

ABSTRACT

Rachel K. Edwards. PERCEPTIONS OF HEAD NURSES REGARDING COMMUNICATION BEHAVIORS NEEDED BY NURSES. (Under the direction of Dr. Bonnie Duldtt) School of Nursing, April, 1988.

This survey was designed to determine the perceptions of head nurses regarding interpersonal communication behaviors. The following three research questions were addressed: 1) What are the specific communication behaviors most necessary for nurses? 2) How often is the use of ineffective communication behaviors noted by nurses? and 3) When nurses use ineffective communication behaviors, how detrimental is it to their performance? Using a descriptive survey design, a sample (N=50) of head nurses from five eastern North Carolina hospitals was asked to respond to the Communication Behaviors Questionnaire. Duldtt's humanistic nursing communication theory provided the theoretical framework for the study.

Findings were that 1) effective communication behaviors are perceived as very important to the nurse's performance; 2) negative communication behaviors are perceived to be quite detrimental to nurses; 3) negative communication behaviors are not used very often by nurses; and 4) listening is the communication behavior most necessary for nurses to have and most detrimental when not effectively demonstrated. Findings supported Duldtt's theory of humanistic nursing communication

as a potentially useful framework for practice, education and research.

PERCEPTIONS OF HEAD NURSES REGARDING
COMMUNICATION BEHAVIORS NEEDED BY NURSES

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CHAPTER 1

INTRODUCTION

Man's greatest need is the need to "overcome his separateness, to leave the prison of his aloneness" (Fromm, 1956, p. 9). This need is sometimes a difficult one to fulfill. It requires not just someone to talk to, as in monologue, but someone who will listen and participate in dialogue.

Individuals relate to each other through communication, a process which can be observed and experienced. Phenomena such as feeling and thinking can only be inferred. Watzlawick, Beavin and Jackson (1967) believe that all behavior in an interactional situation is communicative, and that "no matter how one may try, one cannot not communicate" (Watzlawick, et al., 1967, p. 45). In order to analyze the interpersonal relationship, communication patterns in the here and now must be observed directly. These patterns maintain and signify the relationship (Watzlawick, et al., 1967).

Nurses must listen to and process a vast amount of information every day in the workplace. Interpersonal data, attitudes, compliance cues and personal histories are often communicated to the nurse who is typically perceived as an empathic listener by the patient. The nurse needs to be

able to use specific communication skills in order to deal with this abundance of information flowing from the patient. At the same time there is a constant barrage of organizational communication including interactions with peers, physicians, supervisors, and other members of the health-care system. (Fritz, Russel, Wilcox & Shirk, 1984). The nurse needs to develop not only the technical skills needed to administer physical care to patients, but also the communication behaviors necessary for managing all aspects of nursing.

Effectively teaching communication skills to nursing students has long been a concern of nurse educators. Interpersonal communication is a key element in establishing and maintaining effective nurse-client relationships as well as relationships with peers and other members of the health-care system. According to Fritz, et al. (1974), there are several advantages to enhancing the interpersonal communication skills of nurses: 1) trust is generated on the part of the patient in the nurse's skills; 2) legal suits related to negligence tend to be prevented; and 3) job satisfaction of nurses tends to increase.

Purpose

This survey was designed to determine the perceptions of head nurses regarding interpersonal communication behaviors of nurses.

Rationale/Significance

Major changes are occurring in the health-care system both in technology and in the increased expectations of nurses and consumers. Concurrent with increasing costs and high technology, there has been a trend toward dehumanization of people as reflected in the literature on communication within the healthcare system (Pincus, 1986; Bradley & Edinberg, 1982; and Seybolt, 1986). Nurses report experiencing job dissatisfaction and burnout, which have led to high job turnover and increased rates of inactivity. Pincus (1986) found that communication is a key contributor to nurses' job satisfaction and job performance. Dehumanizing communication among nurses and other health-care providers is often cited as a reason for job dissatisfaction, and it may be one reason for the current nursing shortage. Moccia (1987) suggests that nurses need to work to change the healthcare system to one that respects the integrity and worth of individuals. She believes this change will help alleviate the nursing shortage (Moccia, 1987).

One explanation for this downward spiral is the tendency for members of the health-care system to interact in a dehumanizing manner, both among themselves and with clients. Duldt, et al. (1984) believe that this trend can be counteracted by effective interpersonal communication.

They contend that health-care educators need to make a concerted effort to promote humanistic relationships. According to Stewart and D'Angelo (1975) effective interpersonal communication is a key element in humanizing relationships. A humanistic philosophical perspective of nursing is particularly relevant to the contemporary health-care system in this country. The emphasis on the potentially dehumanizing business concepts of cost-effectiveness and efficiency presents a sharp contrast.

Generally the role of interpersonal communication skills as a crucial element in nursing has been documented in the literature (Faulkner, 1981; Means, 1986; Weiss, 1984; Sundeen, Stuart, Rankin & Cohen, 1981; Kasch, 1986; and Norris, 1986). However, excluding the psychiatric nursing area, the specific skills needed by nurses remain comparatively ill-defined. In order for nursing faculty to prepare students for a successful nursing career, it is important to know what skills to teach and to consider those skills deemed necessary by practitioners. Faculty have the responsibility of developing, presenting, and evaluating courses in nursing communication. If nursing education is consistent with behavioral expectations in practice, then educational preparation will tend to be realistic and effective for successful practice.

Communication by nurses is unique in many respects. It involves therapeutic, professional and social interaction

with clients as well as peers and other members of the health-care system. Hein (1980) notes that therapeutic communication was not generally recognized as a vital component of nursing until recently. Thirty years ago talking to patients was "something nurses did to fill in the silence while they were bathing patients--nothing more" (Hein, 1980, p. 11). Now communication is viewed as a means of fulfilling the varied roles and functions of nursing. As Hein (1980) states,

Every communicative act initiated in the presence of a patient has an impact on him. The effect of our communication style... is now a part of our learning we cannot afford to waste. The consistent efforts made in the use of these skills demonstrate to patients that their welfare is our primary concern. (p. 12)

Communication, in the context of the nurse-client interpersonal relationship, has been defined both as a means of information transfer, and as a fundamental dimension of the relationship. Sundeen et al. (1981) contend that communication is the relationship and not just the behavioral manifestation of the abstract concept of "relationship". The nurse-client relationship is the crux of nursing according to several nursing communication theorists (Peplau, 1952; Travelbee, 1971; Patterson & Zderad, 1976; and Duldt, Giffin & Patton, 1984). Since

effective interpersonal communication is such a critical element in the nurse/client relationship, the identification of essential communication behaviors assumes a high level of significance in nursing education and practice.

The topic of assertiveness as a mode of communication for nurses has been emphasized in recent years (McCue, 1982; Donner & Goering, 1982; Chenevert, 1978; Weiss, 1984). Weiss proposed a model to facilitate more progressive attitudes and more autonomous, responsible behavior by nurses. The five major areas of content needing to be addressed in this role transformation all contained a communication component. The five areas were: 1) defining and articulating the nursing domain, 2) legitimizing the nursing profession, 3) communicating in professional rather than non-professional modes, 4) negotiating collaborative roles, and 5) cultivating the organizational network (Weiss, 1984). Although assertive behaviors are necessary in order to transform nursing roles, there has also been a trend toward a lack of concern for people as human beings. Thus, dehumanization has led to job dissatisfaction, high job turnover and increased rates of job inactivity (Duldt, et al., 1984).

The physical and social work environment has long been a source of stress for nurses. There is a correlation between job satisfaction and the quality of communication with supervisors and coworkers. Decker (1985) found that

positive work relationships with head nurses and coworkers increased job satisfaction and decreased staff nurses' propensity to leave the hospital. Similarly, Mossholder, Bederian and Armenakis (1982) found that peer group interaction decreased job tension and propensity to leave the hospital among nursing employees. Norbeck (1985) found social support to be associated with lower levels of stress, dissatisfaction and psychological symptoms among female critical care unit nurses.

While there is agreement about the importance of the communication process in nursing, there is less certainty about the best way to teach this concept to nursing students. Friedrich, Lively and Schacht (1985) point out that communication skills still tend to be taught in a piecemeal fashion, even though studies by numerous authorities indicate the effectiveness of using a systematic approach in teaching these skills (Farrall, Haley & Magnasco, 1977; Layton, 1979; Friedrich, Scandrett & Turock, 1979; and Norris, 1986).

The National League for Nursing (NLN) provides criteria for evaluating nursing programs. For baccalaureate programs, some of the roles of the graduate, as a nurse generalist, include serving as client advocate, collaborating with other health team members, and providing health counseling and education for clients. In addition the graduate must be able to use the nursing process in

providing nursing care, and employ leadership skills to enhance the quality of nursing and health practices (NLN, 1987). These characteristics are directly related to effective interpersonal communication. If baccalaureate nursing programs are to maintain NLN accreditation, then the teaching of effective interpersonal communication skills becomes crucial.

The nursing education literature offers ample information about various methods and techniques for teaching communication skills. These include audiotaping and analyzing interactions between students and clients (Browning and Campbell, 1987); using simulation games (Eakes and Finnen, 1985); and using videotapes and roleplay (Menikheim and Ryden, 1985). There are, however, few studies which focus on communication skills in specific as opposed to general terms.

Based on the roles, experiences and internal processes of nursing faculty and practicing nurses, it is possible that differences may exist in their perceptions of necessary communication skills. One study explored specific communication skills needed by practicing nurses according to directors of nursing in order to determine the oral communication skills necessary for success in nursing, and those most in need of improvement (Willmington, 1986). One implication of this study is that nursing educators need to evaluate course objectives and time spent developing various

skills according to their need to be taught more effectively (Willmington, 1986). Although this study generated some new information, it is apparent that many nursing directors have little direct contact with nurse/client interactions. Head nurses, on the other hand, generally have a high degree of contact with nurses and clients, and a unique vantage point for frequent observation of nurse/client interactions. The perceptions of head nurses about specific communication skills deemed necessary for practicing nursing would tend to be a more reliable indicator of what is needed.

Research Questions

Based on this reasoning, this researcher surveyed head nurses regarding their perceptions about the following three research questions: 1) What are the specific communication behaviors most necessary for nurses? 2) How often is the use of ineffective communication behaviors noted by nurses? and 3) When nurses use ineffective communication behaviors, how detrimental is it to their performance?

Assumptions

For the purposes of this study, the following assumptions were made:

1. Effective communication behaviors are essential for nurses' relationships with patients, peers, superiors and other members of the health-care system.
2. Communication behaviors are observable and identifiable.
3. Head nurses are able to identify specific communication behaviors.
4. The time and setting in which the questionnaires are completed will not affect the responses.

Definition of Terms

The following terms are defined for the purposes of this study:

1. Interpersonal communication - a dynamic process involving continued adaptation and adjustment between two or more human beings engaged in face-to-face interactions during which each person is continually aware of the other(s) (Duldt, et al., 1984).
2. Communication behavior - The verbal and non-verbal skills involved in the exchanging of messages between human beings. It includes both attitudes and interaction pattern as defined in Duldt's theory (Duldt & Giffin, 1985).
3. Head nurse - A nurse manager currently employed by a hospital who is administratively accountable for nursing services of a given clinical unit.

Limitations

1. Nurses' perception of the communication behaviors needed for success in nursing may be biased by their own education and clinical practice.
2. The convenience sample of nurses may not be representative of the general population of head nurses.

Summary

Effective interpersonal communication behaviors are crucial for nurses, not only in terms of the nurse/client relationship, but also in terms of the nurse's relationships with peers and other members of the health-care system. This concept is of major significance to nursing. According to the literature, it is taught in a piecemeal fashion in most schools of nursing, often with teaching strategies which seem quite effective. However, few studies focus on communication skills in specific terms, or include the perspective of the workplace as well as the school of nursing. This study focused on specific communication behavior of nurses working in hospitals as perceived by head nurses.

CHAPTER 2

REVIEW OF LITERATURE

The significance of interpersonal communication within the nurse-client relationship is presented first, followed by a discussion of the importance of effective communication with peers and other members of the health-care system. Next there is a review of the models, methods and strategies used for developing communication behaviors. The literature in which specific communication behaviors are perceived as necessary and important for nurses is then explored. Finally, the instrument used for this study is presented, followed by the theoretical framework.

Significance of Interpersonal Communication Within the Nurse-Client Relationship

Theorists

Peplau (1952) was one of the first nurses to develop a theory based on the nurse-patient relationship. While Peplau's theory was intended for the psychiatric setting, it is applicable to all nurse-client relationships. The steps emphasized by Peplau include observing behavior, describing and analyzing the behavior with the client, formulating the connections, testing, and integrating new behavior. The

importance of the nurse assessing her own interpersonal behavior as it affects the therapeutic relationship is also described by Peplau. Communication, as defined by Peplau, is the expression, by both verbal and nonverbal means, of the thoughts and feelings experienced by the interacting parties. The literature shows that little has changed in beliefs about nurse-client communication since 1952.

