Elizabeth Arnold
Kathleen Underman Boggs

Interpersonal Relationships

Professional Communication Skills for Nurses

third edition

Interpersonal Relationships

Professional Communication Skills for Nurses

third edition

Elizabeth Arnold, PhD, RN, CS-P
Associate Professor
University of Maryland
School of Nursing
Baltimore, Maryland

Kathleen Underman Boggs, PhD, FNP-C
Associate Professor
Family Nurse Practitioner Program
University of North Carolina at Charlotte
Charlotte, North Carolina

W.B. SAUNDERS COMPANY
A Division of Harcourt Brace & Company
Philadelphia London Toronto Montreal Sydney Tokyo

W.B. SAUNDERS COMPANY
A Division of Harcourt Brace & Company

The Curtis Center
Independence Square West
Philadelphia, Pennsylvania 19106

Library of Congress Cataloging-in-Publication Data

Arnold, Elizabeth.
Interpersonal relationships : professional communication skills for nurses / Elizabeth Nolan Arnold, Kathleen Underman Boggs.—3rd ed.

p. cm.

Includes bibliographical references and index.

ISBN 0–7216–8103–4

1. Nurse and patient. 2. Interpersonal communication. I. Boggs, Kathleen Underman. II. Title.

RT86.3.A76 1999 610.73'06'99—dc21 98-38372

INTERPERSONAL RELATIONSHIPS:
PROFESSIONAL COMMUNICATION SKILLS FOR NURSES ISBN 0–7216–8103–4

Printed in the United States of America.

Last digit is the print number: 9 8 7 6 5 4 3 2 1

To my beloved husband, George B. Arnold

Elizabeth Arnold

In memory of
Eileen Kelly Underman and Rita Weiber Boggs

Kathleen Underman Boggs

Contributors

Kristin Lynn Bussell, MS, RN, CS-P
Clinical and Classroom Instructor
University of Maryland
School of Nursing
Baltimore
Program Therapist
Developmental School Foundation
Rockville, Maryland

Verna Benner Carson, PhD, RN, CS-P
National Director of Restore Behavioral Health
Staff Builders Home Health & Hospice
Fallston, Maryland

Ann O'Mara, PhD, RN, AOCN
Assistant Professor
University of Maryland
School of Nursing
Baltimore, Maryland

Judith W. Ryan, PhD, RN, CRNP
Director of Clinical Support Services
EverCare
Linthicum, Maryland

Shirley A. Smoyak, RN, PhD, FAAN
Professor
The Bloustein School of Planning and Public Policy
The Institute for Health, Health Care Policy, and Aging Research
Rutgers University
New Brunswick

Adjunct Professor
University of Medicine and Dentistry of New Jersey
Robert Wood Johnson Medical School
School of Public Health
Family Health Track
New Brunswick, New Jersey

Reviewers

Shirley Anderson, MSN, RN
Department of Health Sciences
Kirkwood Community College
Cedar Rapids, Iowa

Joyce Begley, PhD, RN
Baccalaureate and Graduate Nursing
Eastern Kentucky University
Richmond, Kentucky

Janet Burton, MSN, RN
Department of Nursing
Bob Jones University
Greenville, South Carolina

Agnes J. Janoscrat, MSN, RN
Department of Nursing
Delaware State University
Dover, Delaware

David R. Langford, DNSc, RN
Department of Family and Community Nursing
University of North Carolina at Charlotte
Charlotte, North Carolina

Christine Massey, MSN, RN
Department of Nursing
Barton College
Wilson, North Carolina

Deena Nardi, MSN, RN
Department of Nursing
Indiana University Northwest
Gary, Indiana

Shirley Newberry, MSN, RN
Department of Nursing
Winona State University
Winona, Minnesota

Kathleen O'Connell, MSN, RN, NP
Department of Nursing
Indiana University–Purdue University
Fort Wayne, Indiana

Enid Rossi, MSN, RN
Department of Nursing
Northern Arizona University
Flagstaff, Arizona

Jo Stejskal, MSN, RN
Department of Nursing
Winona State University
Winona, Minnesota

