# Effect of Communication Style and Empathy on Self-Disclosure

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ABSTRACT

This study examined the relationship between nurses' communication style (person-centeredness vs. position-centeredness), patients' perception of nurses' empathy and patients' self-disclosure. Based on symbolic interaction theory, it was hypothesized: 1. patients' self-disclosure would be directly related to person-centeredness and perceived nurse empathy; 2. patients' perception of nurse empathy would be more important in predicting patient self-disclosure than communication style.

Sixty one conversations of registered nurses assisting first time mothers with the bathing of their babies were tape recorded. Content analysis was performed to determine nurses' person-centeredness and patients' amount of self-disclosure. Patients' perception of nurse empathy was measured using the Relationship Inventory rating scale. The variable of personal differences in self-disclosure was controlled for its possible effect on actual patient self-disclosure.

A multiple regression analysis showed that: communication style did contribute significantly ($p<.01$) to prediction of patient self-disclosure but perceived empathy did not. Therefore communication style was more important in predicting patient self-disclosure than perceived clinician empathy. Perceived empathy had an inverse nonsignificant relationship to patient self-disclosure. Interpretation of this result was qualified due to the multiple factors involved in measuring empathy. Findings support nurses' use of a person-centered approach in therapeutic relationships.

ABREGE

Cette étude examine la relation entre le type de communication des infirmières (centrée sur la personne versus centrée sur la position), perception de l'empathie des infirmières par les clients et auto-révélation des clients. Basé sur la théorie de l'intéraction symbolique, il est présenté l'hypothèse suivante: 1. l'auto-révélation des clients est directement relié a l'approache centrée sur la personne et la perception de l'empathie des infirmières; 2. la perception de l'empathie des infirmieres par les clients serait d'autant plus importante par la prédiction de l'auto-révélation du client que le type de communication.

Soixante et une conversations entre infirmières licenciées assistant les meres débutantes lors du bain de leurs nouveaux-nés furent enregistrees. L'analyse du contenue a été accompli dans le but de déterminer l'approche centrée sur la personne des infirmières et le niveau d'auto-révélation des clients. La perception de l'empathie des infirmières par les clients a été mesure en utilisant l'échelle de classement de Relationship Inventory. La variable différences personnelle dans l'auto-révélation fut contrôller pour les effects possible sur l'auto-révélation actuelle du client.

Une analyse régression multiple montre que: le type de communication contribue de manière significative ($p<.01$) a prédir l'auto-révélation du client, par contre la perception de l'empathie ne contribue pas a prédir l'auto-révélation. Donc le type de communication est plus important dans la prédiction de l'auto-révélation du client que la perception de l'empathie de clinicien. La perception de l'empathie a une relation nonsignificative inversé par rapport a l-auto-révélation du client. L'intérpretation de ces résultats ont été qualifié par les multipes facteurs impliqué dans la mesure de l'empathie. Les resultats supportent par les infirmières d'une approche centrée sur la personne lors des relations thérapeutiques.

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# INTRODUCTION

Part of the preparation in becoming a nurse is learning how to communicate in a therapeutic manner. In practice, however, nurses vary in their communication styles and may stray from a communication style that elicits the patient's perspective. Instead they may approach the patient with a set of directives or rules that are to be followed based on the nurse's or the institution's expectations. The nurse's communication style can be characterized as person-centered or position-centered and the approach may influence whether or not the content of the message is heeded. With a person-centered approach "speakers assume that the motivations, intentions and feelings of an individual and the character of each situation encountered is always unique" (Applegate, 1980, p.61). The person-centered approach gives empathetic acknowledgement and encourages self-disclosure (Bernstein, 1974, p.147-148). A position-centered response "relies on an interactant's assumption that he and others implicitly recognize and accept the shared sociocultural definitions of the assigned roles in participants, the authority which inheres in those roles, and the behavioral norms operating within such role-based relationships" (Applegate, 1980, p.61). The position-centered approach imposes uniformity and does not encourage self-disclosure (Bernstein, 1974, p.154-155).

Symbolic interaction theory posits that individuals do

not merely react to each others' actions, but respond according to how they interpret what these actions mean to them. Thus it cannot be assumed a patient will perceive a person-centered nurse as empathetic and, therefore, self-disclose or that a patient will perceive a position-centered nurse as lacking empathy and will refrain from self-disclosure. This study explored the possibility that the patient could interpret both person-centered and position-centered comments as either empathetic or not. It would be according to this interpretation that the patient's response could best be understood. The purpose of this study then was to explore the relationship between the nurse's communication style and the patient's perception of clinician empathy and the patient's self-disclosure.

## Theoretical Framework

Although many have contributed to symbolic interaction theory, the early writings of George Mead (1934) contain much of the conceptual underpinnings of modern symbolic interactionism. Herbert Blumer (1969), a leading exponent of the theory, has elaborated on Mead's work.

Blumer (1969) identified three basic premises on which symbolic interaction theory rests:

1. human beings act toward things on the basis of the meanings that the things have for them, (things include physical objects, other human beings, institutions, guiding ideals, situations which an individual may

encounter);

2. the meaning of such things is derived from or arises out of, the social interaction that one has with one's fellows;

3. these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (p .2)

Mead (1934) defines an "act" as "an impulse that maintains the life-process by the selection of certain sorts of stimuli it needs. Thus, the organism creates its environment. The stimulus is the occasion for the expression of the impulse" (p. 6), that is, an individual (in acting) chooses to attend to certain aspects of the environment, therefore defining the environment and responding to it accordingly. In defining the environment an individual gives meaning to an object. This does not refer to the intrinsic makeup of the object, but the meaning which arises through a process of human interaction.

Individuals are capable of responding to the environment in a symbolic manner, that is, they are capable of making indications to others, and interpreting the indications of others. Individuals are able to do this by virtue of possessing a sense of "self" in which they are able to view themselves in guiding their interpretation of the social process. As well, individuals possess a "mind" in which they are able to grasp the attitude of the other

toward their own gesture (verbal and non-verbal behaviour). Blumer (1969) states, "With the mechanism of self-interaction the human being ceases to be a responding organism whose behavior is a product of what plays upon him from the outside, the inside, or both. Instead he acts toward his world, *interpreting what confronts him and organizing his action on the basis of the interpretation*" (p.63).

Another element which influences how the individual responds is the generalized other; this refers to the social groups from which an individual takes on certain attitudes. An individual generalizes the attitudes of individuals within an organized society and then interprets the social process and acts accordingly. In summary, an individual thus controls his or her responses by taking the diverse and emergent perspectives and transforming them into a personal perspective.

This study investigates the stimuli provided in a hospital environment, specifically the stimuli which are present in a nurse-patient interaction when a nurse is assisting a mother with a baby bath. Person-centered and position-centered communication styles are characterized as the symbol or gesture to which the patient reacts. The patient receiving the nurse's gesture, adjusts her response according to her interpretation of the nurse's attitude or behaviour. The person then decides what action or response

should be taken in the interaction. For the purpose of this study, patients were asked to interpret their nurse's gesture in terms of their perception of the nurse's empathy, and the patients' responses were measured for their degree of self-disclosure.

The question that this study addresses is: what is the relationship between nurses' degree of person-centeredness and the patients' perception of nurses' empathy and the extent of patients' self-disclosure.

## Hypotheses

1. The more person-centered nurses are in their communication style and the more patients perceive their nurses to be empathetic, the more patients will self-disclose.

2. Perceived empathy is more important in predicting the extent to which patients will self-disclose than is communication style.

No studies were found to have related position-centered/ person-centered behavior to some therapeutic outcome, nor to the patient's perception of the styles; thus this study explores an area in nursing which is new. The findings will have practical implications for nursing, as they may justify the use of person-centered and/or position-centered approaches and they may provide new knowledge on the facilitation of patient self-disclosure on health care needs. This is pertinent in assisting patients with meeting

their health goals, as studies have shown that patient adherence to a prescribed medical regimen is related to the patient's ability to engage in moderate levels of disclosure (Colten & Janis, 1982; Janis, 1983).

