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Nurses' Verbal Responses in Four Types of Client Situations

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NURSES' VERBAL RESPONSES IN FOUR TYPES OF CLIENT SITUATIONS

By

Ann V. Dilbeck

A THESIS

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ABSTRACT

NURSES' VERBAL RESPONSES IN FOUR TYPES OF CLIENT SITUATIONS

By

Ann V. Dilbeck

The purpose of the study was to determine to what degree nurses vary in their utilization of empathy when responding to patients experiencing different types of physical and emotional discomfort. Nurse participants ($N = 32$) worked primarily in a hospital setting. They were administered the Behavioral Test of Interpersonal Skills and responded to videotaped vignettes. Actors portrayed patients exhibiting pain, anxiety, depression, or anger. "Feeling", "Content", or "Don't Feel" were the three categories scored. "Don't Feel" responses negate or suppress patient's feelings.

A chi - square was done to compare "don't feel" responses to all other responses. "Don't Feel" responses were generally used in depression, anger, and anxiety. Nurses tended to identify feeling responses better in pain. Nurses reflected content more often than feelings for depression, anger and anxiety.

Many nurse subjects offered solutions to the problems offered by the patient. In general nurses use of empathy was limited.

Acknowledgments

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My family has been patient and for that I am grateful. My husband has put my wants before his own and has been extremely supportive and patient. We married during the time of writing this paper and we could not truly begin our new life together with our children until this was completed. I am eternally grateful to him. My children have also had to forego their desires so that I could fulfill mine. Many times I have had to say "no" because of my school work. I hope that they forgive me.

I would also like to thank you the reader. Nursing is a wonderful profession. It needs some refinement in the way communication is given. Each and every one of us has the ability to be more empathetic to those hospitalized. I know that I will do my best and hope you do likewise.

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CHAPTER 1

INTRODUCTION

Empathy is defined as borrowing the feelings of patients in order to completely understand them, but simultaneously being aware of one's own individuality. Empathy should reflect current feelings not those of a previous time or day (Kalisch, 1973). Many nurses chose the nursing profession to care for people, not to simply perform tasks (Herbek & Yammario, 1990). Empathy allows the nurse to respond professionally to a patient (Morse, Bottoroff, Anderson, O'Brien, & Solberg, 1992). Nurses have the obligation to use empathy in their practice. Patients need to feel understood and feel that someone cares for them.

Current literature regarding empathy is difficult to locate. Empathy is no longer a topic of research as it once was in the 1970s and 1980s. Although the concept of empathy remains true, there has been little new literature or research written about the subject.

Studies indicate that nurses do not rate high in empathy (Kramer & Schmalenberg, 1977; La Monica, Carew, Winder, Haase, & Blanchard, 1976). Olson (1993) concludes that in the 1990s, nurses continue to score low in the area of verbal empathy. This may be due in part to discomfort with patients experiencing unpleasant emotions and physical experiences. Yet, effectiveness of communication would increase if more empathy is used (Kramer & Schmalenberg, 1977). In addition, a deeper understanding of another's world would lead to more successful nursing interventions. Positive patient outcomes are the result of language expressions that are in harmony with the patient's feelings (Williams, 1979). A nurse who uses good communication skills would provide a boon in nursing (Olson, 1993). Goals for the patient would be unique and individualized

when empathy is used (La Monica et al., 1976). Stressors felt by patients could be lessened if nurses were more empathetic, thereby helping patients cope with their hospitalization (Herbek & Yammario, 1990).

Because nurses do not rate high in empathy, the purpose of this study was to determine to what degree nurses vary in their utilization of empathy when responding to patients experiencing different types of physical and emotional discomfort. Replication of a study by Olson and Iwasiw (1989) was undertaken.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Nurses are very good at explaining what they think is the best for the patient. Outcomes of nursing care are often based solely on nursing judgments. Patient concerns are often not the priority. If nurses provide an accurate and sensitive understanding of their patient's feelings and experiences, positive patient-centered outcomes will occur (Williams, 1979).

Conceptual Framework

Carl Rogers theory is the conceptual framework used in this study. Carl Rogers proposed three conditions essential for a therapeutic relationship. These are empathy, congruence or genuineness, and unconditional positive regard. The first condition is empathy. According to Rogers (1961), empathy is sensing the private world of a patient as if it were your own. One needs to sense the patient's anger, fear, or confusion without being bound up in it. When the patient's world is clear to the helper, the helper can assist the patient to understanding the emotion that drives the communication. Yet, Truax and Carkhuff (1967) suggest that it is not necessary for the helper to share the client's feelings in any sense that would require him/her to feel the same emotions. Rather, it is a sensitive awareness of those feelings. Also, Morse et al. (1992) propose that nurses need to emotionally detach themselves from patients' feelings because of stressful procedures and treatment.

Rogers (1961) suggests that at high levels of empathy, the helper's remarks fit perfectly with the client's mood and content. Low levels of empathy may represent the helper going off on a tangent of

his/her own and misinterpreting what a client is feeling (p. 46).

Empathetic understanding is important in communication. Rogers (1961) proposes that there is an enormous amount of value gained when another is understood. Understanding precisely the meaning of a statement is risky. This understanding may cause a change. Rogers (1957) defines this idea as constructive personality change. Change causes fear (p.18) but may also create a more responsive person (p. 19). Rogers (1961) suggests there is positive value when a helper can understand. Individuals may develop insight into themselves and their own communication style.

One way to establish a helping empathetic relationship, according to Rogers, is for the helper to feel strong enough to separate personal feelings from those of the patient. When nurses are not upset by another's depression or frightened by another's fear, nurses can feel the strength of being individuals. This strength of feeling allows nurses to be more understanding and accepting of patients without being afraid of losing their individuality.

The second therapeutic condition is congruence or genuineness. Rogers (1961) suggests that a helpful relationship is free of a facade in which behavior and thoughts are different. If anger is the emotion felt by the nurse, then it needs to be conveyed in a non-confrontive manner. If elation is the emotion felt, than it needs to be expressed. Rogers (1961) further suggests a nurse is more helpful when acceptance of oneself is found. Then the nurse is freely and deeply him/her self. The emerging relationship is genuine (Rogers 1957).

This acceptance allows a client to truly become a whole person in a helping relationship. Rogers (1957) proposes that this is the opposite of presenting a facade. Truax and Carkhuff (1967) define genuineness as the absence of defensiveness or phoniness (p. 43). Whereas Rogers (1961) calls this congruence and defines it as being trustworthy. Whatever feeling or attitude is being experienced, it is

matched by an awareness of that attitude. Rogers (1961) implies that this experience makes one a unified or integrated person. Others find this experience secure. When the experience is one of annoyance towards another person and the helper is unaware of it, then the communication contains contradictory messages. This causes distrust. If congruence is present in a relationship, then the relationship would appear helpful.

The third condition is unconditional positive regard. Rogers (1961) indicates that there needs to be a positive attitude towards others. Rogers (1957) defines this concept as unconditional positive regard. The helper will experience a warm acceptance of the client's experiences. There are no conditions to acceptance. If one is afraid to freely experience these positive attitudes, distance builds up and aloofness is present. Rogers (1957) suggests that there needs to be acceptance of negative, painful, fearful, defensive, or abnormal expressions as well as those that are confident, mature, or positive. Rogers (1961) proposes that one must feel safe to care and to relate to others' positive feelings.

Rogers (1961) suggests that when helpers accept and understand themselves, there is less inclination to fix things, to set goals, to mold others, or to manipulate and coerce others to move in a direction that is set by the helper. There is contentment in being oneself and allowing another to be him or herself (p. 21). Rogers (1961) states that a barrier to communication is the tendency to judge, to evaluate, to approve, or to disapprove the statements of others (p. 330). In situations where feelings and emotions are deeply involved, the tendency to evaluate is common. The primary reaction to a statement is to evaluate what has been said from one's point of view, one's own point of reference. Rogers (1961) says that the stronger the feelings are, the more likely there will be no understanding in the communication. Forming an evaluation of an emotionally meaningful statement is a major barrier

to interpersonal communication.

This study focused solely on the use of verbal empathy in response to patient statements of discomfort while acknowledging the role played by congruence and unconditional positive regard in good empathetic communication. Empathetic communication is necessary in nursing. Nurses deal with patients, doctors, administration, and ancillary personnel. They need to use effective communication skills.

Literature Review

Williams (1979) proposed that the level of empathetic communication had a strong probability of enhancing or decreasing the self-concept of patients. Patients respond to the verbalizations of their nurse. Brown and Hunter (1987) suggested that physicians and nurses require different empathy skills depending on work and interaction but all require empathy.