Mary Wilhite, EdD, RN
College of Nursing
University of North Dakota
Grand Forks, North Dakota

Preface

The authentic experience of understanding begins with communication. As nurses we are answerable to our clients, our profession, and ourselves to communicate with clients in a very specific sense, at once physical, psychological, and ethical regardless of what nursing intervention is employed. Despite the technological advances in diagnosis and treatments available to clients and their families, communication remains the single most important, and sometimes under-rated, dimension of nursing practice. We believe that the third edition of *Interpersonal Relationships: Professional Communication Skills for Nurses* will serve as a primary reference source for nurses seeking to improve their communication skills in a variety of health care settings. This text offers a comprehensive and critical analysis of the communication process that occurs with clients of all ages and in a variety of clinical situations.

The third edition strives to spell out the implications of the accountability and the shared reciprocity between nurse, client, and health care system for each client's health and well-being. As the health care system changes, so does the context of our communication with clients and other professionals. This edition has been revised to reflect current trends in health care, specifically shorter encounters, communication technology, and a greater focus on health promotion.

This edition presents new information on critical thinking skills, care of the grieving client, delegation, and incorporation of theoretical concepts related to changes in health care, as well as updated references and revised exercises. A wealth of experiential exercises offers you, as nurse and student, the opportunity to practice, observe, and critically evaluate your own communication skills and those of others. Case examples provide a basis for discussion by helping students to understand and appreciate clients' perspectives and needs. Communication principles assist the student to think through and experiment with alternative approaches to "human encounter with presence" in the daily care of clients and families.

The book is divided into five parts, using a format similar to that in the second edition of presenting the basic concepts of the chapter subject followed by clinical applications. Part I, Conceptual Foundations of Nurse–Client Relationships, provides a theoretical framework and professional guides to practice. Part II, The Nurse–Client Relationship, explores the essential components of this relationship. Two new chapters, one focused on ethical decision making and critical thinking skills and the other on communicating with the grieving client, broaden the therapeutic application of the communication process in contemporary health care. Part III, Therapeutic Communication, examines communication skills related to the needs of population groups. This material has been updated to reflect a greater emphasis on the client as partner in his or her health care. Part IV, Responding to Special Needs, addresses lifespan issues in communication as well as those with clients who require specific adaptations. Finally, Part V, Professional Issues, discusses issues pertaining to communication and documentation with other health care providers on delegation strategies and use of technology. As in previous editions, the third edition of *Interpersonal Relationships: Communication Skills for Nurses* has been designed for use as individual teaching modules or across the curriculum.

Those of us who accept the responsibility of professional nursing as a life commitment are most fortunate because we can constantly learn and grow professionally and personally from our interpersonal encounters with the clients we serve. Ask almost any nurse: These encounters are what make nursing special and replenish our resolve. Some encounters with clients are remembered with joy and satisfaction; others with pain at the missed opportunity to be fully present

or to have that "encounter with presence" experienced by a client. But with each interpersonal encounter, the nurse has yet another chance to appreciate the richness of human experience, the magnificence of the human being, and the many different opportunities for fulfilling human potential through the medium of relationship.

The goal of the experiential format is to enable the student to learn, grow, and develop new insights about communication and relationship concepts brought to life through active involvement in the process. The exercises are designed to foster self-awareness and to provide an opportunity for students to practice communication skills in a safe learning environment with constructive feedback to encourage analysis and synthesis of content. Through collegial sharing of experiences with students and faculty, students are better able to integrate theory with practice-applications and to generalize the classroom experience of communication skills to the larger world of professional nursing.

Additional experiential exercises can be found in the accompanying *Instructor's Manual*, along with strategies for teaching and learning and brief chapter summaries with teaching tips. The test bank in the *Instructor's Manual* has been completely revised to reflect the content of this third edition.

Our hope is that *Interpersonal Relationships: Communication Skills for Nurses* will serve as a conceptual "staging area" for reflective communication, offering room to push off from in the refinement of interpersonal relationships in professional practice. We encourage students and faculty to "prepare the passage for the future" via ever renewed interpretations of the type of behavioral responses that calm, educate, and promote the healing process of our client and compel reasoned action through communication in the service of the client, the family, and the profession.

