.

Homework Suggestion

In the next week identify what nonverbal cues of others please you, are distasteful to you, frighten you, intrigue you and irritate you. Record these in your log. Explore why you think these clues affect you in this manner.

While watching a television program with someone else, block your
ears to prevent hearing the dialogue. Watch for about five minutes, then discuss your perception of what occurred with the person who was both watching and listening to the program. How accurate was your perception?
Active Listening Exercise

Adler's Exercise

Outcome Goal

The participant will become aware of how accurately and completely she/he listens to content, tone and nonverbal aspects of communication.

Instructions

You can practice your listening skills by trying to repeat to yourself the exact substance of verbal expressions made to you in ordinary conversations and by trying to summarize the important elements of longer verbal expressions. After each such attempt, ask yourself if you have missed or left out anything of importance. It is critically important that your listening skills enable you to take in information that is both complete and accurate. And remember--you should be listening for the tone and nonverbal communication as well as the content of each verbal expression.

Homework Suggestion

Practice this exercise over the next week and verify with the speaker the message you received. Record in your log how accurately and completely you perceived the message.
Assertiveness Training

While the birth of assertiveness training dates to the 1949 publications of Andrew Salter's *Conditioned Reflex Therapy*, the definition of assertiveness training varies with different sources. Alberti and Emmons (1974) presented a behavioral definition for assertiveness as "behavior which enables a person to act in his own best interest, stand up for himself without undue anxiety, to express his rights without destroying the rights of others" (p. 2). Hersen, Eisler and Miller (1973), teachers and researchers of assertion, found that not all people behave nonassertively because of anxiety inhibiting them, but rather that they never learned how to assert themselves. Assertiveness then is a skill, a skill which can be learned, similar to playing a musical instrument or giving an injection.

Before continuing, it is important to clarify the difference between assertion, nonassertion and aggression. Nonassertive behavior according to Herman (1978) in her *Becoming Assertive-A Guide for Nurses*, is that:

- type of interpersonal behavior which enables the person's rights to be violated in one of two ways: 1) the person violates her rights when she permits herself to ignore personal rights that are actually important to her, or 2) the person permits others to infringe on her rights. Nonassertive behavior pays off by enabling the individual to avoid potentially unpleasant conflicts with others; however, various unpleasant consequences such as hurt feelings and lowered self-esteem are likely to occur (pp. 55-56).

Several authors contend that women/nurses frequently utilize nonassertive behavior for a variety of reasons: lack of assertive skills; conditioning; maintainence of femininity; and victims of the "compassion trap" (Bush & Kjervil, 1979; Dawley & Wenrich, 1976; Donnelly, 1978;

Aggression, on the other hand, is the expression of one's rights in such a way that it violates the rights of others. The purpose of this behavior (Clark, 1978; Herman, 1978; Jakubowski-Spector, 1973) is to dominate, humiliate, deprecate or embarrass others. It is an attack on the other person rather than the person's behavior. Herman indicates that while generally aggressive people do not go into the profession of nursing, many nurses use an indirect form of aggressive behavior because of the "misery experienced by complete passivity or the resulting isolations from utilizing aggressive behavior. This is the ability to get what one wants by indirect means such as trickery, seduction, alluding to situations, or manipulations" (p. 20).

Herman also states that:

perhaps the main reason nursing has been reluctant to support assertiveness is that the concept of assertiveness has often been misunderstood and confused with aggression. For example, berating the Director of Nursing after being refused a raise or yelling at a doctor because he put you down, illustrates belligerence and antagonism--in other words, aggressive behavior. This behavior not only is inappropriate and self-defeating, but it is not compatible with nursing--whose concerns are the nurturance and caring of others (p. 17).

After being exposed to the components of assertive behavior it would seem a small step for nurses to practice these behaviors. However, social factors can hinder nurses from demonstrating assertive skills. The dominance of females in nursing results in its members being subject to the usual female socialization practices in society (Clark, 1978). For example, some messages that women commonly receive in our society according to Herman (1978) are: "think of others first, never brag or tell others positive things about yourself, always
listen and be understanding, never complain, be attuned to what the
other person is thinking and feeling and be willing to give to others" (p. 285). These messages may not enhance a desire to learn assertiveness skills, may lead one to confuse assertiveness and aggressiveness, and to view assertive behavior as unfeminine. To clarify again, assertiveness is "behavior which enables a person to act in her own best interest, stand up for herself with undue anxiety, to express her rights without destroying the rights of others" (Alberti & Emmons, 1974, p. 2). Assertiveness according to Adler (1977) is also the ability to communicate the full range of one's emotions and thoughts with confidence and skill. This ability gives one options, one can choose the appropriate manner to act in a situation rather than be limited to only one response.

Many people are "situationally unassertive". That is one might express oneself, well most of the time, but lack skill or confidence in certain situations or with certain people. A nurse may exhibit assertive behavior with peers but demonstrate nonassertion with her/his superiors. One may be assertive in the work setting but aggressive in one's personal life. Most nurses know a physician or supervisor who can reduce her/him from an assertive, confident practitioner to a passive, nonassertive role.