This later study looked at whether different psychological characteristics affected empathy. Brown and Hunter (1987) conducted a descriptive study to determine the relationship between various personality factors as measured by the California Psychological Inventory and the ability of the research subjects to express empathy as measured by the Hogan Empathy Scale. The authors proposed that high levels of empathy are associated with favorable therapeutic outcomes but the latter was not measured. A convenience sample of nurses ($n = 54$), hospital administrators ($n = 10$), and psychiatrist ($n = 10$) was used. All nurses were registered nurses (RNs). Administrators were registered nurses performing administrative tasks, such as Director of Nurses. All psychiatrists were in private practice but also had hospital privileges. Nurses worked in a medical-surgical unit ($n = 12$), intensive care unit ($n = 10$), and psychiatric acute care unit ($n = 12$).

There are 17 scales in the California Psychological Inventory that were tested in this study. Those were: Dominance, Capacity for Status, Sociability, Social Presence, Self-Acceptance, Well-Being,

Responsibility, Socialization, Self-Control, Tolerance, Good Impression, Communality, Achievement Independence, Intellectual Efficiency, Psychological Mindedness, Flexibility, and Femininity. The Hogan Experimental Scale for Empathy was also administered. According to Brown and Hunter (1987) there are many differences in the definition and measurement of empathy that could be a potential weakness of this study.

Empathy was significantly related to the first five scales. Brown and Hunter (1987) suggests that these scales often reflected poise and interpersonal adequacy. Those five scales were Dominance ($r = .57$), Capacity for Status ($r = .72$), Sociability ($r = .64$), Social Presence ($r = .64$), and Self-Acceptance ($r = .51$). Intellectual Efficiency was also correlated with the empathy scale ($r = .65$). Four of these scales (Dominance, Capacity for Status, Self-acceptance, and Intellectual Efficiency) showed a significant difference between sample subgroups at a level of $p < .05$. Psychiatric nurses scored the highest in three of the five scales. Next came psychiatrists, administrators, intensive care nurses, and medical surgical nurses. All groups scored in the average range of scores on the California Psychological Inventory. The authors concluded that perhaps the tools would be useful in the selection and prediction of success for nursing school applicants or for those who desire psychiatric training or for suitable hospital assignments.

Two limitations of the study were that there was no reference as to how data were collected nor did the authors reveal the definitions of the various scales. Weaknesses in this study included a very small sample in each of the subgroups and use of only one urban hospital. Because the instruments were pen and pencil, the subjects' verbal empathic ability was not measured.

Another study looked at whether demographic characteristics of nurses made a difference in empathic ability. Forsyth (1979) conducted an exploratory research study of nurses ($n = 70$) and patients ($n = 70$) from two Midwestern cities. The research was to determine if

significant differences existed in empathic ability in relation to various characteristics of nurses and the relationship between the nurses' interactive empathic ability and the perceptions of patients. Nurse subjects responded to 39 true and false items on the Hogan Empathy Scale. Patients' perceptions of the nurses' empathy were measured by 32 items on the Barrett-Lennard Relationship Inventory. According to the author, the inventory measured the patient's perception of the helper's level of empathetic understanding, unconditional regard, and congruence. After at least three interactions with a particular nurse, each of the 70 patients in the sample filled out the inventory while in his or her hospital room.

Descriptive statistics revealed that empathic ability scores for nurses were in the middle to upper level range of scores. Although older nurses scored lower, the variation by age was not statistically significant. Married nurses and those with children also scored higher than single and childless nurses, but it was not significant. Baccalaureate nurses displayed significantly higher levels of empathic ability than diploma nurses ($p < .05$). Associate degree nurses had higher empathy scores than did diploma nurses but the results were not statistically significant. Although nurses who had been in practice for less than two years scored higher in empathic ability than nurses who had practiced longer, there was not a statistical difference. In the area of level of practice, head nurses scored higher in empathic ability than staff nurses. Empathic ability was not significantly related to area of practice. A correlation of .43 was found between education and empathic ability. There was no significant correlation between the demographic variables of the nurses and empathy according to patient evaluations.

Forsyth (1979) suggested that nurses can make empathic responses without experiencing empathy. The author cited that patients' perception of nurses' use of empathy was high, as revealed by Barrett-

Lennard scores of 48 or more, while nurses' scores on the Hogan Empathy Scale showed that only 50% of nurses had high empathic ability. Forsyth (1979) suggested that patients perceive all nurses as empathic, whether they are or not. Findings of the study indicated that the six variables (age, marital and parental status, education, and length or level or area of practice) did not have any predictive ability for determining nurse empathic ability. According to Forsyth, empathic ability needs to be rewarded. Empathy does not just happen, it needs to be taught. Weaknesses of this study were the small sample size and the few male nurse participants. Males who were tested in this study consistently scored higher on empathy than females. Location of the two mid-western hospitals in one city was also a weakness.

Another study looked at levels of empathy of RNs. LaMonica, Carew, Winder, Haase, and Blanchard (1976) conducted a quasi-experimental design study of female registered nurses ($N = 39$). One purpose of this study was to obtain an objective measure of the level of empathy of registered nurses who practiced in an acute care hospital before and after a staff development program was presented. There were three groups. Group 1 ($n = 12$) was the experimental group. The subjects in group 1 received a pretest, a staff development program, and a posttest. Group 2 ($n = 12$) received the pretest and posttest without a staff development program. Group 3 ($n = 15$) received the posttest only to compare to Group 2 and examine the effect of the pretest on the posttest.

A medium sized, urban, acute and chronic care hospital was the setting. Nurses received their education in either a diploma or associate degree program. To avoid an additional variable of higher education, baccalaureate degree nurses were excluded from the study. Ages of the participants were 21-45 years. All nurses worked continually for a minimum of six months prior to the study as staff nurses, assistant head nurses, or head nurses. The obtained data were used to

develop a human relation model for a staff development program. Effectiveness of the human relation model used had previously been documented. According to La Monica et al. (1976), the human relations model was designed to be applicable to all helping professions. Training in perceiving and in responding empathically was the core of the program. The objective of the training program was to examine whether or not communication skills learned could be generalized in work with patients.

Two instruments were used to gather data. Carkhuff's Index of Communication was used to assess the effects of the staff development program. The instrument consisted of 16 short paragraphs that suggested feelings and content often found within helping relationships. Each nurse subject had to read the paragraph and make a response. Carkhuff's Empathy Scale was also used. There were four levels of responses. These levels ranged from a hurtful response to one that encompassed true empathy. The trainer was also tested and had to achieve a 3.94 on a 4.0 point scale to test others. La Monica et al. (1976) reported that a 3.94 on a 4.0 scale is generally recognized as an adequate score for a trainer.

A Mann-Whitney U Test was performed on data gathered from the two pretested groups. La Monica et al. (1976) desired to find out whether the two independent groups had been gathered from the same population. For Group 1 the mean score was 1.47; the median score 1.45. Group 2 had a mean score of 1.49 and median score of 1.45. The results showed no significant differences between groups.

A Kruskal-Wallis one-way analysis of variance by ranks was used to test the differences among the post-test groups. Authors hypothesized that there would be no significant differences in mean scores on Carkhuff's Index of Communication at posttest within all three groups. The experimental group had a mean score of 2.58 and a median score of 2.53. The pre- and posttested control group had a mean score of 1.66 and

a median score of 1.62. The post-test only control group had a mean score of 1.67 and a median score of 1.60. There were significant differences found in the three groups. Therefore, a Mann-Whitney U Test was used to assess the differences in means among the three groups' posttest scores. Significant differences were revealed in both tests between the experimental group and the two control groups at levels less than $\alpha = .002$. Therefore the program was effective in increasing the subjects' ability to perceive and respond empathetically. Another result was that pretesting had little effect on posttest scores and the time lapse of seven weeks between the start and conclusion of the experiment was not a significant variable. According to the authors, these findings suggested that registered nurses as a group possess extremely low levels of empathy.

Several weaknesses were evident in this study. The study was heavily dependent on one standardized instrument and rating scale. No males were used in the study. Also, the small group sizes made differences difficult to detect, yet they did find differences among the groups. The sample was from only one location and the findings cannot be generalized to the larger population of nurses.

