INTERPERSONAL SKILLS OF NURSES
IN SIMULATED INITIAL INTERACTIONS
WITH PATIENTS

by

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ABSTRACT

Nurses' responses to initial interactions with patients were collected by a videotaped simulation in order to provide a descriptive account of their interpersonal skills. The selection of interpersonal skills to be considered followed guidelines described by Carkhuff (1969) and Gerrard (1980). Those skills selected were empathy, respect, warmth and initiating. In addition, the nurses' statements were categorized into the response mode system of Goodman and Dooley (1976) to describe the types of responses used in interactions with patients. The present study also was concerned with the relationships between these interpersonal skills and both experience and training.

Nurses were selected from general medical-surgical wards in two urban hospitals. Approximately equal numbers were selected for three experience groups - Novice, Intermediate, and Experienced - from among volunteers. Data were collected from two male and 45 female nurses.

Nurses were tested individually with the Behavioral Test of Interpersonal Skills which presented a series of 16 videotaped vignettes of patient situations. Nurses'

responses were recorded on audiotape. Scores were independently assigned on five scales and the responses were categorized into the response modes.

The nurses' average scores on both the Gerrard and Carkhuff scales were below the level of 3.0 judged to be minimally facilitative. The scores were particularly low on Gerrard's empathy scale but on the initiating scale they approached a facilitative level. Approximately half of the responses were advisements and information giving. Questioning also was used frequently. In contrast, neither reflection nor self disclosure was used more than 10% of the time despite the view that these modes are particularly appropriate for initial interactions.

In considering years since graduation, it was found that the Novice group scored higher on the empathy scale ($p < .05$) and gave more reflection responses ($p < .05$) than the other groups. Statistically significant correlations were found between years since graduation and empathy scores (Carkhuff; $r = -.42$ and Gerrard; $r = -.34$), respect scores ($r = -.24$), number of advisements ($r = .28$), and number of reflection responses ($r = -.31$).

A particularly important aspect of training in interpersonal skills was found to be the provision of supervised practice. Nurses who experienced this type of training scored higher on empathy, respect, warmth and

initiating than did other nurses ($p < .05$). These nurses also gave significantly more reflections and fewer advisements that did other nurses.

These results supported the conclusion that the interpersonal skills of many nurses, as measured by the Behavioral Test of Interpersonal Skills, are not consistently at the facilitative level. Typically nurses gave many advisements, provided much information and asked many questions. The patients' perceptions and feelings were often ignored. This pattern of interacting seemed to reflect nurses' emphasis on the technical aspects of providing care. The training of nurses also did not provide for supervised practice and intensive study of interpersonal skills. The approach used in the present study provides a means for assessing these skills and a framework for a training program for nurses.

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> Caring is an attitude that is known to foster creativity - a nurturing climate in which delicate, tentative new thoughts and processes can emerge.
>
> Carl Rogers

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CHAPTER 1

STATEMENT OF THE PROBLEM

Nursing is primarily concerned with promoting health, preventing illness, caring for the sick and restoring health (Watson, 1979). As a helping profession nursing is a therapeutic interpersonal process that has caring as its major focus.

"Caring" as used in this study, describes a process of relating to someone, which involves the development of mutual trust and deepening and qualitative transformation of the relationship (Mayeroff, 1971). To care for another person is to help that person grow and actualize. Caring, so defined, is the integral aspect of all nursing practice (Burnsisde, Ebersole and Monea, 1979).

The main vehicle by which the nurse delivers care is through the development of a helping trust relationship with her patient and the nurse's ability to develop this relationship is the most crucial element of delivering care. "The potential for promoting psychological and social growth and development and for facilitating health seeking behaviours resides in that factor alone if that factor is properly recognized, developed and utilized by the nurse" (Watson, 1979, p. 24).

The establishment of this helping, caring relationship is influenced primarily by the nurse's ability to use interpersonal skills effectively. Gerrard (1979) describes interpersonal skills as those skills which promote a good relationship between individuals. The skills most commonly identified as being essential for nurses are empathy, warmth, positive regard and genuineness, with empathy being the one most frequently taught to nurses (Gerrard, 1979).

Thus, the delivery of care is intrinsically linked to the nurse's ability to utilize interpersonal skills.

Purpose of the Study

Broadly speaking the purpose of this study was to examine and describe nurses' use of interpersonal skills in interacting with patients. The use of effective interpersonal skills was at one time considered to be the unique tool of the psychiatric nurse. But now the "therapeutic use of self", delivering care through effective use of interpersonal skills in the context of a nurse-patient relationship, is viewed as a necessary tool of the professional nurse regardless of her area of practice (Pluckman, 1978).

This study was concerned particularly with initial response interactions which occur between nurse and patients on a general medical-surgical unit. Patients' requests or reactions typically require an instantaneous response from nurses. Nurses have a choice regarding how to respond in a given situation and the way in which they initially respond determines the effectiveness of the interaction (Coombs, 1978). Interactions which are characterized by empathy, warmth and respect are considered to facilitate the development of the nurse-patient relationship (Pluckman, 1978; Watson, 1979).

To date, studies which have concentrated on the assessment of nurses' interpersonal skills have failed to examine nurses' empathic abilities while simultaneously describing the types of responses that nurses used when intending to assist patients. These studies have also been limited by a variety of methodological constraints such as the use of a single measure to assess nurses' interpersonal skills, the use of pencil and paper measures and the lack of an instrument which appropriately simulated nurse-patient interactions.

This study extended the present understanding of nurses' interpersonal skills by providing a description of nurses' responses as well as reporting the nurses' level of empathy, warmth and respect. In addition, a tool which

required a behavioral response and which was designed specifically for nurses was employed in this study. This added the dimension of describing how the nurses actually responded rather than the more customary description provided by pencil and paper measures of what the nurse believed to be an appropriate response. Finally, the associations between the types of nurses' responses and both the length of nurses' experience and type of interpersonal skills training were examined.

The specific purpose of this study was to determine and describe the types of responses that practicing registered nurses on general medical-surgical units used in their initial interactions with patients. Further, the relationship between these types of responses and each of the variables (a) years since graduation and, (b) type of interpersonal communication skills training, was considered.

CHAPTER 2

REVIEW OF RELATED LITERATURE

The recent view of nursing as a dynamic interpersonal process has encouraged nurses to place an increased emphasis on the interpersonal skills in the context of the nurse patient relationship. Research in nursing and counselling psychology provides evidence of the influence of this relationship on the delivery of nursing care. The literature was selected and reviewed for the following purposes: (a) to examine the influence of interpersonal skills on the care rendered to patient, (b) to focus on the particular interpersonal skills which are relevant to nursing practice and, (c) to summarize previous studies that have assessed nurses' levels of functioning on the essential skills and thereby demonstrate a need for the present study.

The Influence of Interpersonal Skills and Nursing Care

Evidence exists that nurses' interpersonal skills influence the quality of patient care by improving the patients' ability to cope with recovery from disease.

Twenty-four of the 27 studies (89%) reviewed by Gerrard (1978) showed that positive patient outcomes were related to interpersonal skills. Patients appeared to experience relief from pain and distress as a consequence of nursing interaction (Anderson, Mertz & Leonard, 1965; Moss & Meyer, 1966). Typically, this relief was assessed by comparing the effects of several types of nursing approaches on a variety of physical and behavioral stress-related dimensions. One study (Elms & Leonard, 1966) which was representative of this form of assessment was aimed at determining the effects of nursing approach on relieving distress during hospital admission. Both physiological measures (pulse and respiration rates) and subjective reports (post admission interviews) offered empirical evidence that a patient-centered nursing approach was more apt to alleviate distress than approaches emphasizing attention to administration or medical tasks. Further evidence that patient outcomes were effected by nursing approach was provided in a more recent study (Diers, Schmidt, McBride & Davis, 1972) in which patients complaining of pain were randomly assigned to one of three nursing approach groups and measurements of pulse, respiration, verbal and nonverbal behavior were taken at the beginning and at the end of the interaction, and again approximately one hour later. The nursing approach which

emphasized the patient being viewed as a "feeling, thinking, doing person" was found to be particularly effective when assessed by verbal and non-verbal measures. Only some of the physiological measures (pulse changes significant $p < .01$) supported the conclusion that nursing approach influenced patient outcomes, however, it may be that the patients' perceptions of their experience served as a more accurate indicator of their condition. The researchers stated:

> In the present study, results using patient reports and descriptions of patient behavior seemed more sensitive to the designed independent variable than did the more conventionally used physiological measures of pulse and respiration rate. While pulse and respiration rate may indeed change in a true pain experience, pain as defined in this study was more probably an admixture of physical sensation, worry, anxiety, depression, fear and any number of more less transient states. (p. 426)

A study was conducted by Putt (1970) which placed greater emphasis on patients' perceptions. The effectiveness of two nursing approaches, psychological support and instruction, were compared to the control condition of effectiveness of routine nursing approach in providing care to hospitalized patients with peptic ulcers. As indicators of clinical progress, the groups were compared

regarding the number of hours between admission and the last time the patient reported pain or discomfort and the total number of hours of hospitalization. In addition the patients' perceptions of their illness were measured by the Institute for Personality and Ability Testing Anxiety Scale Questionnaire (IPAT), semantic differential scales and a structured post discharge interview. The instruction of the patient approach was not found to be significantly different from the psychological support approach on the discomfort measure. Both instruction and psychological support were found to be significantly more effective than the approach used by the control group (p .05) in reducing discomfort. The instruction approach was found to be significantly more effective than the psychological support approach and the control group approach in decreasing hospitalization and in altering patient perception of selected concepts relating to the patient's illness. As Putt suggested "Nursing intervention which combines psychological support and patient teaching has been demonstrated to reduce hospitalization time and cost for patients who are afflicted with active peptic ulcers" (P. 492).

Additional support that nurses interpersonal skills are associated with a variety of psychological, physiological and behavioral outcomes for patients is also found in the studies summarized by Peitchinis (1976).

A less direct influence on the quality of patient care relates to the nurses' ability to utilize interpersonal skills functioning as a member of a health team. If nurses are able to communicate effectively with their colleagues they are more likely to experience emotional support and they can concentrate on delivering high quality care to their patients.

Isom (cited in Warren, 1978) reported that both nurses and doctors agreed that when the communication between them was more effective the nursing care improved. Christman (cited in Peitchinis, 1976) stated that hospital staff are becoming more aware of difficulties in communication among staff and the effect of these difficulties on patient care. In his opinion, the level of communication that exists among staff "becomes highly indicative of the quality of patient care" (p. 63). Dyer, Monson & Cope (1975) conducted a study to investigate the effects of a counseling approach on the quality of patient care. Of particular interest here, was the finding that nurses who received higher patient care scores from observers were more satisfied with their relationships with other team members and described the hospital and ward climate in more positive terms.

Everyl and Falcione (1976) reported that the nature of job satisfaction for nurses was to a great extent related to interpersonal relationships with co-workers, and supervisors. "Relationship orientation" accounted for almost 24 percent of the total variance in nurses' ratings of job satisfaction.

It appears, therefore, that nurses interpersonal relationships with their colleagues are of particular importance in determining job satisfaction which in turn influences the quality of care rendered to patients.

Interpersonal Skills Relevant to Nursing Practice

The fact that nurses' interpersonal skills affect the quality of care rendered to patients suggests that it is important to ascertain which skills are particularly relevant to nursing practice. There is a wide variety of skills which are considered to be beneficial to nurses in their relationships with patients. Since the present study was concerned primarily with the nurses' initial response to a patient situation, the focus of this literature review is on those skills which are particularly useful in the initial phase of the relationship.

Carkhuff's Core Dimensions. This study was concerned with a helping profession, nursing, consequently the research of the helping process by Carkhuff (1969) and his associates was reviewed. Carkhuff identified the core dimensions of helping as empathy, respect and genuineness.

Studies summarized by Truax and Carkhuff (1967) and expanded upon by Truax and Mitchell (1971) support the theoretical view that the level of helper's accurate empathy, non-possessiveness warmth and genuineness are related to constructive change in patients. That is, clients' interactions with helpers can have constructive or deteriorative consequences for clients (Truax, 1966). In addition, the extensive research which has been conducted in the area indicates:

> ...to a large degree, the facilitative or retarding effects can be accounted for by a core of dimensions which are shared by all interactive human processes, independent of theoretical orientation; that is, patients, clients, students, children of persons functioning at high levels of these dimensions improve on a variety of improvement criteria, while those persons offering low levels of these dimensions deteriorate on indexes of change or gain (Carkhuff & Berenson, 1967, p. 4).

The core dimensions which receive the most consistent support are genuineness, empathy and respect. Genuineness was viewed as a more crucial skill which emerges as the nurse patient relationship developed. This view is supported by Truax and Carkhuff (1967)

> As we understand (the patients') private world and hence the meaning of certain events for him, we increasingly are able to more easily and freely be ourselves in the relationship (p. 315).

Therefore, empathy and respect were judged by the researcher to be the essential skills required by a nurse making an initial response to a patient.

Empathy as defined by Carkhuff (1973) is:

> A word which we use when one individual is hearing or understanding another. Empathy involves crawling inside of another person's skin and seeing the world through his eyes....Empathy involves experiencing another persons's world as if you were he (p. 58).

Therefore, empathy refers to the nurses' ability to experience the patients' private world and feelings and to communicate a significant degree of that understanding to the patient. As an initial response to patients, empathy is particularly useful in developing trust by making the patient feel cared for and understood.

> Empathy is the key ingredient of helping. Its explicit communication, particularly during

> early phases of helping, is critical. Without an empathic understanding of the helpee's world and his difficulties as he sees them there is no basis for helping. (Carkhuff, 1969, p. 173).

Patients may experience initial difficulty in adequately communicating their need for nursing assistance or the form of behavior initially exhibited by a patient may not always be a reliable basis for assessing the required nursing intervention (Elder, 1963). Empathy can be an effective initial response for clarifying patient communication.

Respect (non possessive warmth) is characterized by Truax and Carkhuff (1967) in the following definition:

> Non possessive warmth (respect) for the client means accepting him as a person with human potentialities. It involves a non possessive caring for him as a separate person....It involves valuing the patient as a person, separate from any evaluation of his behavior or thoughts (p. 58).

The nurse's ability to respond initially in this nonjudgmental manner creates a climate of psychological freedom which assists the patient to explore his reactions and feelings without fear of criticism or judgment.

In considering the effectiveness of empathy and respect during the beginning phase of helping Carkhuff (1969) recommended that to be most effective, helpers (nurses) should communicate in initial stages with empathic

responses that are interchangeable in affect and meaning with those of the client (patient) and should demonstrate respect by communicating unconditional acceptance of what clients (patients) say thereby suspending all critical judgments. Carkhuff described this type of communicating as focusing upon level 3 of the facilitative dimensions. This study, therefore, measured the level upon which nurses responded.

Gerrard's Helping Skills. Gerrard's research, derived from the work of Carkhuff, was narrower in scope in that Gerrard applied the helping skills particularly to health professionals. Gerrard (1980) suggested that, on the basis of experimental and theoretical evidence, there are at least four interpersonal skills which should be assessed for health professionals: Assertiveness, Active Listening (Empathy), Warmth and Initiating.

The types of situations which would require the demonstration of the skill of assertiveness were not used in this study and therefore the nurses' ability to demonstrate this skill was not assessed.

Gerrard defined Active Listening (Empathy) in the following manner:

> Active listening is the skill of understanding what your patient is saying and feeling, and

> communicating to your patient in your own words what you think he is saying and feeling (p. 133).