Elizabeth Arnold
Kathleen Underman Boggs

Acknowledgments

This third edition carries forward the ideas and efforts of students, valued colleagues, clients, and the editorial staff at WB Saunders. The evolution of this text began with an interpersonal relationship seminar that was part of the curriculum in an upper division baccalaureate nursing program at the University of Maryland. It became clear that using experiential exercises to reinforce communication concepts provided a richer learning experience for students. Faculty and students have deepened the understanding of the materials presented in this text through the caring, creativity, and competence evidenced in professional relationships. Their voices find consistent expression in each chapter.

The material also reflects the perspectives of communication in interpersonal relationships derived from the professional reflections of leaders in the field of communication and nursing. Hildegard Peplau's classic work on interpersonal relationships in professional nursing practice provides the nursing framework for this text. Contributors from outside the realm of nursing provide a broader understanding of the communication process to guide therapeutic conversations with clients and professionals involved with their care.

The editorial staff at WB Saunders deserves special acknowledgment for their commitment to the preparation of this book. We owe a special debt of thanks to Terri Wood, our nursing editor, for her encouragement and consistent support in developing the text. Her quick and ready response to issues that arose during the development of the text kept us on track with a tight publication schedule. We also wish to acknowledge the careful attention to detail and the strong working relationship that Marie Thomas, editorial assistant, provided throughout the process. We also want to acknowledge the useful and supportive suggestions made by our reviewers.

We feel most fortunate to have had the competent services of Rachel Bedard once again as developmental editor for the text. Her clarity of thinking, sensitive understanding of the material, revision of the glossary, and suggestions related to editorial revisions was exceptional and deeply appreciated.

Finally, we need to acknowledge the loving support of our families. We are particularly grateful to our spouses, George B. Arnold and Michael J. Boggs, for their unflagging encouragement and support.

Contents

PART I

Conceptual Foundations of Nurse–Client Relationships

1

Theory as a Guide to Practice

Elizabeth Arnold

OUTLINE

OBJECTIVES

At the end of this chapter, the student will be able to

1. Describe the nature and purpose of nursing theory
2. Identify the historical development of nursing theory
3. Compare and contrast different levels of nursing knowledge
4. Describe the implications of Peplau's nursing theory for the nurse–client relationship
5. Analyze psychological models relevant to nurse–client relationships
6. Specify the use of communication theory in nursing practice

Nursing theory ought to guide research and practice, generate new ideas, and differentiate the focus of nursing from other professions.