Olson and Iwasiw (1989) conducted a study that explored whether differences exist in staff nurses' verbal empathy in response to patients who experienced pain, depression, anxiety, or anger. A convenience sample of 66 volunteer nurses participated in the study. Full-time RNs who had been employed as staff nurses for a year qualified for the study. Nurses worked in acute care facilities and community agencies. Twenty-eight community health nurses and 14 acute care nurses had baccalaureate nursing degrees. The remaining 24 acute care nurses had a nursing diploma. Nurses came from six acute care hospitals and two community health agencies in two Canadian cities. The age range of the subjects was 23-59 years old with 71.3% of the nurses in the sample between the ages of 25 and 34 years. Over a third of the nurses had

practiced one to five years and over a third of the nurses had practiced six to ten years.

The Behavioral Test of Interpersonal Skills for Health Professionals (BTIS), developed by Gerrard and Buzzell (1980), was the tool used to test subjects. The BTIS is a color videotape of 26 problem statements. Thirteen are patient situations and an equal number are health professional situations. All were role played by actors and actresses. There is a 30 second period of silence after each situation that allows the subject to respond as if interacting with a real person. The responses were videotaped. Eight patient situations were scored in the Olson and Iwasiw study.

Nurses' responses were rated in three different areas. One area was "content." According to Olson and Iwasiw, content refers to the ability of the nurse to restate patients' verbal messages. Restating the content allowed the patient to feel understood. Secondly, "feeling" was evaluated. Nurses were scored on their ability to respond to any general upset or anger. Lastly, "Don't Feel" statements were scored. "Don't Feel" statements were those that belittled or negated the feelings of patients. That type of statement did not validate patients' feelings or responses. "Don't worry, it will be O.K." is an example of a "Don't Feel" statement. They are attempts to suppress or discourage expression. Higher test scores indicated more empathy and lower test scores indicated less or no empathy.

"Content" scores were higher than "feeling" scores for three of four types of situations (depression, anxiety, and anger). Olson and Iwasiw (1987) suggested that nurses responded to the content easily but responding to feeling was difficult. Thus, differences existed in the staff nurses' responses to the four different patient situations. Nurses most often identified feelings expressed in situations of pain and anger. Feelings of anxiety and depression were most often ignored or avoided. Nurses were able to restate content messages in situations of

pain, depression, anxiety, and anger. "Don't Feel" messages were often given for anger and anxiety. The authors recommended that continuing education is needed for nurses verbal empathy when they deal with the angry or anxious patient.

One weakness of the Olson and Iwasiw study was the overrepresentation of community health nurses. A second weakness might be that only nurses who felt confident with videotape equipment volunteered to be a subject. The third limitation to the study was that the numbers of men and women were not indicated.

Another important study looked at nurses' verbal empathy and how patients perceived what had been spoken. Olson (1993) conducted a research study examining empathy. Its purpose was to determine whether there was a relationship between nurse expressed empathy, patient perceived empathy and patient distress. All subjects were from Canada.

Volunteer hospital-based nurses ($N = 70$), aged 22 - 49 years, were the subjects. Female nurses ($n = 67$) made up 95.7% of the study sample. Male nurses ($n = 3$) made up 4.37% of the sample. Diploma nurses ($n = 61$) were the highest proportion of nurses (87.1%) in the sample. Baccalaureate and post-baccalaureate degree nurses ($n = 9$) comprised 12.9% of the study sample. Nurses practiced from five to over 21 years. Nurses practiced on a medical unit ($n = 37$, 52.9%) or on a surgical unit ($n = 33$, 47.1%). Most nurses worked part time (51.4%).

Five different instruments were used to test the hypothesis. The Behavioral Test of Interpersonal Skills and the Staff-Patient Interaction Scale were completed by nurse subjects. The Barrett-Lennard Relationship Inventory, the Profile of Mood States and the Multiple Affect Adjective Checklist were completed by patient subjects.

Nurse expressed empathy was measured by use of the Behavioral Test of Interpersonal Skills (BTIS). The BTIS provided a measure of actual behavior in response to a wide variety of interpersonal situations. Nurse-subjects were audio-taped while responding to the BTIS. A quiet,

private room was used for the taping sessions. It took 15 minutes. Nurse-subjects completed a demographic data sheet after completion of the BTIS.

Olson used the Staff-Patient Interaction Response Scale to assess nurse subjects' expressed empathy based on written responses to a series of statements made by hypothetical patients. This tool includes four vignettes followed by five patient statements. Nurse-subjects had 30 minutes to respond to the 20 patient statements. Nurse responses could be categorized into three possible levels of empathy. The first level, which was the lowest level, indicated "no care" as shown by responses that belittle or contradict the patient. Second level of empathy, "solution," involved either telling patients to do something or offering a solution to a concern or asking the patient to clarify the statement. The third level of empathy, "affective involvement," included responses that addressed patient's feelings, what precipitated those feelings, or patient self-esteem.

During the day of nurse-subject data collection, each nurse identified patients for whom care was rendered. One patient was randomly selected by the author for potential participation in the study. If participation was refused, another patient was randomly selected from the remaining patients until one consenting patient-subject had been recruited for each nurse-subject. The study was described by the investigator and written consent was obtained. The questionnaires were completed in each patient's room.

The Barrett-Lennard Relationship Inventory was used to measure patients' perceptions of their nurse's level of empathetic understanding, level of regard, unconditional acceptance and congruence.

According to the author, distress is an unpleasant emotional feeling that occurs in response to various situations. One instrument used to measure distress was the Profile of Mood States Inventory. This tool is useful in assessing emotional changes in the normal population

as well as with those that have an emotional impairment. This instrument has been used to assess patients who are not necessarily in pain but have other distressful symptoms. Patient-subjects completed this self-report inventory that measured the dimensions of affect or mood related to feelings of tension, anger, depression, fatigue, confusion, and vigor. The Multiple Affect Adjective Check List was the last tool used in the study. It was a self-administered survey completed by patients that measured feelings of anxiety, depression, and anger. One hundred thirty-two adjectives are used to describe feelings in this checklist.

Olson (1993) presented descriptive statistics for the measures of nurse expressed empathy using the BTIS. The author defined verbal empathy as the reflection of the feelings and content of another's message without any attempt to suppress the speaker's feeling. In the area of "feeling," the possible range of scores was 0-13 with a mean of 4.73. In the area of "content," the possible range of scores was 0-13 with a mean of 7.16. In the area of "Don't Feel" (belittling statements), the possible range of scores was 0-13 with a mean of 1.16. Olson (1993) proposed that the results of this aspect of the study meant that nurses frequently identify the reasons for patients' feelings but do not identify the feelings that are expressed.

Results of the Staff - Patient Interaction Response Scale revealed a mean score of 20.33. There was a possible score of 40 with scores in this sample ranging from 0 to 35. Olson (1993) concluded that the nurses' level of expressed empathy was low. They made empathic responses in less than 55% of the opportunities that they had.

Descriptive statistics for the area of patient perceived empathy (using the Barrett - Lennard Relationship Inventory), showed a possible range of -48 to +48 with a mean in this sample of 26.72. Olson (1993) reported that these scores were higher than expected and might be due to the notion that hospitalized patients might need to maintain confidence

in their nurse. Forsyth (1979) tried to explain similar findings by suggesting that some nurses might present themselves as something they are not or else that patients' perception of reality is substantially distorted in the hospital.

Olson (1993) found that distress levels in the Profile of Mood States and the Multiple Affect Adjective Checklist for the patients in the study was below the 50th percentile. This Canadian researcher suggested that perhaps Canadian patients are less distressed about the financial implications of their hospitalizations and thus expressed less anxiety, anger, and depression. Data analyzed indicated that as nurse empathy scores rose, patients' reported distress scores decreased. Nurses who increasingly were able to verbally acknowledge patients' feelings and the reasons for those feelings had the ability to decrease patients' reported feelings of anxiety, depression, anger and overall distress. Olson suggested that the study affirmed the importance of empathy as one of a nurse's communication skills affecting a patient's distress level.

Weaknesses of Olson's (1993) study include the fact that actual nurse-patient situations are artificial with no on-going nurse-patient dialogue. A second weakness was that 96.7% of nurse subjects were female and only 4.3% of the nurse subjects were male. Also, only medical and surgical nurses were used in this study.

In conclusion, studies have mostly concluded that nurses have a low level of empathy. Brown and Hunter (1987) found that only a few psychological characteristics of nurses made a difference in empathy. Forsyth (1979) found that demographic characteristics, except in the area of education, did not make a difference in empathy. La Monica et al. (1976) found that registered nurses as a group possess a low level of empathy. Olson and Iwasiw (1989) found that nurses show some empathy when dealing with patients who experience pain or anger but need continuing education when dealing with patients experiencing depression

or anxiety. Olson (1993) found that nurses who were able to express empathy were able to lessen the distress of patients. This was a Canadian study. The education of Canadian nurses may have a different focus. Whether this is true of U.S. nurses needs to be further researched.