Subsequent nursing communication theorists tend to support Peplau in the belief that the nurse-client relationship is crucially significant to nursing (Travelbee, 1971; Patterson and Zderad, 1976; and Duldt, Giffin and Patton, 1984).

Travelbee (1971, p. 93) states that communication is "a process which can enable the nurse to establish a human-to-human relationship and thereby fulfill the purpose of nursing, namely, to assist individuals and families to prevent and to cope with the experience of illness and suffering and, if necessary, to assist them to find meaning in these experiences". She further explains that communication is a reciprocal process in which the nurse elicits as well as gives information. It is through communication that the nurse conveys the extent to which she cares for the client, and the client conveys the extent to which he views the nurse as a helping person. The goals of the interpersonal interaction in nursing are: 1) to know persons, 2) to ascertain and meet the nursing needs of clients, and 3) to fulfill the purpose of nursing (Travelbee, 1971).

Patterson and Zderad (1976) suggest three concepts that provide the basis of nursing. These concepts are dialogue, community, and phenomenologic nursing. These theorists believe that nursing is a lived dialogue, an intersubjective experience in which there is real sharing. Community refers to two or more people striving together in a unique way. Humanistic nursing leads to community. It is through the sharing of meaning and community that human beings are comforted and nurtured. Phenomenologic nursing is the methodology of nursing. There are five phases in this phenomenologic approach: 1) preparation of the nurse knower for coming to know, 2) nurse knowing the other intuitively, 3) nurse knowing the other scientifically, 4) nurse complementarily synthesizing known others, and 5) succession within the nurse from the many to the paradoxical one.

Duldt and Giffin (1985) believe that the nurse can provide a positive influence upon the attitudes and beliefs of clients by communicating in a humanistic manner. Duldt's theory of humanistic nursing communication explains that humanistic nursing interventions are implemented by communicating and relating to the client in a manner which leads him to sense warmth and acceptance. The concept of humanism interacts with that of nursing through the phenomenon of interpersonal communication in which individual worth is validated (Duldt and Giffin, 1985).

This theory specifically describes communication "interaction patterns" or behaviors. It provides a continuum of humanizing and dehumanizing attitudes which characterize one's messages. It offers a useful framework for teaching communication skills.

Effect on clients' health

Nursing research has shown that communication influences clients' recovery. It can be a means of improving recovery rates and the well-being of patients (Haywood, 1975, Boore, 1978, and Faulkner, 1981). Faulkner (1981) discussed the crucial role of communication as it relates to the nursing process, particularly the assessment process. In supporting the adoption of the nursing process, Faulkner points out that while assessment does take time, in the long run it saves time. She bases this position on patients' prolonged stays in hospitals caused by poor communication, undiagnosed stress, and the inability to cope at home due to unmet health educational needs. She believes that good communication can reduce the length of hospital stay for some patients.

According to Fritz, et al. (1984), effective implementation of the nursing care plan depends upon the development of trust through interpersonal communication. All nursing behaviors influence trust development. Patients may use a variety of defensive communication mechanisms in

order to reduce the threat of uncertainty in an unknown, frightening environment. Fear of the disease and its treatment is the first barrier to effective healing. By gaining the patient's trust, the nurse can help overcome this barrier. Fritz proposes that an effective repertoire of communication skills will tend to increase client trust in nursing skills, which leads to increased nursing effectiveness in client-care management. Unless effectively communicated to the client, even the most sophisticated scientific techniques may fail. (Fritz, et al., (1984)). Thus, communication exerts a crucial effect upon the client's recovery.

Boyd (1986) studied the relationship between nursing behavior and patient trust utilizing a sample of patients in a rehabilitation center. Four specific nursing behaviors reported to increase patients' trust of nurses were: 1) explaining what they were going to do and why; 2) asking patients about their feelings; 3) giving patients time to answer questions; and 4) involving patients in the decision process about what is to be done. All of these behaviors can be perceived as humanizing communication behaviors.

Eberhardt (1987) used a modified version of The Patient Trust and Nursing Behavior Tool developed by Boyd (1986) to identify behaviors that fostered trust of the nurse by caregivers of Hospice patients. His findings supported those of Boyd. Eberhardt suggests that clients'

trust of nurses depends upon empathy, degree of involvement, authenticity of feelings conveyed, and perceptions of who is in control.

Client education is yet another aspect of nursing which interfaces with communication and with client recovery. Means (1986), a health educator, contends that the most important skill needed in the field of health care is that of communication. Means describes communication as a process of sharing in which "one person transmits verbal and non-verbal symbols to others" (Means, 1986, p. 52). His article includes a discussion of how the health educator communicates, with whom he competes for attention, the use of verbal and visual symbols, and a description of some of the problems he encounters.

Hein (1980) noted that therapeutic nurse-client communication was not recognized as a vital component of nursing until recently. This statement is supported by the nursing literature written prior to the 1970's. A study by Reissman and Rohrer (1957) revealed that although nurses indicated a desire to spend less time on administrative tasks and more time with patients, when given the time, they did not spend it with patients. Instead they spent the time on various administrative duties and activities not involving direct patient contact. In an investigation of the relative importance to nurses of several aspects of patient care, Whiting (1958) reported that nurses indicated

a desire to listen to patients' feelings and concerns, but that they placed priority on the physical and technical aspects of patient care due to their appraisal of the personnel shortage.

Empathy

According to Lane & Lane (1982), empathic responses are basic to all communicative processes and are the essential element in the interpersonal process. Some of the earliest nursing literature used the word "empathy" to characterize nurses' interaction with patients, but it was rarely mentioned again for many years. Empathy has recently become an established concept in the nursing literature. It is also one of the humanizing attitudes linked in Duldt's theory (Duldt & Giffin, 1985). Empathy is defined as "a process whereby one individual (a helper) comes to understand the feelings and expressions of another in the here and now of a face-to-face encounter and successfully communicates this understanding to that individual" (Stetler, 1977, p. 432). Stetler explains that unless the helper successfully communicates to the patient an understanding of these intrapsychic internalizations, there is very little value in the helper's internal knowledge of the patient's feelings.

Carkhuff (1969) believes that the "helper" must communicate acceptance as well as understanding to the "helpee." His "helpers" include physicians, nurses, psychologists, social workers and laymen. The helper's communication of empathy is facilitated through verbal and nonverbal behavior. Empathic behaviors include responsive listening and interchangeable communication behaviors. Responsive listening refers to hearing and understanding the expressions of the client and initiating a helpful response. Interchangeable communication behaviors may be defined as the helper's expression of essentially the same affect, meaning, feeling and content that the helpee is communicating (Carkhuff, 1969). Carkhuff's perspective is broad enough to apply to helping efforts in any human relations problem, and it is specific for the psychiatric client or any person seeking help with emotional problems.

Not only psychiatric patients, but all patients benefit in terms of well-being and satisfaction from effective interpersonal communication. Wallston, Cohen, Wallston, Smith and DeVellis (1978) note that one of the most important aspects of the nurse's role is counseling patients regardless of their diagnosis. In a two-phased study, they examined the responses of medical-surgical nurses to ascertain the degree of person-centeredness in their responses to simulated, audiotaped patient disclosures. Person-centeredness may be considered a

component of empathy. The nurses were instructed to respond "in as helpful a manner as possible" to the 24 statements (Wallston, et al. 1978, p. 156). Nurses in sample one (N = 24) received no intervention between phases, while nurses in sample two (N = 20) listened to a brief message concerning the elements of a helpful response between the two phases. The nurses who received the intervention showed significant improvement in their degree of person-centeredness. From phase I of this study, nurses were judged to be performing somewhere between a level "0" ("Does not elicit information, but gives information") and a level "+ 1" ("Elicits information, but limits patient response"). While few responses were actually therapeutic blocks, there was much room for improvement (Wallston, et al., 1978).

Several studies have revealed that nurses often lack effective interpersonal skills. Matthews (1962) found that two-thirds of the 122 nurses studied did not respond positively to statements related to person-centeredness. Later, in a study of nurses who worked in both acute and chronic care settings, LaMonica, Carew, Winder, Hasse and Blanchard (1976) measured empathic levels using Carkhuff's (1969) Index of Communication Scale as a pre- and post-test. Two judges rated the nurses' responses to items on the scale using Carkhuff's Empathy Scale. Results indicated that these nurses had extremely low levels of empathy. Forsyth (1979) found that when nurses rated themselves using the

Hogan Empathy Scale, only 50% scored high in empathic level.

There is evidence that low empathy levels and a lack of interpersonal communication skills leads to negative patient outcomes. In Graffam's (1970) study of nurse-patient interactions, nurses who interacted with distressed patients blocked communication by changing the subject or failing to assess the situation accurately. The nurse left the patient's room immediately when the patient responded in an emotionally charged manner. Thereby the patient's needs were not met.

Organizational Communication of Nurses

As nursing strives for professional status, it is becoming increasingly important that nurses communicate effectively not only with clients, but also with other nurses, other professionals and various members of the health-care system. The quality of the nurse's communication in this area has a significant impact on the degree of job satisfaction, professional achievement, client-care management, and ultimately, the professional status of nursing. Therefore, it is important that nurses also develop the skills necessary for communicating effectively with other nurses and within the health-care system. Communication between nurses will be presented first, followed by interprofessional communication.

Communication among nurses

Although there are many roles, functions and levels of educational preparation in nursing, nurses are often stereotyped or perceived as being identical (Bradley & Edinberg, 1982). Role relationships and communication between nurses with a diverse array of backgrounds, roles and capabilities are often a source of conflict for nurses. These conflicts contribute to major problems such as reality shock, burnout, absenteeism, and job turnover (Duldt, et al., 1984, Mossholder, et al., 1982, Decker, 1985).

A basic communication principle to be considered in analyzing dyads and roles is that "all communication relationships are either symmetrical or complementary, depending on whether they are based on equality or inequality" (Watzlawick, 1967, p. 70). In symmetrical relationships the partners tend to mirror each other's behavior, whereas in the complementary relationships one partner assumes a dominant attitude. There are situations in which both types of patterns are necessary, and neither is necessarily "bad" or unhealthy (Watzlawick, 1967).

Duldt defines attitude as a "mental position toward a person, fact or state; it is our demeanor or predilection toward something" (Duldt & Giffin, 1985, p. 214). According to her study, an attitude can be either humanizing or dehumanizing in nature. These two attitudes occur on a

continuum which contains 14 sets of polarized communication elements (see Appendix A). Equality and degradation comprise one set of elements. Equality refers to an awareness of the commonly shared uniqueness of being human regardless of the role, symbol or status of one member of a dyad. Degradation, on the dehumanizing end of the continuum, is a "process of depriving another of due rank, honor and status" (Duldt, et al., 1984, p. 265). In order for a communication relationship to be effective and healthy, regardless of whether it is symmetrical or complementary, it needs to involve an attitude of humanism.

Communication conflicts often arise when patterns of symmetry and complementarity are used in unhealthy ways. For example, professionals who perceive themselves as being in a superior or "one-up" position may use defensive behaviors such as blaming. Health professionals who perceive themselves as "one-down" may use defensive behavior such as placating. Conflict can also arise when the interacting parties do not agree as to who is subordinate, superior, or equal to whom (Bradley & Edinberg, 1982). Leary (1955) suggests that dominant behavior in a relationship tends to produce submissive responses and vice versa. If one person is resistant, the relationship may terminate, or a power struggle may ensue. Power struggles often lead to manipulative games or strategies.

Research reveals that nurses frequently experience alienation and anger as a part of their clinical practice. In a survey of 330 registered nurses employed in hospitals, Grant and Giffin (1978) found that three-fourths of the nurses received angry messages during the five days prior to completing the questionnaire, and about one-third of these received three or more such messages. The major portion (40 percent) of the angry messages came from other members of the nursing department with about 20 percent coming from physicians. The remainder came from patients, visitors, and other hospital employees. Receiving angry messages was a serious concern for the nurses. Criticism of task performance was the issue identified as the most common topic (40 percent) for stimulating angry messages. Nurses tended to feel neutral or cold and distant, (alienated) toward the angry person. This alienation was associated with increased turnover rates in the hospitals where these nurses were employed (Grant & Giffin, 1978). This study lends support to the position that coping with anger and alienation represents a portion of avoidable job turnover of nurses. Duldt, et al. (1984) believe that the problem of alienation deserves special consideration, because so many health-care providers appear to have negative attitudes toward others in their immediate environment. They also note that communication behaviors which have been found to be related to social alienation include communication denial

(which implies a denial of the other person's existence), double-bind communication patterns, and anger.