The findings of this study will also have implications for future nursing research dealing with the establishment of relationships between certain nursing behaviours and therapeutic outcomes. It may underline the importance of examining the patient's interpretation of the nursing behaviour in evaluating the effectiveness of the nursing intervention.

# LITERATURE REVIEW

In order to support the relevance of symbolic interaction theory in nursing practice, several nursing theories, which are grounded on the interactionist theory, are presented in this review of the literature and reference is made to nursing studies which are guided by interactionist theory. This literature review also presents relevant literature relating to the variables under study; person-centered and position-centered behaviour, perceived empathy, and self-disclosure. The review of the literature on these variables will include their theoretical explications and research findings.

## Interactionist Theorists in Nursing

Several nurse theorists address nursing as a process of interaction. Theorists selected to represent the concepts of interaction in nursing are Peplau (1952), Orlando (1961, 1972), Wiedenbach (1963) and King (1981).

According to Peplau (1952), "nursing is a human relationship between an individual who is sick, or in need of health services, and a nurse especially educated to recognize and to respond to the need for help" (p.5-6). The nurse responds to the need for help, in part, by assisting the patient to a full understanding of his or her health concerns and assisting him or her to deal with the situation. This necessitates gaining the patient's

agreement and motivation to deal with health issues. This is accomplished by the nurse developing a greater awareness of him/herself, the patient and their relationship. In the previous section, the importance of the concept of "meaning" in an interaction was presented. Peplau also comments on how important it is to seek out the meaning of a "thing" to an individual in order for the nurse to effectively relate to the patient. She states that the nurse "will permit the patient to express his feelings so that he can become aware of what they are" (Peplau, p.28). The nurse should be able to "observe and gather evidence on the way the patient views the situation confronting him, visualize what is happening inside the patient, as well as observe what is going on between them in the interpersonal relation" (Peplau, p.50). The concept of "self" is also discussed: "The self always responds selectively to experience and is the organizer and integrator of experience" (Peplau, p.222). The concept of self the patient has and the concept of self the nurse has, will have an effect on their relationship. In summary, Peplau views the nursing process as "educative and therapeutic when nurse and patient can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solution of problems" (Peplau, p.9).

Orlando (1972) also envisions nursing as being responsive to individuals who are in need of help. She has

categorized nurses' reactions to patients as either "automatic" or "disciplined professional".

An automatic personal response is one in which the interactants do not verify their understanding of each other's verbal and non-verbal behaviours (gestures), and misinterpretations may be made about what the individual is experiencing. A disciplined professional response, on the other hand, is one in which the nurse expresses and explores his or her reaction to the patient's behaviour, providing for validation and correction of the interpretation he or she has made of the patient's behaviour. It involves a continuous process of reflection as the nurse attempts to explore the meaning of the behaviour of the patient by him or herself and with the patient. The deliberative or disciplined approach, therefore, allows the nurse to gain an understanding of the meaning of the patient's behaviour. The nurse can identify the patient's need, and evaluate how effective the nursing activities are in responding to the patient's need for help.

Orlando's nursing theory is consistent with the views of symbolic interaction theory. She also sees individuals as acting/reacting beings, who bring with them a unique perspective in their interpretation of the social interaction. Given these beliefs, she feels that the meaning of the patient's behaviour and the perceptions of patients and nurses must be validated in a nurse-patient

interaction.

Wiedenbach and Orlando worked together in developing concepts in nursing and thus their theories have quite a few similarities. Wiedenbach (1963) also refers to a deliberate approach in nursing. She has applied it to her three phases of nursing practice. In the deliberate approach the nurse needs to understand the meaning of the patient's behaviour when identifying the need for help, ministering the help needed and validating the effectiveness of the measure (Wiedenbach's three phases of nursing practice). This is done by validating whether the nurse's perceptions of the meaning of the behaviour are accurate and making known to the patient how he or she is interpreting the behaviour, as well as determining what the patient's understanding is of the nurse's behaviour.

King (1981) defines nursing "as a process of action, reaction and interaction whereby nurse and client share information about their perceptions in the nursing situation" (p.2). The patient is recognized as a participant in decision making so that the individual has some independence and control over the situation. King states "nurse and client are in a reciprocal relationship in that the nurse has special information to help the client set goals; client has information about self and perceptions of problems or concerns that when communicated to the nurse will help in mutual goal setting" (p.150); that is, common

purpose will allow the nurse to be effective in providing patient care and the patient to be satisfied with the care received. King refers to the importance of determining meaning in the patient's behaviour: "The nurse has a responsibility to search for meaning in the behavior of the patient" (King, p.87) and to verify if his or her perceptions are accurate. As in the interactionist theory, a significant symbol implies a certain meaning; King states, "interactions can reveal how one person thinks and feels about another person, how each perceives the other and what the other does to him, what his expectations are of the other, and how each reacts to the actions of the other" (p.85). Thus, one of the goals in nursing is to create purposeful interaction, which King states "requires openness in the exchange of information and mutual agreement about the means to achieve identified goals." (p.87)

The major theme of interactionist theories in nursing is that in order for there to be congruence between patient's needs and nursing care given, the nurse must recognize and validate the patient's perception of the situation.

Research

Research has shown that a nursing process focused on how the patient defines the situation is more effective than other approaches in dealing with pain (Barron, 1966; Bochnak, 1963); in understanding patient's needs (Cameron,

1963); in decreasing postoperative vomiting (Dumas & Leonard, 1963); in relieving distress experienced by patients during admission to the hospital (Elms & Leonard, 1966); and in increasing patients' satisfaction with the nursing care they receive during labor (Shields, 1978).

A number of studies have focused on examining the properties and components of health professional and patient interactions. Harrison, Pistolessi, and Stephen (1989) compared communication styles of sophomore, junior and senior groups of nursing students. Nursing students were asked to rate their perceptions of their communication style by completing the Communication Styles Q-Set. The researchers found differences in communication between the levels were numerous in both negative and positive behaviours, however there was an overall lack of change in communication effectiveness over the three levels as the gains and losses were found to be roughly equal across the three levels. Students in the senior year saw themselves as more sympathetic and egalitarian in their approach to patients, but they also perceived themselves as less likely to listen carefully and respond socially, and more likely to interrupt, disagree and criticize. Graffam (1970) found that in responding to patients in distress, nurses infrequently explored with patients what they felt to be the cause of the distress. Instead, the majority of nurses' comments were for the purpose of informing, suggesting

relief, comforting, cheering and directing. Teaching statements were also infrequent. In a study of nurse and patient interaction during labour, Beaton (1990) also found that nurses did not acknowledge and/or seek out the patients' perceptions of the situation. She studied nurse and patient verbal responses during different nursing activities. Patient and nurse responses were classified according to Stile's Taxonomy of Verbal Response. She found:

1. Low attentiveness (speakers' interest in other's experience) values in both patients and nurses. The most frequent mode of expression by patients was disclosure and by nurses it was advisement (described as the nurse expressing what she or he wanted done). Nurses were less attentive during certain activities such as during vaginal examinations and when monitoring equipment.

2. Nurses and patients were found to be non-acquiescent (not allowing viewpoint of the other to direct the conversation). Nurses and patients were more acquiescent during activities related to the monitoring of equipment, with nurses frequently offering information and patients acknowledging the explanation. Both nurses and patients were less acquiescent during comfort and coaching activities.

3. Nurses were significantly more presumptuous (speaker assumes to have knowledge of the other's experience) than patients during all care activities except comfort involving

the use of objects and administration of medications. Nurses were most presumptuous when coaching patients.