Gerrard suggested that by taking a few minutes to "active listen" to your patient a helping relationship of trust and understanding is established which will later assist in problem solving with that patient. For this reason active listening was viewed as an appropriate initial response by the nurse to a patient statement and was measured in this study.

The third skill, Warmth, as described by Gerrard:

> ... is the skill of communicating to a patient that you care about him as a person. Being warm means being friendly--smiling at your patient, greeting him by name, showing pesonal interest in him (p. 113).

Although warmth is primarily conveyed in a non verbal manner it can also be communicated to a patient by what you say. Warmth can be viewed as "one of the many possible vehicles for communicating respect" (Carkhuff, 1969, p.180). Warmth is considered "a powerful skill for building trust with your patient" (Gerrard, 1980, p. 113) and is therefore viewed as an appropriate initial response for a nurse to utilize when interacting with a patient and was measured in this study.

Gerrard (1980) defined the fourth skill, initiating, in the following way:

> Initiating is a task and problem-oriented interpersonal skill. Health professionals use initiating to encourage the patient to take some action that will help solve his problem. Initiating includes: giving information, carrying out some physical action, initiating a discussion, offering an alternative solution, making requests and stating an opinion (p. 263).

Gerrard viewed these skills -- empathy, warmth and initiating-- as parts of a two stage model of helping. First, rapport is developed by utilizing empathy and warmth skills, then action is initiated by employing an initiating skill. Although Gerrard recommended that warmth and empathy be communicated early he would also accept the use of an initiating skill as part of the initial response of a nurse to a patient. Gerrard believes that:

> The competent health professional must not only be able to respond to patients in a facilitative and rapport-building manner--the health professional must also be able to initiate some effective action that will lead to a resolution of the patient's particular physical or interpersonal problems.

However, the introduction of an action oriented skill in the initial phase of helping seems contrary to Carkhuff's facilitative dimensions and Goodman and Dooley's response

modes (discussed below). Nevertheless, it was decided that the skill of initiating warranted further consideration in this study as a possible alternative for the nurses' initial responses to a patient statements.

Goodman and Dooley - Response Mode Categories. A framework for studying interpersonal responses has been developed by Goodman and Dooley (1976) from their research on "help-intended communication". The "response mode categories" generated by them permit both the assessment of helpers' skill levels and the planning of training programs. The six response mode categories are: Questions, Advisement, Silence, Interpretation, Reflection and Self-Disclosure. These categorizations of response mode are intended to expand the helpers' options and provide a basic communication repertoire since each of these skills serves a different purpose. It is beneficial for the helper to understand the function served by each mode to accurately apply a specific mode in a practical setting. Of particular interest to this study were the categories of reflection and self-disclosure.

A reflection response entails

> the relatively non-arousing re-representation of the other's expressed thoughts and feelings....The reflective response appears to be an effective way of demonstrating accurate empathic understanding and has been associated with favorable therapy and interview process. (p. 112)

At minimum, the reflection response demonstrates to the patient that the nurse is paying attention. Accurate reflections transmit an understanding which becomes the basis for further discussion and exploration.

A self disclosing response is a "statement in which the speaker reveals a non obvious aspect of his condition (feelings, thoughts and experiences) through a distinct self reference" (p. 112). Due to the "reciprocity effect" in which the speakers tend to match each others' intimacy level, a nurse's initial self disclosing statement could elicit a similar response from the patient. Also "the reflection of feeling response can be viewed as a variant of self-disclosure" (p. 113). The nurse's disclosure of the patient's perceived experience becomes the reflection response. Under some circumstances, reflection could be viewed as disclosed empathy.

For these reasons, reflection and self disclosure types of responses are considered to be appropriate as an initial response to a patient statement and were measured.

In summary, the nurses' initial responses to a patient might be expected to be a reflective or self disclosing statement conveying warmth, respect and empathic understanding. The nurses' responses may also include an initiating skill.

Assessment of Interpersonal Skills in Nursing

Despite the acknowledgments that the nurses' interpersonal skills are important, there is evidence that nurses, in fact, do not communicate effectively with patients. In addition, the studies that have provided this evidence have suffered from certain methodological constraints. The literature was reviewed to highlight those findings and limitations.

> Patient surveys show that from 5% to 96% of patients are dissatisfied with the communication they have with health professionals.... The mean percentage dissatisfaction with communication expressed by patients for nine studies is approximately 42%. Some of the areas of dissatisfaction investigated by these studies were; structure and equipment, amenities, noise, food, nursing care, medical care, after-care, and communications. When, for each of the nine studies mentioned, dissatisfaction percentages were rank ordered from highest to lowest, communications occupied the top rank in six studies, and the top two ranks in eight studies. This suggests that patients were mainly dissatisfied with communication (Gerrard, 1979).

Further evidence is provided by Carstairs who found that:

> the majority of patients who have a complaint will not voice it and that when patients do complain about some aspect of their care, a

> majority feel that their complaint is not dealt with satisfactorily (cited in Gerrard, p. 32).

Interpersonal skills are essential to nurses in permitting exploration with the patient concerning how he feels, what the patient thinks he needs and whether the patient feels he has been helped. Dye (1963) demonstrated the importance of this understanding in her conclusion that:

> Without such exploration only five of 14 patients studied in a medical-surgical unit could tell the nurse why they were in distress adequately for her to determine the nursing care they needed (p. 56).

In an early attempt to examine nurses' interpersonal skills Mathews (1962) developed an instrument to measure psychological aspects of the nurse-patient interaction. One hundred and twenty-two staff nurses from nine Californian hospitals were asked to respond to a questionnaire composed of nine simulated nurse-patient interaction situations, as if the statements had been directed to them by a patient. The responses were assessed for person-centeredness by means of content analysis. There were four response categories; Person-centered response category, Non-person centered response category, Person-positive response category, and Neutral response category. A person-centered response was considered to be one which "encourages the patient to

disclose how he sees the world, what he is experiencing and the meaning these experiences have for him" (p. 155). The categories were each assigned a valence and a person-centeredness score for each nurse was obtained. Two-thirds of the 122 nurses obtained scores indicating that they were non-person centered and only eight nurses gave one or more responses that encouraged the patient to disclose what he was experiencing.

As acknowledged by the author, the written responses were not considered to be equivalent to oral responses but rather were assumed to represent responses that nurses believed should be made to patients. In relating person-centeredness with the number of years since graduation from nursing training, Mathews found that as years since graduation increased there was tendency for person-centeredness to decrease. Two points arise from Mathew's study. The first is that the pencil and paper measure used was restricting when trying to predict actual performance in the clinical setting. The second point, and one which was influential in the design of this study, was that an important variable to consider in assessing nurses' empathic abilities is the number of years since the nurses' graduation.

Hays (1966) attempted to analyze 100 verbatim recorded discussions between patients and student nurses. Although the analysis was not reported, Hays did identify five nontherapeutic communication techniques that occurred frequently. They were: requesting explanations, introducing unrelated topics, reassuring, probing and making stereotyped comments. Hays' contribution of a listing of techniques for more therapeutic interactions with patients has been widely used in nursing. Besides the lack of information regarding the analyses of the interactions, this study was also limited in that students wrote verbatim notes during the discussions with patients, which were later recorded. Writing notes may interfere with the nurses' spontaneous responses and ability to pay close attention to the statements of the patients.

Graffam (1970) conducted a study which tested a tool designed to examine nurses' responses to patients' complaints of distress. Over a five month period, 75 registered nurses from five hospitals were observed responding to 157 patients who made 196 complaints of distress. Nurses were accompanied during their tour of duty by the investigator, who recorded the entire event from the initiation of the complaint to the conclusion of the response. Each patient complaint - nurse response was considered one event. A record was kept which included the

nature of the complaint, how and to whom it was communicated, the type of response, the apparent intention of each action and the time of each event. Analyses of the observed data were based on the events occurring from the initiation of the complaint to completion of the relief response, the number of times the nurse visited the patient, the interaction which occurred and the length of the interaction. The assessment tool which evolved included a check list based on the observed data. As a byproduct of this study certain findings emerged which have implications for future research. In very few of the events did the nurse detect the patient was in distress unless he complained and in only three events did the nurse visit the patient specifically to ascertain if he was in distress. The types of responses that nurses typically made to patients' complaints of distress are summarized in Table 1.

In at least 60% of the events (informed, directed, blocking) the nurses' responses were unilateral and did not provide for the patients' reaction or contibution. In fact, in 13% of interactions nurses actually blocked patients' expression by failing to follow a cue, leaving the room abruptly following an emotionally charged statement made by the patient, or changing the subject. Graffam reported that some of the nurses' comments were characterized by "contradicting, scolding, ridiculing and controlling"

TABLE 1

Types of Nurses' Responses to Patients' Complaints
of Distress (Based on Graffam, 1970)

Nurse's response to complaint	Frequency
Informed patient	33%
Directed patient	14%
Blocked expression	13%
Suggested relief	17%
Comfort and cheered	15%
Explored cause of distress	10%

Note. Based on 196 nurse-patient interactions.

(p. 335) of the patient. In only 10% of the interactions did the nurse encourage the patient to explore the cause of distress. Graffam concluded that nurses are generally not meeting the needs of the distressed patient as compassionately and as effectively as they might and that "the nurse's response is too often impersonal, automatic and limited" (p. 335).

Sethee (1976) developed a tool to assess the nature of responses nurses selected to deal with emotion-laden situations representing those encountered in public health nursing. Thirty practicing public health nurses completed a questionnaire consisting of 30 descriptions of situations, each followed by five potential responses: Type I to V randomly sequenced. On a continuum Type I was the most desirable response, Type II, III, IV and V being less desirable; with Type V signifying lack of skill. Additional information was acquired with a questionnaire. Responses varied with the majority choosing either Type I (36%) or Type III (34.6%). In considering the perceptions of what the patient usually seeks from the public health nurse only one nurse gave Type I response top priority and two nurses chose this response as the least commonly sought by patients. "Seventy percent of the respondents believed that patients most typically seek a Type II response, yet only five percent of the total responses they selected were in

this category" (p. 367). As suggested by Sethee this discrepancy between the verbal responses selected and the nurses perception of what the patient seeks, may be due in part to the fact that what nurses believe to be important and what they put into practice may differ greatly. A second possible explanation for this disparity may be that what the nurse believes the patient seeks may not necessarily be what the nurse believes to be the best for him. Whatever the explanation, there was obvious confusion about what was effective communication.

La Monica et al (1976) conducted a study, representative of a recent shift in the literature, which attempted to assess nurses' empathic abilities when interacting with patients as opposed to attempting to describe how nurses respond. The study tested a staff development program designed for registered nurses who scored low in empathy. Thirty-nine female registered nurses employed in an urban hospital were assigned to one of three groups; Experimental group (n=12), Pretest - posttest control group (n=12), or Posttest only group (n=15). The experimental program consisted of seven sessions, involving a total of 11 hours, with both didactic and experimental components. Training in perceiving levels of empathy and in responding with empathy were provided. The nurses' levels of empathy were assessed on Carkhuff's Index of

Communication, which is composed of 16 vignettes to which the subjects provided written responses. Nurses who had the experimental program scored higher on Carkhuff's Empathy Scale than nurses in the two control groups (p = .002). The authors concluded that the initial low level of empathy was improved by the program, but that more extensive training was needed for nurses to reach the minimally facilitative level. A limitation of this study was that the instrument used is characterized by educational vignettes which are not typical of nursing situations. Nurses may have had difficulty relating to the situations or, given that they did respond appropriately the validity of these findings must be considered in terms of the nurse-patient interaction.

Other researchers have provided nursing situation in their assessments of communication skills. Wallston, Cohen, Wallston, Smith & DeVellis (1978) utilized an instrument characterized by 24 simulated patient situations to assess 44 medical-surgical staff nurses degree of person-centeredness as described by Mathews (1962). One group (N = 24) listened to the patient situations (statements 1 - 24) and responded orally to each statement. These responses were recorded and later coded for patient-centeredness. The second group (N = 20) listened and responded to the first 12 situations (phase I) and then,

before responding to the next 12 situations, received an intervention consisting of a short audio taped message concerning "the elements of a helpful response". The four suggested elements of a helpful response were (1) "pause briefly to review in your mind what the patient has expressed and what seems most important to the patient for you to respond to", (2) "reflect the feelings or concerns the patient has just expressed", (3) "encourage further discussion by the patient of their concerns so that both you and the patient perceive the situation accurately and totally" and (4) "give information only after a more complete understanding of the patients' need is acheived." Based on the first 12 statements nurses were judged to be performing between level "0" ("Does not elicit information, but gives information") and level "+1" ("Elicits information, but limits patient response"). "Few responses were judged to be actually countertherapeutic; but at the same time, there was much room for improvement". Comparing the mean differences on the last 12 statements the nurses' level of person centeredness was significantly enhanced by exposing the nurse to a specific message as to what constitutes a helpful response.

Summary Review of the Literature. In final summary, a review of the literature lends support to the contention that the nurses' interpersonal skills do make a difference in the quality of care rendered to patients. Although early research did attempt to focus on descriptions of nurses' responses, these studies were limited mainly by the pencil-paper measure employed or by the lack of reported analysis. More recently, research has focused on the empathic abilities of the nurse but has neglected to consider the types of responses nurses do make when intending to help. Most of these studies have also been limited by the lack of an instrument that adequately simulates nurse-patient interactions.

The recognition that the nurses' interpersonal skills do affect the quality of care rendered to patients and the apparent lack of these skills by nurses seem incongruous. It is important to determine how nurses do respond to situations to which they are exposed daily. If they are not using these skills how are they responding when trying to assist patients?

In the present study both the types of responses that nurses make to patients and the empathic abilities of nurses were considered. In order to fully describe the nurses' interpersonal skills several questions will be considered.

The primary research question of this study is:

1. How effective are registered nurses in demonstrating their ability to use appropriate interpersonal skills with patients?

More specifically;

(a) Do registered nurses' interpersonal skills meet the minimally facilitative level on such variables as empathy, respect, warmth and inititating?

(b) In interacting with patients, what proportion of times do registered nurses use the more facilitative modes (reflection and self-disclosure) compared to the more directive non-facilitative modes (advisement, questioning, and interpreting)?

The secondary questions of this study are as follows:

1. Is there an association between the experience of registered nurses, as indicated by years since graduation, and scores in the response categories of empathy, respect, warmth and initiating?

2. Is there an association between the experience of nurses, as indicated by years since graduation, and the proportion of responses that are categorized as reflections, advisements, questions, self-disclosures and interpretations respectively?

3. Is there an association between the type of interpersonal skills training of nurses and the nurses' ability to demonstrate responses of empathy, warmth, respect and initiating respectively?

4. Is there an association between the type of interpersonal skills training of nurses and the proportion of responses that are categorized as reflections, advisements, questions, self-disclosures and interpretations respectively?

CHAPTER 3

METHOD

Subjects

This study was conducted with practicing registered nurses working on general medical surgical wards in two urban hospitals. Following the circulation of general information regarding the study (see Appendix A) a total of 47 nurses volunteered to participate in response to a direct appeal by the researcher on the ward. The educational preparation of the nurses in the sample included 42 nurses from diploma programs and five nurses from degree programs.