Hypotheses

All registered nurses receive communication training during their educational preparation. Their utilization of verbal empathy was tested. Specific hypotheses were:

1. There will be the same number of "Don't Feel" responses regardless of the feeling state as measured by the BTIS.
2. There will be the same number of content and no feeling responses as feeling and no content responses regardless of the feeling state as measured by the BTIS.
3. There will be the same number of good or very good responses for each feeling state regardless of the feeling state as measured by BTIS.

Definitions of Terms

Empathy -- interpreting the feelings of patients in order to completely understand them, but being aware of one's own individuality. In this study, empathic comments are those that incorporate feelings and their source (i.e., feelings and content).

Content -- the informational and factual portion of a patient's verbalization; a nurse's comment is categorized as "content" only when a factual response is made.

Feeling -- the portion of a patient's verbalization that indicates the perception of a sensation that could be categorized as anger, depression, pain or anxiety; a nurse's comment is categorized as "feeling only" when only the feeling is acknowledged in the response..

Don't Feel -- nurse responses that negate, belittle, or suppress the expression of a patient's feelings.

Helper -- a registered nurse who provides both physical and

emotional care to a patient

Patient -- a person who is hospitalized for relief of physical or emotional concerns

BTIS -- a colored videotape of 26 problem statements; 13 are patient situations and 13 are health professional situations role played by actors and actresses

CHAPTER 3

METHODS

Design

The study used a descriptive design. Its purpose was to determine to what degree nurses vary in their utilization of empathy when responding to patients having different physical and emotional discomfort. Several alternative hypotheses may account for the results in this descriptive study. A problem with this study is that the accessible population may not be representative of the target population. Generalizations may not be reasonable. History may also be a research concern. Data collection occurred over a five week period of time. During this time period, there were changes at the hospital that affect nursing, for instance, inconsistent census. There may also have been experimenter effects. Unconscious communication by this researcher to the subjects regarding the hypotheses may have been given. To control for these concerns, the researcher kept conditions as consistent as possible. Approval for the study was given by the Human Research Review Committee at Grand Valley State University (see Appendix A).

Sample

This study took place in a rural hospital in Northern Michigan. The hospital is licensed for 125 patients. Thirty-two nurses participated as subjects. Table 1 summarizes the subject characteristics of the sample.

Table 1

Characteristics of Nurse Subjects (n=32)

Characteristic	n	%
Gender		
Male	1	3
Female	31	97
Age Range		
20 - 25	2	6
26 - 30	1	3
31 - 35	2	6
36 - 40	6	19
41 - 45	11	41
46 - 50	2	6
51+	7	22
Highest Degree in Nursing Held		
Associate Degree	18	53
Diploma	3	9
Bachelors	9	31
Masters	2	6
Area of practice		
Obstetrics	5	16
Emergency	2	6
Medical/Surgical	14	44
Intensive/Special Care	5	16
Hemodialysis	4	13
Clinical Education	1	3
Home Care	1	3
Outpatient (Surgical)	1	3
Surgery	1	3
Psychiatric Medicine	2	6
Length of Practice as an RN in Years		
1 - 5	4	13
6 - 10	8	25
11 - 15	9	28
16 - 20	3	9
21+	8	25
Work Hours		
7 a.m. - 3 p.m.	9	31
3 p.m. - 11 p.m.	2	6
7 a.m. - 7 p.m.	10	34
Other: 8 a.m. - 5 a.m. or 6 a.m. - 6 p.m.	11	38

Table 1 (continued)

Characteristics of Nurse Subjects (n=32)

Employment Status

Full Time	28	88
Part Time	3	9
On - Call	1	3

Marital Status

Married	19	59
Single	5	16
Divorced	8	25

Parental Status

Parent	29	91
Non - Parent	3	9

One person who responded to the survey worked at a community mental health agency. She was a Masters level nurse who completed a Ph.D. in psychology. She indicated on the questionnaire that she still was a hospital based nurse. Four nurses indicated that their work was equally divided between two separate areas. All nurses in the sample are licensed in the State of Michigan and are U.S. educated. The test hospital does not have head nurses. All nurses were either staff nurses or educators or in a management position. No one indicated that they worked the night shift hours.

Instruments

A questionnaire to ascertain sample characteristics was devised and given to each nurse (see Appendix B). Background information about the nurses included the following: gender, age, highest degree in nursing held, area of practice, length of practice as an RN, work hours, employment status, marital and parental status.

The Behavioral Test of Interpersonal Skills (BTIS) (Gerrard & Buzzell, 1981) was used to gather information about use of empathy from the nurses. Permission for the use of this instrument was obtained from Brian A. Gerrard, Ph.D. (Refer to Appendix C). He is an Associate Professor in the School of Education at the University of San Francisco

in California. This tool consists of 26 common situations recorded in color on videotape. Thirteen situations are related to health professionals and 13 are common patient situations. This writer only had access to one of the two videotapes. It contains 14 vignettes. Nine are patient situations and five are health care professional situations. Only seven patient situations and one health care professional situation was used in this study. Of these, there are two vignettes about depression, two vignettes about anger, two vignettes about anxiety, and two vignettes about pain. Situations are role played by actors and actresses who portray patients and health care workers. After each situation there is a 30 second period of silence in which participants responds in writing with what they would say in response to the patient. An example of a BTIS vignette for each feeling is found in Appendix D - (Depression), Appendix E - (Anger), Appendix F - (Anxiety), Appendix G - (Pain).

The four interpersonal dimensions assessed by the BTIS are empathy, warmth, assertiveness, and initiating. Table 2 indicates how the four dimensions are scored when subject responses are videotaped. In this study, only the empathy dimension was examined.

Table 2

Scoring Interpersonal Dimensions Using the BTIS

Rating Scale	Content Analysis
Empathy	Feeling Content "Don't Feel _____"
Warmth	Relaxed Face Smile Quiet Voice
Initiating	Encourages discussion Suggests solution Gives information
Assertiveness	Helps patient say what he/she feels

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

Subject responses are scored according to whether the categories are present or absent. The three main categories for empathy are "feeling," "content," and "don't feel." "Feeling" indicates that the nurse used empathy and identified the feeling state when responding to the patient's general or specific mention of pain, depression, anxiety, or anger. "Content" indicates that the nurse could identify the content and background of the patient's physical or mental discomfort. "Don't Feel" indicates that the nurse suppressed or discouraged patient feelings.

According to the manual, subject responses may be videotaped, audio-taped or written. In this study the subjects wrote their responses. Advantages of this method are that no expensive equipment is needed and groups of subjects can be tested at one time. A disadvantage is that it does not allow an assessment of the dimension of "warmth" through facial expression or voice tone.

Because subjects' responses were written and no guidelines were given for written responses, subject responses were scored using the BTIS Rating Scale. The categories of Feeling, Content, and "Don't Feel" had one combined score. Responses received a 4 for a very good response in which underlying feelings and content were accurately reflected. A 3 was given for a good response in which surface feelings and content were accurately reflected. A 2 was given for a poor response in which only content was reflected or feeling without content was reflected. A 1 was given for a very poor response where neither feeling nor content was reflected or the subject changed the topic (i.e., a "don't feel" response). See Appendix H for the BTIS Rating Scale scoring sheet.

Test-retest reliability of the BTIS was established by the authors (Gerrard & Buzzell, 1980). No significant differences in

subjects' initial scores and those at six and sixteen week intervals were found. The results are displayed in Table 3 and Table 4.

Table 3

Test - Retest Reliability for 8 First Year Nursing Students After 6 Weeks

Dimension	Time of Rating		t	p
	Initial mean	6 Weeks mean		
Feeling	6.88	7.50	.47	.65
Content	9.63	9.50	.09	.93
Don't Feel	3.63	3.88	.45	.67

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals" by B. Gerrard and M. Buzzell, 1980.

Table 4

Test - Retest Reliability for 10 First Year Nursing Students After 16 Weeks

Dimension	Time of Rating		t	p
	Initial mean	10 Weeks mean		
Feeling	7.20	7.80	.77	.46
Content	11.70	10.40	1.30	.23
Don't Feel	3.70	2.30	2.04	.07

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

The 18 subjects used for test-retest reliability were randomly selected from a group of 75 subjects (Gerrard & Buzzell, 1980). No

training in interpersonal skills was given during the 6 and 16 week intervals. Participation in one group did not lead to inclusion in the second group. Gerrard and Buzzell (1980) established inter-rater reliability with one of the authors who had 30 hours of practice scoring the videotapes and a health sciences graduate student who had 10 hours of scoring the videotapes.