One may act unassertively for a variety of reasons. The myth that assertiveness is unfeminine has already been discussed. Other possible reasons for acting nonassertively (Adler, 1977; Clark, 1978; Donnelly, 1978; Herman, 1978) include:

1. One may act nonassertively because she/he was never exposed to
better alternatives. Assertiveness training is a skill which can be learned.

2. One may act nonassertively because she/he has been reinforced for doing so. Getting a good evaluation for always accepting requests to do overtime may reinforce not asserting oneself.

3. One may act nonassertively because she/he has been punished for being assertive. Asserting oneself in refusing a request from the supervisor may result in working nights with every Wednesday and Sunday off.

4. One may be nonassertive because she/he believes in one or more irrational myths.

Adler describes these myths as:

1. The myth of perfection. This myth is particularly appropriate to nurses. Most nurses, besides being subject to female sex role stereotypes, have been told at some time during their education that if they make an error, they can kill a patient. This reinforces the myth that one must be perfect. Subscribing to this myth can act as a force to diminish one's self-worth. How can one like one's self when one doesn't measure up to perfection?

2. The myth of acceptance. One way to judge the worth of one's actions is by the approval they bring. Being nice many times results in acceptance. Doing overtime results in acceptance from the boss. Buying an unwanted item gains acceptance from the salesclerk. Making coffee results in acceptance from the physician. Preparing dinner gets
acceptance from a roommate, spouse or friend.

3. Myth of causation. One must not do anything which might possibly hurt or in any way inconvenience others. This frequently results in failure to have one's own needs met. One might resent the person whose behavior is bothersome. When one of the nurses is consistently late for duty, one may have to care for her/his patients as well as one's own. Allowing this to continue often results in not meeting one's own needs and resentment for the other person may build.

4. Myth of helplessness. Satisfaction in life is determined by forces beyond one's control. Nurses may complain about the system without confronting issues or use feminine wiles when relating with male physicians. "I have to do what the doctor says." "I can't change pharmacy, they never get the drugs here on time."

5. Myth of catastrophic failure. This is the assumption that if something terrible can possibly happen, it will. Usually the world will not end, nor will patients die if the nurse goes to lunch.

Cotler and Guerra (1976) report beliefs in four other myths. These are:

1. The myth of modesty which indicates that one must be modest at all costs. Believers of this myth have difficulty accepting praise or compliments from others or themselves, and tend to be self-critical. This compares with one of the common messages women receive in society, "never brag or tell
others positive things about yourself."

2. The myth of the good friend indicates that any good friend, spouse or significant other who cares about someone should be able to know what that person thinks, feels, and wants without being told. "If he loved me, he would know I want..." When the other does not respond as desires, one may feel unloved, taken advantage of, or abused.

3. The myth of anxiety states that there is something unusual, abnormal or wrong about experiencing or revealing anxiety when dealing with others.

4. The myth of obligation says that if a friend asks a favor, one is obligated to oblige, and therefore to ask a favor is to impose.

There are consequences of nonassertiveness (Adler, 1977; Herman, 1978; Smith, 1975). These include: communication is inhibited; rights are infringed upon or denied; anxiety; ignorance and guilt can be used to manipulate the nonasserter; nurses are hindered from accepting authority commensurate with patient responsibility; low self-esteem results; relationships are difficult to build, loneliness and psychosomatic illnesses occur. The consequence of using nonassertion was aptly described by Jourard (1964), "Being polite out of fear of being offensive and hiding one's discomfort with the situation or the behavior of the other is a sure way of either destroying a relationship or of preventing one from really forming" (p. 38). Also, Jakubowski-Spector (1973) maintains that one will be happier if she appropriately exercises her rights.
Presentation of self is one component of assertiveness training. This component includes verbal and nonverbal aspects. Some nonverbal areas to assess are speaking in a loud enough, firm, fluent voice; maintaining eye contact; and using appropriate facial expressions, gestures, body posture, and positioning. No matter how clear the verbal message may be, if one doesn't maintain eye contact, she/he will appear unsure. Assessment of these nonverbal cues have been practiced by nurses in patient related situations. The smiling patient who is complaining of excruciating pain may cause the nurse to question the veracity of the complaint. Likewise the smiling nurse who says she/he is angry will give double messages.

Facing the person whom one is addressing is an assertive presentation of self. Sitting or standing can influence how the message is conveyed and received. When asserting one's self with a six foot physician when he is standing and the asserter is seated may impede assertion and eye contact. However, if both are seated or standing, it is much easier to be assertive.

Verbal areas to assess include: thinking and talking about oneself positively; expressing thoughts; feelings; and expectations in a clear concise manner; stating and staying with the problem or issue at hand; and using "I" messages (Clark, 1978; Herman, 1978).