According to Bradley and Edinberg (1982) communication between nurses involves both a personal role identity and a professional role identity. Too strong an affiliation in either of the two role identities can result in communication conflicts. Nurses are expected to "act in a professional manner, giving the impression at all times that they know what they are doing." Yet, nurses need to be personally sensitive and attending to the needs of clients. It is sometimes difficult to attain a balance between personal and professional role identities (Bradley & Edinberg, 1982, p. 190).

One study shows that supervisors of nurses are seldom aware of the communication skills required in working with other nurses. Bradley and Edinberg (1982) surveyed a group of graduate nurses asking them to describe situations which were sources of communication problems between nurses. The situations described were primarily those in which there was a lack of respect and reciprocity in relation to the nurse's work role. For example, the nursing supervisor may ask the staff nurse to work overtime because there is no one else available, even though plans have been made for that particular day off. Interpersonal communication of nurses in leadership positions often seems to be less than desirable.

Nurses need to become aware of methods for dealing with the stress and conflict inherent in the nurse's role. Winstead-Fry (1977) points out that in order to actively deal with stress, the nurse must first identify the signs of stress, and then locate the sources of stress. Having done this the nurse can learn to adjust his or her behavior through utilizing exercises or relaxation techniques or by increasing a sense of "nursing self."

Bradley and Edinberg (1982) point out that, in dealing with conflicts, some nurses use defensive communication patterns, which waste a great deal of time and energy. They perceive a threat and react by concentrating on the impact of their behavior on others instead of listening to others. Bradley and Edinberg (1982) advocate anticipating these defensive behaviors. The conflict can then be depersonalized by recognizing that the attack is not directed toward one's self-worth.

Haw (1980) argues that open communication and extended dialogue can be destructive, while bargaining and compromise can be successful in resolving conflict. She believes that the problem-solving approach can be effective when the conflict is a result of perceived (as opposed to real) incompatibility of goals, but that it is usually ineffective and can lead to deterioration in relationships when there is an actual incompatibility. Instead of moving toward agreement as dialogue continues, the group members become

more firmly entrenched in their positions. The alternatives suggested involve acknowledgement of the incompatibility, bargaining and compromise.

Gordon (1982) in a presentation of some generalizations about nursing home employees, proposes that one of the factors which motivates these employees is the opportunity to develop warm, supportive relationships with fellow employees. They tend to enjoy group-centered work activities, teamwork, and interdependence. In the homes which have stable work groups and assignments, there is a sense of serenity and camaraderie. This article was written for the purpose of assisting employers and managers in nursing homes to develop a motivating environment and thereby reduce staff turnover. Many of the generalizations made have application for nurses working in hospitals. This article underscores the importance of interpersonal relationships in the workplace. Seybolt's (1986) model of work-role design, which was used to study premature employee turnover, supports the stance that the kinds of interactions occurring on the job are an important factor in job satisfaction and stability.

Interprofessional Communication

Nurses interact professionally with a wide range of other members of the health-care system including aides,

clerks, pharmacists, physicians, psychologists, social workers, and various technicians and allied health personnel. Bradley and Edinberg (1982) maintain that nursing has grown to the point of having identified its professional boundaries and is now beginning to communicate with other disciplines. They believe that mutual trust and reciprocity are beginning to replace the defensiveness that has existed between the medical and nursing professions. While there is some agreement that interprofessional relationships are improving, some authors point out the need for more positive changes, particularly in the area of nurse-physician relationships. Weiss (1984), in proposing a model to facilitate more positive attitudes and more autonomous, responsible behavior by nurses, lists five major areas which need to be addressed. One of these is communicating in professional rather than non-professional modes. She notes that nurses need to learn to assess their own modes of communication and use those modes which lead others to see them as authoritative professionals. She contends that the nurse's credibility has been diminished in the eyes of the medical world due to suggestions based on personal feelings or intuition. She suggests that recommendations need to be substantiated with detailed rationale and factual data. She also suggests that nurses avoid conveying any quality of subservience when relating to physicians and administrators, and that nurses increase the

frequency of their contributions to patient care decisions. Weiss believes that nursing needs to be accorded a more dominant status within the health-care system, and that one way to claim more influence is through effective, professional modes of communication.

Some studies have demonstrated that when doctors and nurses share a common view of their roles, communication is effective (Sutterly & Donnelly, 1973; Wesson, 1972; and Bradley & Edinberg, 1982). It is when nurses perceive themselves as independent and physicians perceive nurses as dependent that communication blocks occur (Sutterly & Donnelly, 1973). In many instances, however, nurses as a professional group have a poor self-image and do not perceive of themselves as independent, nor as having reciprocal relationships with physicians. Many nurses see the physician as the decision-maker who is in a "one-up" position. A study by Wesson (1972) demonstrated that while physicians initiated and directed 23 percent of their communication to nurses, nurses initiated and directed only 9 percent of their messages to the physician. This is consistent with communication research reporting that persons of higher rank initiate interaction toward persons in lower rank more often than vice versa. (Watzlawick, et al., 1967; Satir, 1972).

Even when no personal hostility or defensiveness exists, there tend to be misunderstandings between

professions based on differences in the discipline's approach to clients. Use of communication skills such as summarizing, focusing, and asking for clarification may be helpful in handling interprofessional misunderstandings. When these misunderstandings become emotionally charged issues, however, it is important for the nurse to use active listening, self-disclosure, "I" statements, reflection and paraphrasing. According to Bradley and Edinberg (1982), the purpose of using these skills is to help the nurse "create symmetry in the relationship and model a willingness to share and be sensitive to the emotional needs of other professionals" (Bradley & Edinberg, 1982, p. 179).

Traditionally, nurses were taught to be passive and submissive in their relationships with physicians and other co-workers. Nonassertive behavior was associated with feminine traits, and nursing was composed primarily of women. In the late 1960's assertiveness training was introduced, initially as a tool for passive psychiatric patients. Women's groups began to adopt assertiveness as a way of coping with feelings of inadequacy and inferiority. Most nursing schools have since included some component of assertiveness in their curriculum (Hutchings & Colburn, 1979).

Assertive behavior is defined as that type of interpersonal behavior that enables individuals to act in their own best interest, to stand up for themselves without

anxiety, and to exercise their rights without denying those of others (Alberti and Emmons, 1974). It also involves taking responsibility for those actions. Duldt & Giffin (1985) define assertiveness as "expressing one's needs, thoughts, feelings or beliefs in a direct, honest, confident manner while being respectful of others' thoughts, feelings or beliefs." (Duldt & Giffin, 1985, p. 216). These authors point out that assertive behavior is a choice, and that it can be done in a humanistic manner.

As part of a presentation entitled "The Growth and Development of Nurses," Donner and Goering (1982) engaged in dialogue with the audience of nurses. Many of them identified situations in which they felt helpless, powerless, or discouraged. They felt alone with regard to these problems. These authors have since conducted workshops and classes on assertiveness for nurses. They describe their experiences with these workshops and encourage others to provide similar opportunities for nurses (Donner & Goering, 1982).

Duldt, et al. (1984) discuss verbal abuse as a special communication problem encountered by nurses, particularly within the nurse-physician relationship. They too believe that nurses must assert themselves. It is often the nurses' perception of their role that prevents them from being assertive. They may feel isolated and see only limited options. Whenever a physician becomes verbally abusive, the

nurse is often made aware of her subordinate role and the political power of the physician to have her fired if she retaliates. It is the covert, subtle expression of hostility and sexist values that keeps women, including nurses, subordinate to men according to these authors. They maintain that communication between the two professions will tend to be closed to the degree to which professional men (physicians) tend to so alienate professional women (nurses). Some of the potential barriers to communication in nursing according to Duldt, et al. (1984) are social alienation, sex-role problems, interpersonal distrust and prejudicial gaps between groups and between cultures.

Alvin Toffler (1979) has made some relevant predictions about nursing. He notes that professional turnover rates are high and, therefore, relationships tend to be temporary and transient. There is pressure to make more and faster decisions with less information. Nurses need to take control of change and begin now to influence the health care of the future. Toffler stated that nursing education was the key for the future and that learning was the primary cure for solving major problems in the health-care system.

If learning is the key, and if nursing is a humanistic discipline, then, according to Duldt, et al. (1984), interpersonal communication, the vehicle for the humanistic perspective, needs to become a highly developed concept in

nursing. Duldt, et al. (1984) also believe that nurses can develop an awareness of their own interpersonal influence through the use of interpersonal communication skills. The nurse can then deliberately choose to intervene in situations so that predictable results can be obtained (Duldt, et al. 1984). The next section presents the various methods used for teaching communication skills.

Teaching Methods and Models for Developing Communication Skills

While there is agreement in the literature about the importance of interpersonal communication skills in nursing, there is less agreement about what to teach and how to teach it. Most schools include a unit on basic interpersonal communication in introductory nursing courses, then teach more specific skills in psychiatric nursing and leadership courses. Although there can be considerable variation in the content and methods used, the National League for Nursing (NLN) does specify that communication skills must have a prominent place in the curriculum (NLN, 1987).

The literature presents several theoretical models, both nursing and non-nursing, for the development of communication skills. The ones which will be discussed are Egan's developmental model (Egan, 1982), Carkhuff's model (Carkhuff, 1969), Orlando's theory (Orlando, 1961) and Duldt's theory of humanistic nursing communication (Duldt & Giffin, 1985).

Egan (1982) presents a developmental model which is goal-oriented and composed of progressive, interdependent stages. Constructive behavioral change is the primary goal. The model has a pre-helping phase that stresses the importance of attending and listening. The three stages of the model are: 1) problem clarification, 2) focused problem exploration, and 3) goal-oriented action. In stage one, the helper assists the client to explore himself. In stage two, the helper uses the skills of accurate empathy, self-disclosure, and confrontation to help the client realize the need to change. In stage three, the helper assists and supports the client in making constructive choices and implementing plans for meeting goals.

Carkhuff (1969) offers support for the proposition that a high level of discrimination is critical to a high level of communication. Sensitive discrimination allows the helper to discern the 'helpee's strengths and weaknesses and make accurate prescriptions and prognoses about which treatment modes might be most effective. Carkhuff found that the level of trainee communication depended in large part on the level of functioning of the trainer. He suggests that training helpers to communicate be done in three stages: 1) responding to taped material, 2) role-playing, and 3) contact with a helpee. The one central ingredient to the training experience is roleplaying (Carkhuff, 1969).

Orlando's (1961) model views communication as a dynamic interaction between unique individuals. Orlando's theory contains four major components: 1) the interactional process, 2) presenting behavior, 3) exploration, and 4) behavioral change. The interactional process between the nurse and patient consists of the patient's behaviors as perceived by the nurse, the nurse's reaction to the patient's behaviors, and the nurse's actions taken to assist the patient. Presenting behavior may represent a "plea for help" regardless of the form it takes according to Orlando (1961, p. 40). She believes it is difficult for patients to ask for help directly. Her concept of exploration refers to the nurse assisting the patient to express the specific meaning of his behavior in order to identify his distress and determine what help he needs. The last component, behavioral change, refers to improved patient behaviors in the immediate sense, and is seen as a positive outcome of effective communication.

Duldt's theory of humanistic nursing communication defines interpersonal communication as a "dynamic process involving continued adaptation and adjustment between two or more human beings engaged in face-to-face interactions during which each is continually aware of the other(s)" (Duldt, et al., 1984, p. 9). It is existential and involves an exchange of meaning. It contains both a humanizing and a dehumanizing set of attitudes. Communication which is

humanistic involves an awareness of the unique characteristics of being human, while that which is dehumanizing ignores the unique characteristics of being human. Communing, the heart of humanistic communication refers to "dialogical, intimate humanizing communication between two or more people", and it involves trust, self-disclosure and feedback (Duldt & Giffin, 1985, p. 215). This theory proposes that people tend to receive the type of communication attitudes and patterns with which they communicate to others, whether it be humanizing or dehumanizing. The interaction patterns include communing, asserting, confronting, conflicting, and separating. One has a choice of which interaction pattern to use and what degree of humanizing attitude to take (Duldt & Giffin, 1985). This theory provides a framework for the teaching of communication. Further discussion will be provided in the theoretical framework.

Nursing educators often use an eclectic approach in teaching communication behaviors. There is no unifying framework; instead, the focus is on rote learning of communication techniques. Friedrich, Lively, and Schacht (1985) point out that student discomfort and lack of proficiency in using communication skills have resulted from this piecemeal approach. These authors selected Egan's developmental communication model as a basis for teaching communication skills in an integrated curriculum. They

reported growth in students' empathic responding, a decrease in irrelevant questioning, more independence by students in critiquing their own interpersonal style, and a positive correlation between self-awareness and more effective communication skills. Faculty used a step-by-step method of description, demonstration, practice, and application as a format for teaching these skills consistently.

