Patient & Person

Interpersonal skills in nursing

5th Edition

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CHAPTER 3

Nurse as therapeutic agent

KEY CONCEPTS

Communication competence
Emotional intelligence and emotional labour
Self-awareness
Reflective practice
Personal values and beliefs
Authenticity and congruence
Respect and warmth
Confidence and assertiveness
Developing a personal style

Introduction

That nurses have a sense of agency is the basis on which they form relationships with patients. A sense of agency means that nurses understand and appreciate that they can make a difference to patients' lives, and that they know how to use their professional influence and knowledge to the benefit of patients. While such power could be used to harm the patient, a nurse's professional agency is employed in service to the patient (i.e. for therapeutic benefits).

In developing therapeutic agency, nurses need a wide and varied repertoire of interpersonal skills and an understanding of their use, as well as practical know-how. In employing their agency, nurses need an awareness of how effectively they are using their skills because such awareness enables them to evaluate their own performance. Nurses who are able to reflect upon and evaluate their own performance are in a position to learn, grow and become more skilled and effective in their interactions with patients, thus increasing their potential for therapeutic agency.

The previous chapters have outlined a moral imperative for nurses to focus their attention on patients during their interactions. This may be interpreted to mean that nurses should disregard or forget themselves whenever they engage in nursing care. By focusing on patients, at the exclusion of themselves, nurses run the risk of failing to recognise the significance of how *they* are affecting patients and how patients are affecting *them*. In the process, nurses may fail to attend to their own reactions and responses, erroneously perceiving their subjectivity to be superfluous or irrelevant to patient care.

The skills presented in the following chapters of this book can be learnt, developed and refined. Nevertheless, the skills are only as effective as the person

using them. Each nurse employs the skills in a unique way. Effectively relating to patients involves more than simply using the right skill, at the right time, with the right patient. *What matters and makes a difference are not the skills themselves but the nurse who is using the skills.* Each nurse develops a style of relating to patients that is 'right' for that particular nurse. Nurses who focus solely on the skills without awareness of their own personality run the risk of contrived performance that lacks spontaneity and a personal touch. For these reasons, the initial focus of interpersonal skill development is placed on communication competence, emotional intelligence, self-awareness and reflective practice.

CHAPTER OVERVIEW

This chapter begins with a discussion of the importance of communication competence in developing a sense of therapeutic agency. Nurses with such competence have the ability to be responsive to what others are thinking, feeling and perceiving, along with an ability to express what they are thinking, feeling and perceiving. Emotional intelligence and emotional labour are reviewed as they relate to communication competence. The importance of understanding in developing such competence, particularly in light of the concept of the 'use of self' in nursing, is then reviewed. The use of self as a therapeutic agent is discussed next. This is followed by a brief overview of reflection and reflective practice, as such processes are an effective means of increasing self-awareness and understanding. Reflective processes involved in developing self-understanding are then reviewed, with an emphasis on the interactive nature of these processes. The processes for developing greater self-understanding include introspection, feedback from others and self-sharing.

The next section provides an overview of the facets of the self that are of critical significance in patient–nurse relationships. The qualities and traits of effective helpers are also reviewed because self-understanding enhances the development of these. Challenges frequently encountered when learning interpersonal skills are then discussed. The final section, self-assessment of interpersonal skills, provides useful guidelines for evaluating present skill level and suggested directions for further skill development.

Therapeutic use of self

Therapeutic use of self, a term coined by Travelbee (1971), is the direct expression of the art of nursing. Use of self requires creative thinking in response to the uniqueness of each individual patient. For example, nurses who are natural comedians can effectively use humour for those patients who are not coping through finding a funny side to their circumstances. Other nurses will find that their strength lies in the area of providing explanations to patients who want more information. As such there is no one description or definition that captures the use of self as an art, as each nurse's enactment of agency will be as unique as the nurse.

Developing the art of using oneself will be a career-long process for nurses whose therapeutic agency is realised. Nonetheless, there are basic requisites for developing therapeutic agency, which are communication competence, emotional intelligence and skill in labouring the emotions, as much of what makes people unique is how

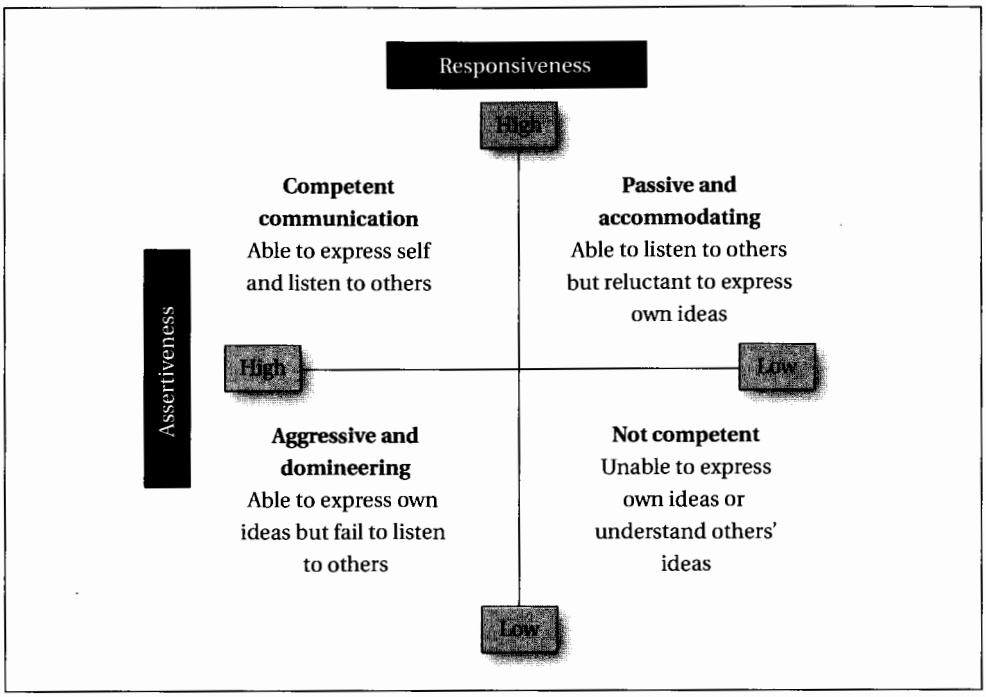

FIGURE 3.1 Communication competence

they feel and respond emotionally. Because nursing care situations often involve strong emotions, nurses must be skilled in effectively managing their own feelings (emotional labour) if they are going to be of value to patients.

Communication competence

Nurses must be competent communicators if they are going to develop their own personal sense of agency and use their interactions with patients to be of assistance and to provide help. Communication competence involves two types of skills: those of being responsive, able to listen to and understand what others are saying; and those of being assertive, able to state their point of view and express their needs. People who are competent communicators are able to express their own ideas, opinions and feelings while also having the ability to understand the expressed ideas, opinions and feelings of other people. That is, they are skilled at balancing both assertive and responsive skills in their interpersonal interactions with others. Figure 3.1 depicts communication competence along two axes: assertiveness and responsiveness. A competent communicator will have a balance of both types of interpersonal skills and will lie in the upper outer quadrant of the matrix.

Overly assertive people who are not able to listen to and understand others' opinions and ideas are usually considered aggressive or domineering in their communication, as they often do not listen to others while continuing to emphasise

their viewpoint. As such, they are prone to override others' views. Highly responsive people—those people who are very adept at understanding others yet are unable to state their own ideas—are often considered passive or accommodating in their interpersonal interactions. As such, they often miss opportunities to be heard. Neither type of person is competent in communication, as they lack a balance between the skills of responding and the skills of asserting.

Nurses need to be competent communicators because they need to be both responsive and assertive as they enact their therapeutic agency. For example, they are often in a position to advocate on behalf of a patient, thus needing to use the skills of assertion. Likewise, empathic expression, developed through using responsive skills, is necessary to understanding the experience of patients. Responding skills are covered primarily in Chapters 5 and 6, and the skills of assertion are reviewed fully in Chapters 10 and 11.

Emotional intelligence

Competent communicators possess what is termed 'emotional intelligence'—the 'ability to carry out accurate reasoning focused on emotions and the ability to use emotions and emotional knowledge to enhance thoughts' (Mayer et al. 2008, p. 527). This includes a capacity to recognise emotions in oneself, as well as those of others, and to monitor those emotions and manage their feelings within themselves and in their relationships. People who are emotionally intelligent possess internal qualities of resilience, initiative, optimism and adaptability (Goleman 1998). In their interactions with others, they acknowledge the significance of human feelings and are able to use their hearts as well as their heads when deciding how to act. Emotional intelligence has been discussed as important in nursing because nursing work requires the capacity to understand the emotional realities of patients (Akerjordet & Severinsson 2007; Bulmer Smith et al. 2009; McQueen 2004).

Emotional intelligence has been conceptualised as the ability to: manage emotional responses; understand emotions and their meaning; assess emotions in situations; identify and recognise emotions in other people; and use emotions for reasoning (Mayer et al. 2008). These abilities promote both an understanding and regulation of emotions. An alternative view of emotional intelligence is that it is a personality trait—emotional self-efficacy (Nelis et al. 2009; Petrides & Sevdalis 2010). According to Goleman (1998), who popularised the notion of emotional intelligence, there are five dimensions of emotional intelligence—self-awareness, self-regulation, motivation, empathy and social skills—which are hierarchical and interdependent, with self-awareness as the basis on which other dimensions are developed. Self-awareness includes accurate assessment of self, along with self-confidence. Self-regulation involves control over one's emotions and being trustworthy. Motivation includes commitment, initiative and optimism. Empathy (see Ch 6), a central dimension in emotional intelligence, includes not only understanding other people but also maintaining a service orientation towards others. Finally, the social skills necessary for emotional intelligence include conflict management, cooperation and collaboration (see Ch 10).

Developing emotional intelligence is essential to becoming a competent helper (Ivey & Ivey 2010). In nursing, emotional intelligence is considered a core

competence because care is provided through interpersonal relationships and emotions are vital to these relationships; nurses have a moral obligation to make emotional connections with patients in their care (Bulmer Smith et al. 2009).

The critique of emotional intelligence is that it is poorly defined and that claims about its relevance have been overstated (Bulmer Smith et al. 2009). However, the research into emotional intelligence is at an early stage (Mayer et al. 2008) and the criticisms of the concept may reflect the need to clarify the concept.

Nonetheless, emotional intelligence is receiving attention in the nursing and healthcare literature (Akerjordet & Severinsson 2007; Bulmer Smith et al. 2009; McCallin & Bamford 2007; McQueen 2004; Skinner & Spurgeon 2005). Emotional intelligence is evident in stories told by nurses that reveal how they use their knowledge (Kooker et al. 2007). Other research findings reveal that emotional intelligence has a positive relationship with the level of clinical performance (Codier et al. 2008), nurses seeking a deeper understanding of practice (Akerjordet & Severinsson 2004) and nurses choosing collaborative solutions in conflict situations (Jordan & Troth 2002). In addition, it is associated with lower stress in nursing practice (Gørgens-Ekerman & Brand 2012).