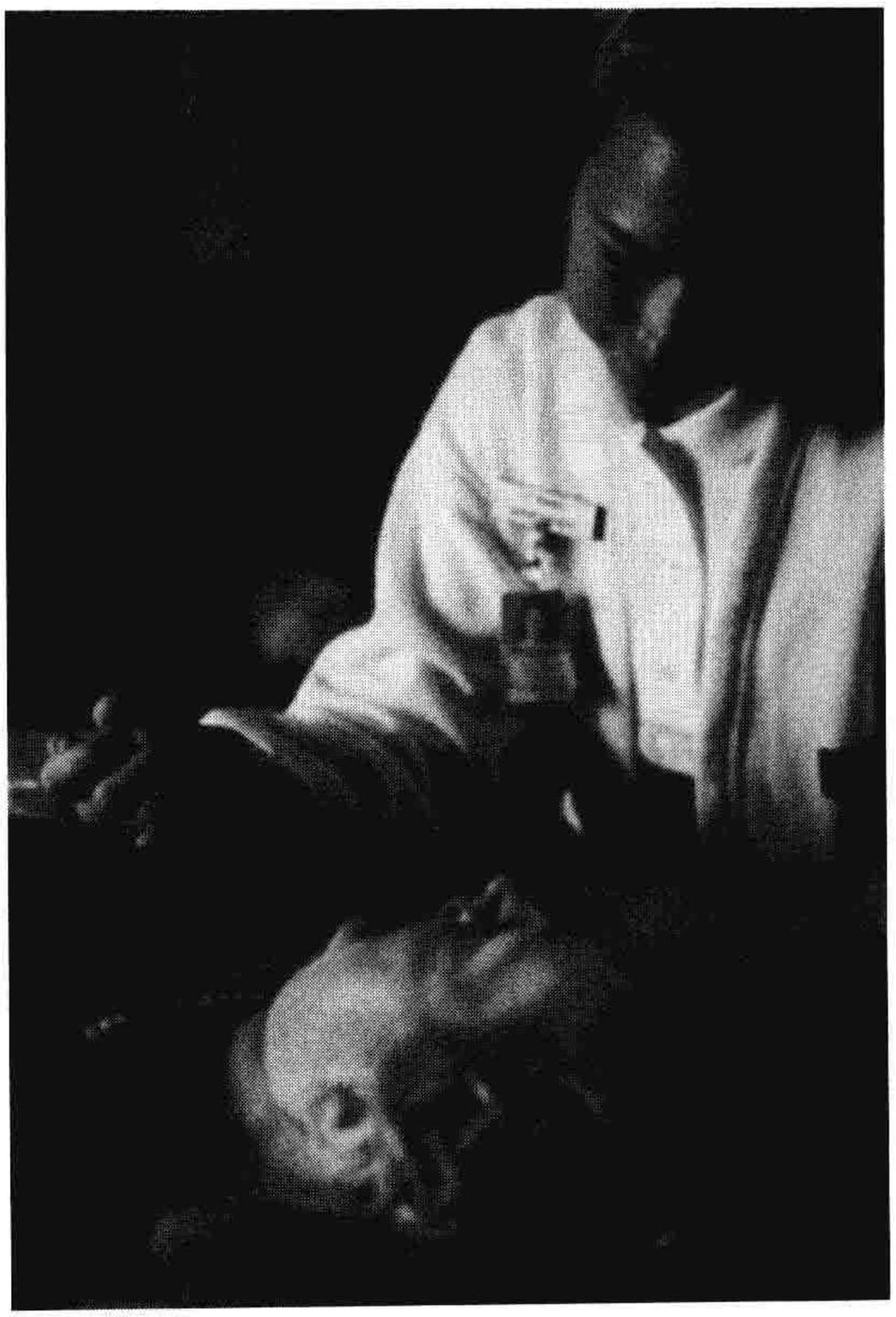
Chinn & Jacobs, 1987

Chapter 1 focuses on the role of theory as a necessary foundation for the nurse–client relationship. Dienemann (1998) suggested that theories "enable a person to critically analyze what otherwise would be too difficult to comprehend" (p. 269). Included in the chapter are the structural components of nursing knowledge and a brief overview of theoretical perspectives found in the nurse–client relationship drawn from nursing and other disciplines.

Having nursing models to describe professional nursing is more important than ever in today's health care environment. As we enter the 21st century, a variety of factors—economics, multidisciplinary approaches to health care delivery, and advances in technology—are changing nursing's professional landscape (Booth, Kenrick, & Woods, 1997). Such changes obviously affect the traditional formats of the nurse–client relationship but not its essence. Basic therapeutic communication principles and theory-based applications of the nurse–client relationship persist as valuable and current. This is because client reactions to illness and health have not changed despite the revolution in health care delivery.

Life for each individual still is a personal tale of comedy and tragedy, joys and sorrows, peak moments and despair, accomplishment and defeat, happiness and pains, an original adventure story. Some people are born with or acquire defects that alter the human story. For others, physical and emotional disturbances, injuries, and personal life situations occur to create a new chapter. When a human story takes a turn requiring health care, people seek help from nursing professionals to reduce their sense of discomfort, to find relevant answers to difficult problems, and to rediscover the meaning of their lives now changed through illness or injury (Paterson & Zderad, 1988).