Haggerty (1985) has used Orlando's theory as a framework for teaching communication skills to nursing students. She notes that Orlando's model emphasizes process rather than techniques, and, once the student is able to grasp the framework, the techniques can then be placed in their proper interactional context where they become useful. This stance is supported by Bruner (1960) who indicates that a basic structure must be taught if transfer of learning from one situation to the next is to occur. He writes, "To understand something as a specific instance of a more general case...is to have learned not only a specific thing but also a model for understanding other things like it one may encounter" (Bruner, 1960, p. 25).

Norris (1986) studied the effects of the learner attributes of learning style and maturation, and method of instruction (lecture or role play) on outcomes for the area of basic communication skills in nursing. A sample of students (N = 147) was randomly assigned to role play or lecture groups. (field dependent or independent) and

traditional/nontraditional instructor ratings of students' skills on four dimensions of communication in process recordings of actual nurse-patient interactions. Norris found that the field-independent group had higher mean scores on objective tests than did the field-dependent group. The nontraditional group (older with prior academic degrees and life experiences) had higher scores on initial objective tests and on instructor ratings of caring, concreteness and empathy than did the traditional BSN student group. When the students evaluated instructional methods, the role-play students indicated greater interest, involvement and preference for the method. Lecture students indicated greater confidence that the method met the objectives. However, statistical differences in overall mean performances were not found (Norris, 1986).

Implications for strategic placement of communication content in the curriculum were derived from the study by Norris. Basic level students may be able to grasp the cognitive structure of interviewing for data collection and demonstrate respect for the client and attending behaviors; the more complex skills such as genuine caring and empathy, however, may need to be placed later in the program or reinforced when taught earlier (Norris, 1986).

Since communication is assumed essential to all interpersonal interactions, it is necessary for this concept to be introduced prior to students' clinical experiences.

Sundeen, Stuart, Rankin & Cohen (1981) believe that the nurse must first grow in self-knowledge before the therapeutic use of self can be realized. They indicate that quality nursing care depends on the nurse's therapeutic communication skills. Based on this assessment, Keller (1987) reported a curriculum redesign to improve psychosocial assessment skills of first semester baccalaureate students. It included having students complete a self-assessment index. Students wrote personal goals for the semester and plans for meeting these goals. Each week students participated in self-awareness exercises prior to interacting with clients. Various methods (informal assessment tools, hand-puppets, and drawings) were used to heighten students' awareness of how they communicated and related. The changes were reported to have positive effects on the interpersonal skills of students (Keller, 1987).

Perceptions of Communication Behaviors Needed by Nurses

Perception

Duldt, et al. (1984) suggest that one's interpersonal "orientation", or habitual ways of viewing other people may be either productive or counterproductive. If one tends to have a negative view of people, then one may respond with

aggression or withdrawal. If, on the other hand, one views people in a positive light, one is more likely to respond in cooperative, helpful ways. All interactions with an individual are influenced by a person's perceptions of that individual. The process of interpersonal perception involves both the selective recording of data in a simple form, and the mental prediction of future events based on the inferences drawn from this data. Perceptions of persons do not usually remain static, but are modified over time (Duldt, et al., 1984).

Jourard (1974) notes that the act of giving meaning to perception is known as "construing." He believes that personal meaning is indigenous to perception. This personal meaning is dependent on past and present events, as well as immediate needs of the individual (Jourard, 1974). In essence, perception is not right or wrong, but is the event as discerned by the individual. Perception influences interpersonal communication.

Perceptions of people are often inaccurate. Haney (1967) offers five sources of differing perceptions: 1) different background environments lead one to attach importance to different aspects of a person; 2) actions or behaviors of a person are noted differently; 3) the use of differing sensory receptors causes behavior to be noticed differently; 4) differing internal states tend to cause people to notice different characteristics of a person; and

5) differing attitudes or response patterns are evoked in different people (Haney, 1967). Thus, there is a wide margin for error in perceptions of people. Difficulties in relating and communicating with a person may be due to errors in perception.

Errors and differences exist not only with interpersonal perception, but also with perceptions of things (objects, events, places, etc.). Differences in perceptions of faculty and nursing students regarding the purpose, necessity and precise nature of communication skills can be a significant factor in the teaching of these skills according to one study. Based on a field study in Northern Ireland, significant perceptual variation was found between teacher and student groups in the following areas:

- 1) the purpose of communication skills;
- 2) the degree to which teaching is perceived as necessary for acquiring these skills;
- and 3) perception of the precise nature of the subject matter (Eastwood, 1985).

This author concludes that perceptual dissonance over the specific purpose and value of communication skills in nursing must be reduced if improvement is to be made in teaching this aspect of nursing.

Specific communication behaviors

Although the focus of this study is interpersonal behaviors within the context of nursing, much can be gleaned

from other disciplines such as psychology, speech communication and business. Di Salvo (1980) summarized 25 studies which were done to discover essential communication skills in various segments of the business world. He concluded that the skills most frequently identified are: listening; written communication; oral reporting; motivating/persuading; interpersonal skills; informational interviewing; and small group problem solving.

While communication in nursing is unique in many respects, many of the same skills found to be essential in business and other disciplines have also been found to be crucial in nursing. Sundeen, Stuart, Rankin, and Cohen (1981), for example, refer to listening as the most important element of communication, and they describe it as an active process requiring a nurse's complete attention and a great deal of energy.

Fritz, et al. (1984) believe that listening is such a critical element in the health-care scene that an entire chapter is devoted to it. These authors call listening an art, the chief goal of which is to enable others to sort through the complexities of their problems and arrive at conclusions aided by the skill of the listener. Listening skills enable a nurse to process complex interpersonal data, make sound judgments about the patient, and give the patient certain cues to facilitate rather than retard the flow of information. Listening is referred to by Fritz, et al. as a

"crisis management technique: a technique for managing an abundance of riches (information). Nurses who have special skills for dealing with this crisis find that they are valued by peers and gain a high degree of professional satisfaction from their interactions with patients" (p. 108).

Davis (1984) argues that, while methods and theories of communication are important, unless the human element and the uniqueness of each person are recognized, communication falls short. Understanding is based on listening and responding in ways that reflect concern, sensitivity, and compassion. The helper must give up the role of conversationalist and assume the role of listener. Listening is hard work, which requires active concentration and self awareness. A therapeutic listener needs to possess the following skills and attitudes: 1) wants to listen, 2) has a desire to help, 3) gives undivided attention to what client says, 4) is patient and avoids interrupting client, 5) listens for central themes, 6) monitors personal emotions, 7) accepts the client's feelings, and 8) recognizes each client's potential for problem solving (Davis, 1984).

Willmington (1986) studied the specific oral communication skills needed for success in nursing, and those most in need of improvement according to directors of nursing. One finding was that listening skills were most

important and also in greatest need of improvement by nurses. One implication of this study is that nursing educators need to evaluate course objectives and time spent on developing various skills according to their need to be taught more effectively as indicated by nursing directors. Willmington noted that listening instruction is rarely taught in nursing schools. Instead the two variables which fill much of the instructional time in communication courses are vocal and physical variables. However, no documentation is provided to support this observation. Willmington concludes that the vital variables (listening, message, language, emotional and style) need to be systematically taught to nursing students.

Instrument

The analysis and categorization of communication behaviors can be a difficult task. Many instruments for measuring communication behaviors by nurses are available; however, many of them are focused on communication as it pertains to a specific aspect of nursing such as empathy (Settler, 1977, and Truax, 1961) or assertiveness (Hutchings & Colburn, 1979; and Donner & Goering, 1982). The design of this study required a more global instrument.

Other communications instruments that have been used in nursing research include the Person-Centeredness Scale

(Wallston, et al., 1978), Carkhuff's Index of Communication (Carkhuff, 1969), and the Therapeutic Relationship Inventory (Authier & Gustafson, 1979). The reliability and validity of these instruments, however, have not been documented. Some of these instruments require direct observation of interactions by the researcher. For this particular study, direct observation was not feasible. Since it was the perceptions of head nurses and not those of the researcher that were being elicited, a revised form of Willmington's (1986) tool was used (Appendix B). Permission was obtained by letter to use or revise the questionnaire (Appendix C).

Willmington's (1986) questionnaire was designed to measure desirable oral communication behavior of employees as reflected by responses from their supervisors. It is composed of two lists of communication behaviors. The first list containing 37 behaviors was developed by virtue of the frequency with which certain behaviors appeared in the literature and in basic communication courses. In Willmington's study, nursing directors indicated the importance of each behavior for success in nursing according to the following scale: 5 - very important; 4 quite important; 3 somewhat important; 2 - not very important; and 1 unimportant. The second list consisted of 40 behaviors which roughly repeated the first list except that the wording was reversed to be read as undesirable rather than desirable behaviors. Subjects were asked to respond to each

undesirable behavior according to the frequency it was noted among their employees: 5 - very often; 4 - often; 3 sometimes; 2 rarely; and 1 - practically never. Willmington identified what appeared to be seven general types of behaviors on the list: 1) listening variables, 2) message variables, 3) language variables, 4) vocal variables, 5) physical variables, 6) emotional variables, and 7) style variables. Each specific behavior was then placed under the variable which seemed most appropriate. The instrument was then field tested, revised, and used to survey 36 directors of nursing (Willmington, 1986).

The behaviors on the first list are generally reflective of Duldt's humanizing set of attitudes. They relate to the interaction patterns of communing and asserting. Behaviors on the second list tend to reflect Duldt's dehumanizing attitudes.

Since Willmington's instrument was not tested for content validity, it was decided that inter-rater agreement with respect to the categories would be done as a test of validity. A panel of three experts was selected and instructed to place each behavior into the appropriate identified category. One panelist was a university faculty member in the school of education with a doctorate in adult education. Two of the panelists were nursing faculty in a university. One nurse had a doctorate in speech communications, and one taught therapeutic communication

skills to baccalaureate nursing students enrolled in psychiatric nursing. Based on the degree of agreement among the raters, the questionnaire was revised. Revisions are addressed in chapter four.

Theoretical Framework

Duldt's theory of humanistic nursing communication (Duldt & Giffin, 1985) serves as the framework for this study (Appendix A). This theory was selected because it focuses on patterns and attitudes of interpersonal communication in all aspects of nursing as opposed to nurse/client communication only. It provides a useful basis for teaching the communication process to beginning nursing students.

It is helpful to examine the concepts of humanism, nursing and interpersonal communication in order to understand Duldt's theory. Humanism as a historical movement first emerged during the Renaissance period and since then it has re-emerged several times as a prevailing viewpoint. The humanist recognizes a person's ability to think and make choices, and thereby to improve his life. Value is placed on the essence of being "human" and on the quality of life experienced by human beings. Humanism within the nursing context is manifested by the "caring, concerned, and thoughtful relationship that the caregiver establishes with the client" (Duldt, et al. 1984, p. 3).

Leventhal (1975) has suggested that dehumanization has negative consequences in illness. He defines dehumanization as "the feeling that one is isolated from others and is regarded as a thing rather than a person" (Levanthal, 1975, p. 120). He proposes that dehumanization can be avoided by redirecting the interaction between a person's processing system and his environment. Levanthal offers the following set of criteria for dehumanization: 1) separation of the physical and psychologic self; 2) isolation of the psychologic self; 3) uncertainty and cyclic thought; 4) planlessness and loss of competency; 5) emotional distress, hopelessness, and despair; and 6) barriers to communication. Duldt, et al. (1984) believe that Levanthal's description has relevance to nursing in solving the problem of faulty communication. Self awareness on the part of the nurse and a sharing of human characteristics with the client are important aspects of nursing from a humanistic perspective.

Duldt proposes the following definition of nursing: "Nursing is the art and science of positive, humanistic intervention in the changing health states of human beings interacting in the environment of potential or actual critical life situations" (Duldt and Giffin, 1985, p. 212). Humanistic nursing interventions are implemented by communicating and relating to the client in a manner which leads him to sense warmth and acceptance. The nurse-client relationship is an equitable one, each respecting the

other's feelings, concerns and values. The concept of humanism interacts with that of nursing through the phenomenon of interpersonal communication, through which individual worth is validated (Duldt and Giffin, 1985). Patterson and Zderad (1976) believe this warm, open validating relationship is essential if people are to develop to their fullest potential. A subset of elements of nursing identified by Duldt & Giffin (1985) are communicating, caring and coaching.

Duldt, et al. (1984) define communication as a "dynamic interpersonal process involving continual adaptation and adjustment between two or more human beings engaged in face-to-face interactions, during which each person is continually aware of the other(s)". Duldt's Theory of Humanistic Nursing Communication is based on the process oriented, symbolic interactionist model which grew out of a dissatisfaction with the linear, speaker-centered, traditional communication theory (Smith and Williamson, 1977).