Emotional labour

One aspect of being emotionally intelligent is the ability to self-regulate and manage emotional responses, especially in relation to the context in which they occur. There is a link between this dimension of emotional intelligence and the concept of 'emotional labour' (McQueen 2004; van Dusseldorp et al. 2012). Emotional labour involves keeping natural emotional responses concealed in order to demonstrate an emotional response that is in keeping with the context of service provision (Hochschild 1983). Such labour involves regulating and displaying emotions that are considered professionally desirable (Larson & Yao 2005).

Nurses do learn to appropriately manage their emotional responses to patients, especially when there is a perceived gap between what they feel and what they believe they should feel (Smith 1992). For example, if nurses respond to physical deformity of a patient with disgust, they hide these feelings from the patient as they serve little useful purpose in trying to be of help. In this sense, emotional labour is considered to be necessary to therapeutic relationships (McQueen 2004).

Emotional labour involves regulating one's emotions, along with employing what is called 'surface acting' and 'deep acting' (Hochschild 1983). Surface acting is the overt expression of an emotion not felt by the person, yet thought to be needed in the situation. For example, if a nurse is feeling overtaxed by a heavy workload and a patient apologetically asks for help, stating 'So sorry to bother you ... ', a nurse may conceal their stress and say 'no bother at all' in a calm, pleasant manner. Deep acting involves a shift in emotional response within the nurse. For example, trying to understand a situation from the patient's perspective may result in the nurse changing their views about the situation.

Like emotional intelligence, the concept of emotional labour is also receiving attention in the nursing and healthcare literature (Bolton 2000; Chou et al. 2012; de Raeve 2002; Mann & Cowburn 2005; Timmons & Tanner 2005; Yang & Chang 2007). The concept has been studied to reveal how this type of work may affect nurse

retention (Yang & Chang 2007) and work-related stress (Mann & Cowburn 2005; Mikolajczak et al. 2007) in an effort to reveal the potential negative effects of this type of work. Deep acting is positively related to job satisfaction, while surface acting is related to emotional exhaustion and poorer job satisfaction (Chou et al. 2012).

While the link between the self-regulation of emotional intelligence and emotional labour has been made, Goleman (1998) asserts that emotional labour is not sufficient to explain the self-regulation of emotional intelligence and its effect on job performance. This may be because the workers in the original study on emotional labour (Hochschild 1983) suppressed their emotions in service to their company, so money was not lost through poor customer service. In contrast, nurses are called to manage their emotions at work in service to the patient. The work satisfaction that is felt when enacting a professionally compassionate role, in keeping with the ideals of a caring profession, is the reward nurses often receive when they manage emotions in service to the patient.

Emotional labour has been criticised in the nursing literature as problematic because inauthentic behaviour, as occurs in surface acting or 'faking it', could disrupt the building of trust in the patient–nurse relationship (de Raeve 2002) (see Ch 2). One study demonstrated how nurses did manage a 'work persona' and a 'personal persona' for both the patients' and their own benefit (Macintosh 2007). The nurses in another study (Bolton 2000) not only engaged in emotional labour but also emotional work through empathy (Ch 6) that was offered as a form of authentic caring behaviour. Emotional labour has been linked to the expression of empathy in other clinical situations as well (Larson & Yao 2005).

The importance of self-understanding

An understanding of self in relation to patients, termed *personal knowing* (Carper 1978), is considered fundamental to forming therapeutic relationships in nursing. Personal knowing assists nurses in attending to the mutual relationship, not simply the patient in the relationship. A failure to take into account the effects nurses themselves have on patients, and their relationships with them, can lead to mistaken assumptions and judgments about what patients are experiencing.

Personal knowing, referred to here as self-understanding, is developed for the purpose of becoming authentic, congruent and open with patients. If nurses are authentic with patients, they are sincere and genuine, not only as people who care what happens to patients but also as people who are unafraid to show they are human. The more nurses are aware of themselves, the more likely it is that their interpersonal skills will be used in an authentic and natural way. Self-understanding enables nurses to act in ways that are in harmony with who they are, and congruent with and true to their unique nature and style. Openness with patients is the ability to accept patients as they are, rather than how nurses may want them to be.

Consider the following story:

> *Sylvia is an experienced registered nurse who prides herself on her ability to care for seriously injured and impaired victims of brain damage. Peter had become one of those patients whom all the nurses on Sylvia's ward had come to dislike. He was labelled as uncooperative and difficult. Because some alleged his injuries had been self-inflicted, he engendered little sympathy from the nursing staff. They did not like*

caring for Peter and often complained bitterly to each other about their negative feelings towards him.

One day during change-of-shift report, Sylvia began to listen to her colleagues' complaints and negative judgments about Peter. After reading a journal article on the topic, she had been thinking about how some patients are labelled as difficult. She came to realise that Peter had fallen into this unfortunate category. To her colleagues' relief and surprise, she asked to be assigned to care for Peter. Little did they realise that Sylvia was challenging herself to try to understand Peter as a person rather than a label.

That day when she entered his room she noticed, for the first time, the frightened and uncomfortable look on this young man's face. His primary manner of communication was through blinking his eyes because he had sustained an unstable neck injury. His hands were restrained because he was in the habit of pulling at tubes and equipment. Sylvia stood there for a moment, noticing and absorbing his situation.

Without even thinking, she suddenly realised the cool temperature of the room and noticed that Peter had nothing more than a light sheet draped over his naked body. She looked at him and said, 'I bet you're cold.' His eyes blinked furiously in the affirmative. She immediately went to get him a warm blanket. The look of relief on his face was incredible. Throughout the entire time, no one had noticed that Peter was cold. They did not notice because they had failed to perceive him as a person.

Sylvia no longer could say 'no' to the 'personhood' of Peter by thinking of him as a label. She began to question the dynamics that had led the nursing staff to label Peter and dismiss him as troublesome and difficult. Through reflection Sylvia had become more self-aware. Her awareness allowed her to put aside the labels used about Peter and to attend to his comfort needs.

This story highlights the importance of self-understanding—through active reflection and open acknowledgment Sylvia was able to take corrective action. Sometimes nurses try to deny the existence of negative patient labels, claiming that such evaluations are unprofessional and therefore unacceptable. They do so in the erroneous belief that nurses, by virtue of being professional people, can rise above their natural human tendency to judge, or that at least nurses can put such judgments aside so they do not interfere with their nursing care. Such denial is unfortunate because it diminishes self-understanding. Furthermore, there is empirical evidence that nurses' judgments about patients can and do influence patient care (Hill 2010).

The results of numerous studies demonstrate how nurses' attitudes and interpersonal behaviour towards patients are affected by judgments made about patients. The judgments were based on patients' characteristics such as: the nature of their disease; their understanding of the situation and expressed interest; similarity of their values and nurses' values; social skills; ability to communicate; and gratitude for care (Armstrong-Esther & Browne 1986; Baer & Lowery 1987; Carveth 1995; Drew 1986; Forrest 1989; Grief & Elliot 1994; Kelly & May 1982; McAllister et al. 2002; Olsen 1997; Sayler & Stuart 1985; Woodward 1999).

Johnson and Webb (1995a) found that nurses do judge the social worth of patients and that such judgment does have moral consequences. Nevertheless, their findings from a field study of nursing indicate that social evaluations of patients are not simply tied to personal characteristics of patients and their individual circumstances (e.g. bearing responsibility for their illness). Referring to the process as 'social judgment', Johnson and Webb (1995a, 1995b) describe a complex and

dynamic system whereby evaluations of patients' social worth is negotiated and renegotiated throughout their interactions with nurses. That is, nurses' evaluations of patients can and do change over time.

More recent studies have shown how nurses make efforts to provide compassionate care, even with patients for whom they feel little sympathy (Camilli & Martin 2005; McCann et al. 2007). McCann et al. (2007) found that nurses working in emergency departments held sympathetic views towards patients who had deliberately harmed themselves and, more importantly, they did not discriminate against such people when providing care.

The evidence suggests that it is useful to encourage nurses to actively reflect on their evaluative perceptions of patients rather than deny or ignore that their judgments can and do affect patient care. Once negative evaluations are brought into conscious awareness, nurses can explore their meaning and, like Sylvia in the story, take corrective action if necessary. Reflection will not prevent negative evaluations, but it will assist nurses in challenging or altering them.

The more nurses know about themselves, the more likely they will come to accept themselves. The more nurses understand about themselves, the easier it becomes for them to understand patients. The more tolerant nurses are of themselves, the more tolerant they can be of patients. The more comfortable nurses are with themselves, the more comfortable they can be with patients. It is through coming to accept and understand their own perspective that nurses can come to accept and understand patients' perspectives. As nurses come to know their own experiences as human beings, they are better able to relate to the person who is the patient.

Self-understanding helps nurses to build emotional intelligence and a healthy self-concept. Self-understanding can lead to comfort with the self, and genuine liking of the self. This is no easy task to achieve. It often takes a long time—a person's relationship with the self is dynamic, not static.

Liking oneself is not the same as thinking one is without faults or failings. Liking oneself is about knowing one's strengths and areas for improvement, putting these together and concluding that what exists is acceptable, along with a continuous desire to grow and learn. When nurses know, understand and like themselves, they are less likely to hide behind their professional role, and more likely to make contact with patients on a genuinely human level.

Self-awareness versus self-consciousness

Completing Activity 3.1 often engenders feelings of self-consciousness and discomfort in people. This is because focusing on the self, especially the positive aspects, is usually a private affair and 'seeing yourself on paper', even when it is not shared with anyone else, brings the private into the open and often creates a sense of self-exposure and vulnerability.

In bringing the self into awareness, even through an activity such as this, there is a danger of becoming preoccupied with self and uncomfortably self-conscious. Self-awareness can result in self-consciousness. There needs to be a balance between the self-consciousness that is experienced through focusing too much on self, and the lack of self-understanding that leads to alienation from the self. Achieving this

ACTIVITY 3.1 What do I have to offer patients? ➡ 313

Process

1. Divide a blank piece of paper into two columns. In the first column, record a description of those aspects of yourself that you think are positive—ones you like about yourself. In the second column, describe those aspects of yourself that you would prefer to change—ones you do not always like about yourself. You don't need to share this list with anybody else. Be as honest as possible with yourself.
2. From your list of positive aspects (in the first column of your paper) reflect on how you could put these aspects to use in caring for and relating to patients.
3. From your list of negative aspects (in the second column of your paper) reflect on how these may affect your relationships with patients, for better or for worse.
4. Write a brief summary of how you could use your personal self in developing your professional self.