Nurses see clients at their most vulnerable in health care situations. They share peak moments, both good and bad, with their clients in birth, death, and much of life in between. Feeling centered as a personal self is difficult when clients are confronted with life-altering health conditions. The learning clients experience in the process of redefining their identity while maintaining continuity of self is unique and intensely personal. In each nursing intervention, the nurse–client relationship serves as its foundation for helping clients maintain continuity of self while expand-



The nurse integrates three fundamental forms of nursing knowledge—theoretical, technical, and creative—in the nurse–client relationship. (Courtesy of the University of Maryland School of Nursing.)

ing their definition to include a distinct change in health status.

Nursing interventions cover the spectrum of care ranging from health promotion to caring for clients in the home, caring for critically ill clients in the hospital, caring for clients in prisons and nontraditional settings, and caring for the dying client in a hospice.

BASIC CONCEPTS

Definition of Theory

Theory comes from the Greek word *theoria*, meaning "something examined into, a viewing" (Shipley, 1945, p. 333). A theory represents a theorist's thoughtful examination of a phenomenon, defined as a concrete situation, event, circumstance, or condition of interest. Theory takes raw data about phenomena, fashions the data into a meaningful whole, provides a common language to describe the data, and gives a collective shape to the phenomena that people understand. This examination takes place over a long time and leads the theorist to make educated guesses about its nature. The theorist describes the significant elements (concepts) that make up the phenomenon and includes tentative assumptions about the relationships among them. Tentative assumptions become hypotheses that other scientists can test empirically.

A theory is neither reality nor truth. In examining theoretical frameworks or models, nurses need to explore a theory's usefulness in explaining behaviors rather than to question its truthfulness. Theoretical models are subject to change and adaptation as new information develops. A simple illustration: Descartes convinced many people of the full separation of mind and body in medieval times. This theoretical understanding, widely accepted for centuries, we now know to be false. Early nursing theorists viewed health from a disease perspective, as the absence of disease, and focused on body systems or physical interventions as a way of organizing data about an individual in need of nursing care. Their views mirrored popular understandings at the time. Modern nursing theories have broadened the definition of health to focus on well-being as the desired health outcome with a strong emphasis on disease prevention and health promotion.

There can be, and usually is, more than one theory about the same phenomenon. Each theorist focuses on different aspects and consequently draws contrasted conclusions, and this is good. Just as there is no one universal truth applicable in all situations, there is no one universal explanation for a particular phenomenon. Some theories are more useful in certain nursing situations than others. For example, Peplau's (1952, 1997) theory of interpersonal relationships is particularly useful as a framework for nurses working in psychiatric and long-term settings but much less so to nurses working with comatose clients or critically ill newborns. On the other hand, Levine's theory of energy conservation could prove helpful to neonatal intensive care unit (NICU) nurses and would not be as effective in psychiatric settings. Most nurses take elements from different theories to develop a personally relevant theory of nursing to guide their clinical practice.

Purpose of Nursing Theory

Theory informs nursing practice by (1) furnishing a distinct body of nursing knowledge governing the scope of practice, (2) providing professional values to guide nurses in the decision-making processes, and (3) portraying the expected role of the nurse in a multidisciplinary health care environment. Nursing theories provide practitioners with a systematic way to view client situations and a logical way to organize and interpret health data (Raudonis & Acton, 1997). In all nursing theory frameworks, the client is the central focus, and the goal of nursing is to promote and maintain the health and well-being of individuals, families, and communities (Doheny, Cook, & Stopper, 1997).

Nurses often question the relevance of nursing theory for professional practice (Kim, 1994). Nursing theory seems abstract and so far removed from what nurses do every day. Yet having a body of knowledge that is distinctly nursing, separate from, but related to, what nurses actually do, is critical to the survival of nursing as a profession. Without a body of knowledge to characterize the nature of professional nursing and to describe its distinctive elements, registered nurses have no independent identity as a profession. For example, how is the nursing role different from the medical or the social work role or distinct

from the paraprofessional role? Is the nurse an autonomous practitioner? If so, what is the body of knowledge that governs and guides his or her practice?