Actively thinking positive thoughts and making positive self statements in conversations increase both self-respect and self-confidence. When most thoughts and statements are positive, it results in greater self-esteem and respect from others (Herman). Gaining self-respect reduces the dependency on others for approval.
Expressing thoughts, feelings and expectations in a clear concise way plays a role in asserting one's self. Intershift reports are an example of using clear, concise communication to convey what has occurred with the patient. Most nurses are comfortable with reporting data, "Dr. Jones, Mr. Smith's vitals are changing. His B/P is falling and his pulse is rapid and thready." The area in which nurses have some difficulty is with expression of their own thoughts and feelings. Jourard (1971) refers to this ability as self-disclosure, the stating and sharing of one's own thoughts and feelings with others. It is a method of giving information to others about yourself.

Stating and staying with the problem or issue at hand involves persistence to avoid manipulation. Smith (1975) refers to using the technique of the "broken record"--"to keep saying what one wants over and over again without getting angry, irritated or loud" (p. 74). When one speaks as if one were a broken record, one learns to stick to the point of the discussion and to be persistent. To keep saying what one wants to say, and by ignoring all side issues brought up by the other person, is persistence. Herman gives the following example:

Nurse: "I want a new pain medication order, Dr. Taylor. Miss White was in pain last evening and all night. The Darvon compound was given but did not help her discomfort."

Dr.: "Well, try two Darvons then."

Nurse: "Miss White has taken two and also had a back massage and is still in discomfort. I want a new pain medication order for her."

Dr.: "Darvon helps the kind of pain she is having."

Nurse: "That may be true, but it has not helped her. She told me she has taken Demerol and obtained some relief. Would you write an order for that?"
Dr.: "Oh, all right" (p. 40).

Use of "I" messages is another aspect of verbal assertiveness. Gordon (1974) refers to these as "responsibility messages." "I" messages convey that the speaker takes responsibility for what she/he feels, thinks or wants. They also convey that the person believes in and trusts her/his thoughts and feelings and that she/he has decided they are worthwhile to share. It reduces blaming others and may enhance further communication. For example, when one says to a co-worker, "You don't care about the patients, you're always going to your meetings and I have to care for your patients", this blames the coworker. An alternative response might be, "I feel angry when you're at your meetings and I have to take care of your patients." In this response, the speaker has taken responsibility for her/his own feelings and fosters more communication on the issue.

The mere use of "I" in a sentence does not necessarily convey an "I" message. It is important to remember that in a true "I" message, the speaker takes responsibility for her/his thoughts, feelings and wants. Messages masquerade for "I" messages when the speaker tries to take responsibility for the other person by pretending to know what the other wants by manipulating the other into thinking, feeling, or acting in a specific manner. For example, "I think you ought to...", "I feel you should...". These are not true "I" messages.

In review, then assertiveness is a learned manner of communication in which one maintains her/his rights without infringing on the rights of others, declares her/his feelings, thoughts and desires, and accepts responsibility for these feelings, thoughts and desires.
ASSERTIVENESS TRAINING

Objectives

The objectives for the participant of this section are that the participant will:

1. Be able to distinguish between nonassertive, assertive and aggressive behavior.
2. Be able to identify advantages of assertive behavior.
3. Be able to identify her/his own style of communicating (nonassertive, assertive or aggressive).
4. Be able to identify if her/his usual style of communicating differs depending on the situation or the person(s) involved.
5. Be able to identify verbal and nonverbal components of communication.
6. Begin to demonstrate some assertive behaviors.
7. Be able to recognize true "I" messages.


ASSERTIVENESS TRAINING

Suggested Readings


Assertiveness Training Exercise
Identifying Own Feelings

Outcome Goal

The participant will begin to identify and take responsibility for her/his feelings in a variety of situations. She/he will also gain insight into how behavior of others affect her/him.

Instructions

Complete the following sentences. Do not dwell on the answers, but respond with the first response that comes to mind.

1. When I am alone I usually feel ______.
2. When I have to admit an error I feel ______.
3. When someone calls in sick I feel ______.
4. When I'm asked to work overtime I feel ______.
5. When a patient turns bad I feel ______.
6. When my boss calls me in I feel ______.
7. When I don't get enough sleep I feel ______.
8. When I can't leave the unit for lunch I feel ______.
9. When I'm late for a meeting I feel ______.
10. When I make a medication error I feel ______.
11. When a patient falls out of bed I feel ______.
12. When Dr. ______ yells at me I feel ______.
Assertiveness Training Exercise

Identifying Own Feelings

Homework Suggestion

During the next week, pay close attention to your feelings and record them in your log. Can you identify them? What do you think causes them? What do you do when particular feelings emerge?
Assertiveness Training Exercise

Expression of Thoughts and Feelings

Outcome Goal

The participant will learn to identify her/his thoughts and feelings and will begin to express these to others.

Instructions

How well do you express your thoughts and feelings?

You can begin to answer this question by:

Find a quiet spot where you will not be interrupted.

Now picture yourself talking with an important person in your life. Imagine yourself sharing:

a. The 2 things you most appreciate or admire about that person.

b. Two ways in which you would like the person to change.

Would you have difficulty communicating any of these messages?

Would you like to send any of them better?

Assertiveness Training Exercise
Expression of Thoughts and Feelings

Homework Suggestion

Throughout the next week, determine if there are positive messages you wish to relate to an important person in your life. What are they?