Discussion

1. Which was easier: describing positive aspects of yourself or negative ones?
2. Which column contains more information?
   - Frequently, when completing activities such as this, it is difficult to separate the 'you' that you want to be (ideal self) from the 'you' that exists (real self). How true was this for you in completing the activity?
   - Ask someone who knows you well and whom you trust to describe what they see as positive and negative aspects about you. Compare what they say with your list and reflect on similarities and differences.

balance is important for nurses because the risks of focusing too much on themselves are as great as the dangers of failing to take themselves into account at all.

Egan (2010) refers to the need to be 'productively self-conscious' when engaged in helping relationships. Productive self-consciousness has positive effects because it is the ability to be absorbed in an interaction, while simultaneously being aware of internal reactions and perceptions. It is the ability to raise self-understanding to a level that enhances reflection on the self while not becoming so preoccupied with the self that there is a lack of ability to focus on the person being helped.

The relationship between self-understanding and professional growth

Nurses need to be able to evaluate how effectively they are relating to patients, and self-understanding is essential in this assessment. Evaluating performance in using the skills presented in the following chapters is best achieved through the process of self-assessment. In assessing their performance, nurses begin with an awareness of how they are interacting with patients. By considering their *intentions, actions, responses* and *reactions,* nurses are able to evaluate their own performance in the interest of learning how to be more effective. Self-understanding is not simply a

matter of perceiving the self as is; it is also a process of encouraging self-growth to become more effective in relating to patients. It would be irresponsible for nurses simply to accept themselves and not challenge themselves to change and grow through their nursing experiences. Through challenge comes change, and nurses willing to challenge themselves are open to personal and professional growth.

Developing the self as a therapeutic agent

When relating to patients therapeutically, nurses are deliberately using their interactions for the benefit of patients. This is the conscious 'use of self' as a therapeutic agent as nurses make choices and decisions in their interactions. Benner et al. (1996) define a nurse's clinical agency as an understanding of one's impact on what happens to the patient. A sense of agency is needed to influence and guide patients (Ch 8). Most importantly, this sense of agency develops through continual learning as a result of clinical experience.

In developing this sense of agency, nurses need to become aware of what they have to offer patients (e.g. they need to know their personal strengths and their personal areas for improvement). Self-understanding enables nurses to view themselves as human beings with failures, faults, successes and strengths—as people who have something to offer patients.

Self-understanding is an essential ingredient in a nurse becoming a therapeutic agent. It is unlikely that nurses, or anyone else for that matter, will ever fully know and appreciate all facets of themselves. Nevertheless, nurses can develop their capabilities to engage in self-reflection, to perceive and accept input from others and to openly disclose themselves to others to increase their self-understanding. In fact, engaging in these processes and being motivated to keep improving are essential to becoming emotionally intelligent.

When considering how to increase self-understanding, the process of introspection, or self-reflection, often comes to mind. This often begins with noticing what elicits a personal response. 'Why did I react negatively when that patient told me he wanted to die? Why did I want to leave the room? Was it that I felt helpless, or unsure about how to respond? Do I believe that self-destructive thoughts are unacceptable? Have *I* ever felt this way before? Why did I find it so hard to listen to what he was saying?' Often when something or somebody spurs a response, the tendency is to look to that person or thing, rather than to reflect on the self. Noticing and reflecting on thoughts about oneself involves introspection, which is one of the principal ways that self-understanding develops.

Paying attention to such thoughts and feelings (i.e. allowing them to enter into rather than forcing them out of awareness) encourages nurses to discover more about themselves. Introspection and listening to oneself mean trusting oneself, being honest with oneself, accepting oneself and sometimes challenging oneself. Nevertheless, introspection is only effective in increasing self-understanding when personal thoughts and feelings are used for the purpose of discovering more about oneself.

Many nurses interpret the need to maintain control over their emotions, as in the self-management of emotional labour, to mean that they should be void of emotions. Rather than deny their emotional responses, although they may be concealed from patients, it is better for nurses to be aware of and reflect on such reactions. Without

awareness, it is likely that these emotions will be expressed inadvertently to patients. Nurses who keep in tune with their emotional responses have a greater chance of maintaining true control than those who try to control emotions by ignoring them.

More importantly, nurses' feelings and reactions to patients serve a purpose—they provide useful information in measuring how the relationship with a patient is progressing. For example, anger and frustration towards a patient, when left unexamined, may lead to labelling that patient. It could be that the feelings of anger and frustration are a result of the nurse's inability to understand what the patient is experiencing. Perhaps the patient is not conforming to the nurse's expectations of a 'good patient'. A host of other possibilities exist. Self-reflection enables nurses to discover what their emotional reactions might be revealing about *their* relationships with patients. Reflecting on personal thoughts and feelings triggered through interaction with patients provides useful sources of information about oneself.

Reflection and reflective practice

Reflection is an active exploration of personal experiences, consciously employed for the purpose of making sense of those experiences. Some people naturally engage in reflective processes, thinking deeply on life and their experiences of it. Other people may need guidance and assistance to be reflective. Professional nurses are often encouraged to engage in reflection because nursing knowledge is embedded in practical experience.

A spirit of enquiry sparks reflective nurses to think about their actions while they are engaged in clinical practice. In this sense, reflection is a way of functioning. It involves a here-and-now pursuit to make sense of the everyday world of nursing practice as it unfolds; this is reflection that 'looks on'. Reflection also involves thinking about experiences after they have occurred, which involves a there-and-then thinking process in order to use experience for the purpose of considering new ways to practice; this is reflection that 'looks back'. Finally, reflection can occur prior to action, as nurses consider their intentions and plans for patient care; this is reflection that 'looks forward'. While all three processes are possible, experienced nurses are most likely to use the 'looking back' type of reflection (see *Research highlight*).

Regardless of whether it occurs before, during or after clinical practice, reflection is a process for understanding and appreciating experiences (Gustafsson et al. 2007). This is especially true when experiences are novel or formidable. Nurses do tend to reflect more when they consider care as troublesome (e.g. when there is an unexpected patient outcome) (Gustafsson & Fagerberg 2004). More importantly, reflection is a way of challenging and changing perspectives (Bulman et al. 2012; Gustafsson & Fagerberg 2004; Peden-McAlpine et al. 2005; Smith & Jack 2005; Taylor et al. 2005), the purpose of which is to improve practice. Such improvements are aided and enhanced by linking reflections to theory. In this sense, reflective processes accompany learning, encouraging nurses to develop theoretical understandings that will serve as guides for future action. They promote continuous professional development and the courage to try different approaches.

In addition to developing new insight and understanding, reflection has been shown to enhance nurses' capacity for empathy and appreciation of the uniqueness

RESEARCH HIGHLIGHT

Do experienced nurses reflect on their practice?

Asselin, M.E., Schwartz-Barcott, D., Osterman, P.A., 2012. Exploring reflection as a process embedded in experienced nurses' practice: a qualitative study. Journal of Advanced Nursing 69(4), 905–914

Background

Reflection is viewed as a critical process for professional development and advancement of nursing practice. There is an assumption that reflection is a deliberate process that develops over time. While the process of reflection is used extensively in nursing education, there is little evidence for what actually happens in practice.

Purpose of the study

The aim of this study was to describe how experienced nurses in an acute care setting perceive and use reflective practice.

Method

This was a descriptive, qualitative study in which 12 experienced acute care nurses were interviewed and asked to describe a clinical situation to which they had given considerable thought.

Key findings

The clinical situations that the nurses described were ones that required immediate intervention. Their reflection about this situation occurred in four distinct phases. The first phase involved 'framing the situation' in light of their professional role and emotional responses. Next was pausing to consider what to do, which was followed by engaging in active reflection in order to gain insight into the situation. The final phase was moving to an intention to change practice in light of the insight gained.

Implications for nursing practice

Reflecting on practice assists nurses to develop insight into how they can change practice. Structured, facilitated reflection has the potential to enable nurses to move their intentions to change to actual changes in practice.

of the patient (Gustafsson & Fagerberg 2004). In this sense, reflection is a process used both to protect the patient as a person (Maggs & Biley 2000) and to promote interpersonal competence in the nurse.

While the above studies do hold promise that reflection can result in learning and actual changes in practice, a study by Mantzoukas and Jasper (2004) demonstrated that nurses acknowledged the importance of reflection, yet they felt constrained in using reflection because ward culture invalidated reflective practice as a means of improving practice. Likewise, the participants in another study reported that while they engaged in reflective practice, they were unsure whether the process resulted in increasing their sense of clinical competence (Cirocco 2007).

While there is evidence that reflection results in learning, more empirical evidence is needed as to whether reflection actually results in changes to practice (Gustafsson et al. 2007).

Nurses can reflect on various aspects of practice: the technical (e.g. treatment regimens); the practical (e.g. routines in care); the social and political (e.g. how healthcare resources are expended); and the personal (e.g. knowledge of the self) (Clarke et al. 1996). 'The focus of reflection is *the self* within the context of the specific practice situation' (Johns 1999, p. 242). In this respect, the processes of reflection are closely related to increasing self-understanding. Nevertheless, a certain amount of self-understanding is required for reflection to occur in the first place.

PROCESSES FOR REFLECTION

Effective reflection requires active strategies to support the process (Johns 1995; Maggs & Biley 2000; Wilkinson 1999). This means that the most successful reflection is accompanied by structured activities, such as keeping a professional diary or completing the activities in this book. Unless there is some means of tracking an individual nurse's reflections over a period of time, sustainable professional growth through reflection may be difficult to attain.

With increasing frequency, clinical supervision (Ch 11) is considered by many as an ideal method to encourage and support reflective practice (Fowler 1998; Kim 1999). Clinical supervision, whether conducted individually or in groups of nurses, is aimed at using reflective processes for the purpose of improving the quality of nursing care. It has been shown to be useful in developing interpersonal skills (Tichen & Binnie 1995) and in increasing self-understanding (Begat et al. 1997).

PITFALLS IN REFLECTION

Despite its obvious benefits, reflection does have its potential pitfalls. It is important to remember that effective reflection will inevitably lead to anxiety (Haddock & Bassett 1997) because the process of reflecting involves change and challenge. It requires nurses to show a willingness to be challenged to view experiences in different lights and to reconsider what may be long-held and cherished beliefs. The anxiety and discomfort that accompanies effective reflection points to the need for support systems to be in place (e.g. colleagues who serve as skilled facilitators and mentors) (Foster & Greenwood 1998).

Another pitfall relates to the difficulty of reflecting after an event has taken place. This difficulty is called 'hindsight bias' (Jones 1995), a term that describes the way people recall events that fit with the known outcome. For example, if a nurse were to interact with a patient who seemed distressed about a forthcoming procedure, only to discover that the distress involved another life event, then it would be difficult in retrospect for the nurse to recall that they initially associated the patient distress with the procedure. The nurse's recall of events would match what they now understand, not what was originally thought.