McKenna (1993) argued that nursing theory provides nurses with a distinct health care identity in collaborating with other members of the interdisciplinary health care team. General theories of nursing lay out the domain of the profession, establish the boundaries of professional nursing, provide a basis for research, and serve as a guide for curriculum development and clinical practice.

Nursing is not applied theory (Allmark, 1995). The effective practice of nursing depends on more than nursing theory. It includes critical thinking and clinical judgment based on integrated applications from scientific, ethical, and personal knowledge. Most theorists describe nursing as both an art and a science.

> The artistic aspect includes, but is not limited to, tender care, attentive compassion and concern, advocacy and various hands-on practices to enhance the comfort and well-being of sick people. The developing scientific component of nursing includes knowledge applied for understanding of a broad range of human problems and psychosocial difficulties, as well as for health restoration and maintenance (Peplau, 1997, p. 162).

To sustain critical membership as part of the interdisciplinary health care team, nurses need to view nursing practice as an arena for new theory development as well as for applying nursing knowledge (Reed, 1997). Nursing theory models provide a framework for discussion, research, and the development of new thinking about the profession. They force the reader to challenge what is and to create fresh alternatives.

Nursing Theory Development

Theory development in nursing began with Florence Nightingale and her classic work *Notes on Nursing* (1940). She described nursing as "the care that puts the patient in the best condition for nature to act." She defined health as "not only to be well, but to use well every power that we have." The validity of her ideas is represented in the timelessness of their applicability.

After Nightingale's work there was a long period of silence about nursing until the 1950s. Nurses in the early part of the 20th century were trained using an apprenticeship model in hospital-based schools that viewed nurses as ancillary personnel or semiprofessionals rather than as professionals. Their training followed the medical model, and in most settings nurses were regarded as the handmaiden of the physician or angel of mercy rather than as autonomous competent practitioners of professional nursing.

The primary impetus for the development of a body of knowledge distinctively described as professional nursing came in the 1950s from universities where nursing leaders found themselves coping unsuccessfully with confusion and ambiguity about the role of nurses, particularly those with higher degrees. That "a nurse is a nurse is a nurse," regardless of educational preparation, was hard to dispute without a specific body of knowledge labeled professional nursing and descriptive of its nature. At about the same time, nursing education in college settings began to emerge as the preferred educational route for registered nurses, and hospital-based diploma training of nurses was replaced with associate degree and baccalaureate education.

Nursing leaders in higher education began to insist on defining the domain of professional nursing practice. They saw it as critical to the evolution of nursing as a profession to establish a logical academic structure of professional nursing education with a distinctive body of knowledge, clearly linked to what nurses actually do. Since that time, theorists such as Virginia Henderson, Myra Levine, Martha Rogers, Imogene King, Sister Callista Roy, Madeline Leininger, Dorothea Orem, Jean Watson, Dorothy Johnson, Betty Neuman, and Rosemarie Parse have devoted their professional lifetimes to developing theories about the body of knowledge unique to professional nursing.

As we enter the 21st century, nursing education is part of the career ladder that many nurses use to enhance their practice; more and more nurses elect to pursue advanced education at the master's level. Nursing theory continues to be relevant as curricular and practice threads for the associate degree, baccalaureate degree, and advanced practice with a master's degree.

The scholarly thinking of graduate nursing students has helped to further nursing theory development. Graduate nursing students have