The hospital experience of the nurses was considered to be an important variable in the study. Three experience categories were established following the criteria suggested by Mathews: Novice (0 - 1 years), Intermediate (1 - 5 years) and Experienced (over 5 years). An attempt was made to maintain approximately equal numbers in each of the three groups. Complete data were collected on 14 novices, 14 intermediates and 19 experienced nurses. For two other subjects, the data collected could not be scored. One of these subjects responded in the third person and the other gave no response to most of the situations. Since

psychiatric experience was considered to have potential influence on communication skills, subjects were asked if they had had this type of experience. Four out of 47 reported this specialized experience.

Design

This study is primarily descriptive in nature. Questions concerning the level of interpersonal skills were answered by considering the means and standard deviations of four variables: empathy, warmth, respect and initiating. In addition, data were collected on the distribution of these scores. Examples of verbatim responses which exemplified various levels on these variables were selected and reported.

The descriptions of response modes were provided by reporting the proportions of responses that were reflections, advisements, questions, interpretations and self-disclosures. For these five response categories the means, standard deviations and distributions of scores were calculated.

A correlational design was followed in answering the secondary questions about the relationships between interpersonal skills and both types of training and years

since graduation. The correlation coefficients and comparison of mean scores by analysis of variance were computed.

Instrumentation

The Behavioral Test of Interpersonal Skills for Health Professionals (Gerrard, 1980) was used to assess the nurses' interpersonal skills. This test consists of 30 common patient and health professional situations that have been role played by actors and actresses and recorded on videotape. After each vignette is presented the nurse is required to make an oral response to the situation as if he or she were interacting with a real person.

This tool was selected for three reasons. First, it is a measure of actual behavior rather than paper and pencil test or indirect measure, such as head nurses' ratings. Second, it presents a wide variety of interpersonal problems commonly faced by nurses: aggression, distress, positive emotion and performance evaluation. Third, it provides a standardized set of situations thereby permitting comparison among subjects within this study and also with findings from previous research. Goldfried and Kent (1972) stated that there is support for the assumption that role played responses parallel behavior in real life settings. Stanton

and Litwak (1956) reported a high correlation (.82) between subjects' responses to role played situations involving interpersonal stress and independent ratings by informants who were familiar with the subjects' behavior in this type of situation. Further, Goldfried and Kent (1972) concluded that a behaviorial approach to measurement "is a potentially usefully approach toward the construction of assessment procedures that can more accurately predict human behavior". It was intended that the experimental rigor gained by having nurses role play responses to a simulated patient statement would offset any disadvantages inherent in this type of methodological approach.

In Gerrard's use of this test two types of scores have been considered. The Content Analysis Category System requires the rater to judge the presence or absence of 10 types of responses such as Feeling, Warm Voice Tone and Gives Information (Table 2). The interjudge reliability of these content analysis scores, based on two judges rating responses of 10 nurses, ranged from r = .75 to 1.00 with a median of r = .89 (Gerrard, 1980). The intra-rater reliability of the content analysis scores after a ten day interval ranged from r = .88 to .99 for the ten types of responses with a median of r = .94. The second scoring approach developed by Gerrard is the Rating Scales System which requires the rater to assign a score between one and

TABLE 2

A Comparison of Behavioral Rating Scales and content Analysis Categories

Rating Scale	Content Analysis Categories
Empathy	Feeling Content "Don't feel ________"
Warm	Warm Face Smile Warm Voice Tone
Initiating	Invites the other person to talk further
	Suggests alternative (Appropriate) Solution
	Gives Information
Assertiveness	Assertive Speech Errors

four for each of three categories: Empathy, Warmth and Initiating. This second approach was used in this study and its characteristics are described below.

Gerrard provides evidence of concurrent, construct and content validity. As an indicator of concurrent validity, the extent to which Content Analysis scores correlated with ratings by peers and supervisors (n = 26) was reported. Most of the correlations did not reach statistical significance possibly due to the indirectness of the information about nurses' performance provided by peer and supervisor ratings.

Evidence for construct validity was provided by comparing scores of two groups whose communication skill levels were known to be different: first year nursing students and Master of Health Sciences nursing students. The basic finding was that:

> the Master of Health Science students make significantly more responses in which they reflected feelings or invited the "other person" to talk about his or her feelings and opinions. This explains the lower scores obtained by M.H.Sc. students on Alternative Solutions and Information. Whereas, first year nurses would frequently make responses containing "premature solutions" in the form of advice or information, the M.H.Sc. students would first check out the patient's (or health professional's) feelings and then try to get the patient (or health

> professional) to come up with his(her) own solution to the problem (p. 29).

Further evidence for construct validity was provided by examining the effects of a six week empathy training program. Nurses in the program received higher scores on three indices of empathy than did those in a waiting control group.

Content validity was demonstrated by the process of constructing the scale. A panel of health professionals viewed a series of vignettes and only those rated as being relevant were selected. Also, each vignette that was used in this study presented a patient seeking a response from a nurse. From the approaches cited in the literature only this scale and one other provided nurse-patient situations in a measure of actual behavior.

Because the present study was concerned primarily with nurse-patient interactions, only those vignettes specifying patient problems were selected. Seventeen vignettes, were thus selected, one of which was a sample situation. Gerrard suggests four alternative ways of recording responses: videotape, direct observation, audiotape and written response. In this study responses

were audiotaped so that data could be collected and rated with relative ease and, therefore, a larger sample could be considered.

Measures

The nurses' responses to a single instrument were scored according to three different measures: the Response Modes reported by Whalen and Flowers (1977), Gerrard's (1980) Behavioral Rating Skills and Carkhuff's (1969) Measures for Assessing Interpersonal Functioning.

Response Modes. The scoring system reported by Whalen and Flowers (1977), based on six response modes described by Goodman and Dooley (1976) is composed of 19 categories which include three types of reflection, two types of interpretation, five types of advice, three types of questions, two types of self-disclosure, two types of evaluation and two residual categories (Appendix B). The response modes are based on the theoretical and empirical work of such authors as Ivey, Kagan and Danish (Goodman and Dooley, 1976). Goodman and Dooley reported interjudge reliability of r = .80 based on the ratings of three judges assessing over 130 five minute interactions. Whalen and

Flowers (1977) reported interjudge reliabiltiy of r = .97 based on two judges assessing the responses of 21 subjects to 14 videotaped vignettes.

The tape-recorded responses of each nurse were divided into components, defined as relatively complete thoughts which are separated from other components by change in voice tone or by silence, and assigned to one of the 19 categories. Proportions of total responses in each of the six basic categories were computed for each nurse. High proportions of reflections and self-disclosures were considered to be appropriate responses to the types of situations portrayed in the vignettes (Goodman and Dooley, 1976).

Behavioral Rating Scales. The rating scales reported by Gerrard consist of four rating scales: Active Listening (Empathy), Warmth, Initiating and Assertiveness. In the present study the Assertiveness scale was not used, since the vignettes requiring an assertive response had been deleted from the videotape. Nurses' responses were scored on each of the remaining three scales on a four point system described in Appendix C. Information concerning the reliability and validity provided by Gerrard for these Behavioral Rating Scales is indirect, based on the Content Analysis categories. The relationship between the

Behavioral Rating Scales and the Content Analysis Categories is shown in Table 2. The Content Analysis System is primarily useful as a learning tool as it enables precise feedback to be given on specific behaviors. The large number of scores produced and the inability to compare these scores to other measures in the present study, led to the selection of the Behavioral Rating Scales approach. The interjudge reliabiltiy of the Behavioral Rating Scale was checked by having three judges independently rate the responses of 10 randomly selected subjects. The responses to seven vignettes, representing the different types of situations, were selected producing a total of 70 statements. The average rating of each of the three judges is reported in Table 3. On the Initiating variable, the scores were the same and for the other two scales the largest difference was 0.2 points. These results indicated a high degree of interjudge agreement. The second approach to considering the interjudge reliability was to compute the percentage agreement among the pairs of judges. As reported in Table 4 the percentage of times when judges gave the same scores was approximately 80% for empathy and initiating. For warmth, approximately half of the ratings by judges were the same but in almost all of the cases the scores were with in one point of each other. On the basis of this data the

TABLE 3

The Mean Scores Assigned by Three Independent Raters to Responses Selected for the Reliability Study.

RATER	SCALE		
	Empathy	Initiating	Warmth
1	1.6	3.0	2.2
2	1.4	3.0	2.4
3	1.4	3.0	2.2

Note. Based on 70 responses

TABLE 4

The Reliability of the Gerrard Measures as Indicated by the Percentage Agreement among Raters.

Scale	Amount of Difference	Combination of Raters 1 & 2	1 & 3
Empathy	same	78%	78%
	within 1 point	15	18
	within 2 points	6	3
Initiating	same	85	85
	within 1 point	14	14
	within 2 points	2	2
Warmth	same	59	55
	within 1 point	39	45
	within 2 points	2	0

Note. Based on 70 responses

Empathy and Initiating scales were shown to be very reliable. Less assurance can be placed on the Warmth scale scores.

A score from one to four was assigned to each response for each of the three scales. The scores for 16 vignettes were averaged to produce mean scores for each nurse for Empathy, Warmth and Initiating. A minimally facilitative response was considered to be a rating of 3.0.

Carkhuff's Measure for Assessing Interpersonal Skills. The asssment tool described by Carkhuff consists of eight scales for various interpersonal skills. Two of these scales, Empathy and Respect, were used in the present study because they were considered particularly appropriate in the phase of communication required by the Behavioral Test. Each measure is composed of a five point scale described in Appendix D. These scales are based on extensive research summarized by Carkhuff & Berenson (1967). Anthony (1971) reported a rate - rerate reliability of r = .80 and an interjudge reliability of .70 for two pairs of raters assessing 30 responses of 13 subjects. Carkhuff (1970) reported rate - rerate reliabilities of r = .90; r = .94 on the Empathy Scale and r = .95; r = .89 on the Respect Scale for two raters assessing three randomly selected two minute interactions.

The 16 tape recorded responses for each nurse were rated producing a score ranging from one to five on each scale. A mean score for each nurse was produced for each of the two scales. A minimally facilitative response was considered to be a rating of 3.0 on Carkhuff's Empathy Scale and Respect Scale.

Each of these three measures, Response Modes, Behavioral Rating Scales and Measure for Assessing Interpersonal Functioning, was scored independently by completing all of the scoring for one measure before beginning another. The variables of empathy, warmth, respect and initiating from the Behavioral Rating Scale and the Measure for Assessing Interpersonal Functioning, were also scored independently. These three measures produced a total of seven variables. These seven variables were scored independently by completing all of the scoring for one variable before beginning another.

Procedure

A videotape playback unit and an audio tape recorder were set up in a quiet room in the hospital. Each volunteer was greeted by the researcher and the first few moments were spent putting the nurse at ease. The nurse was assured that the responses made would be kept confidential. He or she was

seated in front of the video playback unit and received instructions concerning the procedure of the Behavioral Test generally as follows. "A series of 16 patient situations will be presented on the T.V. monitor. Following the presentation of each situation there will be a 30 second pause, during which time you will make a verbal response to the situation as though interacting with a real patient. These responses will be tape recorded". If the nurse had no questions the initial portion of the videotape, which consisted of instructions and the first sample patient situtation, was presented. Following the 30 second pause after the first situation, the videotape was stopped and the nurse's understanding of the procedure was checked. If there were no questions, the videotape was again started and (as suggested by Gerrard, 1979) the researcher left the room so that the nurse would feel more relaxed in making responses. The researcher remained outside of the room, but nearby to ensure the researcher's availability to the nurse. On completion of the task the nurse was interviewed briefly to gain information concerning the number of years since graduation from nurses training and the nurses' type of interpersonal skills training. The nurse was also asked to refrain from discussing the Behavioral Test with her colleagues as they may have also been participating in the study.

For ease of assessment the data collected on the audiotape was later edited leaving only the nurses' responses. These edited tapes were rated for each of the variables in the following order: Response Modes, Empathy (Gerrard), Warmth (Gerrard), Initiating (Gerrard), Respect (Carkhuff), Empathy (Carkhuff).

CHAPTER 4

RESULTS AND DISCUSSIONS

The first research question posed the problem of how effective nurses were in demonstrating appropriate interpersonal skills with patients. The nurses' average scores on the variables of empathy, respect, warmth and initiating, reported in Table 5, were found to be consistently below the level of 3.0, judged to be minimally facilitative by Carkhuff (1969) and Gerrard (1980). Even if a more generous discrimination level of 2.5 is considered, only the nurses' scores on the initiating variable reached this level. The average scores for empathy, warmth, and respect remain at an non-facilitative level (Table 5).

Empathy

The nurses' average score on Carkhuff's (1969) five-point empathy scale was 2.1, described by Carkhuff as the nurses "subtracting noticeable affect" from the communication of the patient.

> The helper may communicate some awareness of obvious, surface feelings of the helpee, but his communications drain off a level of

TABLE 5

Means and Standard Deviations of Scores on Gerrard and Carkhuff Scales for the total Group

Variable	Mean	Standard Deviation
Gerrard [a]		
Empathy	1.4	.47
Warmth	2.2	.35
Initiating	2.6	.43
Carkhuff [b]		
Empathy	2.1	.35
Respect	2.1	.37

Note. N = 47

[a] possible range of scores 1 - 4

[b] possible range of scores 1 - 5

> affect and distort the level of meaning. The helper may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the helpee (p.174).

As reported in Figure 1, over 90% of the nurses' scores were below the 2.5 level. Only two nurses reached the facilitative level of 3.0 which according to Carkhuff is characterized by the nurses' responses being essentially "interchangeable" with those of the patient. "The helper responds with accurate understanding of the surface feelings of the helpee but may not respond to or may misinterpret the deeper feelings." On Gerrard's (1980) four-point empathy scale the nurses' performances were similar. The nurses average score was 1.4 (Table 5); Gerrard describes a score of 1 as response in which "neither feeling nor content is reflected"; "a destructive response". Again, 90% of the nurses' scores fell below the 2.5 level with only two nurses reaching the 3.0 facilitative level (Figure 2).