Taylor (1997) cautions nurses in the wholehearted embrace of reflection as a way of changing practice through empowerment and emancipation of nurses. The structural arrangements that are required for such emancipation may not be easy to

attain, and reflection alone does not guarantee success in making such structural changes. In fact, reflective practices may result in nurses feeling less empowered by systems of healthcare delivery.

A final pitfall in using reflection is perhaps the most challenging of all in relation to beginning practitioners and students of nursing. It is that a nurse may need to be clinically experienced in order to benefit from reflection (Fowler 1998). This implies that the nurses who most need to learn in terms of clinical experience may be least able to benefit from the process of reflection. Nevertheless, structured reflection, especially under the guidance of a more experienced nurse, is a useful way for beginning nurses to assess their own interpersonal skills and to improve self-understanding through raised awareness of the impact of self on nursing practice.

INPUT FROM OTHERS / INTERACTIVE REFLECTION

There are limits to how far self-understanding can progress and develop through introspection alone. Natural 'blind spots', the ease with which self-reflective thoughts can be ignored, dismissed and defended, along with the tendency to protect the self through self-deception, pose barriers to the introspective process.

Other people provide useful information through the way they react and respond. For this reason, another effective way to complement, not replace, self-reflection occurs when nurses attend to feedback from others, be it solicited or unsolicited. Feedback from good friends is useful and can be solicited. Feedback from patients is another useful source of information, although nurses usually do not solicit it.

INPUT FROM PATIENTS

Patients are not only expressing information about themselves when they interact with nurses, they also are expressing information about how they perceive the nurse. Patients reveal how they feel and what they think about the nurses who are interacting with them by the manner in which they behave. What they choose to discuss, how freely they disclose information and how comfortable they seem during an interaction are examples of input that patients provide about how they see the nurse. The cues that indicate the effect nurses are having on them automatically surface throughout interactions. Nurses need to be receptive to such input from patients because this feedback informs them about themselves. In this regard, nurses need not actively solicit patient feedback.

Perceiving such input from patients begins with an awareness and understanding of its relevance. Next, nurses need to be open to receiving the information. Asking themselves questions such as, 'What is it about me that enables patients to openly express their feelings?', 'Why is this patient telling *me* this?' and 'Have I inadvertently communicated that I don't want to hear what this patient is saying?' enables nurses to become open to input from patients.

It is natural for nurses to ignore or reject input and feedback about themselves when this information lacks congruence with personal images (what nurses believe they are or want to be). Nurses who are feeling inept may not notice when patients reveal that they *are* quite effective. For this reason, feedback and input from others, especially patients, may challenge nurses to reconsider their current perspectives.

ACTIVITY 3.2 Feedback from patients

Process

1. Reflect on a recent interaction with a patient. Record what happened between you and the patient.
2. Describe how this patient responded to you.
3. Through reflection about how this patient responded, try to determine what this patient was 'telling' you about how they perceived you.
4. Discuss the situation and your experience with another participant.

Discussion

1. What are the various ways that participants interpreted how patients responded to them? What cues indicated these responses?
2. At the time of the interaction with the patient, how aware were participants that patients were actually revealing how they perceived the nurse?
3. How many participants described negative/ineffective interactions? How many described positive/effective ones? What does this indicate?

Self-sharing

Another process that is effective in increasing self-understanding arises out of a combination of self-reflection (introspection) and interactive reflection (input and feedback from others). It is the process of self-sharing—the disclosure of personal thoughts, feelings, perceptions and interpretations by openly expressing them to others.

HOW SELF-SHARING INCREASES SELF-UNDERSTANDING

Self-sharing enhances self-understanding because it triggers (and therefore solicits) feedback from others, and also because it intensifies self-reflection. When internal thoughts, feelings and attitudes are made external through open discussion, they are often internally clarified, expanded and accepted. Sometimes self-sharing persuades nurses to internally challenge and alter their thoughts, feelings and attitudes. In this sense, self-sharing often transforms into a process of 'thinking aloud,' and then having a dialogue with the self while using the other person as a sounding board.

At other times, self-sharing enables nurses to test the validity of their current thoughts, feelings and attitudes. In 'testing' their internal responses, nurses are asking others what they think or feel about these responses. This often leads nurses to reconsider their responses in light of what others think and feel.

The relationship between self-sharing and self-understanding is a circular one (see Fig 3.2). While a certain degree of self-understanding is helpful to begin self-sharing, it is not vital. Through self-sharing, further input is received, both from others and from the self, which is then useful in increasing self-understanding.

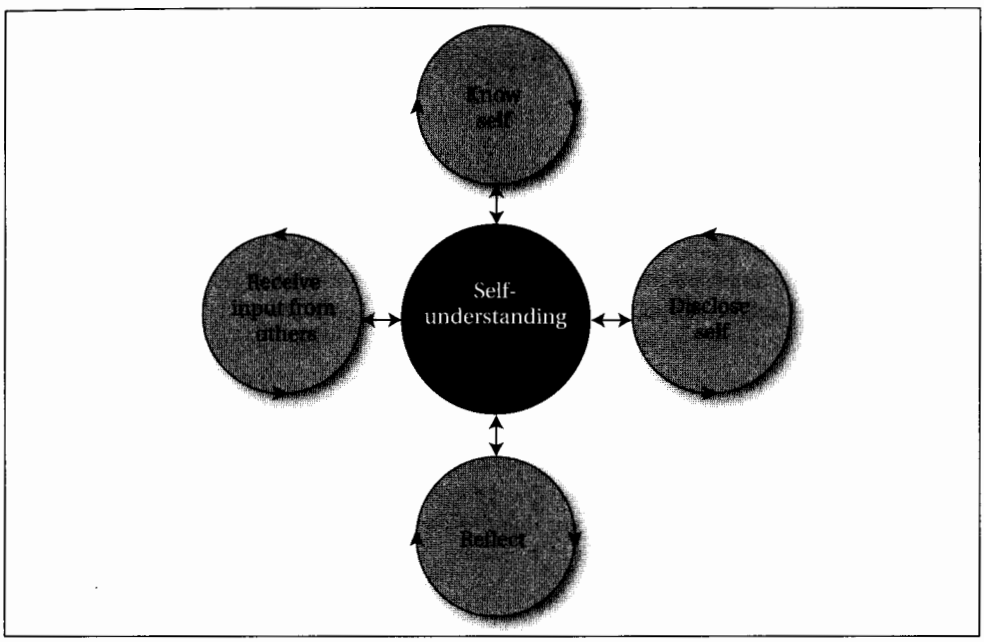

FIGURE 3.2 Relationship between self-sharing and self-understanding

RISKS OF SELF-SHARING

Despite its potential value for increasing self-understanding, disclosing oneself to others is not always easy to do. There are many reasons for keeping to oneself, and choosing not to disclose. Activity 3.3 is designed to uncover some of the reasons why self-sharing may be difficult.

The major difficulty in disclosing self is the exposure that it brings. Once people are exposed, they often feel vulnerable, especially if the disclosure has been about problem areas or negative thoughts, feelings and perceptions. There are risks of being rejected, being hurt and being challenged by others. This sense of vulnerability is not necessarily destructive to nurses because of its potential to increase feelings of empathy with patients, who often feel exposed and vulnerable when they disclose themselves to nurses. While there are obvious risks in exposing self, these are offset by its potential benefits.

THE CLIMATE CONDUCIVE TO SELF-SHARING

Because of the exposure and vulnerability that self-sharing can bring, it needs to take place in an atmosphere of trust and respect—trust in the sense that the disclosure will not be met with rejection and respect in the sense that disclosed information will be considered, and not dismissed or ridiculed.

As a general rule, there is ease and comfort with disclosure when it is likely that personal thoughts, feelings and attitudes will be understood and appreciated by the other person. This is more likely to happen when the other person shares similar experiences. For this reason, nurses often benefit by disclosing themselves to other

ACTIVITY 3.3 Difficulties in self-sharing

Process

1. Working on your own, rank each of the following topics from 1 to 12, according to what is easiest for you to disclose about yourself (1) to what is hardest to disclose (12). Place these topics in the context of interacting with someone you do not know very well.
   a Talking about my fears
   b Sharing my hopes and dreams
   c Discussing my family life
   d Describing my previous health problems
   e Stating what I dislike about other people
   f Complaining about a mark on an assignment
   g Expressing my political views
   h Stating what I want or need
   i Expressing confusion or uncertainty
   j Describing how I like to be treated by others
   k Complaining about being treated unfairly
   l Telling others that I am not pleased about something they have done
2. Review your answers and reflect on those items that you determined as easy to discuss (those ranked 1–5). Record your reasons for evaluating these items as easy to disclose.
3. Review your answers again, this time reflecting on those items that you determined as difficult to disclose (those ranked 8–12). Record your reasons for evaluating these items as difficult to disclose.
4. Compare your responses with two other participants. Discuss your responses to steps 2 and 3. Summarise what is easy to disclose and what is hard to disclose, focusing on your reasons.
5. This step lists some of the reasons for lack of self-disclosure. Working individually, rate each of these reasons in terms of how often it is true for you. Use the following descriptions:
   - often
   - sometimes
   - rarely.

   If I tell others what I think and feel ...
   a I may hurt them
   b they may take advantage of me
   c I may appear weak
   d I may become emotional
   e they may hurt me
   f they may talk to others about me
   g I may discover something about myself that I'd rather not know
   h they may use what I've said against me
   i I may discover problems I never knew I had.
6. Working in the same groups of three as for step 4, discuss those items that you rated as 'often' and 'sometimes'. What similarities are there in your responses? What differences are there?

Discussion

1. What are the major reasons for reluctance to self-disclose?
2. What are the major disadvantages of self-disclosure? What are the major advantages?
3. How does self-disclosure promote self-awareness?

nurses (see Ch 11). Through the process of self-sharing, nurses can be supported by other nurses. They may also be challenged at times to reconsider their perceptions, thoughts and feelings.

Self-disclosure with patients

Self-disclosure with patients (see Chs 5, 6 and 7) is different from self-sharing. Self-disclosure with patients is employed as a therapeutic skill and is therefore for the benefit of the patient, not the nurse. Although self-disclosure with patients may result in increased self-understanding for the nurse, this is not its primary focus. The intent of self-disclosing with patients is to promote interaction and increase interpersonal involvement with patients. The primary intent of self-sharing with people other than patients is increased self-understanding in the nurse.

AREAS OF SELF-EXPLORATION

It is important that nurses not only understand the processes for promoting greater self-understanding but also that they recognise those areas of themselves that are most relevant to the nursing-care context. There are many facets of each nurse's personal self that are woven together to create the essence of the person who is the nurse. While many aspects of the self can be considered, those addressed in Activity 3.4 have a potential to affect the way nurses approach helping patients.

Personal philosophy about health

Personal value systems, the 'shoulds' and 'ought tos' that direct individual behaviour, are part of all people's lives. These values and beliefs, which are personal and unique to the individual, assist a person in making choices and decisions about living. They provide direction about what is important, what matters, what is seen as significant and what is worthwhile. These values and beliefs are not static; they are altered, revised and adapted through life experiences. Nurses often find that their beliefs and values alter throughout their professional lives.