Several studies have investigated how interactants perceive and respond to each other within the context of practitioner-patient interactions. Browne (1979) found the nature of the patient's verbal behavior had an effect on the nature of the health professional's response and vice versa. Studies by Eisler, Wolfer & Diers (1972) and Pienschke (1973) explored how patients' perceptions may influence clinician-patient interactions and their relationships. Eisler et al. (1972) found a slight correlation existed between social approval needs of patients and their reports of physical well-being. The authors challenge the assumption that validation indeed gets at patients' true perceptions of the situation, as they contend that the patient's response is also influenced by a need for social approval. Pienschke (1973) studied guarded and open approaches used in telling cancer patients about their diagnosis and prognosis. She found that patients generally had confidence in their nurses and doctors regardless of the approach used, but there was greater confidence in health professionals when they were open in discussing the patient's diagnosis and prognosis. Patients generally reported satisfaction with nursing care regardless of the approach used, but there was marked increase in nurse's effectiveness of intervention to provide care (as perceived

by the nurse and the client) when the open approach was used. Barton, Baltes and Orzech (1980) explored nurses' responses to patients and what effect this had on patients. They found that dependent behavior in elderly residents in a nursing home was reinforced by the staff and that independent behavior was not reinforced by the staff. The authors suggested that the independent behaviors by residents were perhaps maintained from some other sources (internal or external).

The studies by Eisler et al. (1972) and Pienschke (1973) underline the need to further test the interactionist theory as a theoretical framework in nursing studies in order to more clearly understand the nature of nurse-patient relationships. Kasch (1986), in working towards a theory of nursing, stated: "Many have recognized the relevance of interaction theory for understanding the nature and function of nursing action .... However few have been able to translate interactionist principles into a systematic theory-based program of research" (p.226).

## Person-Centered and Position-Centered Communication Styles

The terms person-centered and position-centered come from Bernstein's (1974) theory, which is an analysis of cultural differences in speech codes. Bernstein's theory is grounded in George Mead's analysis of social interaction. According to symbolic interaction theory, it is through

communication of symbols that individuals learn huge numbers of meanings and values, and hence ways of acting, from other individuals. Individuals have a culture, a set of meanings and values shared by members of a society, which guides much of their behavior.

"A restricted code will arise where the form of the social relation is based upon closely shared identifications, upon an extensive range of shared expectations, upon a range of common assumptions .... The form of commmunication reinforces the form of the social relation rather than creating a need to create speech which uniquely fits the intentions of the speakers" (Bernstein, 1974, p.146-147). A restricted code may be characterized as position-centered where the communication pattern is based on common understanding of the social roles. Communication within a position-centered orientation "is less likely to facilitate the verbal elaboration of judgements, their basis and consequences; it does not encourage the verbal exploration of individual intentions and motive" (Bernstein, 1974, p.154-155). An elaborated code "will arise wherever the intent of the other person cannot be taken for granted .... Speakers are forced to elaborate their meanings and make them both explicit and specific .... An elaborated code in principle, pre-supposes a sharp boundary or gap between self and others which is crossed through the creation of speech which specifically fits the differentiated 'other'"

(Bernstein, 1974, p.147-148). Thus, there is a difference in person-centered and position-centered orientations in the importance of and need for verbal communication about an individual's recognition of the beliefs and values of others.

Bernstein (1974) argued that the elaborated code (characterized as person-centered) and the restricted code (characterized as position-centered) constitute the dominant modes of speaking in, respectively, the British middle and working classes. He implied that these class differences reflected differences in how children were able to accommodate themselves to an academic environment.

Applegate (1980) studied teacher-student relationships in a day care center, applying Bernstein's concepts of person-centered and position-centered speech within regulative and interpersonal functional levels of communication. He reformulated Bernstein's theory, adding a developmental-constructivist perspective. Applegate studied the relationship between person-centered qualities in teachers' communication and abstractness in their systems of interpersonal constructs. He developed a coding system to measure person/position-centered communication in teachers as they interacted with children.

Kasch and her associates have proposed a nursing framework which links the process of nursing with theory in interpersonal competence (Kasch, 1984, 1986; Kasch & Dine,

1988; Kasch, Kasch, & Lisnek, 1987; Kasch & Knutson, 1985; Kasch & Lisnek, 1984). They have incorporated Bernstein's theoretical definition of person-centered and position-centered communication in their nursing framework and adapted Applegate's coding system on person- and position-centered communication to apply to a nurse-patient situation (Kasch & Lisnek, 1984). Interpersonal competence is identified as an important factor in determining how effective a caregiver will be in meeting the goals of the nursing process. More specifically, "strategic message competence" will influence how successful the nurse may be in dealing with nursing objectives (instructional, relational, identity, regulative and comforting objectives). Person-centeredness within an interpersonal competence nursing framework "can most usefully be conceptualized as the degree to which the form and content of communication strategies incorporate knowledge of, and adapt to the psychosocial perspective of, the patient in the pursuit of *specific nursing goals*" (Kasch & Dine, 1988, p.323).

Nurses vary in their ability to adapt messages (or vary in their ability to employ the most effective communication strategy) to the unique demands of persons and situations. This flexibility is partly dependent on how capable nurses are in constructing person-centered communication strategies (Kasch & Dine, 1988). As an example of differences in how nurses may approach patients in order to accomplish

important nursing goals; the position-centered nurse, in attempting to regulate the patient's behavior, may assume that the patient has the same health values as the health team and thus approach the patient in the following manner, "Mrs. Jones, we all want what is best for you, so you must try harder to follow your prescribed diet." This differs from the person-centered approach, which explores the patient's thought and feelings, "I notice you have difficulty following your diet. How do you feel about it?"

Research

Matthews (1962) measured person-centeredness in nurses. While she refers to neither Bernstein's theory nor the term position-centered, her concepts of person-centeredness and non-person-centeredness do seem similar to Bernstein's concepts. Matthews defines a person-centered response as one which "encourages the patient to disclose how he sees his world, what he is experiencing, and the meanings these experiences have for him" (p.155). She defined a non-person-centered response as one which "discourages or prevents the patient from further communication. This may be brought about by imposing the authority of nurse, doctor, or institution on the patient; by denying the individuality of the patient; or by responses which are defensive, judgemental, or threatening to the patient" (p.156).

Matthews (1962) developed a coding scheme to measure person-centeredness. She prepared 12 patient statements

which expressed a patient's feelings or concerns about safety, security, self-esteem, irritation or conflict. A content analysis was performed on the written responses the nurses made to the patient statements, using a binary method to analyse the data, so that, "Content categories are arranged by levels of decision-making from general to specific. At each level a dichotomous decision (i.e., to decide between two alternatives) is required of the judges" (Matthews, p.155). She found that two-thirds of the nurse respondents were non-person-centered and as years-since graduation increased, there was a tendency for person-centeredness to decrease.

Wallston, Cohen, Wallston, Smith and DeVellis (1978) used Matthews' concepts of person-centeredness and non-person-centeredness, and Matthews' coding scheme of person-centeredness in their study. The study assessed the degree to which professional nurses respond effectively to patients and determined whether a minimal intervention could increase the nurse's effectiveness. Two samples of nurses listened to audiotaped disclosure statements from simulated patients. Responses to the patient statements were taped (phase 1). The experimental group then received an intervention in the form of a brief message designed to improve helpfulness of their responses. They were immediately tested on the remaining simulated patient situations (phase 2). The taped responses were coded according to Matthews' scale. The

study's findings were: in phase 1, for both sample groups, nurses were judged to be performing somewhere between level 0 (does not elicit information but gives information) and level +1 (elicits information but limits patient's response); the experimental group who received the brief intervention had a significant increase or improvement in person-centeredness from phase 1 to phase 2, in comparison to the control group, suggesting that nurses need only a brief reminder as to how they are supposed to behave in order to do so. Limitations of this study, as identified by the authors, were that it was set in a laboratory rather than a natural clinical setting, and the time interval was very short between the "helpfulness" intervention and the assessment of its effectiveness. It does support Matthews' findings that nurses use non-person-centered, rather than person-centered responses in interactions with patients.