Tell the person two positive things, what you most appreciate or admire about him/her. How did the person respond? How did you feel? Record this in your log.
Assertiveness Training Exercise

Observing an Assertive Person

Outcome Goal

The observer will begin to see assertive nonverbal behaviors and how they add to the communication process.

Instructions

1. Identify assertive persons with whom you have contact.
2. Observe their nonverbal behavior when they interact.
   - facial expressions
   - body posture
   - gestures
   - eye contact
   - distance from others
   - positioning (sitting, standing)
3. What you have observed?
Homework Suggestion

Identify a consistent nonverbal behavior the assertive person you have observed demonstrates--a behavior you think you would be comfortable using. Practice this behavior in front of a mirror and then use it in communicating with another person. How did you feel using this behavior? What happened to your verbal exchange? Do you think your new nonverbal behavior affected your verbal communication? Record your observations and feelings in your log.
Assertiveness Training Exercise

Rights

Outcome Goal

The participant will be able to define her/his rights as a person, a female/male, and a nurse.

Instructions

As a person I have the right to...

As a female/male I have the right to...

As a nurse I have the right to....
Assertiveness Training Exercise

Nurses' Bill of Rights

1. The right to be respected—to be listened to.
2. The right to have and state thoughts, feelings and opinions.
3. The right to question or challenge.
4. The right to understand and have in writing what is expected at work.
5. The right to say "no".
6. The right to be an equal member of the health team.
7. The right to ask for changes in the system.
8. The right to a reasonable work load.
9. The right to make a mistake.
10. The right to make decisions regarding health or nursing care.
11. The right to do health teaching.
12. The right to choose not to assert oneself.
13. The right to be a patient advocate or to teach patients to speak for themselves.
14. The right to change one's mind.

What additional rights do you choose? Think when you last stood up for a human right in which you believed. Does this happen frequently? If not, why not?

Assertiveness Training Exercise

Rights

Homework Suggestion

At the end of each day in the next week, review your list of rights. Were these rights honored by others that day? If not how were they violated and by whom? Write down this information in your log. Is there a pattern emerging? Are specific rights being violated by specific persons? How and why do you think this is occurring?

Add to your list of rights as you think of new ones.
Assertiveness Training Exercise
Thinking and Feeling Positively About Self

Outcome Goal

The participant will identify specific behaviors and skills of which she/he is proud. This will enhance her/his self-esteem by defining those things about which she/he feels good.

Instructions

I am good at...

My skills include...

I am proud when I...
Assertiveness Training Exercise

Thinking and Feeling Positively About Self

Homework Suggestion

Select one day in the next week--a day that is typical for you--and consciously pay attention to things that you do which made you proud. Record these in your log.
Assertiveness Training Exercise

Things I Am Proud Of

Outcome Goal

The participant will identify specific behaviors and skills of which she/he is proud. This will enhance her self-esteem by defining those things about which she/he feels good.

Instructions

Sidney Simon (1974) in his Meeting Yourself Halfway, declares that one cannot have a decent self-concept of who one is as a whole person without pride. False humility is as harmful as false pride. Be proud of what you do and who you are. Be willing to publicly affirm it. You should be able to define those things about which you feel good. Here is a checklist to help you get started. Feel free to make additions to this list.
EXERCISE

THINGS I AM PROUD OF

Something that I recently made as a gift for someone special.
My ability to organize my work.
Some aspects of my last year's vacation.
My response to the energy crisis.
My savings account.
My family.
What I can accomplish independently of others.
My many good and loyal friendships.
My difficult decisions within the last year that required risk.
A sports accomplishment.
The way I responded to a friend who was in need.
My nationality and family customs.
Something I did that did not require a great deal of courage but is a source of satisfaction.
Something unseemly that I was very tempted to do but did not do.
Praise I received for some special achievement.
My ability to express my opinions, even when they differ from others'.
My responsibility for making someone else very happy.
My good taste in clothes and talent for dressing well.
Some difficult skill that I recently learned.
I realized a long-sought-for goal.
Helping someone through a difficult problem.
Something I did to help the pollution problem.
Something I did that expressed my honesty and moral principles.
EXERCISE

THINGS I AM PROUD OF

A time when I asserted real leadership.

My driving record.

Self-disciplining regarding my eating and drinking habits.

I showed extreme sensitivity to someone else's feelings.

I helped someone in financial trouble.

I helped a parent and child get together again.

My willingness to participate in the democratic process.

My ability to keep up with new developments in my field.

The religious beliefs that I live by.

A response by me that involved danger and required physical and moral courage.

Time when I was especially creative.

It was difficult to forgive a friend but I did it.

An occasion when I was particularly open and honest.

I helped a younger brother or sister understand a problem.

My compassion and understanding.

A surprise I planned for someone dear.

My professionalism.

My ability to think positively about people and the world.

Something I did that demonstrates my love for nature and beauty.

It was difficult to tell the truth but I did it regardless.

Something I read recently that required much thought.

Attention to my family that showed my concern.

Something I learned recently that helped my perspective.
THINGS I AM PROUD OF (continued)

An occasion when my good example inspired others to follow.