For the symbolic interactionist, the purpose of communication is to find meaning and understanding. Burke (1966) views communication as the means by which Man achieves unity. Burke states that Man uses symbolism in order to transcend conflicts and join in some cooperative effort of mutual concern. Language is the means for labeling reality. Burke explains this through the concept

of a "terministic screen" of past experiences, personality and whole essence of the person, which "selects, deflects and reflects" in such a manner that reality is perceived through a "fog of symbols." (Burke, 1966, p. 12).

Meaning, according to the symbolic interactionist, resides within, not between, people. It is through interpersonal communication and interaction that the self is developed and affirmed (Smith and Williamson, 1977). Duldt and Giffin (1985) note that communing involves a unifying of two or more people in which a new unit is formed. Individual differences are retained, making the relationship unique. Through symbols or language, a shared experience of reality occurs in which human beings experience each other. This shared experience can be either humanizing or dehumanizing (Duldt and Giffin, 1985).

This study focused on the perceptions of head nurses in relation to three research questions: 1) What are the specific communication behaviors most necessary for nurses? 2) How often is the use of ineffective communication behaviors noted by nurses? and 3) When nurses use ineffective communication behaviors, how detrimental is it to their performance?

Summary

A review of the literature revealed that interpersonal communication behaviors are indeed considered crucial to

nursing. The following statements summarize the position of most authors. Within the nurse-client relationship, communication has an effect on client recovery rates, length of hospital stay, and the clients' ability to cope with illness and to maintain health. Effective implementation of the nursing process hinges on the nurses' ability to develop empathy and a trusting interpersonal relationship with the client through the use of communication skills.

Nurses must also communicate with peers, colleagues, superiors and other members of the health-care system. Job satisfaction, professional achievement, and client-care management have been found to be significantly affected by the nurses' communication skills. Conflict, anger and alienation among nurses is reported to frequently contribute to job turnover, burnout, absenteeism and reality shock. Assertiveness as well as the ability to bargain and compromise are recognized by many as necessary skills for interacting with various members of the health-care system. Other skills include summarizing, focusing, seeking clarification, active listening, reflecting and paraphrasing.

Although the national accreditation criteria require that communication skills have a prominent place in the nursing curriculum the literature shows that there still tends to be some confusion about what to teach and how to teach it. A variety of models and methods for developing these skills are reported to have been used with success.

A review of related literature reveals that many of the same communication skills found to be essential in other disciplines have also been found to be crucial in nursing. The one noted most frequently in the literature as most important is that of listening. It is described as an active process which requires not only skill, but patience, self-awareness, a desire to help, and acceptance of the client's feelings.

Few studies have explored specific communication behaviors needed by nurses. In the present era of cost-effectiveness, efficiency and high technology, the literature notes the tendency toward dehumanization. If nursing is a humanistic discipline, then it becomes essential that nurses communicate in a humanistic manner. And it is known that behaviors which reflect a humanistic attitude can be learned and practiced. This study explored the perceptions of head nurses regarding the specific communication behaviors needed by nurses.

CHAPTER 3
METHODOLOGY
Design

This study consisted of a survey of head nurses working on various hospital units to determine what they perceived to be the interpersonal communication behaviors most necessary for nurses, the frequency of use of ineffective patterns of communication among nurses, and detriment to performance resulting from ineffective communication.

Setting

The setting for this study was five general hospitals in eastern North Carolina. Three county hospitals, one small private hospital and one federal (Veterans Administration) hospital provided the source of the head nurse sample. All of the hospitals were accredited by the Joint Commission of Hospital Accreditation. One of the county hospitals was a teaching hospital affiliated with a medical school. Since a variety of types of hospitals is more likely to provide a representative sample of head nurses, the hospitals were selected to include variation in size, source of funding, and teaching hospital status.

Sample

The convenience sample consisted of all of the head nurses employed by the five hospitals who voluntarily participated in the study. A total of 78 head nurses were contacted, and 50 participated in the study.

Instrument

The questionnaire used in this study is a revised version of Willmington's (1986) tool (Appendix B). It has been described in the review of literature. Demographic information about the head nurses was also collected. This included: age, sex, marital status, educational preparation for nursing, educational degrees in other areas, type of unit working on, number of years in present position and number of staff nurses on unit. Following the demographic data, the three research questions were addressed on three separate forms. Form A, entitled "Most Necessary Communication Behaviors" elicited the head nurses' opinion about the specific communication behaviors most necessary for nursing. Form B, "Frequency of Negative Communication Behaviors," asked how often the use of negative communication behaviors by nurses was noted. Form C, "Detriment of Negative Communication Behaviors," elicited opinions regarding the degree of detriment the use of negative communication behaviors was to the nurse's performance.

Procedure

The directors of nursing of the five hospitals were contacted both by phone and by letter requesting permission to conduct the study at their institutions. Signed consent forms were obtained (Appendix D). The head nurses were contacted in person or by mail by the researcher and asked to complete the questionnaire. A cover letter explaining the study was attached to each questionnaire (Appendix E). All subjects were told that their participation was voluntary and that all responses would be anonymous and confidential. The questionnaires were returned to the researcher in sealed envelopes provided.

Data Analysis

The demographic data were analyzed first in order to obtain a description of the characteristics of the group. Then the responses for each of the three research questions were analyzed separately. Internal consistency reliability of the items comprising each category of communication was determined through the use of coefficient alpha. This is reported on page 61. The mean scores for each overall scale were computed as well as the mean ratings for the categories of communication variables. In addition, analysis of variance was used to determine any effects of demographic information. The assistance of a statistician was utilized in the analysis of the data.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

In this study, head nurses working on various units in five eastern North Carolina hospitals were surveyed to determine their perceptions of the interpersonal communication behaviors most necessary for nurses to exhibit, the frequency of negative communication behaviors by nurses, and the detrimental effects of negative communication to the nurse's performance. This chapter presents an analysis of the demographic data and the data collected using the Communication Behaviors Questionnaire (Appendix B). An analysis of the internal consistency reliability of the six categories of communication variables for each question is also provided.

Description of the Sample

Nursing directors from five eastern North Carolina hospitals were contacted and agreed to have their head nurses participate in the survey. The head nurses were contacted either by the investigator or nursing director at a head nurse meeting, or by nursing office staff on an individual basis. From a potential sample size of 78, a total of 50 (64%) head nurses participated in the study with a response rate between 45 and 100 percent according to site (Table 1).

Table 1

Number of Available Head Nurses and Number and Percentage of Respondents by Hospital

Site	Employed		
	Head Nurses	Respondents	Percentage
Hospital 1-County Teaching	35	18	51
Hospital 2-County	15	13	87
Hospital 3-Federal	11	5	45
Hospital 4-County	10	7	70
Hospital 5-Private	7	7	100
Total	78	50	64

The majority of the respondents were female (95.9%), married (72%), and ranged in age from 26 to 58 years with a mean age of 38.8. The highest level of nursing education of this sample was the MSN degree (4%), with the majority of respondents holding a BSN degree or a diploma (Table 2). The two respondents with MSN degrees were both from the same hospital.

Table 2

Frequency and Percentage Distribution of Respondents by Highest Level of Nursing Education

Educational Level	Respondents	Percentage
AD	8	16
Diploma	19	38
BSN	21	42
MSN	2	4
Total	50	100%

An analysis of the types of units on which the respondents worked revealed a fairly evenly divided number working on medical (18%), surgical (16%), and critical care units (16%). Of the 24% who checked "other" units, the descriptions given included rehabilitation unit, gynecology unit, recovery room, ambulatory medical unit, flight nurse, outpatient surgery, and one sub-acute unit for nursing home placement and overflow. One respondent worked on a combination medical-surgical-pediatric unit. Table 3 presents the respondents by type of unit on which currently working.

Table 3

Frequency and Percentage Distribution of Respondents by Type of Unit on Which Currently Working

Unit	Respondents	Percentage
Medical	9	18
Surgical	8	16
Critical Care	8	16
Emergency Room	4	8
Operating Room	2	4
Pediatric	3	6
Obstetrical	3	6
Psychiatric	1	2
Other	<u>12</u>	<u>24</u>
Total	50	100%

Participants were asked to report the number of years in their present position. There was a fairly even division among these categories, with the smallest percentage (12%) falling in the 3-6 year category (Table 4).

Table 4

Frequency and Percentage Distribution of Respondents by
Number of Years in Present Position

Number of Years	Respondents	Percentage
Under 1 year	11	22
1-3 years	11	22
3-6 years	6	12
6-10 years	12	24
More than 10 years	10	20
Total	50	100%

The head nurses were asked to give the number of full-time staff nurses working on their unit. This number varied from 3 to 33 with a mean of 15.

Validity and Reliability of Questionnaire

As noted in chapter two, inter-rater agreement with respect to the categories of communication behaviors was done as a test of the content validity of Willmington's (1986) questionnaire. Only those items on which two out of three judges agreed were retained on the questionnaire. Due to a lack of inter-rater agreement on style variables and emotional variables, these two categories were combined to form style/emotional variables. The original 37 items were reduced to 26 items on Form A, and the original 40 items were reduced to 28 items on Forms B and C (Appendix B).

Since the questionnaire used in this study was a revised version of Willmington's instrument and was first

tested with this sample, it was necessary to examine the internal consistency reliability of the three overall scales (most necessary communication behaviors, frequency of negative behaviors, and detrimental effects of negative behaviors). In addition, the six subscales (listening, message, language, vocal, physical, and style/emotional) were also examined for internal consistency reliability. The coefficient alpha internal consistency reliability was determined to be adequate on all scales and subscales (Table 5). The reliability overall was .90, .94, and .93 for the three scales, respectively. The instrument was, therefore, found to be valid and reliable.

Findings

In order to ascertain the perceptions of head nurses regarding the communication behaviors most necessary for nurses to exhibit, descriptive statistics were used to analyze the scores on Form A of the questionnaire (Appendix B). Results for the total scale and for each subscale are reported in Table 6. The possible range of responses for each item in the six subscales was 1.00 to 5.00.

Based on the overall mean score of 4.14 on all of the variables, the participants perceived the communication behaviors to be at least "quite important."

Table 5

Internal Consistency Reliability of Scales and Subscales

I. Most Necessary Communication Behaviors

Subscale	Number of Items	Reliability	
		Coefficient	Alpha
Listening variables	4	.59	
Message variables	4	.59	
Language variables	4	.56	
Vocal variables	5	.72	
Physical variables	3	.74	
Style/Emotional variables	6	.74	
Overall Scale	26	.90	

II. Frequency of Negative Communication Behaviors

Subscale	Number of Items	Reliability	
		Coefficient	Alpha
Listening variables	4	.74	
Message variables	4	.86	
Language variables	5	.83	
Vocal variables	5	.87	
Physical variables	3	.77	
Style/Emotional variables	7	.90	
Overall Scale	28	.94	

III. Detrimental Effects of Negative Communication Behaviors

Subscale	Number of Items	Reliability	
		Coefficient	Alpha
Listening variables	4	.80	
Message variables	4	.80	
Language variables	5	.71	
Vocal variables	5	.86	
Physical variables	3	.77	
Style/Emotional Variables	7	.86	
Overall Scale	28	.93	

Table 6

Descriptive Statistics of Responses to Most Necessary Communication Behaviors

Variable	Mean	Std. Dev.	Minimum Score	Maximum Score
Listening	4.58	.42	3.50	5.00
Message	4.31	.45	3.25	5.00
Language	3.82	.52	2.75	4.75
Vocal	3.99	.57	2.80	5.00
Physical	3.89	.65	2.33	5.00
Style/Emotional	4.18	.52	2.83	5.00
Overall	4.14	.40	3.31	4.85

Table 7

Descriptive Statistics of Responses to Frequency of Negative Communication Behaviors

Variable	Mean	Std. Dev.	Minimum Score	Maximum Score
Listening	3.19	.66	1.75	4.50
Message	2.76	.70	1.00	4.25
Language	2.59	.71	1.20	4.40
Vocal	2.60	.68	1.40	4.40
Physical	2.43	.68	1.00	4.67
Style/Emotional	2.48	.71	1.00	4.14
Overall	2.66	.57	1.39	4.21

There is some variation among responses to the different categories, however. The listening variable contained the least variation with a minimum score of 3.50 ("somewhat" to "quite" important) and a maximum score of 5.00 ("very important"). Listening variables also received the highest mean score (4.58) and were perceived as "quite important" to "very important." Physical variables contained the most variation, having a minimum score of 2.33 and a maximum score of 5.00. This category also contained the fewest number (3) of items. Language variables received the lowest mean score (3.82), but responses still indicated that language variables

are "quite important" as part of the communication behaviors necessary for nurses to exhibit.

Descriptive statistics were used to analyze the scores from Form B of the questionnaire in order to answer the second research question: How often is the use of negative communication behaviors noted by nurses? Table 7 contains the results for responses to the total number of behaviors as well as for each individual variable. The possible range of responses for each item within the six categories was 1.00 (practically never) to 5.00 (very often).