DeVellis, Adams & DeVellis (1984) have investigated the impact of information on nursing students' attitudes and their communication behavior. Communication behavior was examined as person-centered responses. Nursing students were presented with a hypothetical situation: a childless female patient who was about to undergo surgery for sterilization. Nursing students were randomly assigned to four experimental conditions, each student read one of four paragraphs describing the patient as self-referred (voluntary choice) and mentally retarded or non-retarded,

physician-referred (medical reason) and mentally retarded or non-retarded. They then responded to the same five audiotape recorded statements. DeVellis et al. measured the verbal responses of the nursing students with a modified version of Matthews' coding scheme. The findings as far as the impact of information on communication behaviour were: there was a significant main effect for referral source, with nurses in the physican-referred conditions responding to the patient in a more person-centered manner. There was also a significant main effect for intelligence label, with nurses who believed that the patient was retarded speaking in a more person-centered manner than nurses who believed that the patient was of normal intelligence.

Studies on person-centeredness have investigated the degree to which nurses are person-centered or not, patient and situational factors which may influence the communication approach nurses may use, and how a therapeutic intervention may improve person-centeredness in nurses' communication. All the nursing studies have used Matthews' coding scheme to assess the level of person-centeredness in the nurses' communication.

## Perceived Empathy

This study examines the nurse's communication style (person-centered or position-centered) and the patient's interpretation of the communication style (perceived empathy) on patient self-disclosure. Perceived empathy is

thus viewed as one of the two independent variables in the study.

Zderad (1969) states "the union of the individuals in an encounter arises in their mutual experiencing of an event" (p.658). A position-centered orientation binds individuals to the extent to which they identify with each other according to the norms expected within a given social setting. A person-centered orientation is one in which individuals focus on understanding the experiences of others, as it is anticipated that they may be different from their own.

Carkhuff identifies empathy as one of the conditions required to promote facilitative human relationships. He defines empathy as "a word which we use when one individual is hearing or understanding another. Empathy involves crawling inside of another person's world as if you were he" (Carkhuff, 1973,p.58). The operational definition of empathy as measured by Barrett-Lennard's Relationship Inventory and which will be used in this study, is

> Maximum empathic understanding of B, by A, requires that A be able to discriminate and permit in his awareness all that B gives direct or indirect signs of consciously experiencing ... with A. This, in turn, requires that A be quite unthreatened and non-defensive in relation to B. To the extent that A identifies with B's feelings, or unconsciously projects feelings of his

> own into his perception of B's experience or in any other way confuses B's experience with experiences that originate in himself, his empathic understanding of B will be reduced. (Barrett-Lennard, 1962, p.3-4)

Barrett-Lennard states that empathy is an ongoing process. It involves receiving the communication, understanding the meaning of it to the individual, and accurately reflecting back to the individual what is relevant to the individual at that moment.

Research

Nursing studies on empathy can be divided into two areas of concern: characteristics of empathic ("empathic" is synonymous with "empathetic" in this manuscript) nurses and the relationship between empathy and its effectiveness as a therapeutic agent.

There have been inconsistent findings for levels of empathy in nurses and how empathy relates to a variety of factors. These inconsistencies may be due to the different instruments and, hence, to the different definitions of empathy employed in these studies.

In relation to levels of empathy, Truax and Millis (cited in Peitchinis, 1972) reported that registered nurses were generally low in empathy in comparison to 12 other occupational groups. This is consistent with findings by Hills and Knowles (1983). They found that nurses' scores on the Empathy and Respect scale to be consistently below the

level judged to be minimally facilitative. In contrast, scores based on the Hogan Empathy Scale in Forsyth's (1978-79) study and scores based on La Monica's Empathy Construct Rating Scale in Rogers' (1986) study, found that the majority of nurses and student nurses respectively, were moderately well developed in their empathic abilities. Both of these studies also found that patients' ratings of nurses' empathy were consistently higher than nurses' self-ratings, with Rogers finding a significant correlation between patients' and nurses' ratings that was not found in Forsyth's study. A study by Stetler (1977) categorized nurses into two groups, those who were perceived by "patients" (role playing actresses) as more highly empathetic and those perceived as less highly empathetic. The study found that the two groups did not differ in their verbal and vocal communication behavior.

Findings on the relationship between demographic variables and empathy are also inconsistent. Forsyth (1978-79) found no significant relationship between empathic ability and area of practice, age or length of practice. This differs from Brown and Hunter's (1987) findings. They used the empathy scales of the California Psychological Inventory and found medical-surgical nurses had the lowest mean scores and psychiatric nurses had the highest mean scores on empathic ability. Gallop, Lancee and Garfinkel (1990) investigated level of empathy in psychiatric nurses.

Nurses' written responses to hypothetical patient stimuli were rated according to the Staff Patient Interaction Scale which has three levels: no care (e.g. belittles), solution (e.g. offers or invites explanation) and affective involvement (e.g. addresses feelings). Findings were similar to those found in two previously cited studies by Graffam (1970) and Beaton (1990), that is, 51% of the responses fell in the "solution" category, 29% fell in the "affective involvement" category. Most of the nurses were found to be unempathic in their responses (Gallop et al.,1990). Findings by Pennington and Pierce (1985) found age and length of practice to be significantly correlated with verbal empathy. The findings are based on trained observers' ratings of nursing home staff members interacting with nursing home residents.

Macdonald (1977) compared empathy ratings between female and male nursing students and found males had higher scores than females, while Becker and Sands (1988) did not find a significant difference between males and females in empathy. Forsyth's (1978-79) study and a pilot study by Iwasiw and Olson (1985) have found that nursing education is a significant factor affecting nurses' empathic abilities. Baccalaureate nurses were found to have significantly higher levels of empathic ablility than diploma nurses. Mynatt (1985) however, did not find any significant differences in level of empathy in students in diploma, associated degree

or generic baccalaureate programs. Bagshaw and Adams (1985-86) found registered nurses in a nursing home to be more empathic than practical nurses or nursing aides. Rogers (1986) did not find a significant improvement in student nurses' empathic abilities in a cross-sectional study of different levels of nursing education.

Patient characteristics and attitudes towards patients appear to be related to nurse' empathy. A study of nursing home nurses by Bagshaw and Adams (1985-86), found a significant positive correlation between a low level of empathy, negative attitudes towards the elderly and a custodial orientation toward treatment. Olsen and Iwasiw (1989) found that nurses responded with different levels of verbal empathy to four types of patient situations. Nurses acknowledged simulated patients' feelings more readily in situations where patients were experiencing pain or anger than when patients were experiencing anxiety or depression. Nurses blocked expressions of feelings in situations where patients expressed anxiety or anger as opposed to those situations where patients expressed pain or depression.

Studies which explore the relationship between empathy and effectiveness as a therapeutic agent include Williams' (1979-80) study of the effect of the degree of nurse therapist empathy on overall change in the client's self-concept. Elderly residents of a nursing home were assigned to one of two group therapy sessions: one where they

received high levels of empathy or one where they received low levels of empathy. The empathetic nurse made a significant difference in improvement in outcome. La Monica Wolf, Madea, and Oberst (1987) investigated the effects of nurse empathy training on oncology client outcomes of anxiety, depression, hostility, and satisfaction with nursing care. Clients cared for by nurses in the experimental group showed less anxiety and hostility than clients cared for prior to the experimental treatment; mean differences on depression and satisfaction with care were in the hypothesized direction. Findings in the study are based on comparison of group scores pre and post-treatment in which the patient population did not remain stable. Nurse and client-rated empathy mean scores for both experimental and control groups were very high. Findings are questionable for client-rated empathy scores as nurses selected the patient who would rate them on empathy.