Assertiveness Training Exercise

Things I Am Proud Of

**Homework Suggestion**

Select one day in the next week—a day that is typical for you—and consciously pay attention to things you do which make you proud. Record these in your log.
Assertiveness Training Exercise

"I" Messages

Outcome Goal

The participant will be able to determine true "I" messages and will begin to assume responsibility for her/his messages.

Instructions

Determine which of the following statements are true "I" messages.

1. I feel you ought to come in early tomorrow.
2. I think that's a good idea.
3. I want to go to lunch now.
4. I think you could do a better job.
5. I want you to give Mr. Jones his injection now.
6. I think you feel hurt.
7. I'm concerned that you're upset.
8. I want to discuss discharge planning for Mrs. Smith.
9. I'm angry about this situation.
10. I'm depressed today.
Assertiveness Training Exercise

"I" Messages

Homework Suggestion

During the course of the next week pay particular attention to your use of the word "I". Are there particular instances, places, or persons with whom you use the word more frequently? Do you assume responsibility for the "I" message you convey? Indicate these answers in your log.
Assertiveness Training Exercise

Discriminating Assertive Responses

Outcome Goal

The participant will be able to discriminate between assertive, nonassertive and aggressive responses.

Instructions

Situation 1:

Your relief nurse arrived an hour late and you had to fill in for her. She did not call to let you know she would be late. When you see her, you say:

a. "Boy, what a busy day. Too bad you weren't here."

   assertive
   nonassertive
   aggressive

b. "Where have you been? If you think I'm going to cover for you again, you're crazy!"

   assertive
   nonassertive
   aggressive

c. "I expected you an hour ago. I would have appreciated your call to let me know you would be late."

   assertive
   nonassertive
   aggressive

Situation 2:

Your supervisor calls you aside to tell you what a great job you've been doing teaching diabetics. You worked hard on this and you say:

a. Nothing. You blush and change the subject.
   
   ____ assertive
   ____ nonassertive
   ____ aggressive

b. "Thanks. I worked hard."

   ____ assertive
   ____ nonassertive
   ____ aggressive

c. "I don't know why you haven't noticed my good work before."

   ____ assertive
   ____ nonassertive
   ____ aggressive
Situation 3:

You notice that the head nurse always asks you to work overtime, even though there are others who could work. The next time you see the head nurse, you:

a. Say to her, "I'd like to talk with you about working overtime."
   
   _____ assertive
   _____ nonassertive
   _____ aggressive

b. Walk by her, and then feel angry at yourself because you didn't talk to her.
   
   _____ assertive
   _____ nonassertive
   _____ aggressive

c. Say to her, "I've had it! No more overtime for me, so don't ask!"
   
   _____ assertive
   _____ nonassertive
   _____ aggressive
Situation 4: You are busy charting when an aide interrupts you for the fourth time. You say:

a. "Can't you see I'm busy?"
   
   ___ assertive
   ___ nonassertive
   ___ aggressive

b. "Can I help you?" (while grimacing and sighing).
   
   ___ assertive
   ___ nonassertive
   ___ aggressive

c. "I can't help you now. I can help you in 30 minutes."
   
   ___ assertive
   ___ nonassertive
   ___ aggressive
Situation 5:

An aide approaches you, pointing out that you forgot to give her a requested day off. You say:

a. "Not now, I'm busy."
   ___assertive
   ___nonassertive
   ___aggressive

b. "You're right, I did forget. I'll take care of it."
   ___assertive
   ___nonassertive
   ___aggressive

c. "It's not my fault, you should have reminded me."
   ___assertive
   ___nonassertive
   ___aggressive.
Situation 6:

One of the staff nurses never completes her charting. As head nurse, you decide to deal with this situation by asking to meet with the staff nurse. When you get to the meeting, you:

a. Start chatting about a patient.
   
   ____ assertive
   ____ nonassertive
   ____ aggressive

b. Say, "Part of this job requires daily nurses' notes. Here are some examples of effective charting. I expect you to chart this way daily."
   
   ____ assertive
   ____ nonassertive
   ____ aggressive

   
   ____ assertive
   ____ nonassertive
   ____ aggressive
Situation 7:

Dr. Jones tries to get you to give a medication to a patient, and you know the patient is allergic to it. When you point this out, the doctor says, "Give the medication or I'll report you to your supervisor." You:

a. Say, "perhaps you and I together could talk this over with the supervisor."
   
   ____ assertive
   ____ nonassertive
   ____ aggressive

b. Give the medication and hope nothing happens.
   
   ____ assertive
   ____ nonassertive
   ____ aggressive

c. Say, "I won't give the medication and I don't care who you talk to about it!"
   
   ____ assertive
   ____ nonassertive
   ____ aggressive
Situation 8:

There is one doctor who always refers to you as "Honey". You prefer to be called Ms. Smith. The next time he calls you "Honey" you say:

a. "All right, Dear!" angrily and grimace at him.
   
   __ assertive
   __ nonassertive
   __ aggressive

b. "Yes, doctor."
   
   __ assertive
   __ nonassertive
   __ aggressive

c. "I prefer to be called Ms. Smith."
   