Gerrard and Buzzell's (1980) findings are reported in Table 5. Olson, Iwasiw, and Gerrard (1991) established content validity through extensive literature review and input of health professionals.

Table 5

Inter-Rater Reliability Coefficients for BTIS Scoring Categories

Dimension	Interrater Reliability r
Feeling	.99
Content	.92
"Don't Feel _____"	.93

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

In this study, the principle investigator scored the RN responses to the BTIS. Prior to conducting the study this researcher and a Masters level social worker scored responses by seven test subjects (six co-workers and one student nurse) to the eight vignettes used in this study. The two raters scored these independently after discussion about what was sought in each response. A total of 56 responses were scored. According to Polit and Hungler (1991) interrater reliability occurs when two raters independently assign a similar rating to that which is being measured. Interrater reliability for this pilot study was established. There was 86% agreement in scores. Further discussion was held about the 14% of the scores for which there was disagreement. Some of the

disagreement revolved around the use of the word "difficult" by the subjects. Discussion was held regarding whether "difficult" was a feeling word. A decision was made that the word "difficult" is not a feeling word for this study. It was decided that the raters would mimic the BTIS response samples closely and use the feeling words described in the manual. A decision was also made that the word "frustrated" was a feeling word. Consensus was then reached about how responses should be scored. Refer to Appendix I for a comparison of the two rater's scoring.

Procedure

The researcher made initial contact with the Vice-President of Nursing. Permission was given for using the hospital and its RNs (See Appendix J). An explanation of the study was given by delivering a letter explaining the study to each eligible Registered Nurse employed at the study hospital (See Appendix K). A sign-up list was posted on the door of the scheduler so that nurses from all shifts had the opportunity to volunteer if they desired. Participation was voluntary. Data were collected during work hours. A reminder poster was placed by the time clock, in all elevators, and on each participating nursing unit three days before the data collection period. One hour before testing, an overhead announcement by the hospital operator was made. Another letter was given to each nurse prior to testing that was a summary of the first letter, included a signature line indicating permission to be included in the study, thanked them again for their participation, and asked them not to discuss the vignettes (See Appendix L). The lone nurse who worked at a community mental health agency also volunteered to complete the study. The procedure for data collection was the same.

Data Collection

Several problems arose during data collection. Data collection was to be completed over two consecutive Saturdays from 9:30 a.m. - 9:30 p.m. in the hospital auditorium. Nurses found it impossible to leave

their assigned work area to complete the study. Permission was given by the nursing supervisor to go the work area of the staff nurses to show the BTIS. This investigator pushed the VCR cart to patient care areas. On the second Saturday permission was given by the nursing supervisor, but after a few hours of collection, some of the staff apparently felt intimidated by the investigator and thus, collection was only half finished. The Vice President of Nursing was contacted. Remaining data were to be collected at group meetings. Eventually, data were collected over four weeks by going to nursing units or attending meetings where nurses were for the day. Initially, data were gathered from only staff nurses, however, nurses in management positions had to be included in the study to allow for a sample size of at least 30 nurse subjects.

First, nurses completed the subject characteristic questionnaire.

Second, the videotape was shown to various groups of nurses. The nurses responded to all 14 vignettes even though only 8 were actually scored for this study. Third, the completed subject characteristic sheet and response sheet were sealed in an envelope by each subject. Envelopes were placed in a manila envelope by each subject. At the end of the day, the manila envelope was placed in a covered box. Only then was the envelope handled by the investigator.

Assumptions

There were some assumptions made in this study. They are as follows:

1. The assessment instrument measures Rogerian concepts.
2. Test-subjects gave their best responses.
3. The assessment time was adequate.
4. There was a good attitude regarding the instrument by all participants.

CHAPTER 4

RESULTS

Vignette Response Description

Depression. Of the two depression vignettes, the first dealt with underlying feelings of hopelessness related to chronic pain which began after surgery. The male patient states, "I wonder if it's worth going on." Very poor responses were given 19 out of 32 (59.4%) times. An example of a very poor response was, "Can you be more helpful - explain what and why. Where have you been before?" In this response feelings of the patient were ignored. Poor responses were given 9 (26.1%) times. Of the poor responses 60% contained only parroting of the patient's verbalization (i.e., content only) and 40% contained a feeling state alone. An example of a poor response was, "What makes you feel this way? Was your surgery successful?" In this response, the focus was on content, (i.e., that surgery the reason for the discomfort). Good responses were given 6.3% of the time. An example of a good response was, "You sound kind of blue [surface feelings] - what type of surgery [content] did you have?" Both content and surface feelings were expressed. A very good response was, "You seem depressed [underlying feeling]. What type of surgery [content] did you have? Have you discussed your feelings with your doctor?" Both content and underlying feelings were expressed in this response. Very good responses were given 6.3% of the time.

In the second vignette regarding depression, a nurse had to deal with a father who had just learned that his son had died of a cardiac arrest. Thirty of the 32 responses (93.8%) were very poor. An example of a very poor response was, "Mr. Smith - I'm very sorry about your

son...pause, touch hand." Another example was, "I'm so sorry. Is there anyone I can call. Need a chaplain?" Neither response mentioned the death nor an underlying feeling such as devastation or sadness that was felt by the father. Poor responses were given 6.3% of the time. An example of this type of response was, "Mr. Smith - I see you're grieving appropriately for your son's death. I'll just stay here for awhile in case you want to talk with me - continue expressing your grief." There was an expression of content (death) in the response. Acknowledgment of the fathers' feelings was necessary for good or very good responses. There were no good or very good responses given by the respondents.

Anger. Anger was the emotion in a vignette that dealt with a hospitalized patient reporting that he was being neglected and no one would help. In this first vignette, very poor responses were given 16 out of 32 times (50%). An example of this type of response was, "What exactly do you feel is needed? I'll check to see what is ordered. Let's work together. I have time for you." Another example was, "Tell me some of your concerns for example. I'd like to hear your concerns." No one validated the patients' feelings in these responses. Poor responses were given 14 (43.8%) times. An example of a poor response was, "Well, you're really angry. Can you or will you begin at the beginning?" Another example was, "Sounds like you are angry. What do you feel we should do to assist you. What can you do to help yourself?" The emotion of anger was validated in 62% of these poor responses and 38% conveyed a surface feeling but no content, (i.e., no one seems to care or no one helped you with your walking). Good responses were given 6.3% of the time. An example of a good response was, "I'm hearing that you're feeling very angry and disappointed about how things are going. Tell me more about how you'd like to see your day go." This response contained surface [anger] and underlying [disappointed] feelings. It also contained content [how your day is going]. There were no very good responses for this vignette.

In the second vignette of anger, the nurse had to deal with the anger expressed by a patient who had experienced someone unsuccessfully attempting to draw blood seven times. Very poor responses were given 26 of 32 (81.3%) times. An example of this kind of response was, "We can have someone else try. It's important. "Feelings were ignored in this response. Poor responses were given 5 times (15.6%). An example of a poor response was, "I hear your anger and I don't blame you - perhaps we can find someone else who can do a faster and better job - since the doctor wants more blood taken." This response contained surface feelings [anger] instead of content but validated the feelings of the patient. This type of response was given in 62% of the poor responses. Content only responses were given in 38% of the poor responses. Good responses were given 3.1% of the time. An example of this type of response was, "You sound pretty upset. Can I take a look? How many times?" Surface feelings [upset] and content [How many times?] were expressed. There were no very good responses. That type of response would have contained underlying feelings, (i.e., "hurt or pain" and content which is accurately reflected).

Anxiety. In the first anxiety vignette a female patient reported that she was dizzy and weak and, therefore, did not know what to do about her situation. Very poor responses were given in 24 out of 32 (75%) responses. An example of a very poor response was, "First of all, relax. You need to think positively. It takes time to recover - when did you come to the hospital?" Again, feelings of the patient were not validated. "Poor responses" were given 8 (25%) times. An example of a poor response was, "You seem afraid. What is it you're most worried about. "Another poor response was, "Take a deep breath. Sounds like you are feeling helpless - would you like to discuss this?" This type of feeling response was given 86% of the time and content only responses were given 14% of the time among the poor responses. There were no good or very good responses.