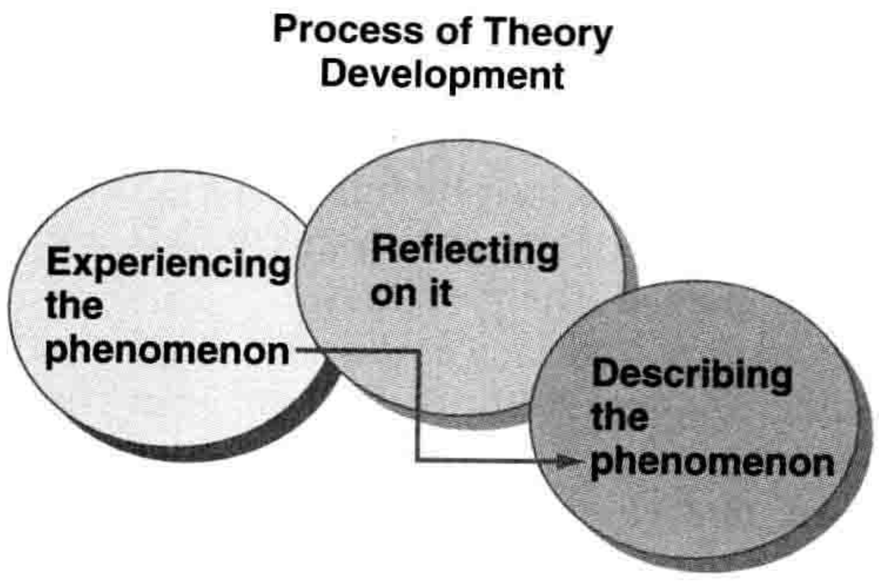


Figure 1–1. Process of theory development.

provided ideas, struggled to understand the language and meaning of concepts, critiqued ideas, and developed important research studies to support the validity of nursing theory (Fig. 1–1). Thus, the nursing theories that guide professional practice today have a richness evolving from scholarly inquiry and an integrity springing from the commitment of its primary and contributing authors to explaining the phenomenon of professional nursing.

Nursing theories are classified as grand theory and midrange theory. *Grand theories* encompass thinking about nursing as a whole and are the most abstract of theoretical knowledge. Examples include Martha Rogers's theory of unitary beings and Dorothea Orem's self-care model. *Midrange theories* cover more discrete aspects of a phenomenon and describe concepts in professional nursing in depth rather than exploring all aspects of phenomena. Hildegard Peplau's theory of interpersonal relationships in nursing is an example of a midrange theory (Armstrong & Kelly, 1995). More recent midrange theories cover topics such as therapeutic touch, pain, resiliency, dignity, and presence. Exercise 1–1 provides an opportunity for students to critique an article using nursing theory in clinical practice.

Structure of Nursing Knowledge

Metaparadigm

Nursing knowledge proceeds from general to more specific in a structural hierarchy that begins with the broadest level of nursing knowledge—nursing's metaparadigm—and proceeds to the most discrete level of nursing knowledge—nursing theory. A ***paradigm*** is a broad worldview. A *metaparadigm* contains the common ideas held across all paradigms. Nursing's metaparadigm reflects the central elements of nursing practice held to be valid regardless of setting: (1) person, (2) environment, (3) health, (4) nursing (Marriner-Tomey, 1994). Early theorists added nursing as a separate component to reinforce its importance, and caring as a fifth essential

◆ Exercise 1–1. **Critiquing a Nursing Theory Article**

Purpose: To provide the student with an opportunity to understand the connection of nursing theory to clinical practice

Procedure:

1. Select an article from a professional journal that describes the use of nursing theory or nursing concepts.
2. Suggestions of journals include *Nursing Science Quarterly, Journal of Advanced Nursing, Journal of Professional Nursing, Advances in Nursing Science.*
3. Read the article carefully and critique the article to include (1) how the author applied the theory or concept, (2) relevance of the concept or theory for nursing practice, (3) how you could use the concept in your own clinical practice, and (4) what you learned from reading the article.

Discussion:

In your class group, share some of the insights you obtained from the article and engage in a general discussion about the relevance of nursing theory for the professional nursing role.

element finds advocates in later works. Figure 1–2 provides a diagram of the structural hierarchy of nursing knowledge.

Concept of a Person. ***Person*** is a unitary concept with integrated physiological, psychological, spiritual, and social dimensions. When a person suffers a physical change in health status, he or she also has a psychological response to it. The change will influence social and spiritual meanings about the change.

The holism of person is key to effective nursing practice. The nurse views the client as a whole person, "not as an additive summation, but rather as a gestalt" (Paterson & Zderad, 1988, p. 25). The concept of person helps the nurse understand what makes an individual human and allows for protection of the person within the critically ill newborn, the comatose client, and mentally ill client as with the most contributing member of society. Nurses usually are the health professionals most intimately involved in promoting a person's health and well-being, preventing further injury and providing practical intervention to the client, with educational and emotional support given to their families.