The overall mean score for the frequency of negative communication behaviors noted by nurses was 2.66, which clusters between "rarely" and "sometimes" as opposed to "often" or "practically never". The negative variable which was observed most frequently by the head nurses was that of listening, with a mean score of 3.19 representing slightly more often than "sometimes". The least often noted negative communication behavior variables were the physical ones (2.43). Responses to the physical variable also contained the most variation with a minimum score of 1.00 and a maximum score of 4.67.

Responses to Form C of the Communication Behaviors Questionnaire were analyzed in order to answer the third research question: When nurses use negative communication behaviors, how detrimental is it to their performance? The

possible range of responses was 1.00 (practically of no detriment) to 5.00 (very detrimental). Table 8 provides the descriptive statistics for responses to the third question.

Table 8

Descriptive Statistics of Responses to Degree of Detriment of Negative Communication Behaviors

Variable	Mean	Std. Dev.	Minimum Score	Maximum Score
Listening	4.21	.67	2.50	5.00
Message	3.94	.76	1.00	5.00
Language	3.62	.63	2.00	5.00
Vocal	3.66	.78	1.60	5.00
Physical	3.41	.80	1.00	5.00
Style/Emotional	4.10	.61	2.00	5.00
Overall	3.86	.54	2.32	4.93

The overall mean score of 3.86 indicates that participants perceived negative communication behaviors to be just less than "quite detrimental" to the nurse's performance. While the mean scores of the various categories were clustered fairly evenly, the highest mean score was in listening (4.21), followed closely by style/emotional (4.10). Listening was also the variable containing the least diversity of responses (minimum score 2.50, maximum score 5.00).

Intuitively, the respondent professional demographic characteristics could influence perceptions of communication. Therefore, one way analysis of variance was used to determine what effect, if any, four of the selected demographic

characteristics (level of nursing education, place of employment, type of unit on which currently working, and numbers of years in present position) had on the responses of the head nurses to each of the three questions. These characteristics were selected because of their relevance to professional preparation and work experience. Table 9 presents differences in responses to the first question (What communication behaviors are most necessary for nurses to exhibit?) in relation to the four variables. Results indicate that none of the four variables had a significant effect on the responses at the 0.05 level.

Responses to the second question, asking for the frequency of observed negative communication behaviors by nurses within the past two weeks, were analyzed in relation to the four selected demographic characteristics. Table 10 presents the results of this analysis. None of the four variables made a difference in the responses at the 0.05 level of significance.

The third question asked respondents to rate the degree of detriment using negative communication behaviors had on the nurse's performance. Table 11 presents an analysis of the differences in responses related to level of nursing education, hospital site, type of unit worked on, and number of years in present position. These four selected demographic characteristics had no effect on responses to this question at the 0.05 level of significance.

Table 9

Differences in Perceptions of Most Necessary Communication Behaviors in Relation to Level of Nursing Education, Hospital Site, Type of Unit and Number of Years in Present Position

Level of Nursing Education	n	Mean	Standard Deviation	F Ratio	Percentage
Associate degree	8	4.09	.63		
Diploma	19	4.16	.38		
Baccalaureate degree	21	4.10	.31		
Masters degree	2	4.38	.54		
Total	50	4.14	.40	.36	.78

Hospital Site	n	Mean	Standard Deviation	F Ratio	Percentage
1-County, Teaching	18	4.28	.29		
2-Federal	5	4.02	.39		
3-County	13	4.03	.40		
4-County	7	3.93	.56		
5-Private	7	4.24	.41		
Total	50	4.14	.40	1.57	.20

Type of Unit	n	Mean	Standard Deviation	F Ratio	Percentage
Medical	9	3.92	.37		
Surgical	8	4.22	.40		
Critical Care	8	4.00	.47		
Emergency Room	4	4.00	.43		
Operating Room	2	4.31	.76		
Pediatrics	3	4.45	.47		
Obstetrics	3	4.19	.47		
Psychiatry	1	4.42	--		
Other	12	4.23	.30		
Total	50	4.14	.40	.98	.47

Years in Present Position	n	Mean	Standard Deviation	F Ratio	Percentage
Under 1 year	11	4.27	.26		
1 - 3 years	11	4.11	.42		
3 - 6 years	6	3.96	.33		
6 - 10 years	12	4.15	.45		
Over 10 years	10	4.09	.49		
Total	50	4.14	.40	.63	.64

Table 10

Differences in Frequency of Observed Negative Communication Behaviors by Nurses in Relation to Level of Nursing Education, Hospital Site, Type of Unit and Number of Years in Present Position

Level of Nursing Education	n	Mean	Standard Deviation	F Ratio	Percentage
Associate degree	8	2.59	.51		
Diploma	19	2.76	.70		
Baccalaureate degree	21	2.63	.49		
Masters degree	2	2.26	.18		
Total	50	2.66	.57	.55	.65

Hospital Site	n	Mean	Standard Deviation	F Ratio	Percentage
1-County, Teaching	8	2.53	.55		
2-Federal	5	2.42	.58		
3-County	13	2.94	.61		
4-County	7	2.85	.39		
5-Private	7	2.46	.58		
Total	50	2.66	.57	1.82	.16

Type of Unit	n	Mean	Standard Deviation	F Ratio	Percentage
Medical	9	2.82	.26		
Surgical	8	2.69	.43		
Critical Care	8	2.60	.49		
Emergency Room	4	2.84	.82		
Operating Room	2	1.88	.23		
Pediatrics	3	2.90	.73		
Obstetrics	3	3.07	1.00		
Psychiatry	1	1.39	--		
Other	12	2.56	.54		
Total	50	2.66	.57	1.75	.12

Years in Present Position	n	Mean	Standard Deviation	F Ratio	Percentage
Under 1 year	11	2.61	.45		
1 - 3 years	11	2.55	.64		
3 - 6 years	6	2.45	.45		
6 - 10 years	12	2.93	.46		
Over 10 years	10	2.63	.76		
Total	50	2.66	.57	1.02	.41

Table 11

Differences in Perceptions of Degree of Detriment Effected by Nurses' Use of Negative Communication Behaviors in Relation to Level of Education, Hospital Site, Type of Unit, and Number of Years in Present Position

Level of Nursing Education	n	Mean	Standard Deviation	F Ratio	Percentage
Associate degree	8	4.01	.45		
Diploma	19	3.83	.45		
Baccalaureate degree	21	3.79	.65		
Master's degree	2	4.18	.25		
Total	50	3.86	.54	.57	.63

Hospital Site	n	Mean	Standard Deviation	F Ratio	Percentage
1-County, Teaching	18	3.79	.60		
2-Federal	5	4.06	.22		
3-County	13	3.98	.57		
4-County	7	3.87	.33		
5-Private	7	3.63	.64		
Total	50	3.86	.54	.70	.60

Type of Unit	n	Mean	Standard Deviation	F Ratio	Percentage
Medical	9	3.75	.61		
Surgical	8	4.16	.26		
Critical Care	8	3.61	.70		
Emergency Room	4	4.09	.37		
Operating Room	2	3.14	1.16		
Pediatrics	3	4.30	.55		
Obstetrics	3	3.89	.34		
Psychiatry	1	3.86	--		
Other	12	3.82	.36		
Total	50	3.86	.54	1.51	.18

Years in Present Position	n	Mean	Standard Deviation	F Ratio	Percentage
Under 1 year	11	3.92	.34		
1 - 3 years	11	3.85	.54		
3 - 6 years	6	3.63	.68		
6 - 10 years	12	4.08	.37		
Over 10 years	10	3.65	.73		
Total	50	3.86	.54	1.23	.31

Summary

This chapter presented findings based on data from the Communication Behaviors Questionnaire. The demographic data indicated that the sample was predominantly female and married, but had diverse ages, years of experience, and educational backgrounds. There was a wide assortment of types of units on which respondents worked.

The reliability of the instrument was shown to be adequate (at least .90 for the total scales; at least .56 for the 3 to 7 item subscales) using coefficient alpha internal consistency reliability. Both the overall scales and the six subscales were examined.

The data indicated that the sample group perceived communication behaviors generally to be "quite important" (4.14 on a 5-point scale) and negative communication behaviors to be "quite detrimental" (3.86 on a 5-point scale) to the nurse's performance. The major finding of this study centers on listening. The listening variable was rated as the most important communication behavior, as well as the most detrimental when not utilized effectively. The frequency of use of negative communication behaviors by nurses was perceived as "rare" or "sometimes," with listening variables being the most frequently observed ones.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This study was designed to determine the perceptions of head nurses regarding the communication behaviors most necessary for nurses, the frequency of negative communication behaviors by nurses, and the degree to which these behaviors are detrimental to the nurse's performance. It was believed that knowledge of the specific communication behaviors deemed important in the workplace would be important in the nursing education arena. Since interpersonal communication was found to be of crucial significance to nursing, the question of specifically what to teach and how to teach it needs to be given careful consideration.

Also, it was noted in the review of literature that if nursing is a humanistic discipline, then communicating in a humanistic manner is essential. The items on Form A, Most Necessary Communication Behaviors, were found to be representative of Duldt's (1985) humanizing communication attitudes while those on Form B, Frequency of Negative Communication Behaviors, were representative of Duldt's dehumanizing attitudes. The focus of this study was interpersonal communication behaviors in nursing practice,

both nurse-client and nurse-colleague. Since Duldt's theory of humanistic nursing communication encompassed all these aspects of nursing communication, it served as the theoretical framework for this study.

Discussion

Several findings from this study merit closer examination and discussion. First, the demographic data indicated that the sample group was young to middle aged (range of 26-58 years with a mean age of 38.8 years), married (72%), and almost evenly divided according to those with a BSN or higher degree (46%), and those with diplomas or associate degrees in nursing (54%). The participants represented a wide variety of hospital types and types of units within the hospital. Respondents had been in their head nurse positions for varying numbers of years from less than a year to more than ten years, and they each supervised a mean of 15 full-time staff nurses. From these data, it appears that the sample group was a fairly diversified one.

Perceptions of head nurses about the communication behaviors most necessary for nurses to exhibit suggest two important conclusions which are consistent with the literature in nursing communication. First, respondents perceived positive (or humanizing) communication behaviors ($m=4.14$), in general, to be at least "quite important" for

nurses to have. Secondly, the listening variable ($m=4.58$), was perceived as the most important of the six variables for nurses to have. The four items under this variable included listening to others without frequent interruption, understanding what others are saying, spending time listening to others, and paying attention to what others are saying.

Responses to the second question regarding the frequency with which nurses used negative (or dehumanizing) communication behaviors indicate that nurses used these behaviors "rarely" or "sometimes" ($m=2.66$). The negative communication behaviors most often observed were related to the listening variable. This variable included the following four items: 1) interrupting others, 2) not understanding what others are saying, 3) not paying close attention to what others are saying, and 4) unwilling to listen to others. On a five-point scale ranging from "practically never" to "very often" (Form B, Appendix B), poor listening by nurses was noted to occur slightly more often than "sometimes" ($m=3.19$). These data indicate that although negative or dehumanizing communication behaviors are not prevalent among nurses, there is room for improvement, particularly in relation to listening behaviors. Since listening was also perceived as the most necessary variable, it is especially important that nurses develop effective listening behaviors.

Scores on the third question, which asked the respondents to rate the degree of detriment negative communication behaviors have on nurses' performance, revealed that these negative behaviors were perceived as "quite detrimental" to nurses' performance ($m = 3.86$). Again, the highest mean score (4.21) was found to be listening. This indicates that of all the communication variables, ineffective listening is most detrimental to the nurse's performance. The fact that use of negative or ineffective communication behaviors was perceived overall as "quite detrimental" supports the conclusion that the sample group perceives effective interpersonal communication behaviors to be an important part of nursing. The listening variable as the most important of the six variables is also supported by this finding. These findings are consistent with those of Willmington (1986). The primacy of listening was noted irrespective of the level of education, place of employment, type of unit on which nurses worked, or number of years in present position.

Limitations

This study was conducted to gain information regarding perceptions of head nurses working on various units in a variety of types of hospitals. When assessing the data, it

must be remembered that the sample of convenience used was relatively small. In addition, the sample was selected from five hospitals in one region of the country. Therefore, generalizing beyond this population must be done with caution.

A second concern is that of assessing communication behaviors of nurses through global perceptions of head nurses. Staff nurses may perform differently in the presence of the head nurse than when the head nurse is not present. Observations made by the head nurse may not be a reflection of the whole spectrum of behaviors, but rather a reflection of opportunities to observe. The use of global judgment without a specific observational schedule may yield distorted or unstable responses.