An appropriate empathic reponse involves the accurate reflection of the topic that the patient has talked about and how he feels about that topic. Typically the nurses responded to the patients' requests by focusing on the content of what the patient said. For the most part, nurses' responses did not focus on either the patients'

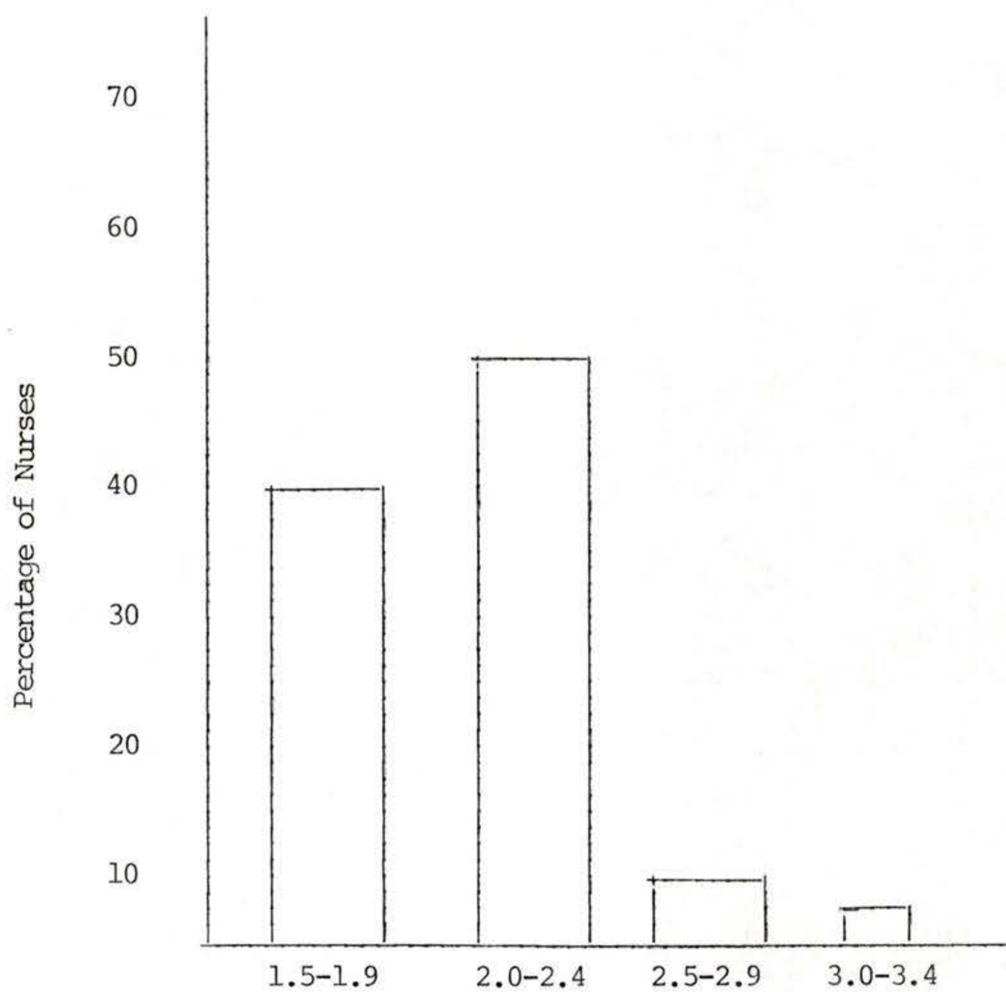

Figure 1. Distribution of Scores on Carkhuff Empathy Scale

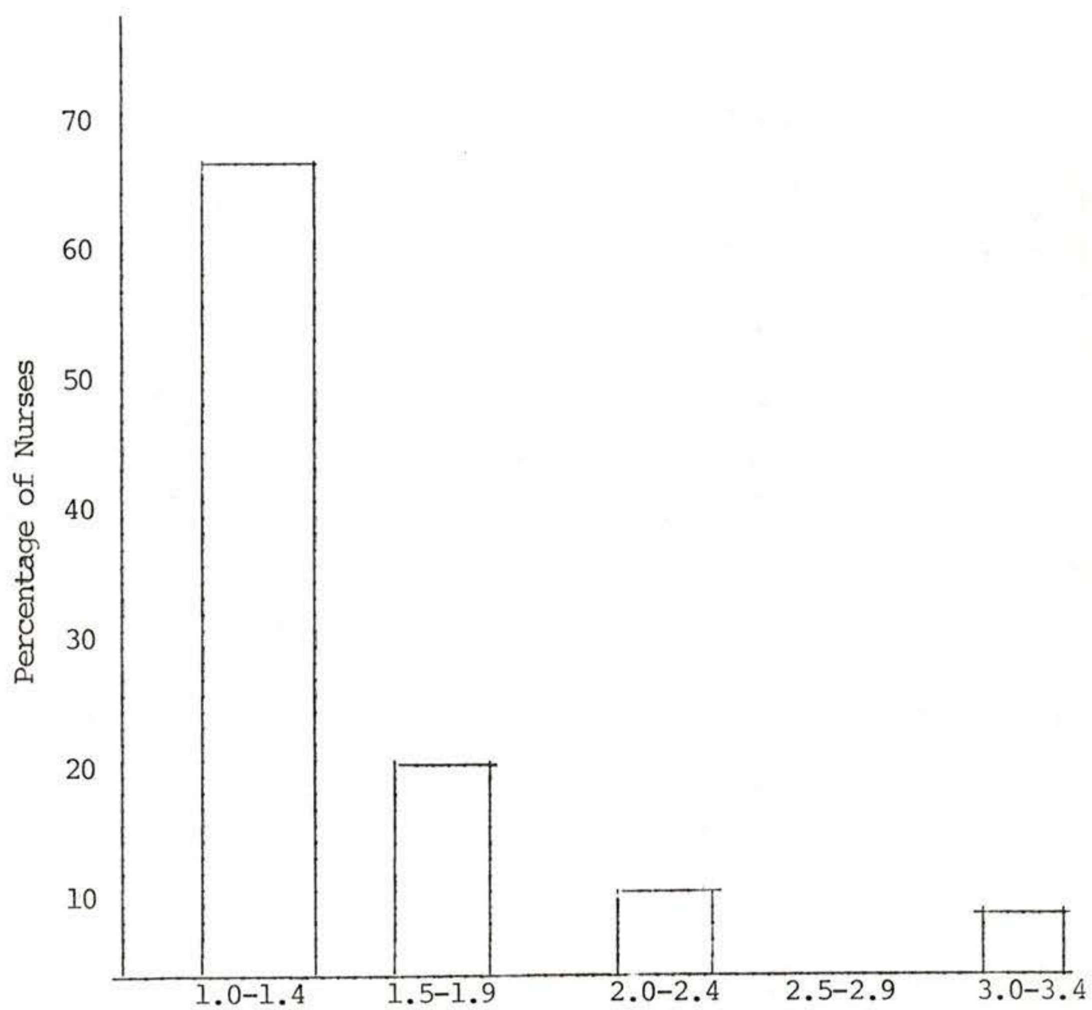

Figure 2. Distribution of Scores on Gerrard Empathy Scale

feelings or perceptions of the situation. In general nurses failed to demonstrate an understanding of the patients' experiences. In response to the patient statement:

> I don't think you really understand. I just got married and I really love my husband. I'm scared that I wouldn't be able to, you know, have sex since I had this surgery. I really don't know what to do.

Some nurses focused on the content by asking a series of questions such as:

> What kind of relationship did you and your husband have before the surgery? What kind of relationship do you have? Do you talk to each other a lot? How does your husband feel about the operation and about you since the operation?

Other nurses focused on the content by trying to reassure the patient or suggesting something the patient might do such as:

> It's important that you and your husband talk together about it with the Doctor. I'm sure he can reassure you and tell you that your life will resume in a normal pattern. And it's best for you to ask him all the questions you want and if there's anything I can answer I'll do my best to try and help you. And there's no reason why we shouldn't be able to fit you back into a normal routine, a normal life pattern.

In contrast, one nurse did focus on the patient's perception of the situation and identified the patients' feelings in her response:

> It does sound like it is a concern for you. Being newly married and not feeling like you're going to be able to have sex with him. That probably, well it does sound like it is a big concern for you right now.

Even the more emotionally laden patient situations did not elicit empathic responses from most nurses. One vignette presented a middle aged man who looked depressed and concerned and said:

> Ever since my surgery life hasn't been the same. Now every time I get a pain somewhere it really scares me. I wonder if it's worth going on.

This situation might be expected to elicit a more empathic response because of the obvious emotional cues. However, the majority of nurses still responded to the content rather than the feeling component of the situation. One nurse responded by denying the patient the right to feel the way he did. Her response was:

> Of course it's worth going on. If you have a pain something must be the matter, so we're going to try and help you, and give you things to help you. And we do tests and things to find out what is the matter. You have to try and have a bright outlook on things.

Another nurse minimized the patient's feelings by responding philosophically to his situation.

> Well there's a lot of times, I guess, when we can question whether life is worth going on, but I guess we have to try and look at the bright side of things sometimes and try and get over those humps that make it a little bit more difficult. We're trying to help you the best that we can. If there's something we can do, you know, let us know.

Another way that the patients' feelings were minimized was by the nurse not only denying the patients' feelings but also by judging the patients' feelings as being inappropriate:

> Well I think this is just something that you have to work through. I'm sure life is worth living. It's just very difficult to cope with pain after surgery cause you're still really uptight about the whole business. You've got to get your self confidence back in life and start thinking healthy.

A few nurses tried to focus on the patients' feelings. One nurse showed some understanding of how the patient was feeling but her primary concern appeared to be a solution of the problem rather than a discussion of it.

> Well you're going to have pain and I know things haven't been going quite so well for you but maybe--let's just sit down and talk. Maybe we can work something out for you. Get some of these

> things out in the open. I don't understand what you're afraid of. Let's talk about it and we'll get things fixed up.

Another nurse also tried to focus on the patient's feelings by asking the patient to clarify how he was feeling.

> Do you want to talk a little bit more about it? Can you elaborate just a bit more for me? What do you mean when you say it's not worth going on? What exactly are your feelings right now?

Although this response does focus on feelings rather that content it shows little understanding on the part of the nurse as to how the patient might be feeling. Also, a series of questions may make the patient feel interrogated rather than understood. A single question would probably be as effective in encouraging the patient to express his concerns.

Two nurses did respond empathically to this vignette by reflecting both content and feeling of the patients' situations. One nurse responded:

> You really look down in the dumps. it must be hard for you to be scared about the pains that you're having. Maybe we can talk about that a little more.

Another nurse showed understanding of the patients' perception by responding:

> Surgery can be a very frightening experience and it can cause worries and anxieties about your future health. It does make you more

> conscious of pains that you have. I know that these pains can be worrisome.

In summary, only two or three nurses in this sample clearly demonstrated a facilitative level of empathy in their responses. In general, nurses' responses tended to minimize or discount patients' feelings and seemed more concerned with getting information or solving the problem. One possible explanation for nurses' low scores on empathy could be that nurses do not recognize the importance of the patient feeling understood. In general, considering the examples given above, the nurses' responses seemed to indicate that their intention was to help the patient. It may be that nurses were unaware of effective ways of demonstrating their helping intentions to patients. In almost every response the underlying intent of the nurse seemed to be to help the patient. Another possible explanation for nurses' low scores on empathy could be that nurses view empathic responding as too time-consuming in their busy schedules. Nurses may feel that it is more efficient and effective to make unilateral decisions regarding patient care. It may seem easier for the nurse to decide on plan of action and simply tell the patient what the nurse thinks is best for the patient.

Considering that empathy is viewed as perhaps the most crucial of all the helping dimensions and that without empathy it is felt that there is no basis for helping (according to such researchers as Carkhuff), it is distressing that nurses seem to perform so poorly on this skill.

Respect

The nurses' average score on Carkhuff's (1969) five-point respect scale was 2.1 (Table 5). Carkhuff describes a level 2 response as the helper demonstrating a lack of respect or concern for the clients' feelings, experiences, and potentials. "The first person may respond mechanically or passively or ignore many of the feelings of the second person" (p.179). Approximately 85% of the nurses' scores were below 2.5 with only two nurses reaching 3.0 facilitative level (Figure 3) described by Carkhuff as the helper minimally acknowledging regard for the clients position and demonstrating concern for the clients feelings, experiences and potentials. "The helper communicates an openness to the prospect of the helpee's ability to express himself and to deal constructively with his life situation" (p. 179). Generally, the nurses showed little regard for the patient as an individual who could act constructively in

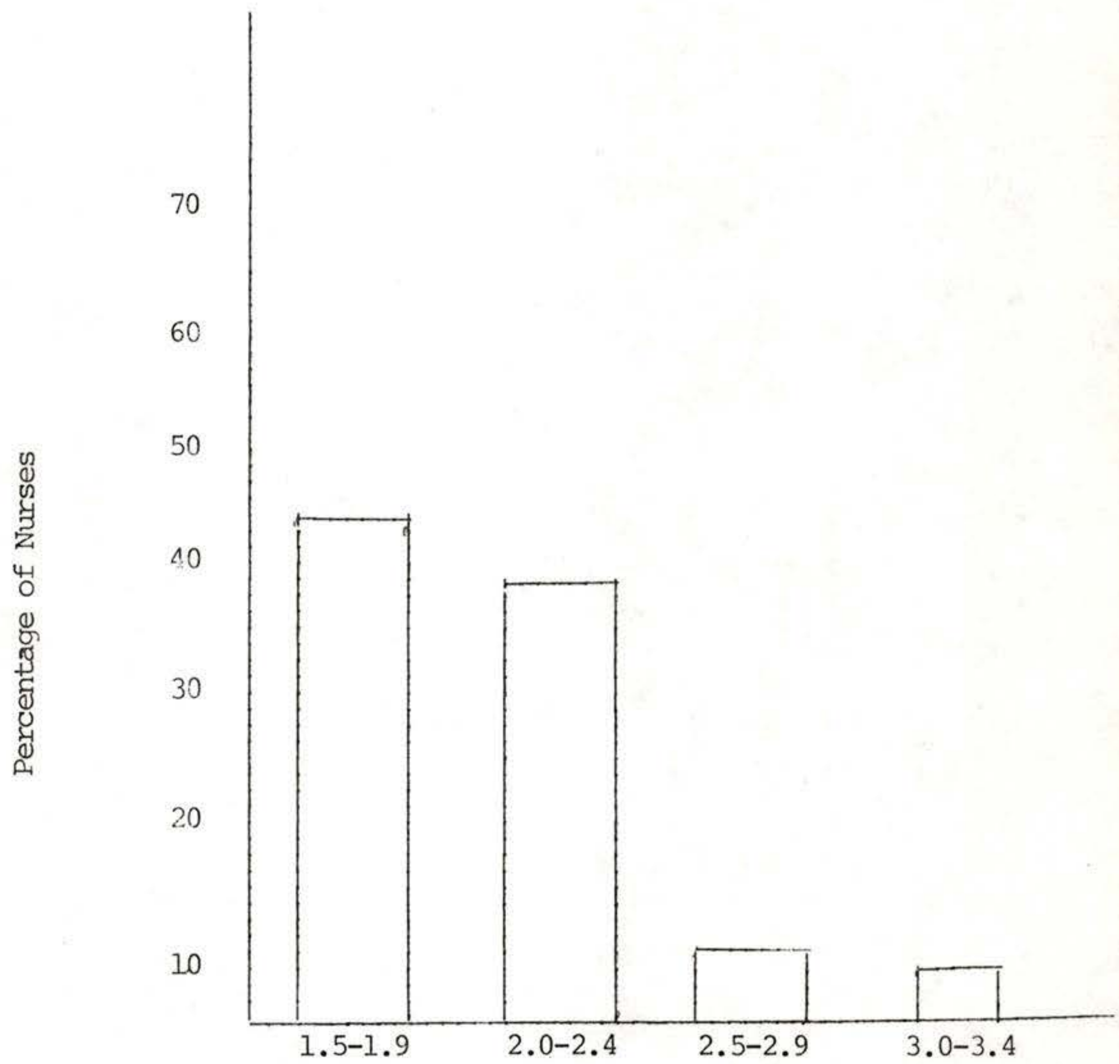

Figure 3. Distribution of Scores on Carkhuff Respect Scale

his own life. One vignette which elicited a variety of responses presented a young girl patient who looked angry and exclaimed:

> I'm not letting that idiot take my blood again. She's tried seven times. Look at my arm! What does she think I am, some pin cushion that she can come and jab any time she likes? If she comes back, I'm leaving!

Typically nurses responded to this situation by taking charge and ignoring the resources that the patient had to help herself. One nurse responded:

> Well don't worry about it, we'll see if we can get someone else to try and take the blood for you. It's very important we have a blood sample. We have other people who could try.

Often the nurses' responses were critical or judgmental. One nurse responded to the preceeding vignette in the following way:

> All right just settle down and let's look at this. You're in the hospital for a reason. And do you wish to get well? Cause if you wish to get well we can help you. If you can't then you're wasting our time, your time, and the facilities, which are very limited. And you must consider that we're not doing this for our pleasure, but it's for your good, and you've got to learn to co-operate.