The nurse–client relationship always begins with the understanding of each individual client as a holistic being even before considering the nature of the specific health care problem. Preserving and protecting the client's basic health rights as a person is in the forefront as an ethical responsibility of nurse to client in the nurse–client relationship.

Concept of Environment. ***Environment*** refers to the cultural, developmental, physical, and psychosocial conditions that influence the client's perception and behaviors, growth, and development. Just as plant growth cannot be fully understood without an analysis of its environment (i.e., the soil and the balance between sun and shade required for each plant's development), persons cannot be fully understood without an analysis of the environment that supports or compromises their existence.

Environmental factors do not simply include tangible physical settings. Psychosocial environmental elements, such as family, social norms, culture, and religion, are important factors for the nurse to consider. For example, a new mother may be anxious about her ability to care for her child depending on the amount and type of family assistance that she will receive when she goes home. Cultural or religious beliefs can make it difficult for the client to comply with treatment if they are in conflict with prescribed treatment. What a child sees parents doing at home can reduce the effectiveness of the best health prevention education about drug use or sexually responsible behavior.

Concept of Health. Harvey (1998) observed that "Americans are moving away from the idea of ***health*** as the absence of disease and the result of medical intervention to a broader definition that includes both personal responsibility and quality of life" (p. 187). Prevention, self-care, and optimal well-being are the focus of new conceptualizations of health and healthy behaviors.

In today's health care environment, the client is a consumer and an active partner in determining the focus and in planning and implementing health care measures. The personal meaning of health varies, affected by many factors, including the person's perception of wellness or illness (Frean & Malin, 1998).

Empowering clients to take primary responsibility for their health through education, emo-

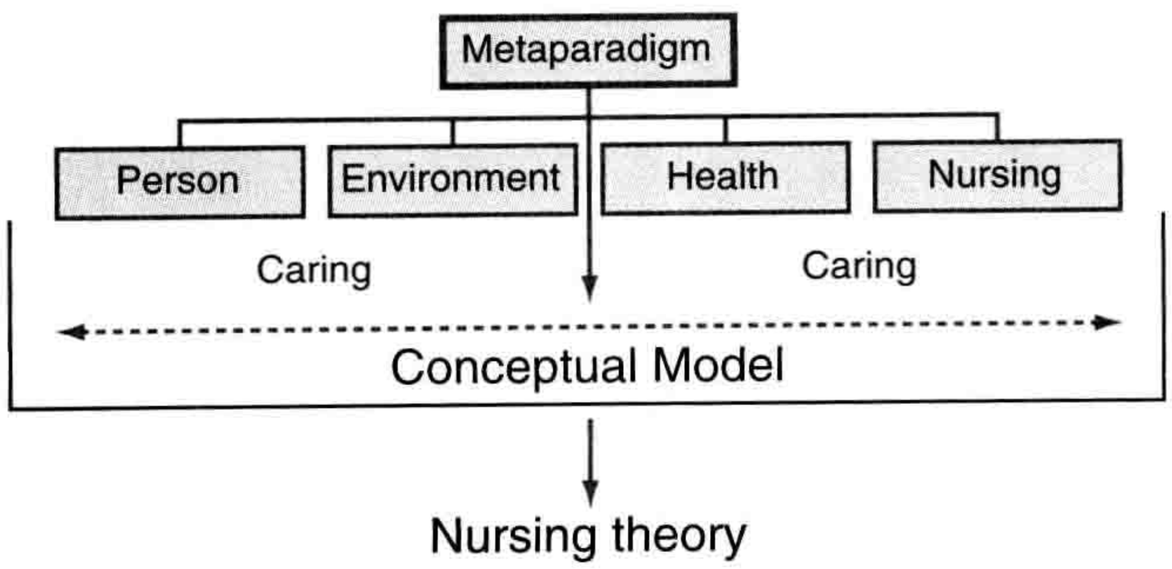


Figure 1–2. Hierarchy of nursing knowledge.