Conclusions

The following conclusions are based on the findings of this study:

1. Head nurses generally believe that a) effective interpersonal communication behaviors are a very important aspect of nursing and b) that the use of ineffective or negative communication behaviors is detrimental to nurses.
2. Listening was identified as the specific communication category most necessary for nurses to exhibit, most often

noted to be ineffective, and most detrimental to the nurse's performance when it is ineffective.

Although the study was not designed to investigate demographic characteristics in relation to perceptions of head nurses regarding communication behaviors, the data did show that level of education, place of employment, type of unit on which nurses worked, and number of years in present position did not influence the perceptions of head nurses regarding communication behaviors.

Implications

Some implications can be identified for nursing practice and education. First, although the crucial role of interpersonal communication in nursing has been documented in the literature, the specific behaviors needed by nurses (excluding psychiatric nurses) have remained comparatively ill-defined. It is important for nursing faculty to teach those communication behaviors deemed necessary by practitioners. Based on the findings of this study, positive, humanizing communication behaviors, with specific emphasis on listening behaviors, have been identified as an important behavior which needs to be taught to nursing students in a systematic fashion.

Second, the findings have implications for Duldt's humanistic nursing communication theory. When combined with

the humanizing attitudes, "communing" is the interaction pattern which characterizes nursing as humanistic. Communing includes the elements of trust, self disclosure and feedback. One must trust the nurse as a listener, hoping that she will be humanizing in her attitude, will pay attention and understand, and will use what she hears in a helpful and caring way. Self disclosure is telling the nurse how one feels, what one thinks, or what one believes; it is this self-disclosure for which the humanistic nurse listens. For the one who self discloses, it involves interpersonal risk. If the nurse cannot be trusted to listen with humanizing attitudes, then there is potential for loss and for experiencing dehumanization (Duldt & Giffin, 1985; and Duldt, 1988). According to Patton and Giffin (1981, p. 367):

"A theoretical formulation of the trust paradigm in the communication process includes both interpersonal and intrapersonal trust:

1. Trust of a speaker by a listener, called 'ethos'...
2. Trust of a listener by a speaker, called 'sense of psychological safety'...
3. Trust of oneself as a speaker...opposite of speech anxiety...and
4. Trust of oneself as a listener."

Listening, then, is an important component of communing. According to this rationale, this study lends support to the heart and core of Duldt's humanistic nursing communication theory.

While data did not reveal an extensive use of ineffective, dehumanizing communication behaviors by nurses, it suggests that some improvement is needed. For example, some respondents rated "paying attention to what others are saying" as "very important," and "not paying close attention to what others are saying" as very detrimental. The fact that this behavior was observed "sometimes" may mean that nurses generally recognize the value of attentiveness. However, it could mean that a head nurse is not willing to accept the nurse's failure to use this positive behavior even "rarely" or "sometimes". If the nurse's values and behaviors regarding communication were not congruent with those of his/her immediate supervisor, the nurse could behave according to the expectations of the immediate supervisor only in her presence.

Recommendations

Based on the findings of this study, the following recommendations for nursing research are presented:

1. Replication of this survey using a larger, random sample of head nurses is needed in order to generalize the findings to the nursing population.

2. Further testing and refinement of the Communication Behaviors Questionnaire and its relation to Duldt's theory of humanistic nursing communication is needed.
3. A comparable study might be done to determine what staff nurses perceive as the most important communication behaviors for nurses to exhibit and whether their nursing education included these variables.
4. Using an experimental design with random selection and assignment of subjects to control and experimental groups, a course in nursing communication based on Duldt's theory of humanistic nursing communication needs to be taught to the experimental group of nursing students and a comparison made with the control group regarding any communication behavior changes resulting from the course. These behaviors could then be compared with those perceived as most important by practicing nurses.

Summary

This descriptive study was designed to determine the perceptions of head nurses about the communication behaviors of nurses. The head nurses were of the opinion that effective communication behaviors were quite important for nurses to exhibit, particularly the ability to listen. Nurses were not perceived as using negative communication behaviors to a great extent, but there was a need to develop effective listening behaviors.

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APPENDIX A

Duldt's Theory of Humanistic Nursing Communication

Theorist: Bonnie W. Duldt

Theory: Humanistic Nursing Communication

Phenomenon Observed: Interpersonal Communication between Nurse and Client, Peers and Colleagues

Analysis by: Bonnie W. Duldt

References: Bonnie Weaver Duldt, Kim Giffin, and Bobby R. Patton, *Interpersonal Communication in Nursing: A Humanistic Approach*. (Philadelphia: F.A. Davis, 1983); the present text.

Assumptions	Concepts	Relationship Statements	Evaluation
Derived from Philosophy: 1. Human beings exist in a "here and now" existential context from which there is no escape. 2. Human beings are continually concerned with such existential elements as: being, becoming, choice, freedom, responsibility, solitude, loneliness, pain, struggle, tragedy, meaning, dread, uncertainty, despair, and death. 3. All elements of existential being and the communication imperative are salient issues to be dealt with in critical life situations. 4. Growth and change arise from within the individual and to a considerable degree depend upon one's choice. 5. The nurse shares with the client all characteristics of being human. Derived from Communication:	Human being: Man is a living being capable of symbolizing, perceiving the negative, transcending his environment by his inventions, ordering his environment, striving for perfection, making choices, and self-reflecting. Characteristics: 1. Living: Able to function biologically and physiologically as an animalistic, viable entity. 2. Communicating: Able to label things and to talk about them when they aren't present. 3. Negating: Able to talk about the symbolic negative (-1, no, none, not), make rules (laws regarding the "thou shalt not's"), worry about what may not happen, and consider his own nonexistence. 4. Inventing: Able to be aware of, know, and do things beyond his or her immediate environment, to invent things, and to change his relationship to the environment. 5. Ordering: Able to develop categories and hierarchies according to some	1. The degree to which one receives humanizing communication from others, to that degree one will tend to feel recognized and accepted as a human being. a. While applying the nursing process, the degree to which a nurse is able to use humanizing communication, to that degree will the client, peer, or colleague tend to feel recognized and accepted as a human being. b. In a given environment, if a critical life situation develops for a client, to the degree the nurse uses humanizing communication attitudes and patterns while applying the nursing process, to a similar degree will the health of the client tend to move in a positive direction. 2. To the degree a nurse uses humanizing elements to communicate, he or she will tend to receive humanizing communications from peers, colleagues, and superiors.	1. Clearly stated: This theory is presented in an organized, logical sequence, and is readily understood. Assumptions are stated according to widely recognized academic patterns. Its concepts are extensively defined. The relationship statements are presented in a pattern that covertly implies research designs and statistical analysis. This theory is expected to stimulate more research efforts than the theories of Dube and of Patterson and Zderad. 2. Scope: This theory is applicable to nurse-client interpersonal communication in all areas of nursing. It is also applicable to nurse-peer and nurse-colleague relationships. As a paradigm variation of Dube's "I-Thou" and of Patterson and Zderad's humanistic nursing theory, this theory provides a more readily testable and measurable approach to abstract concepts. It also incorporates the writings and research of Burke (1960), Jourard (1971), Egan (1970, 1971), Berlo (1960), Patterson and Zderad (1970), Yura and Walsh

6. Survival is based on one's ability to communicate with others in order to share feelings and facts about the environment and ways of coping.

7. The environment is a "booming, buzzing" world of strange sensations that must be sorted out to determine which are most important; this sorting is achieved through communication with other people.

8. The need to communicate is an innate imperative for human beings.

9. Due to innate fallacies, human beings use and misuse all capabilities, especially the ability to communicate. An example is speaking to a human being as a thing rather than a person.

10. The way in which a person communicates determines what that person becomes.

11. Interpersonal communication is a humanizing factor that is an innate element of the nursing process (assessment, planning, implementation, and evaluation) and of the communication that occurs between nurses and clients, nurses and peers, and nurses and professional colleagues.

12. Evaluation of a person's own communication skills is subjective

value of theme; gives structure and system to one's environment.

6. Dreaming: Able to dream of how things could be if all were perfect; expectations, hopes for future.

7. Choosing: Able to consider numerous alternatives, implications for the future.

8. Self-Reflecting: Able to think about and talk about self, reflect on own behavior and understand self, body, behaviors, etc. Conscious of the existential elements (see assumption #2).

Roles:

Nurse: A human being who practices nursing, intervening through the application of the nursing process to develop a plan of nursing care for a specific client or group of clients. The nurse possesses special educational and licensure credentials as required by society.

Client: A human being who is experiencing a critical life situation, potential or actual. He or she has need of the services of the nurse and is the focus of the nursing process. The client can also be seen to include the support system of family, friends, and so on.

Peer: A nurse having equal standing or status to another nurse.

Colleague: A member of another profession with whom nurses coordinate and collaborate in the practice of nursing—that is, physicians, administrators, ministers, and members of

3. To the degree that trust, self-disclosure, and feedback occur, to that degree humanizing communication or communing also occurs.

4. In the event one tends to experience dehumanizing communication—that is, monological rather than dialogical communication, categorical rather than individualistic, and so on—then one tends to move outward (on the model) to the next pattern of interaction. (See figure.)

5. In an interpersonal relationship of trust, self-disclosure, and feedback, to the degree that dehumanizing communication attitudes are expressed by another, to that degree one tends to use assertiveness as a pattern of interaction.

6. To the degree that assertiveness tends not to reestablish trust, self-disclosure and feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to use confrontation as a pattern of communication.

7. To the degree that confrontation tends not to reestablish trust, self-disclosure or feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another,

(1973), Klerkegaard (1957), Maslow (1954), Mead (1934), Rogers and Truax (1971), Sartre (1957), Patton and Giffin (1977), Giffin and Patton (1974), and others.

3. Applicability: This theory is realistic in that it recognizes the ways in which nursing and health care systems are dehumanizing to nurses, clients and others. However, it emphasizes the choice of the nurse in using communication patterns that tend to be humanizing. It is an "is" theory, not a "should" theory. This is also a "state" theory in that it assumes that communication "here and now" can change the future.

4. Generalizability and agreement with known data: The theory is derived from a broad base of communication theory and research. It brings together information often taught in nursing curricula and puts it into a cohesive perspective that is intended to be more readily understood and used by nurses.

The theory is unique in that it recognizes the negative, unpleasant encounters nurses often have in clinical practices, and it provides a framework for developing modes of coping with dehumanizing communications.

5. Research support for the theory.

a. On trust by K. Giffin (1967). Extensive support from speaker credibility

Assumptions	Concepts	Relationship Statements	Evaluation
One; each individual must make his or her own decisions and choices about communication behavior and choose to change, depending upon his or her ability to utilize feedback. <i>Derived from Nursing:</i> 13. The purpose of nursing is to intervene to support, maintain, and augment the client's state of health. 14. A human being functions as a unique, whole system responding openly to the environment. <i>Specific to the Theory:</i> 15. Health, satisfaction and success in a person's life and work—in other words, that person's state of being—is derived from feeling human. 16. Due to the bureaucratic and complex nature of the present health care delivery systems, there is a tendency for clients and professionals to be treated in a dehumanizing manner and to relate to one another in a dehumanizing manner. 17. Humanizing patterns of communication can be learned and can enhance the nurse's awareness of and sensitivity to the client's state of being and of becoming.	health care professions and community service agencies. <i>Nursing:</i> The art and science of positive, humanistic intervention in the changing health states of human beings interacting in the environment of critical life situations. Its elements are communicating, caring, and coaching. <i>Nursing process:</i> This involves assessment, planning, implementation and evaluation. <i>Health:</i> One's state of being, of becoming; of self-awareness. It is indicative of one's adaptation to the environment. <i>Environment:</i> One's time/space/relationship context. <i>Critical life situation:</i> A situation in which there is a perceived threat to one's health state, in which one's existential state of being is salient, as in cancer, childbirth, accidents, and so on. <i>Communication:</i> A dynamic interpersonal process involving continual adaptation and adjustments between two or more human beings engaged in face-to-face interactions during which each person is continually aware of the other(s). A process characterized by being existential in nature, involving an exchange of meaning, concerning facts and feelings, and involving	to that degree one tends to use conflict resolution as a pattern of communication. 8. To the degree that conflict tends not to reestablish trust, self-disclosure, and feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to terminate the relationship by separation. 9. To the degree that humanizing communication attitudes occur in a relationship, in the event of separation, the relationship can be resumed to the same degree of closeness regardless of the separation. 10. The degree to which a nurse uses humanizing communication, to that degree will the nurse receive humanizing communication from others—clients, peers, colleagues, and superiors 11. To the degree that one is aware of one's own choices (and motives) about interaction patterns and attitudes, to that degree one is able to develop communication skills and habits which tend to have predictable results in establishing, maintaining and terminating interpersonal relationships.	research in the field of speech communication. b. Jourard (1971), Egan (1970, 1971) on self-disclosure and feedback. c. Grant (Duldt)(1977) found that anger expressed in the maintenance mode tends to increase group cohesiveness and maintain relationships between nursing task members; the destructive mode of expressing anger tends to destroy relationships, decreasing productivity and group attraction. d. Duldt (1982) identified the "anger-dismay" syndrome as a complex of behaviors nurses tend to display when receiving destructive-mode anger from others, especially from superiors. e. Duldt (1982) found that training workshops in communicating alienating messages, especially anger, decreases feelings of guilt and increases awareness of alienating patterns of communication. Role-playing and rehearsal also assist nurses in improving coping. 6. Importance to the Discipline: Nursing is being described as humanistic by many nurse authors, but few nurse theorists have reflected this in their theories of nursing. This theory is not intended to stand alone, but explains in detail only the phenomenon of communication. It is intended to serve with other nursing theories to augment and enhance the realistic appli-

18. The goal of the humanistic nurse is to break the communication cycle of dehumanizing attitudes and interaction patterns, replacing these with attitudes and patterns that humanize.