Scolding the patient in this manner is not likely to make the patient feel cared about as an individual.

A few nurses did respond in a way that demonstrated acceptance of the patient as an individual. One nurse showed her ability to accept the patient's feelings and experience without judgment or evaluation by responding:

> You seem really upset with all these tests and everything -- maybe we could talk about it.

The nurse's demonstration of unconditional acceptance encourages the patient to explore his reactions without fear of criticism or judgment.

Even with the more emotionally charged vignettes most nurses did not convey an acceptance of the patient as a person with individual feelings and experiences. One vignette presented a middle aged woman, who looked worried and afraid and pleaded:

> I feel so weak. What am I going to do, I'm afraid I'll never get better. Look at me, I can hardly sit up without feeling dizzy! What am I going to do? What am I going to do?

It might be expected that nurses would accept this patient's distress since it was so obvious. However, the majority of nurses tended to be judgmental or critical and to "take over", conveying that the nurse viewed the patient as unable to deal effectively with the situation. One nurse's response exemplifies this lack of respect:

> The best thing for you to do is just to relax a little and have patience and confidence in us.

> You've been sick and been laying flat in bed for some time. Anybody is bound to feel dizzy. You'll be surprised how quickly you'll come along.

In contrast, one nurse expressed confidence in the patient's ability to deal constructively with the situation in the response:

> It sounds like you've just had to put up with so much so far and you've taken just about all that you can. Come and sit down and we can talk about it.

Among the nurses in this study there was not a high level of respect for the patients' ability to contribute to their care nor for the reactions the patients reported. One possible explanation for this lack of respect demonstrated to patients could be the nurses' focus on the technical aspects of delivering care. This emphasis would mean that the nurse's training and professional skills make her the knowing person. Typically patients would have little or no training in the technical aspects of health care and may be seen as having little to offer. Another possible explanation for the nurses' low respect scores would be that involving patients more actively in their care may be seen as too time consuming by busy nurses. At least in the short term consideration of time, listening to and incorporating information from patients in their care could be seen as detracting form the nurses' immediate duties. The argument

could be made, however, that respecting patients' ability to participate in their care provides a sounder approach to health care in the long run.

Warmth

The nurses' average score on Gerrard's (1980) four-point warmth scale was 2.2 (Table 5). Gerrard describes level 2 responses as characterized by "slightly cool voice tone. . . behavior and speech content convey slight disinterest in the other person. Slightly unfriendly behavior." As reported in Figure 4, approximately 85% of nurses' scores were below 2.5. Only one nurse reached the facilitative level of 3.0, which is described by Gerrard as "warm voice tone. . . behavior and speech content show respect and consideration for the other person. Friendly behaviour." However the absence of non-verbal cues due to audiotaping made this skill more difficult to assess accurately. Also, warmth is evidenced more readily by listening to "how" the nurse responds rather than "what" she actually says. Characteristics such as voice tone and emphasis were considered in the scoring but cannot be included in a written report. Even with these limitations

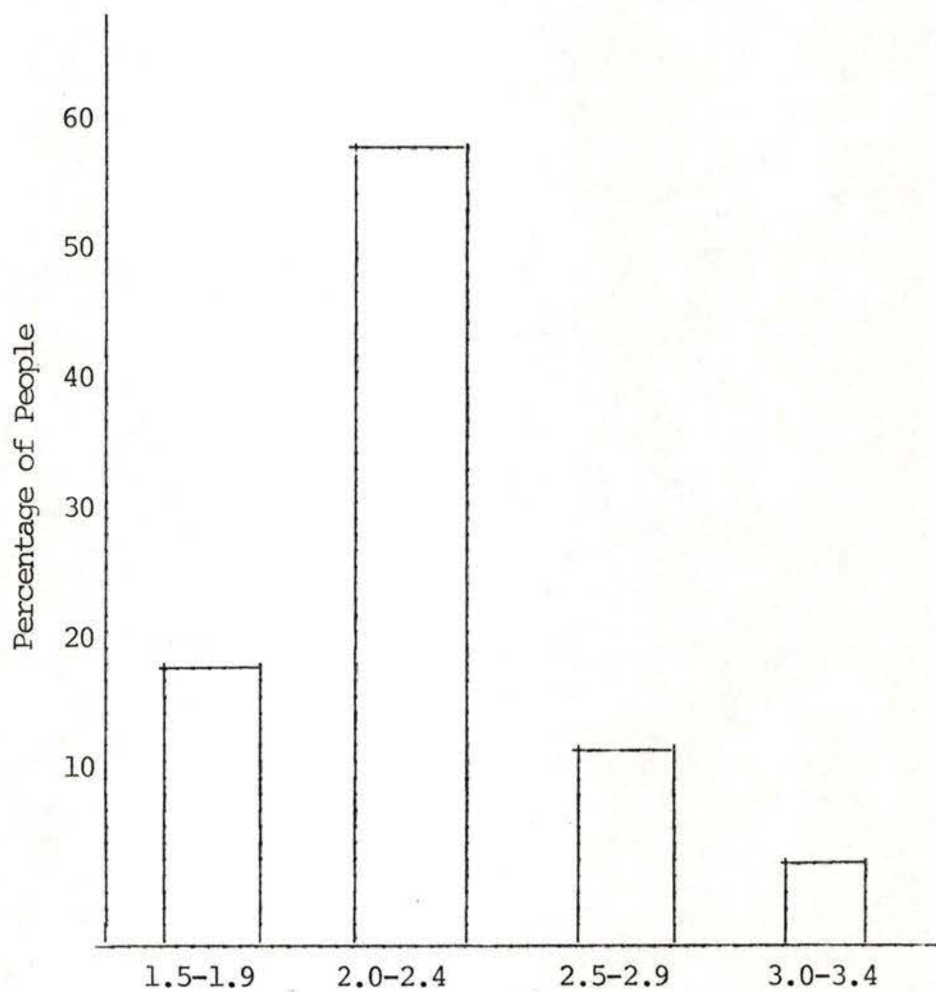

Figure 4. Distribution of Scores on Gerrard Warmth Scale

the nurses' level of warmth can be illustrated by the following examples. One vignette presented a young boy, who appeared angry and shouted:

> Damn it! What's the matter with you people! I must have called at least 20 times before anyone answered. You call yourself a hospital? Are you deaf or something?

Generally, nurses' responses were characterized by a clinical, matter-of-fact tone which seemed to create distance between the nurse and the patient. One nurse responded:

> We're very busy and we have a lot of patients that we have to look after, so you'll just have to be a little bit patient. We come as soon as we can.

This lack of personal interest in the patient emphasizes the "role distance" which can exist between nurses and patients. An extreme example was found in one nurse's response as she threatened the patient:

> All right in a hospital we see who's ringing the bell. We establish our priorities. If you are known for putting your light on frequently for inconsequential things naturally we leave your light till last. We assume the responsibility for making the decision as to who needs our attention first and foremost. If you become demanding, then you are the last to be taken care of.

In contrast, one nurse conveyed warmth in her response:

> You must be really upset right now because we weren't answering your bell. We may have been busy at the time and it was possibly difficult for us to get to you as soon as you wanted us to.

The infrequent occurence of warm responses may have been due to the videotape format. Nurses who may normally demonstrate warmth by nonverbal behavior or actual contact with patients might have domonstrated warmth under different circumstances. Nevertheless warmth is an essential skill in "producing positive outcomes for patients" (Gerrard, 1980, p. 116).

Initiating

The nurses' average score on Gerrard's (1980) four-point initiating scale was 2.6 (Table 5) Gerrard decribes a level 2 response as "gives information only" (p. 274). A level 3 response "shows one of the following responses: offers alternative solution or initiates appropriate physical action" (p. 274). The nurses' responses in this study were between these two levels. As reported in Figure 5, approximately 45% of the nurses' scores were below 2.5 in contrast to the large proportions (about 85%) with low scores on the other variables. On initiating 14% of nurses responses were above the 3.0 level.

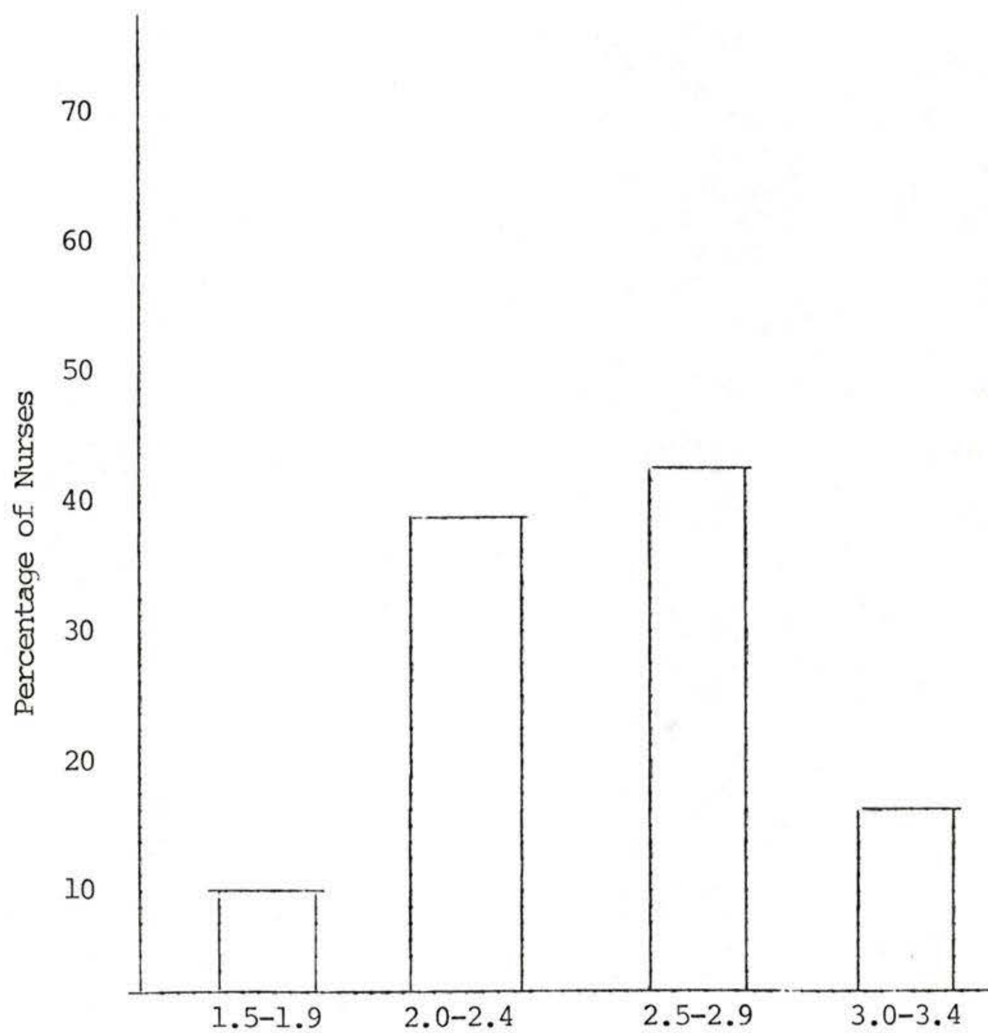

Figure 5. Distribution of Scores on Gerrard Initiating Scale

An appropriate initiating response includes: "giving information, carrying out some physical action, initiating a discussion, offering an alternative solution, making requests and stating an opinion" (Gerrard, 1980, p. 263). One vignette presented a woman who appeared worried and frightened and stated:

> It's a dull nagging pain. It goes on and on, day after day, night after night. I feel I shall never be free of it.

Most frequently nurses demonstrated initiating skills by suggesting alternative solutions, stating an opinion and inviting further discussion. One nurse employed all three techniques in her response:

> Can you tell me where the pain is and what you've had done for you so far? I'm sure that we can do something for you. What does your doctor say about it? There are many ways to contol pain. We have drugs and pain control clinics now that can help you.

Other nurses used a variety of combinations of these techniques in their responses. One nurse invited further discussion by asking a series of questions:

> Where abouts is your pain. Is it just a dull ache? Is the doctor aware of it? Have you been taking anything for it?

Another nurse demonstrated initiating skills by asking questions, stating an opinion and suggesting an alternative:

> What type of medication are you taking for the pain? Is the medication helping the pain at all? And if it isn't helping the pain I think that your medication should be reassessed by your doctor and another choice made.

One nurse made an alternative solution, gave information and stated an opinion in responding:

> The pain medication is not relieving it at all from what you're telling me. Just try to relax and I'll talk with the team leader and see if we can call your doctor and see if maybe we can get some other medication ordered for you. In the meantime you're coping pretty well, just try to do the best you can till I get back to you.

Although these four preceding examples illustrate appropriate initiating skills according to Gerrard, the effectiveness of these skills "to encourage the patient to take some action that will help solve his problem" (p. 263) is questionable. In each of these examples the nurses seem to have taken control of the situation. An understandable response of the patient would be to take no further action on his own. In contrast to this characteristic of the nurse taking contol by initiating, the following example seemed to more effectively encourage the patient to continue to be involved by giving more information:

> You do look like you're in a lot of pain right now. Maybe you want to describe the pain for me a little more.

An important limitation of Gerrard's rating scale is that all five examples would receive similar scores for initiating with no discrimination made on the basis of the probable effect on the patient's behavior.

A related concern is that some of the techniques provided for in initiating would limit the nurse's providing facilitative characteristics of effective communication such as empathy and respect. For example, the nurse's providing an alternative solution may be disrespectful to the patients' ability to respond on his own. The provision of information by the nurse would likely make it difficult to attend to the patients' feelings. This lack of correspondence between initiating and the other communciation skills was examined further by computing correlation coefficients among the variables (Table 6). The correlations involving initiating were positive and significantly different from zero but when compared to the intercorrelations among the other communication variables were very modest. These data support the conclusion that initiating scores are relatively independent of scores on the other communication variables.

TABLE 6

Correlations Among Initiating, Warmth, Empathy and Respect Scores

Variable	Correlation with			
	Empathy G[a]	Empathy C[b]	Respect	Warmth
Initiating	.258*	.356**	.363**	.247*
Warmth	.563***	.592***	.600***	
Respect	.796***	.770***		
Empathy C	.902***			

Note. Empathy G - empathy described by Gerrard

Empathy C - empathy described by Carkhuff

* $p < .05$

** $p < .01$

*** $p < .001$

Another important limitation of the initiating rating scale that was apparent in using it in this study was that the scale seemed to measure two dimensions of responding. The top score on the scale is assigned for inviting the patient to talk yet the next highest score is assigned for the nurse offering an alternative solution or initiating appropriate physical action. These behaviors do not seem to be gradations on the same continuum.

In considering nurses' scores on the variables of empathy, warmth, respect and initiating it was found that a sizable proportion met the facilitative level only on the Initiating scores. Further to this finding that the levels of empathy, warmth and respect were not satisfactory in terms of the criteria established by Carkhuff and Gerrard this study was concerned with what types of responses that were actually used by nurses. Data for this question were provided by Response Mode scores.

Response Modes

Of particular interest in this study was the proportion of times that the more facilitative modes of reflection and self disclosure were used. The average proportion of responses in each of the response modes is reported in Table 7. In addition to the five categories

TABLE 7

Means and Standard Deviations of Response Mode Proportion Scores

Response mode	Proportion of Responses	
	Mean	Standard Deviation
Reflection	9.6%	10.5%
Self Disclosure	10.7%	6.4%
Advisement	34.9%	14.0%
Questioning	19.4%	11.8%
Interpreting	0.1%	0.9%
Information	14.3%	6.2%
Advise/Information	49.0%	15.4%

Note. N = 47

developed by Whalen and Flowers a category called information was created for this study. This category was considered an extension of advisement and provided a way of categorizing responses by the nurse that dealt with content rather than affect, justified medical interventions or offered explanations. These types of responses could not be clearly assigned to the modes described by Whalen and Flowers.