The second anxiety vignette dealt with a patient who was unsure about how her recent surgery would affect her sexuality and recent marriage. Very poor responses were given 19 (56.3%) times. An example of a very poor response was, "You should talk about it with your Doctor." Another example was, "Have you discussed your concerns with your surgeon? He'll be able to tell you more." Neither feelings nor content was expressed. Poor responses were given 13 times (40.6%). An example of this type of response was "What kind of surgery did you have?" Another response was, "What surgery did you have. It may take 6 - 8 weeks before you are comfortable in having sex." Content [might not be able to have sex] was expressed but feelings were not expressed. Parroting of patient's content verbalization was given 15% of the time in these poor responses and feeling responses were given 85% of the time. No good responses were given. Very good responses were given 3.1% of the time. An example of this type of response was, "I hear you are scared - more information about how it may affect your sex life seems in order - let's find out more from your doctor, books, etc." Content [how it may affect your sex life] and underlying feelings [scared] were expressed.

Pain. The first pain vignette dealt with a patient having dull, nagging, chronic pain who was not sure if it would ever go away. In this vignette very poor responses were given in 10 out of 32 (31.3%) statements. An example of this type of response was, "It may not, let's explore how to live with it." Another example was, "Let's see if we can get you something to relieve it." In these responses, feelings were ignored and no content was mentioned. Poor responses were given 19 (59.5%) times. An example of this type of response was, "What are you taking for the pain?" Another example was, "Where is the pain located. Does it radiate anywhere?" These responses indicated that the nurse understood the content [pain]. Content only responses were given 88% of the time and feeling responses were given 12% of the time among these

poor responses. Good responses were given twice (6.3%) times. An example of a good response was, "It's frustrating to be in constant pain." Content [pain] and surface feelings [frustrating] were expressed. One subject (3.1%) offered a very good response. This response was, "This must be frightening for you. Let's talk about the pain and formulate a plan." Content [pain] and underlying feelings [frightening] were expressed.

In the second vignette regarding pain a patient expressed that he felt "terrible" and "so sick." Very poor responses were given 28.1% of the time, in 9 of 32 comments. An example of a very poor response was, "I'm here to help you. In order to help you, I need to know...." Another example was "Can you be more specific?" Patient feelings were ignored in both examples. The remaining responses ($n = 23$, 79.1%) were poor. An example of the poor response was, "How do you feel sick? Pain? Nausea or vomiting? I need some information so I can let your doctor know." Another example was, "Tell me where you feel bad." Both responses contain content [sick and feel bad]. No responses contained feeling. There were no good or very good responses. Table 6 contains a summary of these findings.

Table 6

Vignette Responses

<u>Type of vignette</u>		<u>Type of response</u>							
		very poor		poor		good		very good	
		n	%	n	%	n	%	n	%
depression	# 1	19	59.4	9	26.1	2	6.3	2	6.3
depression	# 2	30	93.8	2	6.3	-	-	-	-
anger	# 1	16	50	14	43.8	2	6.3	-	-
anger	# 2	26	81.3	5	15.6	1	3.1	-	-
anxiety	# 1	24	75	8	25	-	-	-	-
anxiety	# 2	18	56.3	13	40.6	-	-	1	3.1
pain	# 1	10	31.1	19	59.5	2	6.3	1	3.1
pain	# 2	9	28.1	23	71.9	-	-	-	-

Note. "-" indicates no response.

Hypothesis Testing

Hypothesis 1: There would be the same number of "Don't Feel"

responses regardless of the feeling state as measured by the BTIS. A Chi-Square was done comparing "Don't Feel" responses to all other responses. A summary of the results is found in Table 7.

Table 7

Comparison of Don't Feel Responses and All Other Responses

<u>Situation</u>	<u>Depression</u>	<u>Anger</u>	<u>Anxiety</u>	<u>Pain</u>	<u>Row Total</u>
Response	n(%)	n(%)	n(%)	n(%)	n(%)
Don't Feel	39 (61)	42 (66)	42 (66)	19 (30)	142 (55)
Other	25 (39)	22 (34)	22 (34)	45 (70)	114 (45)
Column Total	64(100)	64(100)	64(100)	64(100)	256(100)

$$\chi^2 (3) = 23.33, p < .01$$

A χ^2 of 23.33 with 3 degrees of freedom indicates that there were significant differences at the $p < .01$ level between the "Don't Feel" and the "other" categories. The hypothesis that there would be the same number of "Don't Feel" responses regardless of the feeling state as measured by the BTIS was rejected. For the most part subjects were better at responding to pain than the other emotions. Fewer "Don't Feel" responses were given for pain.

Hypothesis 2: The second hypothesis state that there would be the same number of content and no feeling responses as feeling and no content responses regardless of the feeling state as measured by the BTIS. A Chi-Square was done to compare poor responses; those that contained content but no feeling and those that contained the feeling but offered no content. A summary of the results is found in Table 8.

Table 8

Comparison of Content Responses

<u>Situation</u>	<u>Depression</u>	<u>Anger</u>	<u>Anxiety</u>	<u>Pain</u>	<u>Row Total</u>
<u>Response</u>	<u>n(%)</u>	<u>n(%)</u>	<u>n(%)</u>	<u>n(%)</u>	<u>n(%)</u>
Content/no feeling	9(75)	6(30)	12(60)	38(95)	65(71)
Feeling/no content	3(25)	14(70)	8(40)	2(5)	27(29)
Column Total	12(100)	20(100)	20(100)	40(100)	92(100)
$\chi^2 (3) = 28.58, p < .01$					

A χ^2 of 28.58 with three degrees of freedom indicates that there were significant differences at the $p < .01$ level between the Content/no feeling category and the feeling/no content category. Thus, the hypothesis that there would not be the same number of content/no feeling responses and feeling/no content responses regardless of the feeling state as measured by the BTIS was rejected.

For the most part the responses allowed the patient to know that the message was heard, but the nurse was unable to verbalize back to the patient what emotional feeling provoked the statement. Seventy-one percent of the responses indicated that the nurse understood the content for the patient, but did not indicate the nurse's understanding of what feelings the patient was experiencing. The nurses were best at identifying feelings of anger and the circumstance (content) for pain.

Hypothesis 3: In the third hypothesis, it was expected that there would be the same number of good or very good responses for each feeling state as measured by the BTIS. Only 4% of the total responses that were

scored in the good or very good range. There were only eleven responses that fell into this category. Because of the small size, a chi-square was not done. Table 9 summarizes the findings.

Table 9

Good and Very Good Responses

<u>Situation</u>	<u>Depression</u>	<u>Anger</u>	<u>Anxiety</u>	<u>Pain</u>
Response	n	n	n	n
Good	2	3	-	2
Very Good	2	-	1	1

Note. "-" indicates no response.

Additional Findings

Frequently, nurses who were able to acknowledge patient feeling suggested solutions to the emotional discomfort that the patient expressed. Solution responses were scored as poor responses.

An example of a solution response was given in the vignette of anger. Someone unsuccessfully attempted to draw the blood of a patient seven times. The nurse subject acknowledged the content, but also suggested that someone else might complete the procedure. Another suggestion for this vignette was that the lab supervisor could be notified. Many nurse subjects also apologized.

Solution responses were given for the other feelings. In the anxiety vignette, nurses often suggested that the patient speak with the doctor about whether her sexuality would be affected after recent surgery. In one pain vignette where a patient had chronic pain, a solution was offered to try relaxation techniques. Other suggestions were to further assess the patient. In the depression vignette where a father had just learned of his son's death, many nurses offered to sit with the father quietly and say nothing. Others suggested that they call a minister or chaplain.

CHAPTER 5

DISCUSSION

The purpose of this study was to determine to what degree nurses vary in their utilization of empathy when responding to patients experiencing different types of physical and emotional discomfort. These experiences were depression, anger, anxiety, and pain.

A very good score indicated that the nurse reflected the patient's underlying feelings and the related content accurately. A good score was given when surface feelings and the related content were accurately reflected. A poor score was given when content was reflected or when feelings without content were reflected. A very poor score was given when neither feelings nor content were expressed.

Depression was examined. Sixty-four responses were given in this area. Thirty-two subjects each responded to two depression situations. Most responses were in the very poor range. A few nurses were able to understand the emotion and responded in an empathic manner. These nurses could reflect back to the patient, the circumstance causing the depression and the emotion evoked by the experience. When depression was compared to the other emotions, responses were most similar to anger and anxiety. When "content" was examined, most responses contained a reflection that the patient seemed depressed, but not how the patient felt when depressed. There was only two good and very good responses

for the emotion of depression. Both of the latter type of responses were given when a man spoke of the hopelessness he felt during his situation of chronic pain. Solutions were offered more often when a man learned that his son had just died.