One aspect of personal value systems that is particularly relevant for nurses is their beliefs about health and helping. For example, nurses may feel less inclined to care for patients who they believe are responsible for their own health problems (Olsen 1997).

Activity 3.4 is designed to make participants think about how they would approach helping other people on the basis of two central issues: *blame* and *control* (Brickman et al. 1982). Blame is the degree to which people are held responsible for causing their problems and control is the degree to which they are held responsible for solutions to their problems. Both involve questions of personal responsibility, and assumptions about personal responsibility have direct effects on the type of help offered. Brickman et al. (1982) conceptualised four models of helping based on the issues of blame and control (see Fig 3.3). Although developed many years ago, this conceptualisation remains evident in current literature (e.g. Easter 2012; Lobchuk et al. 2008).

ACTIVITY 3.4 Beliefs about helping in nursing practice ➡ 313

Process

For each of the following statements, record on a separate sheet of paper the response that most closely identifies your personal beliefs and attitudes. Use the following scale:

3 For the most part, I *agree* with this statement.
2 I am *undecided* in my opinion about this statement.
1 For the most part, I *disagree* with this statement.

a Patients should be encouraged to accept that they have contributed to their own health problems.
b What happens in patient–nurse relationships is more the nurse's responsibility than the patient's.
c People are masters of their own destinies; solutions to whatever problems they have are in their own hands.
d There are many social factors contributing to health problems that are beyond individual control.
e Whether they realise it or not, people engage in behaviours that cause health problems.
f Effective health education could prevent major health problems.
g Patients should be encouraged to find solutions and take action on their own behalf when dealing with health problems.
h It irritates me when I hear somebody say that a patient caused their own health problems; most of the time people can't help it.
i Providing advice to patients is an essential aspect of effective healthcare.
j People should be presented with options for healthcare so they can choose what suits them best.
k In recovering from an illness, it is essential that patients heed the advice of healthcare professionals.
l Most people could change their problematic health habits if they really wanted to.
m Patients should determine their own goals when working with healthcare professionals.
n I don't have much time for patients who won't follow the advice of knowledgeable healthcare experts.
o Diseases and illnesses are largely a result of biological and genetic factors, which are usually beyond individual control.
p Patients should place themselves in the hands of qualified health professionals who know best what to do about health problems.

Discussion

1. Reflect on your responses and consider whether you tend to hold people responsible for their health problems.
2. Consider your responses in light of whether you tend to think that people should take responsibility for their own healthcare.
3. In general, what do your responses reflect about your beliefs about health and healthcare?

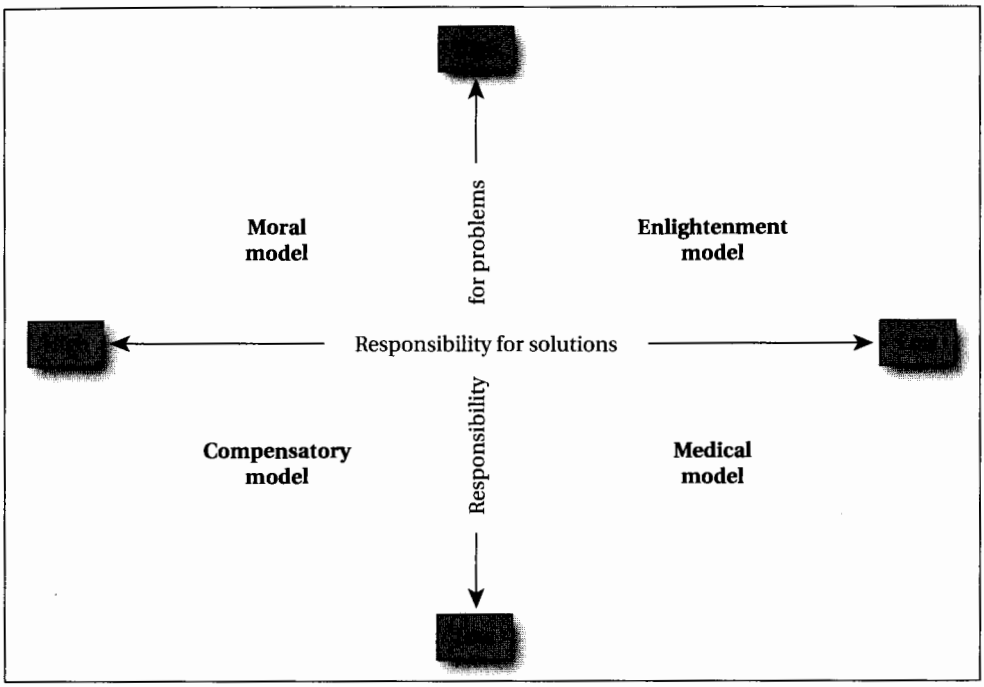

FIGURE 3.3 Models of helping
Based on Brickmon, P., Rabinowitz, V.C., Karuza, J., Coates, D., Cohn, E., Kidder, L., 1982. Models of helping and coping. American Psychologist 37 (4), 368–384

The view from within the 'medical model' is that people are neither responsible for creating their problems nor responsible for solutions to their problems. The 'compensatory model' operates from beliefs that people cannot be blamed for their problems but are held responsible for doing something about them. Beliefs within the 'enlightenment model' are that people are responsible for creating their problems but need to rely on others in solving these problems. The 'moral model' holds people responsible for both creating their problems and developing their own solutions.

Each stance results in an orientation to how to be of help to patients. The 'medical model' relies on expert advice and treats patients as passive recipients of assistance. Patients are expected to seek and heed such advice and assistance. While people are not blamed for their problems, they may be blamed if they fail to cooperate with the solutions offered. Helping in the 'compensatory model' centres on the mobilisation of needed resources, and providing opportunities to compensate for what are seen as failures and weaknesses that are outside individual control. Acceptance of personal blame and reliance on an external authority is the helping approach used in the 'enlightenment model'. The 'moral model' focuses helping on motivating people to change through persuasion, appeal, reprimand and reproach (Brickman et al. 1982; Corey et al. 2011).

In nursing practice, there is likely to be a mixed application of these models, as illustrated in the following examples. Nurses might hold active smokers responsible

for problems such as lung cancer, while lung cancer acquired from passive smoking usually does not bring such blame. In both of these situations, people would not be held responsible for the possible solutions/treatment for the lung cancer. Nursing care would be provided to the active smokers ('enlightenment model'), although some nurses may question the use of healthcare resources on this population ('moral model'). The victims of passive smoking might be approached using the 'medical model,' in which case they would not be held responsible for the cause or the solutions. A person with diabetes mellitus may not be held responsible for acquiring the disease but will be expected to be actively involved in its control ('compensatory model'). A suicidal person may be blamed for the problem and expected to find solutions through effort and willpower ('moral model').

Help may not be effective if the person desiring help and the person offering help are operating from a different set of assumptions about personal responsibility (Brickman et al. 1982). For this reason, it is important not only that nurses realise their own orientation to helping and its underlying assumptions but also that they are aware of and understand patients' orientations to helping.

Personal values and beliefs

Nurses' personal values and beliefs directly affect their interactions with patients. They have the potential to restrict effective relationships with patients; however, they can also enhance these relationships.

One way that nurses' values and personal beliefs may hinder effective relationships with patients stems from the fact that these values and beliefs often function as perceptual filters. Perceptual filters allow some aspects of patients' stories to be accepted, while others are rejected. When values and personal beliefs function as filters, the skills of listening (see Ch 5) are most affected. Cultural stereotypes (see Ch 4), another possible hindrance in relating effectively with patients, often stem from values and personal beliefs.

Another way that personal values create interference occurs when nurses impose or project them onto patients, rather than keeping them in abeyance. When values and beliefs are imposed on patients, they are used as yardsticks for measuring them. Whenever nurses make judgments about what patients 'should' or 'should not' be, there is a chance that they are evaluating patients in terms of their own value system. For this reason, nurses are encouraged to reflect on these types of judgments.

On the other hand, certain values and personal beliefs enhance and strengthen nurses' ability to relate to patients. For example, a personal belief that people are capable, worthwhile and dependable works in favour of establishing effective relationships with patients. Such beliefs help to create a climate of respect and regard for patients.

When relating to patients, nurses cannot be expected to abandon their values and personal beliefs; however, they need to be able to distinguish their own philosophical stance from that of a patient. The more aware nurses are of their own values and personal beliefs, the less likely it is that interference will occur, and the more likely it is that the values that enhance effective relationships will be strengthened.

Expectations of nursing

Most nurses enter nursing with some goal in mind. It might be to secure a job with the promise of sustained demand. It could be that part-time work is appealing. An advertisement in the local newspaper might have sparked interest in nursing in a 'Why not, I'm not doing anything else with my life?' fashion. Assuming there were options available, nursing is usually chosen because of an interest in people. In all likelihood this interest in people is directly related to a desire to be of help to them.

Activity 3.5 probably highlights a common myth about nursing: the belief that all benefits in nursing are for the patient, never the nurse. By focusing solely on their desire to help and to assist others, nurses fail to acknowledge the potential benefits of nursing for themselves.

Activity 3.6 challenges the notion that nurses nurse solely because they are meeting the needs of patients. The 'ideal' nurse is often perceived as self-sacrificing, and so 'others-oriented' that there is a denial of self. Such an ideal does not exist in reality.

Personal needs

Forming meaningful relationships with patients and assisting them with health issues and problems often has benefits for nurses as well as patients. For example, nurses derive satisfaction in seeing patients recover from illnesses, especially when they

ACTIVITY 3.5 Expectations of nursing

Process

1. Think of all the reasons why you chose nursing as a career. Record these on a sheet of paper. Do not place any identifying information about yourself on the paper.
2. Now complete the following sentences, recording your answers on the same sheet of paper:
   a If I could do anything as a nurse it would be to ...
   b In my role as a nurse I see myself as ...
   c Nurses help others because they ...
   d My greatest disappointment as a nurse would be if I ...
3. Collect all the sheets of paper and distribute them among all participants.
4. Record, on a sheet of paper visible to all participants, all the reasons identified by the participants for choosing nursing. If a reason is given by more than one participant, record how many times it is stated.

Discussion

1. Discuss the responses to each of the items in step 2 of the process. Remember, you are not discussing your own responses but rather the ones of the anonymous participant who authored the paper you received.
2. Do motivations for becoming a nurse and expectations of nursing focus exclusively on helping others, or are there references to personal gains and benefits?

ACTIVITY 3.6 Personal benefits of nursing

Process

1. On a sheet of paper that only you will see, answer the following questions:
   a What does nursing do for you?
   b What do you personally gain through nursing?
   c What benefits are there for you in nursing?
   d How does nursing satisfy you?
2. From your answers and personal reflection, list personal needs that are met through nursing.