The studies by Forsyth (1978-79), Rogers (1986) and La Monica et al. (1987) point out the tendency patients have to rate their nurses as being highly empathic. Forsyth questions if client perception of reality is substantially distorted while LaMonica suggests that responses by both self and client ratings may be influenced by the social desirability of the items.

Nursing studies on empathy have focused on the degree to which the nurses' verbal behaviour was empathic. No

studies were found to have identified the impact that non-verbal behaviour has on conveying empathy and/or the extent that non-verbal empathic behaviour was evident in nurses' behaviour.

Studies used several approaches to measuring empathy. Studies used simulated conditions (Gallop, Lancee, & Garfinkel, 1990; Olsen & Iwasiw (1989) and self-rating measures (LaMonica, Wolf, Madea & Oberst,1987). The clinical implications of these research studies are limited as they do not measure nurses' empathic behaviour within real life nurse-patient interactions.

Given the subjective nature of empathy, it is questionable whether external examiners can judge the accuracy with which the nurse understands the patient's experience in a natural setting and communicates it back to the patient. Rogers (1957, p. 99) stated that the mere presence or offering of therapeutic conditions to a patient is not sufficient for positive change. Rather these conditions, attitudes or styles of relating must be communicated to the patient - the patient must perceive them for change to occur. This study was particularly concerned with the patient's perception of the nurse's behaviour, and therefore selected a measure of empathy that assessed the perceptions of the patient.

## Self-Disclosure

"Self-disclosure may be defined as any information

about himself which Person A communicates verbally to a Person B.... The term refers to both a personality construct and a process which occurs during interaction with others" (Cozby, 1973, p.73). Cozby, in a review of the literature, refers to studies which have identified factors which influence self-disclosure as a personality construct: family patterns, religion, sex, race, ethnic group, social class, mental health, femininity, authoritarianism, sociability and extraversion, college achievement and interpersonal trust. Factors which influence self-disclosure as an interactional process are: reward/cost properties, reciprocity, liking, social approval, dependency and self-disclosure over time (the number of previous encounters).

Self-disclosure can be examined by referring to five basic parameters: a) amount of personal information disclosed (number of self-references per thought units expressed); b) intimacy of the information revealed; c) rate of disclosure (number of self-references expressed over a period of time); d) affective manner of presentation; and e) self-disclosure flexibility. Self-disclosure flexibility "refers to the ability of an individual to modulate his or her characteristic disclosure levels according to the interpersonal and situational demands of various social situations" (Chelune, 1979, p.6).

Research

Investigations include those relating to the amount of

self-disclosure elicited and its relationship to other variables. A study by Colten and Janis (1982) found that eliciting a moderate amount of (general) self-disclosure evokes more adherence to a medical regimen than eliciting a low amount of self-disclosure. They investigated client adherence in a weight reduction program. Counselors gave positive feedback to whatever the clients said in all groups. Those who were given only a low disclosure eliciting interview showed significantly less adherence to the counselor's recommendations (including significantly less weight loss) than those who were given a moderate-disclosure interview combined with a balance-sheet procedure. The latter procedure elicited additional self-disclosures concerning personal consequences of following or not following the diet. Janis (1983) refers to two other experiments which also support the hypothesis of the relationship of adherence and moderate self-disclosure. These are a study conducted by Quinlain & Janis (1982) at weight reduction clinics and a study by Mulligan (1982) with male college students in a Red Cross blood donor campaign. Janis contends that these research findings indicate that clients perceive the counselor as a motivating force when moderate levels of self-disclosure are prompted from the client by the counselor. The counsellor is perceived as a caring, supportive person who shows acceptance of the client and his or her weaknesses. Quinlan & Janis (1982) found

that eliciting a high level of self-disclosure resulted in less adherence than eliciting a moderate level of self-disclosure. Janis (1983) contends that when counselors elicit a high level of self-disclosure, clients become somewhat demoralized despite the positive feedback given to them by the counselor. They expect more from the counselor than what is being offered within the scope of the treatment program, that is, wanting to deal with other difficulties they are encountering in their lives.

Nursing studies on patient self-disclosure are limited in number. Johnson (1979) studied the relationship of anxiety and self-disclosure in nurses and patients. She also investigated the level of reciprocal disclosure occurring between nurses and patients on medical, surgical, psychiatric and critical care units. Patients and nurses completed Jourard's Self-Disclosing Questionnaire indicating the extent that they had disclosed information about themselves to each other and the State-Trait Anxiety Inventory. Johnson found that there were low levels of reported self-disclosure between nurse and patient subjects across all units. In regard to state/trait anxiety and self-disclosure of both nurses to patients and patients to nurses, there was a significant negative correlation between anxiety and self-disclosure in both groups. However a study by Byers, St. Onge, Atkins, Prokop & Grano (1988) did not find a significant relationship between state anxiety or

health worry and health and non-health self-disclosures from patients to clinicians. As in Johnson's study, subjects completed the State Trait Anxiety Inventory and Jourard's Self-Report Inventory (non-health self-disclosure) and as well, they completed the Health Worry Scale (designed for the study) and the Patient Self-Disclosure Questionnaire (Dawson, Schirmer, & Beck, 1984) on importance of self-disclosure on health related matters. Other findings relating to self-disclosure in this study were: nonhealth items were rated as less important to discuss with clinicians than were health items; Responses to Health Care items dealing with physical complaints and treatment were rated as more important than Lifestyle, and Personal Problems and Feelings items; there was a significant positive relationship between health and non-health self-disclosures.

Dawson (1985) examined differences in perceived empathy and self-disclosure in hypertensive patients attending a health care clinic. She controlled for the possibility that chronic illness would be a contributing factor to both perceived empathy and self-disclosure by using diabetics as a comparison group along with a non-chronically ill group of patients. Barrett-Lennard's Relationship Inventory was used to measure the clients' perception of clinician empathy. Patients rated health items, according to how difficult and how important it was for them to self-disclose to the

clinician, using the Patient Self-Disclosure questionnaire (Dawson et al., 1984). The study's findings were as follows:

1) overall, subjects reported low to moderate levels of perceived clinician empathy; non-chronically ill patients seeing female health care providers perceived more clinician empathy than those patients seeing male providers; hypertensive patients perceived less clinician empathy than non-chronically ill patients and diabetics;

2) overall, patients reported high importance and minimal difficulty in self-disclosing to their health care provider; hypertensive patients did not report less importance and greater difficulty in self-disclosing than other patients.

"Perhaps the two most clinically significant findings in this study were that all groups rated Responses to Health Care as the most important category of self-disclosure topics to discuss with their clinician, and that reported difficulty in discussing this content area was influenced by perception of clinician empathy" (Dawson, p.197). She concluded that these findings have implications for health care providers in their effectiveness in promoting patient adherence to a therapeutic medical regimen.

The current study also investigated the relationship between perceived empathy and self-disclosure. It differed from Dawson's (1985) study, in that it looked at the nurse's

communication style rather than the patient's medical condition as a possible variable of influence. As well, it measured the dependent variable - self-disclosure by analyzing the verbal content of the patient's communication, rather than using a self-report questionnaire.

Self-Disclosure as a Personality Construct

This study was concerned with the effect the nurse's communication style had on patient self-disclosure; however, the patient's general tendency to self-disclose to a health care provider was also considered as a possible factor influencing the degree to which the patient self-disclosed. "Complex human behaviors such as self-disclosure are currently assumed to be multiply determined through the interaction of both person and situation variables" (Chelune, 1979, p.5). Studies (Bem & Allen, 1974; Campus, 1974; Chelune, 1977; McGee & Snyder, 1975; Snyder, 1974; Snyder & Monson, 1975) suggest that in some areas "individuals differ in the extent to which their social behavior is consistent (trait-like) or variable (trait-free) across social situations" (Snyder & Monson, 1975, p. 637).