The most frequently used response mode was that of advisement. In fact, the combination of advisement and information was used for one-half of the responses made by nurses. Further, questioning was also frequently used. In contrast, the mode considered most appropriate for this initial phase, that of reflection, was used less than 10% of the time on average. The other mode considered appropriate, self disclosure, was used a similar proportion of times.

As reported in Table 8, only one nurse gave reflection responses more than one third of the time. In contrast, 30 nurses gave advisements more than one third of the time. The number of nurses using high proportions of questioning and information was not as great as for advisement but seems large in view of expectation that the patient needs initially to feel understood. These data confirm the pattern apparent in the examples considered above. Many of the nurses assumed control of the situation

TABLE 8

Distribution of the Number
of Nurses Categorized by Proportion Score
for Each Response Mode

Response Mode	Proportion Score Category						
	0-9%	10-19%	20-29%	30-39%	40-49%	50-59%	60-69%
Reflection	33	8	4	0	1	0	0
Self Disclosures	21	21	5	0	0	0	0
Advisements	1	5	11	12	10	6	2
Questioning	9	19	11	4	3	1	0
Interpreting	47	0	0	0	0	0	0
Information	8	30	11	1	0	0	0

Note. N = 47

rather than exploring with the patient how he was feeling. This control was evidenced by the nurses' giving advice and information or asking a series of questions even when the patients had made clear statements of feeling or content.

Experience and Interpersonal Skills

Two of the secondary questions were concerned with the association between the number of years since graduation and the types of responses given to the Behavioral Test. Means and standard deviations were computed for the groups formed on the basis of experience— novice, intermediate and experienced. Comparison of these means were made by analysis of variance. In addition, correlation coefficients were computed between years since graduation and each of the variables.

The comparison of the three groups, as reported in Table 9 and Table 10, support the conclusion that on the Empathy variables nurses in the Novice group scored significantly better than nurses in the other two groups. The Scheffe comparison of means indicated that this difference exists at the level of $p < .05$. No significant differences were found for warmth, initiating and respect.

TABLE 9

Means and Standard Deviations for Scores on Gerrard and Carkhuff Scales for Novice, Intermediate and Experienced Nurses

Variable	Statistic	Group		
		Novice (0 - 1 year)	Intermediate (1 - 5 years)	Experienced (+5 years)
Gerrard [a]				
Empathy	M	1.8	1.3	1.3
	sd	0.64	0.33	0.25
Warmth	M	2.4	2.1	2.2
	sd	0.1	0.25	0.81
Initiating	M	2.6	2.4	2.6
	sd	0.49	0.35	0.44
Carkhuff [b]				
Empathy	M	2.4	2.0	1.9
	sd	0.42	0.19	0.25
Respect	M	2.2	2.0	2.0
	sd	0.43	0.32	0.35

Note. n = 14 for Novice, n = 14 for Intermediate, n = 19 for Experienced Groups

[a] possible range of scores 1 - 4

[b] possible range of scores 1 - 5

TABLE 10

Analysis of Variance of Scores on Gerrard and Carkhuff Scales for Novice, Intermediate and Experienced Nurses

Variable	Source	SS	MS	F	p
Gerrard [a]					
Empathy	Between	252.2	126.1	7.04	.002
	Within	788.1	17.9		
Warmth	Between	39.5	19.7	1.69	.19
	Within	513.8	11.7		
Initiating	Between	40.2	20.1	1.08	.35
	Within	823.4	18.7		
Carkhuff [b]					
Empathy	Between	180.2	90.1	10.15	.0002
	Within	390.6	8.9		
Respect	Between	45.8	22.9	1.69	.20
	Within	595.9	13.5		

Note. n = 14 for Novice, n = 14 for Intermediate, n=19 for Experienced Groups

[a] possible range of scores 1 - 4

[b] possible range of scores 1 - 5

On the Response Mode scores (Table 11 and Table 12) the nurses in the Novice group gave significantly more reflections than nurses in the other groups. The Scheffé comparison of means indicated that this difference was significant at a level of $p < .05$. On the other five modes no significant differences existed.

This association between years since graduation and both empathy and reflections was confirmed by the correlation coefficients reported in Table 13 and Table 14. Significant negative correlations in excess of -.30 were found for empathy and reflection scores. A modest negative correlation was also found between respect scores and years since graduation (Table 13). In addition, a modest positive correlation was found between advisement scores and years since graduation (Table 14). These correlations would indicate that as years since graduation increase, empathy, respect and reflection scores decrease while advisement scores increase.

These findings are consistent with those of Mathews (1962) in demonstrating the existence of a consistent relationship. "As years since graduation increase, there is a tendency for 'person-centeredness' to decrease" (p.159).

One possible explanation for the nurses' low scores on the facilitative skills could be related to the choice of work settings. Perhaps nurses who are interested and

TABLE 11

Means and Standard Deviations for Response Mode Proportion Scores for Novice, Intermediate and Experienced Nurses

Variable	Statistic	Group		
		Novice (0-1 year)	Intermediate (1-5 years)	Experienced (+5 years)
Reflection	M	16.4%	7.5%	6.2%
	sd	14.3%	6.2%	7.2%
Self Disclosure	M	11.6%	10.6%	10.1%
	sd	5.9%	7.4%	6.2%
Advisement	M	29.6%	36.8%	37.3%
	sd	12.9%	12.9%	15.1%
Questioning	M	19.2%	18.4%	20.3%
	sd	8.0%	10.6%	15.0%
Interpreting	M	0.0%	0.4%	0.1%
	sd	0.0%	1.6%	0.2%
Information	M	14.6%	14.0%	14.3%
	sd	5.3%	5.7%	7.5%

Note. n = 14 for Novice, n = 14 for Intermediate, n = 19 for Experienced Groups

TABLE 12

Analysis of Variance For
Response Mode Proportion
Scores for Novice, Intermediate and Experienced Nurses

Variable	Source	SS	Ms	F	p
Reflection	Between	939.6	469.8	5.05	.01
	Within	4097.5	93.1		
Self Disclosure	Between	18.75	9.4	.22	.80
	Within	1839.8	41.8		
Advisement	Between	558.1	279.0	1.45	.26
	Within	8453.9	192.1		
Questioning	Between	29.6	14.8	.103	.90
	Within	6341.9	144.1		
Interpreting	Between	1.58	.79	1.01	.37
	Within	34.38	.78		
Information	Between	2.93	1.47	.04	.96
	Within	1786.90	40.61		

Note. n = 14 for Novice, n = 14 for Intermediate, n = 19 for Experienced Groups

TABLE 13

Correlations between Scores on Gerrard and Carkhuff Scales and Years Since Graduation, Type of Course and Type of Practice

Variable	Correlation with		
	Years Since Graduation	Course	Practice
Gerrard			
Empathy	- .34**	.12	.43***
Warmth	- .22	.06	.43***
Initiating	.06	.21	.33**
Carkhuff			
Empathy	- .42**	.21	.53**
Respect	- .24*	.13	.44***

Note. N = 47
*$p < .05$
**$p < .01$
***$p < .001$

TABLE 14

Correlations between Response Modes and Years Since Graduation, Type of Course, and Type of Practice

Variable	Correlation With		
	Years Since Graduation	Course	Practice
Reflections	- .31*	.11	.40**
Self Disclosures	- .22	.01	.15
Advisements	.28*	- .12	- .34**
Questioning	- .07	.16	.21
Interpreting	- .06	.05	- .01
Information	.23	- .35**	- .31*

Note. N = 47

*p < .05
**p < .01
***p < .001

skilled in interpersonal communication have chosen to work in an area other than general medical-surgical nursing. It could be that nurses who have interpersonal skills are attracted to the specialty areas such as maternity, pediatrics, psychiatry or community health.

Alternatively, nurses who work in a general medical-surgical setting may place a higher priority on the techinical aspects of nursing and may not be interested in or value effective communication as an important skill for a nurse. However, Gerrard (1978) concluded from a survey of the literature that nurses do value interpersonal skills and references made to interpersonal skills in nursing are strongly positive. It is also possible that nurses at one time had effective interpersonal skills and have subsequently decreased in their ability to use the skills. A possible explanation for this loss of skill could be that the hospital administration reinforces and supports nurses spending their time on the more technical aspects of nursing care. That is, the institution places more value on the nurse spending her time doing a dressing or bathing a patient, than sitting talking to a patient. On the ohter hand, thepressures of the ward setting may inhibit the nurse from using interpersonal skills and instead focus attention

on technical skills. As a result nurses may not practice interpersonal skills and this lack of practice may lead to the nurse's loss of skill.

Training and Interpersonal Skills

The other secondary questions were concerned with the association between the kind of interpersonal skills training the nurse had completed and the type of responses given to the Behavioral Test. Two dimensions of training were considered; type of course -- no course, part of nursing training, or independent course, and the type of practice -- no practice, unsupervised or supervised practice. Means and standard deviations were computed for the three groups formed within each of the two dimensions. Comparison of these means were made by Kruskal-Wallis one-way Analysis of Variance. In addition, correlation coefficients were computed between each of the variables and both type of course and type of practice.

Type of Course. The comparison of the mean scores for the three groups on Type of Course, as reported in Table 15 and Table 16, suggested that there was no consistent pattern for the scores on the Gerrard and Carkhuff scales and the type of course that nurses received as part of their

TABLE 15

Means and Standard Deviations for Scores on Gerrard and Carkhuff Scales for Training Groups: Type of Course [a]

Variable	Statistic	Group		
		No Course (n = 6)	Part of Nursing (n = 33)	Independent (n = 8)
Gerrard [b]				
Empathy	M	2.1	2.2	2.2
	sd	.27	.36	.35
Warmth	M	1.2	1.5	1.4
	sd	.14	.53	.30
Initiating	M	2.6	2.5	2.9
	sd	.29	.41	.47
Carkhuff [c]				
Empathy	M	1.8	2.2	2.0
	sd	.17	.38	.24
Respect	M	2.0	2.1	2.1
	sd	.23	.38	.45

Note. [a] Three categories of training were considered - no course (n = 6), part of nursing (n = 33), and independent course (n = 8)

[b] possible range of scores 1 - 4; [c] possible range of scores 1 - 5

TABLE 16

Kruskal-Wallis Analysis of Scores on Gerrard and Carkhuff Scales for Training Groups: Type of Course [a]

Variable	Chi Square [b]	p
Gerrard		
Empathy	1.89	.39
Warmth	.26	.88
Initiating	4.98	.08
Carkhuff		
Empathy	6.0	.05*
Respect	1.15	.56

Note. degrees of freedom = 2

[a] Three categories of training were considered - no course (n = 6), part of nursing (n = 33), and independent course (n = 8)

[b] chi square value corrected for ties

interpersonal skills training. Differences among scores on Carkhuff's empathy scale did reach significance; nurses who had no training scored lower than those in the other two groups (Table 16). On the Response Mode scores (Table 17 and Table 18) no consistent pattern emerged. No significant differences were found using the Kruskal-Wallis one way analysis of variance.

Only one significant correlation was found between type of course and the other variables. As reported in Table 14, information scores were found to be negatively correlated with type of course. There was a tendency for nurses in the Independent course group to score lower than the other two groups on the information variable.

These findings would suggest that the type of course nurses received as part of their interpersonal skills training did not significantly or consistently influence the type of initial response nurses made to patients.

Type of Practice. The comparison of the three groups on Type of Practice as reported in Table 19 and Table 20 supported the conclusion that nurses who received supervised practice in their interpersonal skills training scored significantly higher on the variables of empathy, respect, warmth and initiating.

TABLE 17

Means and Standard Deviations for Response Mode Proportion Scores for Training: Type of Course [a]

Variable	Statistic	Group		
		No Course (n = 6)	Part of Nursing (n = 33)	Independent (n = 8)
Reflection	M	5.3%	10.6%	8.6%
	sd	4.8	11.5	8.9
Self Disclosure	M	8.5	11.8	7.6
	sd	4.0	6.8	4.5
Advisement	M	40.2	34.0	35.0
	sd	16.9	13.5	15.0
Questioning	M	17.7	18.2	26.0
	sd	12.9	9.2	18.5
Interpreting	M	0.0	.2	.1
	sd	0.0	1.0	.3
Information	M	19.3	14.1	11.5
	sd	7.1	5.8	5.9

Note. [a] Three categories of training were considered - no course (n = 6), part of nursing (n = 33), and independent course (n = 8).

TABLE 18

Kruskal-Wallis Analysis of Scores for Response Mode Proportion Scores for Training: Type of Course[a]

Variable	Chi Square[b]	p
Reflection	.87	.65
Self Disclosure	3.65	.16
Advisement	.717	.70
Questioning	.97	.62
Interpreting	1.60	.45
Information	4.49	.11

Note. degrees of freedom = 2

[a] Three categories of training were considered - no course (n = 6), part of nursing (n = 33), and independent course (n = 8).

[b] chi square value corrected for ties.

TABLE 19

Means and Standard Deviation for Scores on Gerrard and Carkhuff Scales for Training: Type of Practice [a]

Variable	Statistic	Group		
		No Practice (n = 6)	Unsupervised (n = 26)	Supervised (n = 15)
Gerrard [b]				
Empathy	M	2.1	2.1	2.5
	sd	.26	.25	.39
Warmth	M	1.2	1.3	1.7
	sd	.14	.30	.65
Initiating	M	2.5	2.4	2.8
	sd	.29	.40	.45
Carkhuff [c]				
Empathy	M	1.8	2.0	2.4
	sd	.17	.24	.42
Respect	M	2.0	2.0	2.4
	sd	.23	.32	.38

Note. [a] Three types of training were considered - no practice, unsupervised practice, and supervised practice

[b] possible range of scores 1 - 4

[c] possible range of scores 1 - 5

TABLE 20

Kruskal-Wallis Analysis of Scores on Gerrard and Carkhuff Scales for Training Groups: Type of Practice [a]

Variable	Chi Square [b]	p
Gerrard		
Empathy	7.90	.019*
Warmth	9.80	.007**
Initiating	6.39	.41 *
Carkhuff		
Empathy	13.82	.001***
Respect	10.44	.005**

Note. degrees of freedom = 2

[a] Three types of training were considered - no practice, unsupervised practice, and supervised practice

[b] chi square value corrected for ties

TABLE 21

Means and Standard Deviations for Response Mode Proportion Scores for Type of Training: Type of Practice [a]

Variable	Statistic	Group		
		No Practice (n = 6)	Unsupervised (n = 26)	Supervised (n = 15)
Reflection	M	5.3%	6.8%	16.3%
	sd	4.8	6.6	14.2
Self Disclosure	M	8.5	10.5	11.7
	sd	4.0	7.0	6.0
Advisement	M	40.2	37.8	27.6
	sd	16.9	14.2	10.0
Questioning	M	17.7	17.5	23.5
	sd	12.9	9.9	13.9
Interpreting	M	0.0	0.2	0.1
	sd	0.0	1.2	0.3
Information	M	19.3	14.2	12.5
	sd	7.1	5.4	6.5

Note. [a] Three categories of training were considered - no practice, unsupervised practice, and supervised practice

TABLE 22

Kruskal-Wallis Analysis of Scores for Response Mode Proportion Scores for Training: Type of Practice [a]

Variable	Chi Square [b]	p
Reflection	7.85	.02*
Self Disclosure	1.36	.51
Advisement	6.75	.03*
Questioning	1.72	.42
Interpreting	.45	.80
Information	4.45	.11

Note. [a] Three categories of training were considered no practice, unsupervised practice, and supervised practice

[b] chi square value corrected for ties

*p .05
**p .01
***p .001

On the Response mode scores (Table 21 and Table 22) the nurses in the Supervised Practice group gave significantly more reflections and significantly fewer advisements than the nurses in the other two groups. On the other four response modes no significant differences existed.