   __ assertive
   __ nonassertive
   __ aggressive
Situation 9:

You are usually on time for work and leave late many times. Tomorrow you have an important appointment you cannot change. The appointment begins five minutes after your shift ends and it is on the other side of town. Today, you request a return of a half-hour overtime so you can get to the appointment. Your supervisor says, "Tomorrow is going to be very busy. I can't spare you and neither can the patients— they need you, and it is your professional responsibility to meet their needs." You say:

a. "You're right, I'll cancel my appointment."
   
   assertive
   nonassertive
   aggressive

b. "I cannot change the appointment, I need to leave at 3 o'clock."
   
   assertive
   nonassertive
   aggressive

c. "Well, I'm taking off at 3 o'clock!"
   
   assertive
   nonassertive
   aggressive
Situation 10:

You make an appointment with your supervisor because she has decided to put your name up for committee chairperson without discussing it with you. When you arrive at the appointment, the conversation proceeds as follows:

You:  "I'm really angry that I wasn't asked about the chairperson position and my name was placed in the hat anyway."

Supervisor:  "Now, now. Don't get excited."

You:  "I'm not excited, but I am angry."

Supervisor:  "I'm glad you're here; I want to talk to you about Dr. Smith."

You say:

a. "Perhaps we can discuss Dr. Smith later. Right now I want to clear up this chairperson deal."

____ assertive
____ nonassertive
____ aggressive

b. "Oh, yes, Dr. Smith..."

____ assertive
____ nonassertive
____ aggressive

c. "I don't care about Dr. Smith. You've humiliated me!" (getting up to leave in anger).

____ assertive
____ nonassertive
____ aggressive
Homework Suggestion

Select specific interactions in which you feel you responded nonassertively or aggressively. Did you respond this way by conscious choice? If not, reconstruct the situation in your log and indicate how you might have been assertive in those particular instances.
Assertiveness Training Exercise
Suds

Outcome Goal

The participant will be able to identify what may be blocking her/his desired responses in a particular situation. She/he will also be able to think clearly even when anxiety is present.

Instructions

"Subjective Units of Disturbance Scale" Exercise Scale ranges from 0 (as comfortable as possible), to 100 (an unbearable feeling). Estimate your scale at specific moments in specific situations.

Use the following questions for self-assessment during interaction.

What is my SUDS level?
What am I doing (verbally and nonverbally)?
Where am I (at work, at home, at a social gathering)?
What am I feeling?
What am I thinking?
What do I want to be thinking, feeling, and doing?
What thoughts, opinions, needs, feelings do I want to express in this situation?
What do I want the other person to know?
What thoughts are keeping me from doing what I want?
What do I think is appropriate to express?
How can I go ahead and express what I want?

Assertiveness Training Exercise

SUDS

Homework Suggestion

Review the suggested questions and adapt them to your needs, to make them comfortable for you. When in an anxiety-producing situation ask yourself as many of the questions as appropriate. Record in your log these situations and how you responded. Also you might indicate how you would respond differently were the situation to occur again.
Assertiveness Training Exercise

Yes-No!

Outcome Goal

The participant will become aware of the full range of loudness available to her/him and to contrast it with the range of loudness she/he is accustomed to. She/he will also be able to recognize how quiet or loud she/he is from an experiential base rather than hearing it from others.

Instructions

1. Form pairs, facing each other.

2. While one person says the word "yes", the other responds with "no" at the same loudness level for a minute or two. The "yes" person should vary the loudness from very quiet to as loud as possible, and the "no" person should match the loudness level each time.


4. Pay attention to nonverbal clues the other person may be giving you (Is the "No" person smiling, stern-looking, maintaining eye contact?).

5. Discuss your feelings doing this exercise.

Assertiveness Training Exercise

Yes-No!

Homework Suggestion

Intentionally talk louder (or softer) than you usually do during a short interaction with someone. Begin to get a sense of how loud or quiet you generally tend to be.

Change the loudness of your voice in a conversation. Assess and record in your log how comfortable you are.

Assertiveness Training Exercise

Making and Refusing Requests

Outcome Goal

The participant will recognize how beliefs regarding personal rights influence behaviors. She/he will be able to assess her/his comfort and effectiveness in making and refusing requests. She/he will be able to discriminate between effective and ineffective refusals and requests.

Instructions

1. Participants are to form pairs.

2. Create a role play situation (co-workers, friends, family).

3. One person is to make a reasonable request and the other just responds with "No", then switch roles and repeat.

4. Clarify if there was more information you wished to impart (did you want the other person to know why you were refusing or that you would be willing to comply in another manner?).

5. Now make and refuse requests, intentionally offering excuses that avoid the real issues (e.g., I can't work overtime because my husband will get mad').

6. The "requester" should persist and confront the "I can't" responses with either solutions or alternatives that still include a request.

7. Switch roles and repeat steps 5 and 6.

8. Now make and refuse requests, attempting to be honest and direct, particularly emphasizing "I don't want to" or "I won't" messages, rather than "I can't".