Wilson & Rappaport (1974) conducted a laboratory study in which they explored the conditions which affect self-disclosure. The study was framed within the context of expectancy theory, so that, self-disclosure was seen to be a function of both generalized (trait) and specific (situational) expectations. There were four study

conditions:

1. generalized expectation: measured by the Jourard Self-Disclosure Questionnaire (JSDQ). This instrument assesses the subject's disclosure tendency based on past and anticipated self-disclosing behaviour.

2. specific expectation: random assignment to one of two expectancy conditions. Subjects were told to expect the disclosure of personal information to be either easy or difficult.

3. interviewer's presentation: personal, impersonal or no disclosing behavior.

4. intimacy: six topics discussed, three topics of high intimacy and three topics of low intimacy value.

The dependent variable in the study was actual verbal self-disclosure for personal and impersonal discussion. Researchers found that JSDQ scores for anticipated self-disclosure, rather than recalled self-disclosure, predicted observed performance. The specific expectancy manipulation and the intimacy level of topics also had significant effects on self-disclosure. Interviewer behavior did not result in significant differences in the amount of personal or impersonal disclosure. They attributed this to the method of interviewer presentation - a single predetermined statement, rather than allowing the interviewer to respond to each of the topics. A three-way interaction between generalized and specific expectancy and topic intimacy was

also found. The authors' conclude "self-disclosure should be a considered result of the situational cues as well as previous cues that the subjects have internalized" (Wilson & Rappaport, 1974, p.907).

Based on the literature review, it is felt that self-disclosure as a personality construct, is an important extraneous variable, and therefore it was assessed in this study.

Self-Disclosure over Time

Taylor (1968) administered a self-disclosure questionnaire to male freshmen roommates after they had known each other for 1, 3, 6, 9 and 13 weeks. Half of the roommate pairs were both high revealers, while the other half were both low revealers. At all points in time, the high revealers reported more mutual disclosure than the low revealing dyads, although the rate of the increase over time was approximately the same for both groups.

The number of previous encounters between the nurse and the patient may influence the amount and rate of patient self-disclosure. To control for this, one of the criteria for the patients in the sample is that they should have been on the ward for no longer than 4 days.

Effect of Patient's Sex and Nurse's Sex on Self-Disclosure

In a literature review, Cozby (1973) found conflicting reports as to whether there are differences in self-disclosing behavior between men and women. Brooks (1974)

investigated the effect of client sex and counsellor sex on self-disclosure in a laboratory study, and found that male subjects disclosed more to female than male interviewers and female subjects disclosed more to male than female interviewers ($p<.05$), subject's disclosure was highest in dyads including a female regardless of whether the female was a subject or an interviewer ($p<.05$). To control for the effect of the patient's sex and the nurse's sex on self-disclosure, only female nurses and female patients were included in the study.

The literature review has identified factors which influence self-disclosure. They can be categorized under two broad headings: personality factors and socio-situational factors. A limited number of nursing studies were found to have used self-disclosure as a variable. Nursing studies (cited previously) have examined patients' responses to nurses who elicit their perceptions of a situation (Barron, 1966; Cameron, 1963; Elms & Leonard, 1966; Shields, 1978). These studies provide knowledge relating to the importance of patient self-disclosure.

## Summary

Symbolic interaction theory is the framework upon which the implications of the nurse's communication style (person/position-centeredness) were to be studied. According to symbolic interaction theory, an individual reacts to an object, individual or situation depending on

his or her interpretation of it (Blumer, 1969). Therefore, in studying the patient's response, this study examined both the nurse's communication style and how the patient interpreted the nurse's behavior.

A review of the literature on nurse-patient communication has found that nurses tend to offer advice and provide information rather than address the subjective experiences of patients (Graffam, 1990; Gallop et al., 1990; and Beaton, 1990). Studies investigating nurses according to degree of person-centeredness found nurses to be predominantly non-person-centered (Matthews, 1962; Wallston et al., 1978). However, no studies were found to have explored the effect that this has on the patient.

Nursing studies on empathy have been inconsistent in their findings as to whether nurses are empathic or not and what its relationship is with various demographic factors. "That this process is hard to measure is evident from the enormous body of literature on the definitional, operational and measurement problems associated with the study of empathy" (Gallop et al., 1990). Yet studies have identified it as an important area of study in bringing about desired patient outcomes (LaMonica et al., 1987; Williams 1979-80).

Research on self-disclosure has examined the construct as situation specific and as a trait. Several studies have determined the positive effect a moderate amount of self-disclosure has in adherence to a health regime. Nursing

studies on self-disclosure include: extent of self-disclosures exchanged between nurses and patients (Johnson, 1979) and factors influencing self-disclosure (Byers et al., 1988, Dawson, 1985, Johnson, 1979).

# METHOD

Conversations between nurses and first time mothers were tape recorded while mothers were bathing their babies. Content analysis was performed on both nurses' and patients' verbal communication to assess the degree to which nurses' were person-centered or position-centered and to determine the extent to which patients self-disclosed. Patients completed questionnaires on how empathetic they perceived their nurses to be during the taped conversations and on their personal tendencies to self-disclose on health related issues. A multiple regression analysis was performed: to determine the relationship between nurses' communication style and perceived nurses' empathy on amount of patient self-disclosure; and to control for the effect of patients' general tendency to self-disclose on actual disclosure during the interaction.

## Design

This study used a descriptive correlational design. This design was used because the study sought to capture what people thought and felt and how they behaved in their natural environments.

## Settings

The settings for this study were obstetrical wards at two hospitals. The Royal Victoria Hospital has two obstetrical wards with a 24 and 22 bed capacity. The Jewish

General Hospital has one obstetrical ward with a 40 bed capacity. Both hospitals have the following characteristics: (a) they have approximately 3,500 deliveries per year; (b) they provide care to high-risk obstetrical patients; (c) in general, patients with vaginal deliveries remain in hospital for about 2-3 days after delivery; (d) they encourage the mothers to room-in with their babies during the day and evening shift; (e) they have unlimited visiting hours for the husband or significant other and limited visiting hours for all other visitors; (f) nurses are expected to teach mothers about health concerns for the mother and baby including teaching new mothers how to bathe their babies; (g) nurses usually demonstrate how to bathe a baby on the day after vaginal delivery and the following day, the nurses observe the mothers bathing the baby (a return bath demonstration); and (h) the baby baths ordinarily occur during the day shift.

## Subjects

The sample was all available and willing registered nurses who were assisting mothers with their return bath demonstration and the mothers they were assisting. The postpartum units at the Royal Victoria Hospital had 57 nurses, all of whom were registered nurses. Of the 57 nurses, 18 were not available to participate in the study. Twelve nurses worked permanent evenings or nights, five worked weekends part time, and one had just been hired. The

postpartum unit at the Jewish General Hospital had 54 nurses: 13 of them were nursing assistants, the remainder were registered nurses. Of the latter group, 12 nurses were working permanent evenings or nights. Therefore between the two hospitals 68 nurses were available to participate in the study. Of the 68: three nurses refused to participate, two nurses failed to complete their questionnaires and/or their patient failed to complete their questionnaires, and near the end of the project one nurse went on vacation and one was deleted from the study due to technical difficulties with taping of the interaction. Therefore the sample consisted of 61 nurses. In five instances nurses were taped twice because of problems with the first taping (technical, patient withdrew from study, or father did bath), the data from the second taping were used for the study. All of the nurses on the units were female. Eligible patient subjects were first time mothers (gravida 1) who had vaginal deliveries. Criteria also included that: they be between the ages of 18-45 years old; their babies were rooming-in or in the regular nursery; and their stay on the ward would not exceed 4 days. Excluded were mothers who had developed complications other than an episiotomy, hemorrhoids, sore or cracked nipples. Mothers who had babies with complications, such as a congenital anomaly, were also excluded. The mothers had to be alert and able to read English, although they could interact with the nurse in French or English.