Discussion

1. How difficult was it for you to answer these questions?
2. What feelings did you experience while completing the activity?
3. Why is it important for nurses to realise that there are personal gains in nursing?

know they made a difference to the recovery. Does this mean that nurses meet their own needs through their nursing relationships? A recognition and acknowledgment of the personal benefits of nursing results in an affirmative answer to such a question.

Nevertheless, there are obvious risks involved because nurses' personal needs may interfere whenever relationships with patients are used as the *primary* source of meeting these needs. For example, relying on patients to satisfy the nurse's need for personal recognition, appreciation and validation is fraught with danger. For this reason, nurses need to develop awareness of potential trouble spots—those personal needs that may interfere in their relationships with patients.

Characteristics that help interpersonal connectedness

The focus of the preceding sections of this chapter has been on increasing self-awareness because such reflection leads to self-understanding, self-challenge and eventual acceptance of aspects that characterise each nurse. Other than considering how these aspects of the self potentially affect relationships with patients, no effort has been made to evaluate them (or the nurse they characterise) in terms of right/wrong, good/bad or desirable/undesirable. No evaluation has been attempted because nurses must first develop awareness of 'what is' before considering 'what should be'. Understanding 'what is' provides a starting point—a reference from which to work towards 'what should be'.

There are certain characteristics, personal beliefs, values and orientations towards helping that enhance nurses' abilities to relate effectively to patients. In this regard, they are the 'what should bes'. When they are present in the nurse, these characteristics help to facilitate interpersonal connections with patients because they help to create the necessary interpersonal climate for developing patient–nurse relationships. The presence of this climate enables nurses to effectively use the skills

ACTIVITY 3.7 Needs that may interfere

Process

1. Use one of the following descriptions to rate questions a–j:
   - hardly ever
   - sometimes
   - most of the time.

   How often do I ...

   a Let people take advantage of me because I am afraid to say no to their requests?
   b Focus on problems and negative aspects of a situation, so I fail to take into account the positive side of people and their strengths?
   c Feel as if I must 'do something' to make other people feel better—to rescue them?
   d Think I need to have all the answers when other people discuss problems with me?
   e Worry about whether or not other people like me?
   f Feel the need to be needed?
   g Need to be in control of situations?
   h Want other people to take care of me?
   i Feel controlled by other people?
   j Act as openly with other people as I want them to act with me?
2. Review your answers. If the majority of your answers are 'sometimes', go back and change them to either 'hardly ever' or 'most of the time'. All of the items will be true for most people *some* of the time!
3. Identify the items that are 'hardly ever' and 'most of the time'. Reflect on these in terms of how these aspects of yourself may affect your relationships with patients.

Discussion

1. The items included in this self-assessment relate to three general areas of basic human needs: the need to feel attached to other people (included); the need to be in control; and the need for affection and affirmation from other people. Which one of these general areas of personal needs is predominant for you?
2. Discuss each of the three basic human needs and how, if they are predominant in a nurse, interactions and relationships with patients may be affected, for better or worse.

and processes described in this book. If the facilitative climate is absent, the use of the skills may become hollow, mechanical and artificial.

From Activity 3.8, you may discover that people perceived to be helpful embody certain characteristics (what they are), demonstrate certain skills (what they do) and possess a degree of understanding about people (what they know). It is the personal characteristics associated with helpful people that are discussed here.

Characteristics that enhance the ability to be helpful include:

- authenticity and congruence
- respect and warmth
- confidence and assertiveness.

Self-understanding enables these characteristics to be fully realised and developed by nurses.

ACTIVITY 3.8 Characteristics of effective helpers

Process

1. Think of someone in your life who you think is helpful to you (i.e. the person you go to for understanding, assistance and guidance).
2. Think about what this person is like. What personal characteristics do they possess? Focus on specific characteristics that are helpful to you. Describe these on a sheet of paper.
3. Now think about what this person does that you find helpful. What specific things does this person do? Describe these on your sheet of paper. Do not be concerned if there are similarities between answers to steps 2 and 3. In some instances, your answers may be exactly the same.
4. Review what you have written. Briefly summarise what, in your opinion, enables this person to be effective in helping you.
5. Compare your descriptions with those of all other participants by compiling an overall description of a person who is helpful. Record this in a place visible to all participants.
6. Select key words from the description and record them.

Discussion

1. What are the similarities in participants' individual descriptions? What are the differences?
2. Focusing on the key words identified in step 6 of the process, describe personal characteristics that are essential for being a helpful person.
3. Is there anything you would add to this list of personal characteristics?

AUTHENTICITY AND CONGRUENCE

To be authentic means that nurses behave in ways that are reflective of their true selves. Authenticity means not hiding behind the role of nurse but rather enacting the role in a manner that expresses the uniqueness of each nurse.

Frequently, when nurses try to use the skills described in this book, feelings of awkwardness and lack of authenticity accompany their first attempts. This is especially true if the skill being tried is unfamiliar and foreign to the nurse's current repertoire of skills. While a skill may be unfamiliar, the personal values from which it emerges may not be. For example, a nurse may be unaccustomed to reflecting feelings (see Ch 6) because of being raised in an environment where feelings were hardly ever expressed and never discussed openly. Unless this nurse believes that patients' feelings are important to understand and comes to realise that, for some patients, feelings are the most significant facet of their experience, the nurse may fail to try to use feeling reflections with patients. This nurse must tap into the authentic desire to help patients in order to overcome feelings of reluctance and awkwardness. That is, a genuine desire to be of help spurs the nurse to express concern and regard for patients through the use of (the skill of) reflecting feelings.

Congruence is related to authenticity because with congruence comes consistency between what nurses believe, how they feel and what they do. The skills

described in this book are only effective if they are used in conjunction with an attitude that matches their intent. There is little point in pretending to listen through appropriate attending behaviour (see Ch 5) if a nurse is not currently interested in what a patient is expressing. A listening posture without an attitude of genuine interest lacks congruence. Attempting to understand (see Ch 6) without an open attitude to the uniqueness of each patient's experience also lacks congruence. A congruent manner is one in which the nurse's intent and related action are in harmony with each other.

The nurse's self-understanding is the key to demonstrating both authenticity and congruence. Without understanding and acceptance of who they are and how they are feeling at a given moment, and an examination of personal motives and intentions, nurses are at risk of losing touch with themselves. Authenticity and congruence cannot be demonstrated under such circumstances.

RESPECT AND WARMTH

With respect comes a deep concern for patients' individual experiences—an acceptance of their perspective and feelings. Respect emerges from the value that each human being has inherent worth and dignity. Under conditions of respect, patients are more likely to feel free in expressing who they are and what they are experiencing. When they are respected, patients are free to be themselves; they need not fear that they will be placed against a standard of what they 'should' be experiencing.

Holding personal judgments in abeyance (see Ch 5) is one of the most striking ways nurses convey respect to patients. This highlights and reinforces the need for self-understanding. Unless nurses are cognisant of their personal values and beliefs, they may inadvertently judge patients against a personal value system.

Respect operates from an attitude of 'being for' patients. To be respectful is to assume the patient's goodwill (Egan 2010), and to believe that patients are doing their best to cope, to adapt and to change. Respect upholds an inherent belief in patients' capabilities and resources. An attitude that is suspicious of patients' motives and behaviours lacks respect if suspicion is the nurse's first reaction.

This is not to say that nurses cannot or should not challenge patients to transform their view of a situation (see Ch 8). Respect means not starting from the point of challenging but rather developing an understanding of the situation (see Ch 6), then intervening to promote change if this is required.

Warmth is a feeling and is conveyed primarily through non-verbal behaviour that demonstrates an active interest in and regard for patients. It is designed to put patients at ease with nurses because, through the expression of warmth, nurses convey friendliness, approachability and interest. In this way, warmth is an active demonstration of respect because it conveys active concern. Warmth is not emotionally effusive or overly friendly behaviour. It cannot be feigned through insincere overconcern for patients; it requires authenticity and congruence in order to be effective.

Too much warmth creates a sense of false solicitude, lacking genuineness. Patients might become frightened at the prospect of a nurse whose concern seems extreme, especially if this occurs early in the course of the relationship. Too little warmth distances patients because this gives an impression of lack of concern and regard. Judging the 'right' degree of warmth, especially in the beginning of a

relationship with a patient, can only be achieved by paying careful attention to how the patient responds to the nurse's demonstration of concern through warmth.

CONFIDENCE AND ASSERTIVENESS

Even when nurses are congruent and authentic, and able to convey respect and warmth, unless they also have an ability to express themselves confidently and assertively they may not be able to make interpersonal contact with patients. Knowing what to say and how to say it becomes inconsequential if nurses fail to use interpersonal skills because they are apprehensive and hesitant. Being confident and assertive is as important as being skilled and aware. High-level awareness and excellent technical ability are meaningless unless they are actually used when called for (Egan 2010). For example, nurses need to be assertive when they share perceptions and take the lead in exploring (see Ch 7), and challenge patients to reframe their perceptions (see Ch 8).

Assertiveness is most often presented as a means of resolving conflict (see Ch 10) and defending individual rights if they have been violated. However, conflict is not the specific focus here. In the general context of patient–nurse relationships, being assertive means that nurses are able to take advantage of opportunities to make interpersonal contact with patients. While not always recognised, assertiveness and caring are compatible (McCartan & Hargie 2004).

While nurses often recognise the need to be assertive when advocating *for* patients (e.g. when another health professional is disregarding a patient's request), they often express concerns about being assertive *with* patients. Whenever nurses think 'I can't say *that* to a patient', they are experiencing concerns about what will happen. These concerns include a fear of upsetting patients, a discomfort with the expression of feelings, a perception that it is intrusive to ask personal questions and a reticence about delving into the subjective experiences of patients. Apprehensions such as these often inhibit nurses and may even restrict them from meeting their professional responsibilities to patients. For example, if a nurse is reluctant to explore a patient's apparent distress (out of fear of compounding that distress), vital information about the patient's experience may be missed or overlooked.

The concerns that inhibit nurses are often based on faulty assumptions such as 'patients will become *more* upset if asked to discuss their distress', 'nurses should be passive and obedient' and 'it is impolite to discuss sensitive and personal matters with a relative stranger'. In becoming assertive with patients, nurses need to overcome these concerns by challenging these assumptions.

First, nurses do not have the 'power' to 'make' patients more upset simply on the basis of bringing patients' distress into the open (although this is different from abuse of power, which is discussed in Ch 10). When patients are distressed, they are often relieved to share their emotional pain with an interested and understanding nurse. Rather than compounding their tension, open discussion can actually provide comfort. Second, while it would be impolite to discuss highly personal matters with a stranger in a social situation, patient–nurse interactions are different from usual social interactions. In caring for patients, nurses need to discuss personal matters with them because this is part of their professional responsibility.