In the area of anger, the majority of the responses were very poor, "don't feel," responses. Compared to other emotions, more nurses were able to identify and reflect the emotional experience but were unable to identify the context or circumstances of the patient's feelings. A few nurses were able to express what they heard and also partially understand how this experience was felt by the patient. Nurses responded with more empathy when a patient expressed that he was being neglected than when a patient had multiple blood draw attempts.

Responses to anxiety were similar with those to anger and depression. Very poor responses were in the majority. Nurses tended to identify the context and circumstances of what the patient was experiencing more than the feelings. Only one nurse could offer "feeling" empathy to a woman who was concerned with the effect of surgery on her sexuality.

In the area of pain, there were fewer very poor responses when compared to other emotions. Most nurses could restate the context of the experience back to the patient while feelings were rarer. Only a few nurses could both express the experience and identify the feeling that the patient had. Most often the latter responses occurred when a patient had dull, nagging discomfort but not when a patient expressed the fact that he felt bad. Frequently the nurse wanted more information.

One kind of response given by many nurse subjects fell into the realm of fixing the difficulty. Rogers (1961) said that when helpers

accept and understand themselves, there are fewer solutions offered and more acceptance of the patient's emotions. Rogers (1961) wrote that there needs to be acceptance of negative feelings as well as positive ones. Acceptance creates a caring experience and makes others feel understood.

"Don't Feel" responses were given most often in all areas except for pain. In contrast, nurses rarely identified the feelings that accompanied the circumstance of pain. So while this sample did not tell patients not to feel pain, they mostly focused on the content of the experience of pain rather than the feelings. This is somewhat different from the results found in the original study by Olson and Iwasiaw (1989) who found that most expressions of feeling were offered when a patient expressed pain. Anxiety and anger were the emotions that were the most difficult for nurses to respond to in an empathetic manner in that study. Perhaps, emotions of anxiety and anger cause nurses difficulty. There may be a greater understanding of pain as most people have experienced pain to some degree.

In the area of "content" , nurses mostly used re-statement of patients' comments. Nurses were more often able to identify an angry state. Most often nurses simply re-stated content even when unable to identify the feeling. Perhaps, it was too difficult to identify feelings or they have had insufficient education and training to focus on feelings. This result is the same as found in the original Olson and Iwasiaw study (1989).

Application

Nurse educators need to review or teach the use of empathy in the areas of depression, anger, anxiety, and pain. Role playing is helpful when teaching communication. This should be done throughout the whole

nursing program. Patients' feelings are often negated or ignored in the situations of anger, anxiety, and depression. Expressions in those three areas in this study are the most problematic for nurses. In-services/education could be given at the place of employment to teach the use of empathetic responses in all types of distressful experiences with the focus on the emotions of depression, anger, and anxiety.

Perhaps staff nurses feel that in the hustle and bustle of hospital nursing, they do not have time to listen and help the patient clarify the meaning of how they feel. Further difficulty may be caused by managed care which encourages doctors to fix patients and return them back to the community. Many nurses report that the nurse-patient ratio is high. Use of empathy could show an increase in patient satisfaction according to post-discharge satisfaction surveys. Reviewing their own communication style is an important part of a nurses' job.

A study done by La Monica et al. (1976) found that a staff development program did increase empathy scores. Another study done by Olson (1993) found that as nurse empathy scores increase, patients' distress scores decrease. Empathetic communication helps to alleviate distressful feelings.

In order to increase empathy, nursing administrators need to model empathic communication to others. They have the power to make changes in communication style by setting an example for others to follow. Nurses in these positions communicate with many different people and they need to lead those that follow them into an area of empathic communication. They would need to be supportive of in-services in empathy as well as in those that explain new technology.

Limitations

Results of this research were limited to the following conditions:

1. The small sample size and the fact that the results could only be generalized to the study sample.
2. Only one male nurse responded to the BTIS. Therefore, this information could not be generalized to all male nurses.
3. Not all respondents were staff nurses. Nurses in management positions and a nurse employed outside of the test hospital were used to complete the needed data. Not enough of these nurses were included to compare them to staff nurses.
4. Comparisons among nurses working in different areas of the hospital were not done due to the small number of subjects from some areas.
5. Nurse subjects viewed the BTIS at their work area. This could have distracted their ability to concentrate on the vignettes and their responses. Other nurses who viewed the BTIS at a group meeting, could have been distracted by non-RNs who also attended the meeting.
6. Interpretations of results were limited to the scoring criteria.
7. Used in this study on the assessment inventory.

Suggestions for Further Research

Further research could be done in empathic communication after in-services have been completed. La Monica et al. (1976) reported that training did increase empathy scores. Olson (1993) reported decreased patient distress when empathy scores rose. The focus of the training needs to be on a better understanding of how the patient truly feels when experiencing unpleasant physical or emotional distress and re-stating this back to the patient. The most difficult emotions to assess were those of anger and anxiety, and to a lesser degree depression.

These emotions are some of the most difficult to respond to as, anger is threatening to one's self-esteem and anxiety invites a deep understanding of what may not be understood by the patient. Depression may be felt by a patient but not always acknowledged. Sometimes the patient is not aware of the cause of these emotions. All emotions deserve an empathic nurse who is not afraid to feel and can allow a patient to feel. After that has happened, clarification of the feeling is possible.

Finally, future research could focus on the relationship between empathy scores and the personality dynamics of nurses. To improve training outcome, the interaction of empathy, personality, and training procedures could be explored.

In conclusion, empathic communication has received little attention in recent years. Nevertheless it continues to be an important area for effective nurse patient relationships. Research into improving the effectiveness of nurses with patients in unpleasant experiences is essential.

APPENDICES

APPENDIX A

APPROVAL TO COLLECT DATA

APPENDIX A

APPROVAL TO COLLECT DATA



1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

December 4, 1995

Ann Dilbeck
710 E. Garfield
Cadillac, MI 49601

Dear Ann:

The Human Research Review Committee of Grand Valley State University is charged to examine proposals with respect to protection of human subjects. The Committee has considered your proposal, "*Nurses' Verbal Responses in Four Types of Client Situations*", and is satisfied that you have complied with the intent of the regulations published in the Federal Register 46 (16): 8386-8392, January 26, 1981.

The committee did request that you include in Appendix G the following statement, "Participants can request a copy of the results".

Sincerely,

A black rectangular box redacting the signature of Paul Huizenga.

Paul Huizenga, Chair
Human Research Review Committee

APPENDIX B

SUBJECT QUESTIONNAIRE

APPENDIX B

SUBJECT QUESTIONNAIRE

001
123

Participant Characteristics

Please circle the proper letter that best indicates the correct response for each question.

- | | | |
|-------------------------------|---|-----|
| GENDER: | <ol style="list-style-type: none"> <u>1.</u> Male <u>2.</u> Female | (4) |
| AGE RANGE: | <ol style="list-style-type: none"> <u>1.</u> 20-25 years <u>2.</u> 26-30 years <u>3.</u> 31-35 years <u>4.</u> 36-40 years <u>5.</u> 41-45 years <u>6.</u> 46-50 years <u>7.</u> 51 years and over | (5) |
| HIGHEST DEGREE IN NURSING | <ol style="list-style-type: none"> <u>1.</u> A.A. (Associates) <u>2.</u> Diploma <u>3.</u> B.S.N. (Bachelors in Nursing) <u>4.</u> Other Degree in Nursing | (6) |
| AREA OF PRACTICE | <ol style="list-style-type: none"> <u>1.</u> O.B. <u>2.</u> Emergency Department <u>3.</u> Medical/Surgical <u>4.</u> Oncology <u>5.</u> ICU/SCU <u>6.</u> Hemodialysis <u>7.</u> Psychiatric Medicine | (7) |
| LENGTH OF PRACTICE AS AN R.N. | <ol style="list-style-type: none"> <u>1.</u> 1-5 years <u>2.</u> 6-10 years <u>3.</u> 11-15 years <u>4.</u> 16-20 years <u>5.</u> over 21 years | (8) |
| WORK HOURS | <ol style="list-style-type: none"> <u>1.</u> 7 a.m. - 3 p.m. <u>2.</u> 3 p.m. - 11 p.m. <u>3.</u> 11 p.m. - 7 a.m. <u>4.</u> 7 a.m. - 7 p.m. <u>5.</u> 7 p.m. - 7 a.m. <u>6.</u> Other | (9) |

EMPLOYMENT STATUS	<u>1.</u>	Full time	(10)
	<u>2.</u>	Part time	
	<u>3.</u>	On-call	
MARITAL STATUS	<u>1.</u>	Married	(11)
	<u>2.</u>	Single	
	<u>3.</u>	Divorced	
PARENTAL STATUS	<u>1.</u>	Parent	(12)
	<u>2.</u>	Non-parent	

APPENDIX C

PERMISSION TO USE INSTRUMENT

APPENDIX C

PERMISSION TO USE INSTRUMENT

Brian Gerrard, Ph.D.
University of San Francisco
San Francisco, CA, 94117 - 1080

I give Ann Lawson permission to use the Behavioral Test of Interpersonal Skills (BTIS) and to include the instrument in her thesis.