Homogeneity in length of stay in the hospital, sex and reason for hospitalization exerted some control over the number of extraneous variables to be considered in the study.

Of the 77 patients approached to participate in the study, 10 refused, 2 failed to return their questionnaires, 3 were deleted because of technical problems (with the tape), and in 1 case the father performed the baby's bath. Therefore there were 61 patients in the study.

## The Interaction

The return bath demonstration was chosen as the interaction to be studied. The nurse often uses this interaction to assess and address the health concerns of the new family, particularly the needs of the mother and the baby. The nurse assesses how the mother handles the baby, how comfortable she appears with the baby and whether mother and baby bonding seems to be occurring. The nurse can impart information about care that has been found to be beneficial for the mother and the baby. The nurse may find out what resources are available to the mother.

The mother, in handling the baby, may voice her concerns about herself and her family. She may share her beliefs, knowledge and opinion about the care she feels the baby needs. She may examine the baby and share her observations. She may express how she feels about the care she and the baby have received from the health team. She

may express how she feels physically and psychologically, such as feelings of fatigue, pain, anxiety or joy.

It is possible that other individuals may be present during the return bath demonstration, such as the father of the baby. Only the mother's communication was analysed for its self-disclosure. The presence and the relationship of the third person to the mother was recorded, and in 75% of the cases no one else was present. Third person(s) present during the recording included only the baby's father (13%), other relatives (2%), only a second health team member (8%), and baby's father and a second health member (2%).

## Instruments

### Measurement of Person-Centered/Position-Centered Communication

This study used Kasch and Lisnek's (1984) coding scheme (appendix II-a) to classify nurses' communication style as to their degree of person-centeredness or position-centeredness.

There are two instruments available which measure the degree of person-centered responses present in a nurse's communication, Matthews' (1962) coding scheme and Kasch and Lisnek's (1984) Message Coding System. Matthews' coding scheme has been used in three studies (DeVellis et al., 1984; Matthews, 1962; Wallston et al., 1978) and in these studies it was tested for its reliability. Kasch and Lisnek's Message Coding System closely follows Applegate's

(1978) coding categories for person-centered communication except that it has been adapted to apply to interactions between nurses and patients. The decision to select Kasch and Lisnek's coding scheme was based on the following reasons:

1. The Message Coding System has a theoretical basis in which the nurses' communication is tied to a particular nursing objective, that of regulating patient behavior so that "nurses can use communication to influence the health relevant beliefs and behaviors of patients" (Kasch, 1984).

2. The Message Coding System is grounded specifically in the distinction between position-centered and person-centered speech, whereas Matthew's coding schema is based on person-centered and non-person-centered responses.

3. The Message Coding System is more specific in its definition of the different nursing communication styles.

4. The Message Coding System attributes a positive value to the nurse providing the patient with information about health concerns, as this implies the nurse recognizes the patients' ability to reason and be autonomous, whereas provision of information in Matthews' coding schema is deemed neutral and not given any value.

5. Eliciting of information in the Message Coding System is tied to its appropriateness in meeting the nursing objective of patient adherence to a plan of care, whereas eliciting any kind of information from the patient is seen

as positive in Matthews' coding schema.

The nurse assisting a mother with the baby's bath can be viewed as a regulative function in which the nurse attempts to influence the mother's health behaviours, so that the Message Coding System is appropriate to the nursing situation under study. Also Matthew's coding system "tends to confound disclosure, empathy and information giving" (Kasch & Lisnek, p.65).

Kasch and Lisnek's (1984) message coding system is a content analysis procedure. "Content analysis denotes a research technique for the systematic ordering of communication processes. Typically it involves procedures for division of content into units, for assignment of each unit to a category or to a position on a metric, and for summarizing or otherwise manipulating coded units to provide a basis for inference concerning their significance" (Marsden, 1971, p.345-6). Several nursing studies have used content analysis (DeVellis et al., 1984; Kalisch, Kalisch, & McHugh, 1982; Powers, Murphy, & Wooldridge, 1983; Swider, McElmurry & Yarling, 1985).

The Message Coding System contains three major categories with three hierarchically ordered sublevels. The ascending levels reflect an increasing degree of person-centeredness. Category I "contains communication strategies that deny or ignore the perspective of the patient, evaluate patient behavior in terms of deviation from rules and norms,

and rely on the power inherent in the role of nurse for controlling patient behavior" (Kasch & Lisnek, p.65). In Category II, " the nurse implicitly displays an understanding of the patient's feelings, beliefs, and motivations, recognizes the patient's reasoning ability and autonomy; but does not elaborate the psychological features of the situation on regulating and advising the patient" (Kasch & Lisnek, p.66). In Category III, strategies are coded "according to the degree to which they reflect increasing recognition and elaboration of the psychological perspective of the patient, that is, increasing person-centeredness" (Kasch & Lisnek, p.68). In a preliminary test of the coding scheme for this study, interrater reliability among three untrained judges was calculated for percentage agreement between judges with 81% agreement for category and 58% agreement for subcategory.

In presenting the coding system, Kasch and Lisnek (1984) did not designate the unit of analysis or describe how it should be scored. For the purpose of this study, the nurse's utterance was determined to be the unit of analysis. An utterance is defined as "an uninterrupted chain of spoken or written words not necessarily corresponding to a single or complete grammatical unit" (Allen, 1990, p.1353). A person-centered score for each respondent was obtained in the following manner: Each of the categories (3 in all) and each of the subcategories (3 under each of the categories)

were assigned a value according to their rated level, with the most person-centered level of response receiving the highest value (a 3 for the category level and a 9 for the subcategory level) and the most position-centered level of response receiving the lowest value (a 1 for either category or subcategory level). A value for communication style was obtained by calculating the mean score (totalling the values for each of the units of content and dividing the sum by the number of units (utterances) in the interaction).

Measurement of Perceived Empathy

Perceived empathy is one of the variables which can be measured in the Barrett-Lennard Relationship Inventory (RI), an instrument used to assess the patient's perception of a therapeutic relationship (appendix I-c). Each variable in the instrument contains 16 statements, each representing either a positive or negative expression of the therapeutic condition. A patient rates each item from +3 to -3 : "I feel it is probably true (or not true) ", "I feel it is true (or not true)', "I strongly feel that it is true (or not true)", thus reflecting clarity and strength of the patient's view. The scores for each variable can range from -48 to +48.

The stability of the RI has been assessed in 14 studies of internal reliability and in 10 studies of test-retest reliability (Gurman, 1977, p.508). The mean internal reliability coefficient across these studies for the empathy

subscale is 0.84. The mean test - retest correlation for the empathy subscale is 0.83.

Evidence exists for the validity of the instrument. The items have been judged by experts for their content validity (Gurman, 1977, p.506). The RI has been found to be predictive of therapeutic outcome in several studies (Barrett-Lennard, 1962; Kurtz & Grummon, 1972), thus establishing its criterion-related validity. In terms of construct validity, Caracena and Vicory (1969), found the RI to be significantly correlated with conceptually related interviewer behavior and nonsignificantly correlated with conceptually unrelated interviewer behaviors. A review of studies in which a factor analysis was done found the intercorrelation to reflect Barrett-Lennard's conceptualization of the therapeutic relationship (Gurman,1977).

In order to limit the possibility of a consistency bias on the part of respondents, items from another variable in the RI, level of regard, were interspersed with the empathy items; only the empathy items were scored.