9. Discuss in your pairs how you felt about each role.

10. Discuss in your group how you felt about each role.

Assertiveness Training Exercise
Making and Refusing Requests

Homework Suggestion

Make three reasonable assertive requests that are somewhat difficult for you; then assess what you liked about how you made them. Record this data in your log.

Assertively refuse any requests you would like to turn down. Record how you felt doing this in your log.

Summary

The purpose of this teaching module is to increase communication skills of nurses. It is designed specifically for nurses regardless of their educational background, years of experience, clinical area of expertise or nature of the facility in which they work. It is proposed that the module and the presenter be offered to institutions in which nurses are employed and that the programs would be presented in these facilities. This would confine the costs of the program to the fee for the presenter.

The module is designed to include learning objectives for the participant, background information and exercises for each topic. The specific needs of each group would be assessed by the sponsoring facility, the group members and the presenter. This might result in presentation of parts of the module or the entire module. Group participation would be also elicit areas to be addressed and specific areas of concern would be incorporated for the group. Exercises, role playing and group participation would be integral parts of the presentations.

The module consists of three areas, values clarification, active listening and assertiveness training. Each topic is designed to address the needs and strengths of nurses. For example, there is little emphasis on assessing nonverbal cues as this is generally a strength of nurses from their patient care experiences. The emphasis is not on patient-nurse relationships but on relationships in general. This choice was made as the focus is to develop the nurse as a person, rather than as a care giver.
CHAPTER V

SUMMARY

Chapter five consists of three sections. The first section re-states the purpose of the study. The second includes discussion and conclusions. The third addresses limitations and recommendations.

Restatement of the Purpose of the Study

The purpose of this study is to develop a practical module to increase communication skills of nurses to assist them in dealing with colleagues, supervisors, physicians, the public and patients; and also to assist them in recognizing some of their own needs and values. The module integrates a variety of approaches applicable to nurses regardless of experiential background, clinical area of interest, or time in the work setting. The module integrates nursing and counseling aspects.

Review of some of the historical and socio-psychological perspectives in nursing reveals contributing factors to the conflicts of the present day nurse such as: subservience; a female-dominated profession; dependency on physicians; a variety of images and roles; conflict between factions of nursing; and a variety of educational preparations.

The variety of basic educational preparations (Diploma, Associate Degree, Bachelor of Science in Nursing) for nurses contribute to diversity not only educationally, but also in terms of the image and role of nurses. The changes in educational philosophies which have emerged over the past few decades with an increasing emphasis on B.S.N.
preparation contributes to this diversity.

Much of the literature in nursing is directed toward specific groups of nurses (e.g., students, new graduates, etc.) or isolated issues (e.g., oncology nursing, dealing with pain, attrition rates, etc.) in nursing. Emphasis is usually not directed to the experienced staff nurse who deals with the day to day problems and concerns associated with patient care and the multiple relationships involved in rendering this care. This module, while adaptable to all nurses, is especially directed to this group. It is also designed to capitalize on her/his strengths while exposing her/him to measures to increase her/his communication skills.

The module consists of three main components: values clarification, active listening, and assertiveness training. Each component includes objectives for the participant, background information, exercises and a suggested reading list. Exercises included in each section may be done prior to, during or after the presentation depending on the time available and the goals of a particular situation. The exercises are designed for the nurse and emphasize experiences common in, and particular to nursing. Any or all of the sections may be presented depending on the needs of the group.

Use of the skills taught in the module should result in: 1) increasing individual nurse's self-respect and self-esteem; 2) the nurturing of respect and esteem for nursing; 3) increased job satisfaction; 4) decreased attrition rates; 5) improved communication within nursing; and 6) recognition of, and assertion of rights.
Discussion and Conclusions

There are several concerns of, and influences upon present day nurses. While some problems may be situational, many are universally present in the practice. This section will discuss some of these factors and will offer some conclusional recommendations.

Most health care settings have three major departments to which the nurse is accountable for her/his actions: nursing, medicine and administration. The goals and philosophies of these departments may be compatible or may vary according to the needs and concerns of the institution. Administration may focus on cost containment and obtaining donations from wealthy contributors. The department of medicine may focus on medical research and providing learning experiences for interns and residents, while nursing might be concentrating on establishing a primary care system and focus on patient teaching. While these foci are not necessarily mutually exclusive, the staff nurse may be expected to focus on all of these aspects while maintaining quality patient care. These accountabilities of the nurse may conflict with individual values, lead to frustrations and a perceived inability to provide quality patient care.

Regulations imposed on health care facilities may also ultimately affect the staff nurse. Regardless of the type of setting in which nurses are employed, governmental regulations apply. These might include the local Board of Health regulations, mandates from the Federal Bureau of Narcotics, Medicare and Medicaid restrictions. Many institutions also are concerned about recommendations from The Joint Commission of Accredited Hospitals. While these regulations and
and recommendations generally provide for the well-being of society, they might hinder the nurse in providing her/his concept of total patient care. For example, Medicare regulations indicate a specific number of hospital days for which it will provide payment for a particular procedure or diagnosis. Thus a patient might be discharged prior to completion of patient teaching adding to nurses' frustration.