There is more to assertiveness than just being able to bring up sensitive and sometimes troubling subjects. At times, being assertive translates into making the

decision 'not' to discuss something. For example, when a patient is coping by maintaining their emotions within manageable limits, a nurse can make an active decision *not* to explore or focus on feelings. Additionally, the discussion of feelings requires trust between patients and nurses (see Ch 6), and a nurse may choose to delay such discussion until trust is established. As long as the decision not to say something is based on an assessment of the situation, rather than the nurse's internal fear, assertiveness is present. Being assertive in relating to patients means that nurses have both the courage to say something and the wisdom to remain silent.

Developing a personal style

Authenticity, congruence, respect, warmth and assertiveness are desirable characteristics that each nurse demonstrates in a unique manner. Although these characteristics help to create an interpersonal climate that enhances meaningful connections, they should not be construed as personality prescriptions for nurses. Each nurse develops personal capabilities for relating to patients.

Skills that are useful in establishing these relationships can be learnt and developed. There are certain conditions, such as respect and warmth, that enable nurses to use the skills most effectively. These conditions can be enhanced and developed. There are approaches to helping patients that can be employed (e.g. challenging patients to reframe their experiences) (see Ch 8). These approaches can be understood and developed.

Each nurse finds a way to use the skills to express the necessary characteristics and to integrate a variety of approaches in a unique expression of that nurse's personality. Some nurses are good at challenging patients, and do so quite effectively and naturally, while other nurses find this approach difficult and are frustrated when they attempt to use it.

In developing a personal style, nurses must learn how to blend the skills and characteristics with their own personalities and to discover how their personal selves merge into their professional selves. A concerted effort to understand, practise and employ the skills results in this blending. Engaging in the processes of self-understanding accelerates the development of a personal style in relating to patients. Nevertheless, some unique challenges arise when nurses attempt to learn and develop the skills of interacting in a manner that is unique to them.

Developing a personal style of relating to patients poses certain learning challenges because beginning nurses have developed a characteristic style of communicating and relating to other people prior to entering nursing practice. Although these familiar patterns of interacting may be comfortable for the individual nurse as a person, they may not be suitable within the nursing context. In learning the skills and developing them for the nursing context, nurses are often challenged to alter or change their customary and usual patterns of interaction. In meeting this challenge, a total transformation of a nurse's particular manner is not necessary because such transformation may not reflect the nurse's personality. Nevertheless, alterations to existing patterns of interacting are often necessary in order to develop a personal style that is both authentic to an individual nurse and appropriate to the context of nursing care. While the person who is the nurse has not changed, the nursing-care context signals the need for a change in approach.

Learning the skills

The following chapters contain descriptions of a range of skills that enable nurses to interact effectively with patients. While theoretical understanding of the skills is a vital aspect of learning, understanding not accompanied by technical know-how in the use of the skills is insufficient. For this reason, learning the skills of interacting with patients is achieved most effectively through performing the skills.

Every nurse is encouraged to attempt each of the skills—see how they fit the particular nursing context and determine what alterations can be made to help them fit better. Some of the skills will be familiar and using them will come naturally because they already exist in the nurse's repertoire. Other skills will be foreign and nurses may feel awkward and unnatural when initially attempting to use these skills. Selecting some of the skills because they are comfortable to use and ignoring others because 'they don't feel right' limits practical learning opportunities and potential.

THE NEED TO 'UNLEARN'

More than likely, the skills presented in the following chapters will be recognisable as everyday activities. For example, listening (see Ch 5) is a process that people engage in daily, whether it be effective or ineffective. This familiarity with some skills, however, presents a specific dilemma to nurses as they approach learning how to fit skills into a nursing-care context as well as blending the skills with their personality.

Because nurses have been interacting with other people all of their lives they may believe they already know how to talk to patients, and they may be disconcerted to find out there is more to learn. But these familiar patterns of interacting may not be effective within the nursing-care context. As a result, some nurses may fail to recognise and appreciate the alterations that may be needed to make their interactions with patients more effective.

Learning how to use interpersonal skills within the nursing-care context is often a matter of 'letting go' of habitual and automatic ways of interacting—ways that have become comfortable. For example, offering advice and giving solutions is a common response to someone who presents a problem. In Chapter 6, this way of responding is shown to be less effective than a response that demonstrates understanding. If offering advice and giving solutions is their customary way of responding to those in need, nurses are challenged to refrain from their usual way of responding. The necessity of letting go of familiar patterns and 'unlearning' ways that may have become entrenched presents a major hurdle in learning and developing effective interactive skills with patients.

Departing from the comfort zone of usual and customary patterns of interacting and attempting new and unfamiliar ways initially results in feelings of being untrue to oneself. Nurses may become confused by this apparent lack of authenticity, which has been discussed as a core condition for effective interactions. Nurses may feel inept, clumsy and overly self-conscious as they struggle to let go of the familiar and to meet the demands of learning new ways of interacting.

Such feelings are often unavoidable during initial attempts to use any new skill and this highlights the need for continuous self-assessment, which raises awareness and understanding of self. Through self-assessment, nurses come to appreciate what they are attempting in their interactions with patients, why they are attempting this

and how it is affecting patients. Nurses are encouraged to promote their own growth as people and as nurses, and to challenge growth within themselves by trying various ways of interacting with patients, even when these ways initially feel awkward. With continuing practice, self-understanding and acceptance, as well as patience with the learning process, the skills will eventually become natural. At this point a personal style emerges.

REACTIONS TO LEARNING THE SKILLS

Some nurses fail to perceive and appreciate the significance of learning interpersonal skills simply because they *have* been interacting with other people all their lives. These nurses view the skills of interacting with patients as little more than commonsense and 'doing what comes naturally'. Because the skills used when interacting with patients are not exclusive to nursing, these nurses fail to perceive the importance of spending time learning them or recognising how the nursing-care context necessitates an alteration in interaction patterns.

Such reactions fail to take into account the fact that common sense is not inborn, but learned behaviour. Toddlers do not have the common sense to recognise the dangers of running onto a street full of moving vehicles. While the common sense that nurses have developed throughout their lives could assist them in learning the skills, there is also a danger that this commonsense approach may inhibit learning. For example, common sense may dictate that patients should not be worried or alarmed by what the nurse perceives to be a minor situation. Under such circumstances, the commonsense approach may be to try to talk patients out of their 'needless' worrying with platitudes and clichés. While such an approach seems to have a rational, objective basis, it fails to acknowledge the reality of patients' experiences, and is therefore less effective than approaching patients by trying to understand their experiences.

In believing that interacting with patients is nothing more than common sense, nurses may fail to develop the self-understanding necessary to recognise when their approach is not effective. They may fail to reconsider habitual and automatic responses and attitudes and to realise that the context indicates a need for a change in these usual approaches. In simply 'doing what comes naturally', nurses fail to learn how to develop skills specific to the nursing context.

At the opposite end of the spectrum are those nurses who accept the importance of learning how to interact with patients and immerse themselves in learning the skills. For these nurses, a different type of learning challenge may present itself. In attempting to learn the skills, these nurses may become reticent about saying anything to a patient out of fear of making a mistake and saying the wrong thing. If they do attempt to employ the skills, these nurses may have a stilted manner.

Most often this reaction is a result of a common misconception that talking to patients is somehow dramatically different from talking to people who are not patients. The nurses who become almost paralysed when trying to use the skills, or who use the skills in a stilted manner, are often stifled by a belief that 'being therapeutic' means being completely different from usual. The major consequence of this belief is that it retards development of a personal style.

The nurses who are resistant to learning new ways of interacting because they believe that interacting with patients is nothing more than common sense assume

that relationships with patients have no special features. The nurses who are reticent to interact with patients out of fear of making a mistake assume that relationships with patients are entirely different from other types of human interactions and that a common ground cannot be established. Both groups are misguided and are acting on false assumptions. The first response reflects a rejection of the professional self ('I'll just be myself'), while the second response fails to recognise the use of personal self ('I no longer *can* be myself').

While relationships with patients have characteristics that are different from social relationships such as friendship (see Ch 2), the person who is the nurse remains the same. Nurses must come to realise that their professional self emerges from their personal self (Hood 2010); neither is a separate entity.

These reactions to learning the skills of interacting within the nursing context highlight the need for continuous self-appraisal and self-challenge. By focusing their efforts on becoming more aware, nurses who react to learning the skills in the ways described in the preceding paragraphs are able to meet the challenges posed by these reactions. By reflecting on their responses, nurses not only become aware of their faulty perspectives (if any exist) on interactions with patients but are challenged to review and revise these perspectives. The essential aim in developing such an awareness when interacting with patients is to be able to assess and evaluate how current perspectives and interpretations could be affecting the development of effective interpersonal skills.

Self-assessment of interpersonal skills

Active and ongoing self-assessment is a dynamic strategy for reflection and is one of the most effective ways to increase interpersonal effectiveness as a nurse. Self-assessment draws on all of the processes for developing self-understanding that are described in this chapter. Nurses need to develop the ability to observe themselves as they participate in interactions with patients. This requires nurses to develop abilities to stand apart from themselves temporarily, and to tune their senses to recognise effective and ineffective interaction patterns. Observing feedback and input from patients, which indicates how patients are responding to the nurse's attempts to interact, adds to this self-evaluation. Discussion with other nurses about relationships with patients offers opportunities to be both reassured and challenged. Finally, sharing motives, intentions, thoughts and feelings, both with oneself and with other nurses, offers further opportunities for growth in interpersonal effectiveness with patients.

ADVANTAGES OF SELF-ASSESSMENT

Self-assessment is a useful way to approach the development of skills for a variety of reasons. Firstly, focusing on self-assessing, especially when initially attempting to use the skills, helps to release nurses from the fear of saying the wrong thing. Through the process of self-assessment, 'mistakes', when made, are viewed as indicators for further growth and development rather than outright failures. Nurses who can recognise when they either miss the point or could be handling an interaction more effectively have an opportunity to recover and move the interaction back on track. When

awareness is lacking, errors and omissions go unrecognised and future learning opportunities are missed.

Second, self-assessment has the advantage of using the nurse's firsthand experience in the interaction. Nurses who have participated in an interaction know best what happened. In this sense, 'being there' provides essential input. Nurses who 'were there' understand their own intentions during the interaction and can therefore evaluate an interaction in light of these intentions. In this regard, evaluation of performance is placed within the context of actual interactions, as opposed to employing rules that are context-free. This approach takes into account the specific factors relevant to a given interaction and places evaluation within the light of these factors.

Finally, and perhaps most importantly, developing the ability to self-assess enables nurses to engage in continual learning. Through awareness and self-assessment, nurses come to understand their personal strengths and areas for improvement, and performance is evaluated in terms of these personal aspects. When every interaction is viewed as an opportunity for learning, nurses engage in continuous professional growth. In this respect, self-assessment (the evaluation of one's own performance) is considered an essential ability, even a skill in its own right.