Brian A. Gerrard

APPENDIX D

EXAMPLE OF DEPRESSION VIGNETTE

APPENDIX D

EXAMPLE OF DEPRESSION VIGNETTE

Male Patient:

"Ever since my surgery life hasn't been the same. Every time I get a pain somewhere I don't know where to turn. I wonder if its worth going on."

<u>Content Analysis Category</u>	<u>Scoring Guidelines</u>
Feeling:	
Underlying:	downhearted, overlooked.
Surface:	frightened, terrified, uneasy.
Content:	Reference to suffering, surgery, physical condition, not getting better.

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

APPENDIX E

EXAMPLE OF ANGER VIGNETTE

APPENDIX E

EXAMPLE OF ANGER VIGNETTE

Male patient:

"I'm sorry but I've got to sound off to someone and you're the first one in here. I can't understand why I'm not getting more care. This is the third day I haven't had any help with my walking. I'm trying to get better and nobody's helping me."

<u>Content Analysis Category</u>	<u>Scoring Guidelines</u>
Feeling:	
Underlying:	ignored.
Surface:	mad.
Content:	No one is helping you with your stroll.
	You are on your own.
	You're alone.

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

APPENDIX F

EXAMPLE OF ANXIETY VIGNETTE

APPENDIX F

EXAMPLE OF ANXIETY VIGNETTE

Female patient:

"I feel so weak. What am I going to do? Will I ever get better? Just look at me, I can hardly sit up without getting dizzy. What am I going to do, what am I going to do?"

<u>Content Analysis Category</u>	<u>Scoring Guidelines</u>
Feeling:	
Underlying:	feeble.
Surface:	terrified, fearful.
Content:	because you...think there is no way to get better.
	...can't sit up.
	...feel dizzy.

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

APPENDIX G

EXAMPLE OF PAIN VIGNETTE

APPENDIX G

EXAMPLE OF PAIN VIGNETTE

Female patient:

"It's a dull nagging pain. I don't know what else I can tell you. It just goes on and on night and day. I don't think it's ever going to go away."

<u>Content Analysis Category</u>	<u>Scoring Guidelines</u>
Feeling:	
Underlying:	desperate, powerless, terrified.
Surface:	uncomfortable, troubled, distressed
Content:	because...the discomfort is ongoing, you think you won't get well.

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

APPENDIX H

EXAMPLE OF BTIS RATING SCALE

APPENDIX H

EXAMPLE OF BTIS RATING SCALE

Rating Scale for Verbal Empathy

Example:

A patient says: "I'm in so much pain. It never goes away. I've tried everything. I just don't know what to do."

<u>Rating</u>	<u>General Description of Scale Position</u>	<u>Behavioral Description of Scale Position</u>	<u>Sample Resources</u>
4.0	Very good response	Underlying feelings and content are accurately reflected.	You are scared because you think you might not get any relief and you don't know what to do to help yourself.
3.0	Good Response	Surface feelings and content are accurately reflected.	You are concerned because you are ill so much.
2.0	Poor Response	Content only is reflected.	You think you won't get better.
1.0	Very Poor Response	Neither feeling nor content is reflected.	I'd like to get you ready for dinner.

Note. Adapted from "User's Manual for the behavioral test of interpersonal skills for health professionals." by B. Gerrard and M. Buzzell, 1980.

APPENDIX I

RATER SCORING IN PILOT STUDY

APPENDIX I

RATER SCORING IN PILOT STUDY

		<u>Rater 1</u>						
<u>Subject</u>		A	B	<u>Items</u>			F	G
				C	<u>D</u>	<u>E</u>		
					<u>Ratings</u>			
1		1	1	1	1	1	1	1
2		2	1	1	1	1	1	1
3		1	2	1	1	1	1	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	1
7		1	1	1	1	1	1	1
8		1	1	2	1	2	1	1

		<u>Rater 2</u>						
		A	B	C	<u>Items</u>		F	G
					D	E		
<u>Subject</u>		<u>Ratings</u>						
1		2	1	1	1	1	2	1
2		2	1	1	1	1	1	1
3		1	1	1	1	1	2	1
4		1	1	1	1	1	4	1
5		1	1	2	1	1	1	1
6		1	1	1	2	1	1	1
7		1	1	1	1	1	1	1
8		1	2	1	1	2	1	1

APPENDIX J

PERMISSION TO USE HOSPITAL

APPENDIX J



MERCY HEALTH
SERVICES NORTH

Community Healthcare System

PERMISSION TO USE HOSPITAL

MERCY HOSPITAL
400 Hobart Street
Cadillac, Michigan 49601
616/779-7200

MERCY HOSPITAL
1100 Michigan Avenue
Grayling, Michigan 49738
517/348-5461

October 18, 1995

Ann Dillbeck, RN
710 E. Garfield
Cadillac, MI 49601

Dear Ms. Dillbeck:

Please regard this as a formal approval for you to invite the Registered Nurses at Mercy Hospital - Cadillac to participate in a research study.

I would ask that you arrange for the sign-up sheets and provide the Nursing Scheduler with a letter of invitation to circulate amongst the staff. As soon as you have identified the dates/times please notify my secretary, Diane Masick, at (616) 79-7283 so that arrangements can be made to reserve the meeting room.

If there is any other assistance we can be to you in your research efforts, please do not hesitate to call.

Sincerely,

[Redacted Signature]

Kathy Zelinsky
Vice President, Patient Care Services

KZ/dsm

APPENDIX K

EXPLANATION LETTER TO POTENTIAL SUBJECTS

APPENDIX K

EXPLANATION LETTER TO POTENTIAL SUBJECTS

Dear Registered Nurse,

As nurses, you interact with many patients with whom you spend most of your time. You have a vast amount of information about how you communicate. I am involved in a research study entitled " Nurse's Verbal Responses in Four Types of Client Situations." This type of research needs to be done in a clinical setting. You are the best source of this type of information. All of you are important in the study as you can provide valuable information about nurses' verbal expressions to their patients.

I am inviting you to participate in the study. There is a sign up sheet posted on the nursing scheduler's door (Lolly's office). I will show you a videotape of common patient situations. At the end of each situation, there will be a 30 second pause for you to write down your response. There will also be a separate questionnaire for information about you, such as your sex, length of practice, nursing degree, etc.

Only one nurse from a floor should sign up at any given time. It will take about 30 minutes to complete the survey. To make sure that all of you are included in this study, the research will be conducted on two Saturdays. Kathy Zelinsky has approved that the survey can be completed during your working hours.

You may be assured of confidentiality. Your name will not be on the response sheet or questionnaire. You may withdraw at any time without consequence. There are no risks for you in taking time to answer the questions and you will be a part of an exciting time in nursing. There are no direct benefits to you.

I would be more than happy to answer any questions that you may have about the study. Other sources that you may use to answer study questions can be directed to Dr. Paul Huizenga at Grand Valley State University (Human Research Review Committee). Phone number is (616) 895-6611.

Cold beverages and doughnuts will be provided.

Thank you for your help,

Ann Lawson Dilbeck, R.N.
775-0498

APPENDIX L

SIGNED CONSENT BY NURSE SUBJECTS

APPENDIX L

SIGNED CONSENT BY NURSE SUBJECTS

Dear Nurse,

Thank you for your interest in the study entitled "Nurse's Verbal Responses in Four Types of Client Situations". You have provided valuable information about nurses' expressions of empathy. All of you, no matter where you work or how many years you have worked, have assisted me. Without you, the study would be incomplete.

If you are interested in a summary of the results of this study, please indicate this on the bottom of your signed consent sheet by including your address. The results of the study will be mailed to you.

PLEASE DO NOT DISCUSS THE TESTING WITH YOUR COLLEAGUES UNTIL EVERYONE HAS HAD A CHANCE TO PARTICIPATE !!

Thank you for your help,

Ann Dilbeck, R.N.

I understand my responses are confidential. I can withdraw from the study at any time. I understand that this study will not affect my employment.

Your Signature _____

LIST OF REFERENCES

LIST OF REFERENCES

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