19. Interpersonal communication is the means by which the nurse becomes increasingly sensitive to and aware of the client's state of being, of the dynamic relationship between the client and his or her environment, and of the client's potential.

dialogical communing. It contains the following set of attitudes:

Humanizing	Dehumanizing
continuum	
Dialogue	Monologue
Individual	Categories
Holistic	Parts
Choice	Directives
Equality	Degradation
Positive Regard	Disregard
Acceptance	Judgment
Empathy	Tolerance
Authenticity (of feelings)	Role-Playing
Caring	Careless
Irreplaceability	Expendability
Intimacy	Isolation
Coping	Helpless
Power	Powerless

Humanistic communication involves an awareness of the unique characteristics of being human.

Dehumanizing communication ignores the unique characteristics of being human.

Set of Interaction Patterns of Communication:

Communing: Dialogical, intimate communication between two or more people; the heart of humanistic communication.

1. Trust: One person relying on another on another, risking potential loss in attempting to achieve a goal, when the outcome is uncertain; and the potential for loss is greater than for gain if the trust is violated.

cability of other theories in clinical nursing. For example, the patterns of interactions and the attitudes of this theory would enhance nursing theories involving the nursing process and the communicating occurring with its operationalization. Also, the patterns of interaction and attitudes of the nurse are a significant aspect of therapeutic touch theory and would augment this theory as well.

Assumptions	Concepts	Relationship Statements	Evaluation
	2. Self-disclosure: Risking rejection in telling how one feels, thinks, and so on, regarding "here and now" events. 3. Feedback: Describing another's behavior, beliefs, and so on, plus giving one's evaluation or feelings. 4. Assertiveness: Expressing one's needs, thoughts, feelings or beliefs in a direct, honest, confident manner while being respectful of others' thoughts, feelings or beliefs: "asserting with authenticity." 5. Confrontation: Providing feedback about another plus requesting a change in his or her behavior: "confronting with caring." 6. Conflict: Requires a decision over an issue in which there is risk of loss as well as possible gain, in which two or more alternatives can be selected, and in which one's values are involved: "conflicting with dialogue." 7. Separation: The end of a relationship due to change, choice, or outside commitments: "separation with sadness." Note: Trust, self-disclosure, and feedback represent the center of humanistic communicating—the central tripod.		

APPENDIX B

COMMUNICATION BEHAVIORS QUESTIONNAIRE

Please indicate your response to the following statements by checking the appropriate blank space or writing in your answers.

1. Age: _____ 2. Sex: M _____ F _____ 3. Marital Status: Single _____ Married _____ Divorced/Separated _____ Widowed _____

4. Highest Level of Nursing Education: AD _____ Diploma _____ BSN _____ MSN _____

5. Educational Preparation other than nursing: No _____ (degrees in other areas) Yes _____ (If yes, please describe) _____

6. Type of unit where you currently work: medical unit _____ surgical unit _____ critical care unit _____ ER _____ OR _____ Pediatrics _____ Obstetrics _____ Psychiatry _____ Other (please describe) _____

7. Number of years in present position: less than 1 year _____ 1 - 3 years _____ 3 - 6 years _____ 6 - 10 years _____ more than 10 years _____

8. Number of full-time staff nurses on your unit: _____

MOST NECESSARY COMMUNICATION BEHAVIORS

This section is designed to discover your perception of the communication behaviors most necessary for nurses to exhibit according to the following scale:

- 5 - Very important
- 4 - Quite important
- 3 - Somewhat important
- 2 - Not very important
- 1 - Unimportant

Please respond to each communication behavior by placing the number of the response which best describes your opinion on the line beside the behavior.

LISTENING VARIABLES

- | | |
|---|--|
| _____ Listening to others without frequent interruption | _____ Spending time listening to others |
| _____ Understanding what others are saying | _____ Paying attention to what others are saying |

MESSAGE VARIABLES

- | | |
|--|---|
| _____ Getting the point across clearly | _____ Speaking from clearly planned and organized ideas |
| _____ Staying on important subjects | _____ Showing a grasp of subject matter |

LANGUAGE VARIABLES

- | | |
|---|---|
| _____ Using colorful, descriptive, and interesting language | _____ Using correct grammar and pronunciation |
| _____ Using words efficiently | _____ Using simple, easy-to-understand language |

VOCAL VARIABLES

- | | |
|--|---|
| _____ Speaking without using vocal distractors ("you know," "ah," "um,") | _____ Articulating words clearly |
| _____ Talking with vocal variety: rate, volume, pitch | _____ Talking with a pleasant voice quality |
| | _____ Using vocal volume which is appropriate to conditions |

PHYSICAL VARIABLES

- | | |
|--|-------------------------|
| _____ Using facial expression | _____ Using eye contact |
| _____ Using physical movement and gestures | |

STYLE/EMOTIONAL VARIABLES

- | | |
|--|---|
| _____ Empathizing; "feeling with" others | _____ Dealing with others in an objective and fair manner |
| _____ Dealing with others tactfully | _____ Showing appropriate sense of humor |
| _____ Showing personal warmth; making others feel close to him/her | _____ Showing friendliness to others |

FORM B

FREQUENCY OF NEGATIVE COMMUNICATION BEHAVIORS

This section is designed to discover your perception of how often you note the indicated communication behavior by nurses within the past two weeks according to the following scale:

- 5 - Very often
- 4 - Often
- 3 - Sometimes
- 2 - Rarely
- 1 - Practically never

Please respond to each communication behavior by placing the number of the response which best describes your opinion on the line beside the behavior.

LISTENING VARIABLES

- | | |
|---|--|
| ☐ Interrupting others | ☐ Not paying close attention to |
| ☐ Not understanding what others are saying | ☐ what others are saying |
| | ☐ Unwilling to listen to others |

MESSAGE VARIABLES

- | | |
|--|--|
| ☐ Unable to get points across clearly | ☐ Having insufficient grasp of subject matter |
| ☐ Speaking in an unorganized, or poorly planned, manner | ☐ Deviating too often to insignificant subjects |

LANGUAGE VARIABLES

- | | |
|--|--|
| ☐ Using poor grammar and/or pronunciation | ☐ Using many words to say very little |
| ☐ Using slang and/or vulgar language | ☐ Using words which are difficult to understand |
| ☐ Using dull or unimaginative language | |

VOCAL VARIABLES

- | | |
|---|---|
| ☐ Using vocal distractors ("you know," "ah," "um") | ☐ Talking in a monotone |
| ☐ Using sloppy articulation | ☐ Talking too loudly or too softly |
| | ☐ Talking with an irritating voice quality |

PHYSICAL VARIABLES

- | | |
|---|---|
| ☐ Using inadequate eye contact when speaking | ☐ Using too little physical movement and/or gestures |
| | ☐ Using distracting physical mannerisms |

STYLE/EMOTIONAL VARIABLES

- | | |
|---|--|
| ☐ Unable or unwilling to "feel with" (empathize) with others | ☐ Showing tactlessness in dealing with others |
| ☐ Showing closed-mindedness towards the ideas of others | ☐ Unable to gain credibility with others |
| ☐ Having a "cold" personality; unable to make people feel close to him/her | ☐ Unable to resolve differences with others |
| | ☐ Showing an inappropriate sense of humor |

FORM C

DETRIMENTAL EFFECTS OF NEGATIVE COMMUNICATION BEHAVIORS

This section is designed to discover your perception of how detrimental, when noted, the presence of this communication behavior is to the nurse's performance according to the following scale:

- 5 - Very detrimental
- 4 - Quite detrimental
- 3 - Somewhat detrimental
- 2 - Not very detrimental
- 1 - Practically of no detriment

Please respond to each communication behavior by placing the number of the response which best describes your opinion on the line beside the behavior.

LISTENING VARIABLES

- | | |
|-------------------------------------|-------------------------------------|
| _____ Interrupting others | _____ Not paying close attention to |
| _____ Not understanding what others | _____ what others are saying |
| _____ are saying | _____ Unwilling to listen to others |

MESSAGE VARIABLES

- | | |
|-----------------------------------|------------------------------------|
| _____ Unable to get points across | _____ Having insufficient grasp of |
| _____ clearly | _____ subject matter |
| _____ Speaking in an unorganized, | _____ Deviating too often to |
| _____ or poorly planned, manner | _____ insignificant subjects |

LANGUAGE VARIABLES

- | | |
|-----------------------------------|---------------------------------------|
| _____ Using poor grammar and/or | _____ Using many words to say very |
| _____ pronunciation | _____ little |
| _____ Using slang and/or vulgar | _____ Using words which are difficult |
| _____ language | _____ to understand |
| _____ Using dull or unimaginative | |
| _____ language | |

VOCAL VARIABLES

- | | |
|-------------------------------------|--|
| _____ Using vocal distractors ("you | _____ Talking in a monotone |
| _____ know," "ah," "um") | _____ Talking too loudly or too softly |
| _____ Using sloppy articulation | _____ Talking with an irritating voice |
| | _____ quality |

PHYSICAL VARIABLES

- | | |
|------------------------------------|---------------------------------------|
| _____ Using inadequate eye contact | _____ Using too little physical move- |
| _____ when speaking | _____ ment and/or gestures |
| | _____ Using distracting physical |
| | _____ mannerisms |

STYLE/EMOTIONAL VARIABLES

- | | |
|-------------------------------------|---|
| _____ Unable or unwilling to "feel | _____ Showing tactlessness in dealing |
| _____ with" (empathize) with others | _____ with others |
| _____ Showing closed-mindedness | _____ Unable to gain credibility with |
| _____ towards the ideas of others. | _____ others |
| _____ Having a "cold" personality; | _____ Unable to resolve differences |
| _____ unable to make people feel | _____ with others |
| _____ close to him/her | _____ Showing an inappropriate sense of |
| | _____ humor |

APPENDIX C



October 20, 1987

Rachel Edwards
Rt. #1, Box 68 J
Newton Grove, N.C. 28366

Dear Ms. Edwards:

Enclosed is a copy of the questionnaire I used to collect the data which were the basis of my article in the Journal of Nursing Education.

This questionnaire is not copyrighted. So you can use it any way you want, including changing it in any way to suit your purposes. Just please do me two favors: (1) Send me a copy of the questionnaire you decide to use, if it's a modification of mine; and (2) Send me a copy of your results.

Best wishes in your research. I am looking forward to hearing of your results.

Cordially,

S. Clay Willmington, Professor
Department of Speech

Enc.
SCW/smw

APPENDIX D

This study has been explained to me. I understand that it is a survey of head nurses on the subject of communication and that it involves no risk to the subjects. I also understand that participation is voluntary and that individual responses will be anonymous and confidential.

I agree to have Rachel Edwards come to this facility and conduct the survey.

Director of Nursing: _____

Date: _____

APPENDIX E

March 7, 1988

Dear Head Nurse:

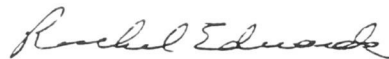
I am a graduate nursing student at East Carolina University. I would appreciate your assistance in a study I am conducting as part of the requirements for my MSN. It consists of a survey of head nurses, most of whom observe staff nurses as they interact with patients, peers and other members of the health team. I would like to determine which communication behaviors you believe to be most needed by nurses and how often you have noted the use of ineffective communication behaviors within the past two weeks. Also, I'd like to know how detrimental you believe the use of ineffective communication behaviors are to the nurse's performance.

Please respond to the three survey questions by rating each of the communication behaviors using the scale at the top of each page. This should take approximately 15 minutes.

Your completed questionnaire constitutes permission to participate in the study. Your responses are confidential, and will not be identified in any way. Do not write your name on the questionnaire. If you would like a copy of the results of this survey, please indicate this by signing the paper that will be circulated.

Thank you very much for your participation.

Sincerely yours,

A handwritten signature in cursive script that reads "Rachel Edwards".

Rachel Edwards