Self-assessment is useful in evaluating interpersonal effectiveness after an interaction has occurred, and this is the most common way in which it is initially developed. When developed to its fullest, self-assessment also enables nurses to determine how best to approach a given situation *during* an interaction.

During interactions with patients, nurses have a range of skill options to employ, assuming their repertoire of skills is extensive. For example, the choice to encourage a patient through attending and listening (see Ch 5), through the use of exploration (see Ch 7) or through the use of empathy expression (see Ch 6) depends on a nurse's ability to evaluate their own performance in the immediate situation and to track the progress of the relationship (see Ch 2). Through maintaining an orientation towards self-assessment, the choices that are made have a more sound basis than those made by using either a trial-and-error approach or a standard textbook description.

APPROACHES TO SELF-ASSESSMENT

Beginning and experienced nurses are encouraged to begin their self-evaluation with an assessment of how they are currently functioning with their interpersonal skills. Activity 3.9 is designed to increase awareness of current interaction patterns. It relies on the process of introspection, discussed earlier in this chapter, and is therefore an activity that should be completed in solitude.

In addition to reflecting on 'everyday' interactions, it is essential that nurses reflect on their interactions with patients. Interactions with patients are different from everyday interactions in the sense that nurses are often focused on being of help to patients. While helping others does occur during everyday interactions, this is not always the primary intent of such interactions.

In order to determine how best to approach situations with patients, nurses must be able to observe and reflect on the interaction, while simultaneously participating in the interaction. The complexity of self-assessment is often overwhelming as a result

ACTIVITY 3.9 Assessment of current skills

Process

1. Observe your interactions for approximately 10 days. Focus on situations in which you are aware of how you are interacting. These situations should contain interactions during which you felt you were effectively interacting with the others, and those that you felt were not as effective. These should be situations that illustrate how you typically communicate and interact with other people. Some examples of the type of situations you may observe include:
   - introducing yourself to a stranger
   - needing to clarify something you have not understood
   - asking another person about themselves
   - speaking in a group
   - asking someone for a favour
   - wanting to say 'no' to a request
   - giving or seeking information
   - receiving negative feedback about yourself
   - explaining why you did or said something
   - disagreeing with someone
   - seeking assistance from someone
   - expressing concern for someone else
   - wanting to help someone else
   - demonstrating to someone that you care about them.
2. Record these situations as soon as possible after they occur. Include a description of what happened, what you thought about what happened and how you felt about what happened.
3. After you have recorded these situations for about 10 days, review them in order to determine your major strengths when interacting with other people and those areas in which you think you could improve.

Discussion

1. Write a brief summary of your interactions, using the following as a guide:
   - what you observed about your interpersonal interactions (e.g. 'I notice that I don't always listen when I am worried about what I am going to say')
   - your strengths and areas for improvement (e.g. 'I'm good at starting conversations with people I don't know')
   - your personal goals for improving your ability to interact and relate to others (e.g. 'I would like to be able to seek clarification so that I'm sure I understand').

of these demands. Because the ability to become a participant-observer during interactions can be quite cumbersome to manage all at once, it is often useful to break up the process of self-assessment into manageable units. Although the ultimate aim is to combine all units, first mastering smaller units helps develop the art of self-assessment. The following approaches and activities focus on these smaller units: observing, perceiving, reflecting, evaluating and making alterations on the basis of the evaluation.

REFLECTION AFTER INTERACTIONS WITH PATIENTS

An effective approach to assessing performance, and one of the most commonly used approaches, is a reflective evaluation of an interaction after it has occurred. This approach to self-assessment is used after nurses have spontaneously participated in an interaction with a patient. Through reflection, nurses are able to identify skills that were used, assess the effects of these skills and, using patient responses and theoretical concepts as a guide, construct a probable explanation of why the skills were effective or ineffective.

Activity 3.10 is presented as a useful way for nurses to reflect personally on interactions with patients, be they positive or negative experiences.

Nurses may fall into the trap of being overly critical of themselves whenever they reflect on their interactions with patients because they place pressure on themselves to 'do it right'. Rather than viewing interactions as opportunities for growth, nurses who want to 'do it right' perceive interactions as tests of effective performance. This view often stifles personal and professional development.

Whenever nurses are asked to reflect on their interactions, there is a danger that they will recall only those interactions during which they felt ineffective. For this reason, it is important that nurses focus on positive, fulfilling and beneficial interactions, as well as on those interactions that could have been more effective. Satisfying and successful interactions are as informative as those that are not.

FOCUS ON SPECIFIC SKILLS DURING AN INTERACTION

At times, nurses will want to develop a specific skill or related set of skills because they perceive these skills as difficult, uncomfortable to use or hard to understand. Under these circumstances, an effective way to self-assess is to focus on these skills during an interaction.

ACTIVITY 3.10 Guide to self-reflection

Process

1. Describe (either through speaking or writing) an interaction in terms of what happened. Do not think about why it happened. Just think about what happened between you and the patient.
2. Answer the following questions:
   - a What did you say that was helpful to the patient?
   - b What was your intent in saying this?
   - c How did you know it was helpful?
   - d What did you say/do that was not helpful to the patient?
   - e What was your intent in saying this?
   - f How did you know it was not helpful?
   - g What could you have said that would have been more helpful?
   - h What were you feeling during this interaction?
   - i What do you think the patient was feeling during the interaction?
   - j How would you have changed this interaction if you could do it again?

ACTIVITY 3.11 Self-assessment of specific skills ➡ 313

Process

1. Identify which skill or set of skills is particularly difficult to understand or seems too uncomfortable to use.
2. Review the section of this chapter that covers this particular skill or set of skills.
3. During interactions with patients, look for opportunities when this skill or set of skills is appropriate to use or notice each time you use the skill or set of skills during an interaction with patients.

Discussion

1. Each time you use the skill or set of skills:
   - Evaluate its effects on interaction with the patient.
   - Observe how the patient responds.
   - Reflect on how you felt and responded.
   - Make a note of the circumstances and immediate situation.

MAINTAINING AN ONGOING RECORD

The previously described self-assessment methods are most effective whenever nurses keep track of a number of patient interactions. Such a record is sometimes referred to as a 'journal' or 'diary'. In maintaining such a record, nurses are able to develop their understanding and use of interpersonal skills by referring to a variety of situations and circumstances. When a variety of situations are evaluated, comparisons and contrasts can be made and patterns begin to emerge. Keeping track of various patient situations, and various ways of interacting in these situations, enables nurses to formulate a more complete understanding than simply focusing on isolated events or isolated skills.

SOLICITING HELP FROM OTHER NURSES

In addition to the introspection that the previous approaches encourage, it is useful for nurses to solicit feedback from other nurses about how they are interacting with patients. The questions in Activity 3.10 can be used to prompt information from other nurses. The questions are exploratory. They refrain from passing judgment and encourage other nurses to reflect and determine how they are interacting.

This approach to helping other nurses is preferable to providing solutions and offering advice. When solutions and advice are given, nurses are not encouraged to generate their own solutions. Also, it is only the nurse who 'was there' during a given interaction who knows exactly what happened. Nurses who were not present, yet receive a reported account of what happened, are relying on the nurse giving the account and are processing the information through their own filters. It is preferable

for the nurse who 'was there' to process the interaction through their own perceptual filters because this approach has the greatest possibility for promoting self-understanding. Other nurses may offer alternative perspectives, thus encouraging a reappraisal of the situation, but it is best to begin with attempting to understand.

PITFALLS IN SELF-ASSESSMENT

The tendency to judge or evaluate their own performance is often automatic, even natural for nurses. Nevertheless, a negative evaluation can be quite troublesome when the perceived stakes are great. In evaluating their interactions with patients, the stakes are often high for nurses because of a need to maintain a positive professional image. Most nurses will want to be effective in their interactions with patients, and performance judged as ineffective may threaten a nurse's professional image and professional esteem. For example, when nurses recognise that they have blocked or inhibited an interaction with a patient, they may find this behaviour unacceptable in a professional sense. In order to preserve and maintain an image as effective professionals, they may overlook, diminish, justify or even reject flaws and mistakes in their performance.

Overcoming this potential pitfall is best achieved through recognition and continuous awareness that self-assessment is done for the purpose of professional growth and development. Continual reflection and evaluation of performance enables nurses to build on their experiences and learn from them. Through self-assessment, nurses determine what was right or wrong, effective or ineffective about their interaction skills and patterns. Nevertheless, this evaluation is not the endpoint of self-assessment. Self-assessment is employed primarily for the purpose of seeking ways to improve. It is not simply an evaluative process but a learning process. A commitment to continual learning is an essential aspect of professionalism.

Another potential pitfall in using self-assessment is a tendency to gloss over performance, perceiving it globally as either all good or all bad. Focusing exclusively on positive aspects is as much a pitfall as focusing exclusively on negative aspects of performance. Nurses who can focus only on mistakes or flaws in their interactions with patients are being too harsh in their self-evaluation. Nurses who can focus only on positive aspects of their performance are failing to recognise areas for improvement and learning, which exist in the majority of situations.

The tendency to view performance globally as either all good or all bad is kept in check through the realisation that most interactions will contain a mixture of positive and negative aspects. Whenever nurses can perceive only one type or the other, their self-assessment lacks accuracy and completeness. If this happens, nurses are encouraged to reflect further in order to develop a balanced view of evaluation.

A final potential pitfall in using one's self as the assessor of performance emerges whenever nurses lack understanding of the criteria on which to base their evaluations. A lack of understanding of how and why interpersonal skills are used is addressed through further reading and discussion about the theory of effective interactions in nursing. Additionally, nurses may need to solicit assistance from an external authority (e.g. an experienced nurse or an educator) in developing appropriate criteria on which to base their self-assessment.

Chapter summary

Nurses need to become competent communicators who display emotional intelligence in their practice environment. In order to do so, they need to develop acute self-understanding whenever they engage in interactions and relationships with patients because the primary tool they are using in these circumstances is themselves. Without self-understanding, nurses run the risk of imposing their values and views onto patients. Values that serve the nurse may be detrimental or useless to patients. There is a danger that without self-understanding nurses may confuse their own values with those of their patients. Although connected through the relationship, nurses need to maintain an identity that remains separate from their patients.

More than any other parts of nursing, interpersonal relationships with patients are likely to engender feelings within nurses. The processes of self-reflection provide assistance in handling such reactions to patients.

This chapter has reviewed three processes for developing self-understanding:

- introspection
- input from others
- self-sharing.

Nurses are encouraged to use these processes in their day-to-day encounters with patients. Reflection, both in solitude and through interaction with others, as well as self-sharing, enables nurses to meet the challenges of self-growth.

Self-understanding is the primary means through which nurses are able to evaluate their effectiveness in relating to patients. Through self-understanding, nurses remain in touch with what they are doing, and how this is affecting patients for whom they care.

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