The variety of educational preparations not only results in a lack of standardization for the clinical preparation of nurses, but also varies in emphasis on communication skills. This variation also occurs within a specific educational preparation. Review of the current college catalogues for the five university based undergraduate nursing programs in Chicago, Illinois (DePaul, Loyola, Rush, St. Xavier and University of Illinois) reveals a varied inclusion of courses on communication skills.

While this module focuses on nurses in practice, preventive measures might include increased consistent emphasis on communication skills in the educational programs for nurses. It is recommended that teachers of these communication skills be cognizant of nursing as well as communication theories and practices, and should ideally be a nurse. At this time it might be beneficial for the nursing profession to seek assistance from those with backgrounds in communication skills or guidance and counseling in preparing students for practice.

The nursing shortage, turnover and attrition rates might best be addressed by increased efforts to retain nurses rather than major emphasis on recruitment. It is recommended that use of a nurse counselor would reduce nurse turnover. This nurse counselor could provide a
resource for personal and professional nursing staff counseling and thus reduce nursing staff turnover rate through improved utilization of human resources. If this nurse counselor were not a member of nursing service or management this would enhance trust and confidentiality and facilitate conflict resolution. Utilization of a nurse counselor would vary with the institutional needs but might include the following: 1) teaching of communication skills and conflict resolution; 2) establishing and facilitating support groups; 3) personal counseling; 4) professional counseling; 5) career guidance; 6) stress management; 7) employee placement; 8) pre-employment interviewing and assessing; and 9) exit interviewing. The use of a nurse counselor would benefit the employees and consequently the employing institution. The individualized attention and concern for the employed nurse would result in increased self-esteem, increased productivity and decreased attrition. The cost effectiveness of such a position would be a benefit to the institution as decreased attrition results in decreased need for recruitment and orientation both of which can be financially and time consuming on an institution's resources.

Present day nurses are products of multiple influences which affect their practice. The nursing shortage, the variety of educational preparations, the rapid increase in medical/nursing technology, the female dominance in the profession, the variety of work settings and clinical areas of specialization, the professional accountability to a variety of persons and/or departments (e.g., patients, peers, nursing supervisors, administrators, physicians and regulatory agents), the physical and emotional stresses resulting from practice of a
helping profession, all influence the individual nurse.

Nursing is described by Paterson and Zderad (1976) as a "response to the human situation" (p. 11). Nursing focuses on the needs of others which may include patients, families, physicians and co-workers. The nurse is involved with others in times of crises, anxiety, fear, pain and a vast number of peak life events. She/he is expected to assist others in surviving and coping. Nurses must become aware that they cannot continue to effectively care for others without receiving care for themselves. They must learn to recognize their own needs, clarify their values and establish and assert their rights. Nurses must assume this responsibility for self-care individually and as a profession. Use of the proposed module will assist nurses in these areas.

This module focuses on the experienced staff nurse who may be practicing in a variety of settings. It is the contention of this module that these nurses are the nucleus of the profession, render care to the majority of patients, continually cope with the vast changes in the health care system and are the group which receives the least recognition and support. This module is designed to attend to this group of health care practitioners in an individualized fashion, and is a means of recognizing the contributions the staff nurses make to the health care system and the patient population.

In this age of specialization in nursing, the staff nurse who meets the day to day needs of the patient, the vital link between the patient and the rest of the health care team, is often neglected or relegated to a position of little or no prestige. Through focusing on
the needs of the staff nurse by use of this module, health care facilities will not only demonstrate recognition for the contributions of this vital group but on the individual her/himself. This long overdue recognition will benefit not only the staff nurse but the health care facility itself. Increased esteem and respect for nurses will increase job satisfaction, decrease attrition and enable the nurse to care for her/himself and thus be better able to care for others.

A summary of recommendations to address some problems in nursing today include: 1) increase emphasis on communication skills in nursing education by those with backgrounds in guidance and counselor and/or communication skills; 2) utilization of a nurse counselor by institutions employing nurses; and 3) utilization of the proposed teaching module to enhance communication skills of the experienced nurse. Implementation of these three recommendations will result in reduction of the problems presently influencing nursing and will prevent some of these problems in the future.

Limitations of Study and Recommendations

The major limitation of this study is that it is a proposed teaching module and has not, as yet, been tested. The absence of implementation of this module with resultant data and conclusions prohibits appraisal of its effectiveness. It is recommended that the module be presented to groups of nurses in a variety of settings and that these groups be composed of nurses with varied clinical and educational backgrounds. Pre-testing and post-testing of these individuals and groups would provide data for statistical analysis in evaluation of the effectiveness of
the module and its components. This data might also suggest application of the module with other individuals, not necessarily in the nursing profession. After testing the module, it is suggested that a manual containing the module be prepared for publication.

It is further recommended that other potential needs of nurses be investigated especially addressing stress management, and conflict resolution. The module is designed to lend itself to adaptation derived from implementation and evaluation. It is suggested that use of the proposed module may assist nurses in identifying and meeting their personal and professional needs resulting in increased satisfaction.
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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Masters of Arts.

Date 4-22-82
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[Signature]