This association between Type of Practice and each of the variables empathy, warmth, respect, initiating, reflection and advisements was confirmed by the correlation coefficients reported in Table 13 and Table 14. Significant positive correlations in excess of .33 were found for empathy, warmth, respect, initiating and reflection. A significant negative correlation (-.34) was found for advisements. In addition a significant negative correlation was found for information (-.31). These correlations would indicate that nurses who received supervised practice as part of their interpersonal skills training tended to use responses characterized by empathy, warmth, respect, initiating and reflection more often than nurses who did not receive this type of practice. In addition nurses who received supervised practice tended to use responses characterized by advisements or information less often than nurses in the other two groups.

Examination of the association between practice and nurses' communication skills provided a further explanation for nurses' low scores on interpersonal skills. It may be that the majority of nurses have never learned these skills. In the brief interview following the Behavioral Test for Interpersonal Skills, the nurses often described their interpersonal skills training as consisting of learning guidelines and techniques of "therapeutic communication" such as "offering general leads", reflecting", "verbalizing the implied" rather than learning particular skills like empathy, respect, or self-disclosure. Most nurses also reported that, although they may have discussed "therapeutic techniques" during nursing training, practicing these techniques occurred mainly with patients on the ward not in the classroom setting. Nurses were often required to report the interactions, usually in writing, to the nursing instructor but rarely did any direct supervision occur. This may further explain the nurses' poor performance of the various skills. Although most nurses were required to show how the techniques should be used appropriately, few nurses were required to actually demonstrate their ability to use the skills.

Another explanation may be related to the placement of the interpersonal skills training. During the interview the majority of the nurses stated that the communciation

skills training was incorporated and taught as a part of the psychiatric nursing rotation. It may be that nurses then associate the communication skills with psychiatric nursing only! Some nurses actually stated that this association had occurrred for them. One nurse stated "Did that (the videotape) ever remind me of "Level Four" (psychiatric rotation in training)! I kept trying to think of all the skills we had learned." Another nurse responded to the task "It really made me think. I kept thinking about all that communication stuff I'd learned in psychiatry." Some nurses even felt that some of the patients on the videotape needed psychiatric help that was beyond the nurses' expertise. One nurse's reaction to the videotape was "Some of those patients were more like psychiatric patients. I didn't know how to respond to them." Another nurse's reaction was "Some patients belonged in a psychiatric setting. You need an expert to deal with those situations. I'm no expert!" It may be that teaching communication skills only during the nurse's psychiatric rotation makes it difficult for the nurse to generalize these skills to the medical-surgical setting.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND IMPLICATIONS

Conclusions

Results from this study support the conclusion that many nurses did not respond effectively in terms of the criteria used in this study on a task designed to measure initial interactions with patients. Specifically, the findings consistently demonstrated that nurses were functioning below the facilitative levels of empathy, respect, warmth and initiating. In addition, evidence was found to suggest that a large proportion of the time nurses responded initially with non-facilitative responses such as advisements, giving information and questioning. These findings are similar to those of Graffam (1970) as detailed in Table 1. Eleven years have passed since Graffam's study and yet the evidence indicated that the proportion of non-facilitative responses used remains the same.

The results generally showed that nurses who had recently graduated performed significantly better on the empathy variable than nurses with more experience. A relationship was also found to exist between years since

graduation and respect. No association was found to exist between years since graduation and either warmth or initiating. These results support Mathews (1962) findings that as years since graduation increased nurses' levels of person-centeredness decreased.

The variable of experience was also associated with the proportion of responses categorized as reflections, advisements, questions and self-disclosures. Nurses with less experience tended to use more reflections and less advisements than did the more experienced nurses. There were no statistically significant associations between experience and nurses' responses of self-disclosure, questioning, giving information.

The type of course of interpersonal skills training that nurses received was not related to the nurses' ability to demonstrate responses of empathy, warmth, respect and initiating. However, it may be concluded that the factor of whether or not nurses practiced skills as part of their training, and specifically what type of practice they experienced, did have a bearing upon their ability to demonstrate the skills. The conclusion can be drawn that supervised practice was a crucial variable in the nurses' ability to utilize facilitative skills in their initial interaction with patients. These findings are consistent with those of Sethee (1976) who reported that nurses in that

study felt that the key to improvement in communication skills in interviewing was "more supervised practice with planned assessment following practice" (p.368). Further there was no association between the type of course of interpersonal skills training that nurses received and the proportion of responses categorized as reflections, advisements, questions and self-disclosures. However, once again the fact that nurses practiced their skills under supervision was significant in the results. Nurses who had experienced supervised practice of skills responded with more reflections and less advisements and information.

The survey of the literature indicated that nurses' interpersonal skills affect the quality of care rendered to patients. Considering the results of this study within that context, the conclusion may be drawn that an important way of improving the quality of care delivered to patients would be to augment the nurses' technical skills by improving their interpersonal skills. In each of the interpersonal skills considered, the average level did not meet a standard judged to be effective.

Limitations

These conclusions should be considered in light of the following limitations.

The major limitations of this study were related to the use of simulation as a means of assessing nurses' interpersonal skills. First,the nurses' use of nonverbal communication could not be measured using this form of assessment. Therefore, the nurses' ability to demonstrate facilitative skills could have been restricted. Second, the lack of information regarding the patients' diagnosis and background may have adversely influenced the nurses' ability to respond. However, it is also possible that a nurses' knowledge of a patients' diagnosis and background could limit the nurses responses by influencing her to act on assumptions regarding past information rather than focusing on the immediate situation. A researcher would have to be cautious in designing a study to control for such variables. Finally, the use of simulation and the fact that the nurses faced an unrealistic number of intense interactions in a short period of time may limit the ability to generalize the results to nurses' responses in actual situations. In spite of these limitations the experimental rigor gained by the use of a simulation requiring a behavioral response was thought to outweigh the inherent disadvantages.

The format of the task meant that only initial interactions with patients were portrayed. Responses to these interactions may not be valid indicators of how nurses

would respond in ongoing interactions. This limitation, however, does not deny the importance of the initial interactions to relationship between the nurse and patient.

A further limitation of this study was the use of audio tape-recording as a means of collecting the data. This method restricted the measurement of nonverbal cues and in particular may have influenced ratings on the warmth variable.

Implications

The results from this study have implications for both future research and interpersonal skills training for nurses.

Future Research. Further investigation of the phenomenon that nurses' facilitative responses decreased as the years since graduation increased may lead to a clearer understanding of practicing nurses apparent lack of facilitative skills.

This descriptive account of nurses' reactions to initial interactions with patients could be extended by studies assessing nurses' interpersonal skills as part of an ongoing interaction. Further, the ability to assess an ongoing interaction in an actual patient care setting would greatly extend the present understanding of the

nurse-patient relationship. The development of a tool to adequately measure the dimensions of this complex relationship is needed.

The role of type of practice nurses received as part of their interpersonal skills training and the nurses ability to respond initially in a facilitative manner deserves further investigation. Further research exploring effectiveness of training nurses in interpersonal skills is warranted.

Interpersonal Skills Training for Nurses. It appears that nurses need more extensive training in interpersonal skills. A systematic approach of teaching a variety of skills, including the function of each skill needs to be developed. The use of supervised practice in learning the skills should be included. Utilizing a behavioral approach upon the completion of training to assess the nurses' level of interpersonal functioning on the various skills would at least ensure that they are functioning at a facilitative level upon graduation.

This study has implications for all nurses committed to the delivery of high quality patient care. Although the prime responsibility for caring resides with the individual nurse, the nursing profession must also meet this challenge.

> Human caring and human relationships are closely interrelated. Human caring remains an essential dimension of professional work, especially in dealing with life crisis, health maintenance problems, and changes in health practices. The socialization process of preparing competent, sensitive and humanistic professional nurses as care-providers is a major challenge for the nursing profession. (Leininger, cited in Watson, 1979, p. xiii).

REFERENCES

Anderson, B., Mertz, H., & Leonard, R. Two experimental tests of a patient-centered admission process. Nursing Research, 1965, 14, 151-157.

Anthony, W. A methodological investigation of the "minimally facilitative level of interpersonal functioning". Journal of Clinical Psychology, 1971, 27, 156-157.

Burnside, I., Ebersale, P., & Monea, H. Psychosocial caring throughout the life span. New York: McGraw Hill Co. Inc., 1979.

Carkhuff, R. Helping and human relations. (Vol.I). New York: Holt, Rinehart and Winston, Inc., 1969.

Carkhuff, R. Helping and human relations. (Vol. II). New York: Holt, Rinehart and Winston, Inc., 1969.

Carkhuff, R. The art of helping. Amherst: Human Resource Development press, Inc., 1977.

Carkhuff, R. & Berenson, B. Beyond conseling and therapy. New York: Holt, Rinehart and Winston, Inc., 1967.

Carkhuff, R. & Burstein, J. Objective therapist and client ratings of therapist-offered facilitative conditions of moderate to low functioning therapist. Journal of Clinical Psychology, 1970, 26, 394-395.

Diers, D., Schmidt, R., McBride, M. & Davis, B. the effect of nursing interaction on patients in pain. Nursing Research, 1972, 21, 419-428.

Dye, M. Clarifying patients' communications. The American Journal of Nursing, 1963, 63, 56-59.

Dyer, E., Monson, M. & Cope, M. Increasing the quality of patient care through performance counseling and written goal setting. Nursing Research, 1975, 24, 138-144.

Elder, R. What is the patient saying? Nursing Forum, 1963, 2, 25-37.

Elms, R. & Leonard, R. Effects of nursing approaches during admission. *Nursing Research*, 1966, 15, 39-48.

Everyl II, G. & Falcione, R. Percieved dimensions of job satisfaction for staff registered nurses. *Nursing Research*, 1976, 25, 346-348.

Gerrard, B. *Interpersonal skills for health professionals: a review of the literature*. Unpublished manuscript, Department of Medicine, McMaster University, 1978.

Gerrard, B. *The construction and validation of a behavioral test of interpersonal skills for health professionals*. Unpublished manuscript, Department of Medicine, McMaster University, 1979.

Gerrard, B., Boniface, W., & Love, B. *Interpersonal Skills for Health Professionals*. Reston: Reston Publishing Co., Inc., 1980.

Goldfried, M. & Kent, R. Traditional versus behavioral personality assessment: a comparison of methodological and theoretical assumptions. *Psychological Bulletin*, 1972, 77, 409-420.

Goodman, G. & Dooley, D. A framework for help-intended communication. *Psychotherapy*, 1976, 13, 106-117.

Graffam, S. Nurse response to the patient in distress - development of instrument. *Nursing Research*, 1970, 19, 331-336.

Hays, J. Analysis of nurse - patient communications. *Nursing Outlook*, 1966, 14, 32-35.

LaMonica, E., Carew, D., Winder, A., Hasse, A. & Blanchard, K. Empathy training as the major thrust of a staff development program. *Nursing Research*, 1976, 25, 447-451.

Mathews, B. Measurement of psychological aspects of nurse - patient relationships. *Nursing Research*, 1962, 11, 154-162.

Mayeroff, M. *On caring*. New York: Harper & Row Publishers, 1971.

Moss, R. & Meyer, B. The effects of nursing interaction upon pain relief in patients. _Nursing Research_, 1966, 15, 303-306.

Peitchinis, J. _Staff - patient communication in the health services_. New York: Springer Publishing Co.,Inc., 1976.

Pluckman, M. _Human communication: the matrix of nursing_. New York: McGraw - Hill, Inc., 1978.

Putt, A. One experiment in nursing adults with peptic ulcers. _Nursing Research_, 1970, 19, 484-494.

Sethee, U. Verbal responses of nurses to patients in emotional laden situations in public health nursing. _Nursing Research_, 1967, 16, 365-368.

Stanton, H. & Litwak, E., Toward the development of a short form test of interpersonal competence. _American Sociological Review_, 1955, 20, 668-674.

Truax, C. Therapist empathy, genuineness, and warmth and patient therapeutic outcome. _Journal of Consulting Psychology_, 1966, 30, 395-401.

Truax, C. and Carkhuff, R., _Toward effective counseling and psychotherapy: training and practice_. Chicago: Adline Publishing Co., 1967

Truax, C. & Mitchell, K. Research on certain therapist interpersonal skills in relation to process and outcome. In Bergin, A. & Garfgield, S. (Eds.), _Handbook of psychotherapy and behavior change_. New York: John Wiley & Sons, Inc., 1971.

Wallston, K., Cohen, B., Wallston, B. , Smith, R., & DeVellis, B. Increasing nurses person-centeredness. _Nursing Research_, 1978, 27, 156-159.

Warren, S. The relationship between morale and communication among health centre team members. _Canadian Journal of Public Health_, 1978, 69, 133-138.

Watson, J. _Nursing: the philosophy and science of caring_. Boston: Little Brown & Co., 1979.

Whalen, C. & Flowers, J. Effects of role and gender mix on verbal communication modes. *Journal of Counseling Psychology*, 1977, 24, 281-287.

APPENDIX A

Letter to Head Nurses

Name: Marcia Hills

Title of Proposed Research: A Behavioral Response Approach to the Assessment of Interpersonal Skills of Registered Nurses

Request to Head Nurses

I am planning a research study to investigate murses' interactions with patients as part of my graduate program at the University of Victoria. As a nurse, I am interested in how nurses relate to patients. At this time I am recruiting experienced nurses to take part in this study and would appreciate your assistance by permitting this study to be conducted with nurses on your ward. The participants would be required to complete a brief task developed for nurses which will require approximately 15 minutes. I hope you will be supportive of this study and permit me to meet briefly with the nurses on your ward. I will be contacting you next week regarding your reaction to this request.

Thank you,

Marcia Hills

APPENDIX B

Whalen and Flowers Response Modes

REFLECTION

01 REFLECTION OR CLARIFICATION: Facilitative paraphrase; a response to which client would probably say, "yes".
"That's aggravating."
"That's really a heavy thing."
"I hear your frustration."
"I sense...."
To I-15: "Death sure is a drag."

Note: Do not base judgment on quality of reflection. Response needn't be the "perfect reflection" to be scored 01.

02 ECHOIC REFLECTION: Exact repeat of all or part of the response.

03 INTERROGATIVE REFLECTION: Would be one of above except for lead-in or tag-on.
"You're confused about the shoulds, aren't you?"

NONVERBAL: THESE RULES ALSO APPLY TO REFLECTION OF NONVERBAL BEHAVIOR.
e.g., "You look very tense" with cues such as wringing hands. "You sound angry" with a raised voice. "You look depressed" when client speaks slowly, appears close to tears, looks down at floor...

IF UNSURE, REVIEW THE TAPE.

INTERPRETATION

04 INTERPRETATION: Therapist is making an assumption,adding something to what client says. To distinguish from a reflection only, an interpretation is news to the client.

Drawing an analogy to a different problem: "This seems to be the same dilemma or feeling you have with your mother."

Jargon or general labels. "That's neurotic." "You have an inferiority complex.

"Your mother probably feels the same way."

"You find it difficult to express anger."

"I feel you really want to say something but are afraid."

"I think that you're avoiding the issue."

"I hear you saying you are fed up with your mother." (Resp. to III-8.)

05 INTERROGATIVE INTERPRETATION: Same as above but in question form.

"Don't you think ...?"

"Could it be that ...?"

"... aren't you?"

"Is it because you feel guilty about what you said?" Resp. to I-13.

"Is there really something so frightening you are hiding?" Resp. to II-3.

To I-6: Do you really want to make a commitment to this particular problem? "

Often either-or questions will fall into this category. (e.g., "Is it really directed at your daughter or are you possibly resentful?" and "Do you think that you have been putting effort into changing your life or have you been assuming I would change it for you?")

NONVERBAL: These rules also apply to nonverbal behavior. "You look like you're afraid to talk."

ADVISEMENT

06 ADVISEMENT: Lectures, suggestions, orders, opinions--for "there and then" -- i.e., not during therapy session. Advisement can minimize the problem (e.g., "We all feel like that sometimes.").

"You should ..."
"I think the most important thing is to be able to express feelings."
"It's not an unusual feeling."
"Go see a therapist"
"Schizophrenia is a psychiatric label with very little agreement about its meaning."
"It's not exactly paranoia." (Resp. to II-2)
"I think it could be important."
"Your problem can be solved."
"He's not going to be that good that you'll have him eating a lot."
"Hey man, don't give up." (Resp. to II-7.)
"I think you should tell him, tonight."
"Don't worry about it."

07 INTERROGATIVE ADVISEMENT: Would be advise except for question form. Is really a command, preceded by "Why don't you...?"

"Why don't you insist on that?"
"Can't you see this as just being a temporary feeling?" (Resp. to I-15.)
"How about trying...?"

When "Have you..." question is quite specific, score as 07 rather than as 11, e.g.: 5

07: "Have you tried telling him about your anger?"
07: "Have you thought about contacting AA?
07: "There's no way you could get the doctor to call him casually and ask him to come in for a check-up?"
07: "Have you discussed the problem with your family doctor?"
"How about (some Carcb)?" Implies suggestion for future. Distinguish from "Have you ever tried ..." which is question about the past and therfore categ. 11.

08 PROCESS STATEMENT: Refers to something during the session, but not a command or suggestion. Often pertains to the role of the therapist or goal of therapy. Less "personal" than self-disclosure.

"So we won't talk more about it."
"Well maybe we can talk some other time."
"I'll stay with you and try to help."
"We can make a sick feeling good."
"I'm here to help you."
"Perhaps now would be a good time to express yourself."
"If you think you are going to kill yourself, I'll have you hospitalized, now."
"I wouldn't do that to you."
"I'm not trying to get all your secrets."

09 PROCESS REQUEST: Suggestions or orders for client to enact during therapy session, commands here and now or time-specified homework.

"Don't be sorry." (Resp. to II-13)
"Tell me more about how you feel."
or "I would like to know more."
"Be specific."
"Leave if you'd like."
"Don't get uptight."

"You're not going to leave my office."
"I want you to feel you can be open whenever you feel like it."
"Let's talk some about ..."

10 INTERROGATIVE PROCESS REQUEST: Would be process request except for question form.

"Can you do what I am asking you to do?"
"Can you describe the problem to me?"
"Could you tell me more about that?"
"Could you make a list of what you have done and leave Mom and me out of it?"
"Would you like to tell me?"
"Would it help you to list some of the things you think might happen?"

"Can you explain how you felt about it?"
"Would you be willing to keep track for the next week?"

QUESTIONS

11 INFORMATION SEEKING QUESTIONS: There and then, content rather than affect. Most why questions, fact questions, questions about others. Questions tangentially (rather than directly) about feelings.

"How do you feel the marriage was?" (not really a question about feeling)
"Like what is bothering you?" (Resp. to II-7)
"Have you talked opening to him about this?"
"What can you do as a person?"
"Why did you do that?"
"Can you remember when ...?"
"Was anything else bothering you?"
"Why are you here?"
"I'd like to know whether there are other alternatives."
"Why wouldn't you want to remain in Social Ecology?"
"When do you have this feeling?"
"Would you like to ...?"
"Have you ever had a close relationship with a man?"
"Do you talk to him about this?"
"Have you discussed this with him?"
"Are you getting along better?" (Referring to life outside therapy session)
"Have you let him know the way you feel?"
"I can't help wondering why you stayed with her."
"Have you ever tried being alone?"
"Do you have a list of jobs you'd like to do?"
"Have you tried any techniques to get in touch with yourself?"
"Have you ever tried to discuss this with him?"

12 HERE-NOW QUESTIONS: Refer to relationship, to ongoing process, to self at this moment or in current time frame

"Why do you think you feel this way?" (About feeling uncomfortable in the session)
"What could I do to help?"
"What do you want me to tell you? What do you want to hear?"
"Now what?"
"Would you like to reschedule the appointment?"
"What can I do to help?"
"What is your initial feeling about these?"
"How are you feeling right now?"

13 PSEUDO-FEELING QUESTIONS: Hypothetical feelings. Past or future feelings. Any request for feelings that doesn't fit Here-now questions described above. Must actually have a feeling word in the response booklet.

"How might you feel if ...?"
"Were you angry?"

DISCLOSURE

14 SELF-DISCLOSURE: Therapist expressing his or her own feeling, with emotional content. Almost any "I" statement except "I think that...". Statement is personal and may increase vulnerability of therapist.

"I can understand."
"Glad you came in"
"I'm afraid"
"That really makes me sad."
"I'm feeling very uncomfortable right now."
"I can empathize with you."
"I'm wondering what that feels like"
"Well that makes it difficult to know what I can do or say."
"I don't want to push you."
"I'm not clear."
"I'm interested in hearing what you have to say.

15 ME-TOO DISCLOSURE: Therapist expresses concerns, experiences, feelings, etc. similar to those of client.

"I had a problem like that once."
"I used to feel that way, too."
"I'd feel the same way in that situation."
"Me either."
"I'm afraid, too" (to II-3)

EVALUATION/FEEDBACK

16 POSITIVE-SUPPORT: Rewards, reassurances, pats on head. Not statements which minimize problem. Self-disclosure takes precedence over support (e.g., "I can understand").

"Good, at least you're clear about what you don't know." (Resp. to III-9)
"You're handling it fine."
"OK (score only if "OK" is the entire response; otherwise score rest of the response and do not score "OK" separately. Same for "mm hmm", etc.
"I feel (or think) you can do it."
"I agree."

17 NEGATIVE-CONFRONTATION: Put downs or take outs; sarcasm, contradictions or confrontations.

"You don't look like you're getting along." (This occurs after client says "I'm getting along fine.")
"That's not very clear."
"You'd confuse me too."
"I'm thrilled sick." (sarcasm)
"Was that necessary?"

"That was stupid."
"I must say that you are a lousy judge of yourself." (Resp. to III-8.)
"Who's living your life?"

(Note: Either SUPPORT or NEGATIVE could be in the form of a question.)

RESIDUAL CATEGORIES

18 NO RESPONSE: Page is blank or person writes "Silence". All others are 19.

19 UNSCOREABLE: Can't decide between two or more categories. Incomplete, fragmentary responses. Responses given in third person or narrative form, e.g.,

"I'd tell him to ..."
"I couldn't understand what was said."

INFORMATION

6 A INFORMATION GIVING RESPONSE: Attends to content rather than affect; giving explanations, facts. Answers that deal tangentially (rather than directly) about feelings.

" We don't allow dogs in the hospital..."

" That's what we are here for..."

" The reason it takes us so long..."

APPENDIX C

Gerrard Behavioral Rating Scales

Example

A patient says: "This pain just doesn't seem to go away. No matter what I try, it's still there. I just don't know what I'm going to do.

RATING SCALE FOR ACTIVE LISTENING (EMPATHY)

Rating	*General Description of Scale Position*	*Behavioral Description of Scale Position*	*Sample Health Professional Responses*
4.0	Very good response	Underlying feelings and content are accurately reflected.	"You're afraid because you think you might not get better and you don't know what to do to help yourself."
3.0	Good response	Surface feelings and content are accurately reflected.	"You're worried because you're sick so much."
2.0	Poor response	Content only is reflected.	"You think your illness isn't going to go away."
1.0	Very poor response	Neither feeling nor content is reflected.	"I'd like to take your blood pressure now. Roll up your sleeve please."
		Presence of subtractive element (a destructive response)	"Don't be silly. Of course you're going to get better."

Example

A health professional is meeting a female patient, age 43, for the first time.

RATING SCALE FOR WARMTH

Rating	*General Description of Scale Position*	*Behavioral Description of Scale Position*	*Sample Health Professional Responses*
4.0	Very good response	Very warm voice tone; relaxed posture; face, posture and behavior show marked interest and attentiveness; behavior and speech content show deep respect and consideration for the other person. Very friendly behavior.	The health professional smiles, walks over to the patient, warmly says, "Hello, Mrs. Jones, my name is Bill Smith," and shakes her hand. The health professional sits down, leans slightly toward the patient, maintains eye contact with the patient, and says, "What seems to be the problem?"
3.0	Good response	Warm voice tone; relaxed posture; face and posture show interest and attentiveness; behavior and speech content show respect and consideration for the other person. Friendly behavior.	The health professional walks over to the patient and says, "Hello, Mrs. Jones, my name is Bill Smith." The health professional sits down, leans slightly forward, and says, "What seems to be the problem?"
2.0	Poor response	Slightly cool voice tone; slightly tense posture; face and posture show indifference; behavior and speech content convey slight disinterest in the other person. Slightly unfriendly behavior.	The health professional walks over to the patient and says, "I'm Dr. Smith." The health professional sits down, avoids looking at the patient for several seconds while he shuffles through some papers. He looks up, a slightly bored expression on his face, and he says, "What seems to be the problem?"
1.0	Very poor response	Very cold voice tone; tense posture; face and posture show disinterest; behavior and speech content show disregard for the other person. Very unfriendly behavior.	The health professional walks over to the patient and, still standing, says, "What's your problem?" His arms are folded across his chest, his voice is cold, and he looks as though he is in a hurry.

Example

A patient says: "This pain just doesn't seem to go away. No matter what I try, it's still there. I just don't know what I'm going to do."

RATING SCALE FOR INITIATING

Rating	*General Description of Scale Position*	*Behavioral Description of Scale Position*	*Sample Health Professional Responses*
4.0	Very good response	Invites the other person to talk further.	"Where exactly are you hurting?"
3.0	Good response	Shows one of the following responses:	
		a) Offers alternative solution.	
		b) Initiates appropriate physical action.	"I want to check your blood pressure. Roll up your sleeve please."
2.0	Poor response	Gives appropriate information only.	"Once we find out what kind of pain you're having, then we'll be able to help you."
1.0	Very poor response	A very inappropriate initiating response, or the complete absence of an initiating response.	"I can't help you—I'm just a student."

Example

A male patient, age 63, says, "Since my heart attack my wife has been treating me like a baby. She does everything for me—even things I can do myself. But I must say, the pain is gone and I rarely need the nitroglycerine tablets."

RATING SCALE FOR INITIATING (Continued)

Rating	*General Description of Scale Position*	*Behavioral Description of Scale Position*	*Sample Health Professional Responses*
4.0	Very good response	Invites the other person to talk further.	"You sound pretty upset about the way your wife's been treating you. Could we talk about this a bit more?"
3.0	Good response	Shows one of the following responses:	
		a) Offers alternative solution.	"Perhaps you could bring your wife in on your next visit, and we'll reassure her and talk to her about the importance of letting you be more independent."
		b) Initiates appropriate physical action.	
2.0	Poor response	Gives appropriate information.	"Your wife is acting the way many wives do when their husbands have heart attacks. She's probably afraid that if you exert yourself, you'll have another heart attack."
1.0	Very poor response	A very inappropriate initiating response, or the complete absence of an initiating response.	"I'm glad to hear the pain is gone."

APPENDIX D

Carkhuff Measure for Assessing Interpersonal Skills

SCALE 1
EMPATHIC UNDERSTANDING IN INTERPERSONAL PROCESSES: A SCALE FOR MEASUREMENT[1]

Level 1

The verbal and behavioral expressions of the first person either *do not attend to* or *detract significantly* from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.

EXAMPLES: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

In summary, the first person does everything but express that he is listening, understanding, or being sensitive to even the feelings of the other person in such a way as to detract significantly from the communications of the second person.

Level 2

While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he *subtracts noticeable affect from the communications* of the second person.

EXAMPLES: The first person may communicate some awareness of obvious surface feelings of the second person, but his communications drain off a level of the affect and distort the level of meaning. The first person may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the second person.

In summary, the first person tends to respond to other than what the second person is expressing or indicating.

Level 3

The expressions of the first person in response to the expressed feelings of the second person(s) are essentially *interchangeable* with those of the second person in that they express essentially the same affect and meaning.

EXAMPLE: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

In summary, the first person is responding so as to neither subtract from nor add to the expressions of the second person; but he does not respond accurately to how that person really feels beneath the surface feelings. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.

EXAMPLE: The facilitator communicates his understanding of the expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings he was unable to express previously.

In summary, the facilitator's responses add deeper feeling and meaning to the expressions of the second person.

Level 5

The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (1) accurately express feelings levels below what the person himself was able to express or (2) in the event of on going deep self-exploration on the second person's part, to be fully with him in his deepest moments.

EXAMPLES: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wave length. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

In summary, the facilitator is responding with a full awareness of who the other person is and a comprehensive and accurate empathic understanding of his deepest feelings.

SCALE 2
THE COMMUNICATION OF RESPECT IN INTERPERSONAL PROCESSES: A SCALE FOR MEASUREMENT [2]

Level 1

The verbal and behavioral expressions of the first person communicate a clear lack of respect (or negative regard) for the second person(s).

EXAMPLE: The first person communicates to the second person that the second person's feelings and experiences are not worthy of consideration or that the second person is not capable of acting constructively. The first person may become the sole focus of evaluation.

In summary, in many ways the first person communicates a total lack of respect for the feelings, experiences, and potentials of the second person.

Level 2

The first person responds to the second person in such a way as to communicate little respect for the feelings, experiences, and potentials of the second person.

EXAMPLE: The first person may respond mechanically or passively or ignore many of the feelings of the second person.

In summary, in many ways the first person displays a lack of respect or concern for the second person's feelings, experiences, and potentials.

Level 3

The first person communicates a positive respect and concern for the second person's feelings, experiences, and potentials.

EXAMPLE: The first person communicates respect and concern for the second person's ability to express himself and to deal constructively with his life situation.

In summary, in many ways the first person communicates that who the second person is and what he does matter to the first person. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The facilitator clearly communicates a very deep respect and concern for the second person.

EXAMPLE: The facilitator's responses enables the second person to feel free to be himself and to experience being valued as an individual.

In summary, the facilitator communicates a very deep caring for the feelings, experiences, and potentials of the second person.

Level 5

The facilitator communicates the very deepest respect for the second person's worth as a person and his potentials as a free individual.

EXAMPLE: The facilitator cares very deeply for the human potentials of the second person.

In summary, the facilitator is committed to the value of the other person as a human being.

VITA

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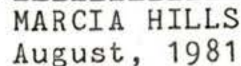
Author: 

MARCIA HILLS
August, 1981