Measurements of Self-Disclosure

In this study, the dependent variable, self-disclosure, was measured as it varied according to different socio-situational factors. An objective instrument, Chelune's (1975) Self-Disclosing Coding System (SDCS) was used to measure this construct. Individual differences in self-

disclosure as a personality trait were recognized as a possible extraneous variable and were also measured, using a self-report instrument - Patient Self-Disclosure Questionnaire (Dawson, et al., 1984).

The Self-Disclosure Coding System (SDCS) is a content analysis procedure, which provides for the simultaneous analysis of all the parameters of self-disclosing behavior (amount, intimacy, rate, affective manner of presentation, and self-disclosure flexibility). The unit of analysis is the thought unit or an independent clause, this is elaborated in the instrument itself (appendix II-c).

In this study self-disclosure was analysed according to the amount of self-disclosure patients made to their nurses. The coding variables which relate to amount of self-disclosure are:

1. Amount (A), the number of thought units.
2. Self-references (SR), the number of thought units, which describe some quality or aspect of the speaker.
3. Self-reference percent (SR %), the <u>basic index of amount of self-disclosure</u>, and computed by the formula: SR % = SR/A.

The rationale for selecting the amount of self-disclosure as an indicator of self-disclosure was that it is an objective measure and requires a single observation. The intimacy and the affective manner parameters are subjective measures requiring that the coder judge the content. To

score self-disclosure flexibility, it is necessary to have repeated observations on a subject from different situations or from different points of time. Measuring rate of self-disclosure was not feasible because it was difficult to determine the exact amount of time patients spoke given interjections made by nurse, baby and/or third parties in the interaction. It would also be difficult to control for the effect of the mother's focus on the physical task of bathing the baby on the rate of self-disclosure.

All the SDCS variables yield a summary or total score based on the total data collected for a given situation. An inter-rater reliability coefficient was computed in Chelune's (1975) study for each process variable (variables scored for 30 second intervals of time, yielding 718 intervals scored by each rater) and for the summary variables (n = 72). The results of interest for this study were as follows: interrater reliability coefficients for process variables: A = .91, SR = .85; and for summary variables: A = .97, SR = .93, SR% = .81. The internal consistency of the process variables was obtained by the odd-even method after summing the two raters' scores for each 30 second interval; the results were A = .87 and SR = .83.

Construct validity for the self-disclosure parameters, as represented by the SDCS variables, was obtained in several ways in Chelune's study. A literature review had

indicated that several variables consistently affected levels of self-disclosure; females were reported to be higher self-disclosers than males; sensitizers verbalized more and elaborated their emotional experiences more than repressors, and subjects varied their levels of self-disclosure depending on the receiver or target person. (Chelune, 1975, p.50). In accordance with expectations, Chelune found that females expressed a greater number of thought units ($p<.05$) and disclosed at a higher rate ($p<.05$) than did males; sensitizers verbalized more in terms of thought units ($p<.10$) and at a higher rate of disclosure ($p<.10$) than did repressors, and significant interview condition differences were observed in the number of thought units expressed ($p<.001$) and the rate of disclosure. As well, construct validity was measured for its discriminative function. Four taped interviews were selected on the basis of sex and high versus low coded scores on A, SR% with A (thought units) controlled. The subjects (from a different test group) rated each taped interview for self-disclosure amount and specificity, using the self-disclosure perception scale. The speakers on the high disclosing tapes were rated as significantly higher in both amount ($p<.05$) and specificity ($p<.001$).

The Patient Self-Disclosure Instrument (PSDI) was chosen to measure self-disclosure as a personality construct because it relates specifically to patient-clinician

situations (Dawson et al., 1984). Differential disclosure may relate to differences in the target person and the topic in a questionnaire (Chelune, 1979). The PSDI (appendix I-d) contains some items adopted from other instruments: those of Jourard, and Taylor and Altman (cited in Dawson et al., 1984). The authors added others that seemed particularly pertinent to the health care setting. The instrument contains seven items for each of three content areas; Personal Problems and Feelings, Response to Health Care, and Lifestyle. The 21 items are rated on a 7 point scale, first for the importance of patient self-disclosure (1 as "not important", 7 as "extremely important") and then for the difficulty of self-disclosure (1 as "not difficult" and 7 as "extremely difficult"). Total scores are obtained by summing the ratings over all items, subscale scores are obtained by summing the ratings of the seven items in each content category.

The reliability and validity of the instrument has been tested in several studies (Dawson et al, 1984; Dawson, 1985, Byers, Lipe & Collins, 1989). The total scale and the subscales were shown to have substantial internal consistency in a study by Dawson et al. (1984): Cronbach's alpha for the total scale was .92 and for Personal Problems and Feeling items .89, for Responses to Health Care items .86 and Life Style items, .76. Test re-test reliablity coefficients also were high; for the total scale r = .85 and

for Personal Problems and Feelings r = .87, Responses to Health Care r = .88, and Life Style r = .81. The subjects in the study were employees of a technical college. In another study (Dawson, 1985), in which the PSDI was used to rate self-disclosure on outpatients in a clinic setting, Cronbach's alphas for the subscales on the importance of disclosing were .91 for Personal Problems and Feelings , .79 for Responses to Health Care and .87 for Life Style items. Similarly for the difficulty of disclosing they were .93, .82 and .86 respectively.

Dawson et al. (1984) presented the following summary of tests of validity on the PSDI instrument. The content validity of the instrument was judged by both patients and clinicians (nursing and medical experts). Previous research had found a relationship between self-disclosure and locus of control, and self-disclosure and perceived empathy; using PSDI to measure self-disclosure, the expected relationships emerged. As well, there was the expected correlation between physiological response (heart rate) to self-disclosure and ratings of difficulty to disclose on items. The construct validity was tested by performing a factor analysis on the items; the results confirmed the "conceptualization of self-disclosure into three different content areas representing distinct dimensions of patient difficulty in disclosing ..." (Dawson et al., 1984, p.42). Byers et al. (1989) tested the validity of the "importance"

rating scale on the PSDI. They examined the differences in ratings between medical and mental health patients. In mental health the Personal Problems and Feelings scale was rated significantly higher than the Responses to Health Care and the Lifestyle scales. In medical subjects the Responses to Health Care scale was rated significantly higher than the Lifestyle scale and Lifestyle scale was rated significantly higher than the Personal Problems and Feeling scale. Byers et al. (1989) also found a significant correlation between the PSDI and Jourard's SD-25. The results attest to the validity of the PSDI.

## Procedure

Ethical approval was granted by the relevant review committees. The study was explained to the head nurses of the obstetrical units and the practical details were worked out about the recruitment of subjects and conduct of the study. Meetings were arranged with the head nurses and the nursing staff of the obstetrical units for presentation of the details of the proposed study (appendix III). Nurses were assured that their involvement in the study would remain strictly confidential. They were then approached individually to provide further explanation about the nature of the study and to ascertain if they were interested in participating. If they were, they were given the opportunity to ask further questions and then asked if they were willing to give their consent to participate in the

study (appendix IV).

Plans were made at the start of the day shift by asking either the nurse in charge or nurses on the ward if they knew of or had patients who were scheduled to give a return bath demonstration (either for that day or for the following day) and if the patients met the sample criteria. If the nurse who was assigned to a patient who met the criteria consented to participate in the study then that patient was considered a potential candidate for the study. The nurse was asked to approach the patient to inform her that a researcher was interested in talking with her (the patient) and ask if her name could be released to the researcher. If the patient consented to this, the patient was approached, presented with the details of the study (appendix III), and if she was willing to participate, she was asked to sign the consent (appendix IV). The patient's nurse was then notified of the patient's willingness to participate and the intention to tape the interaction. The researcher arranged with the nurse and the patient to be called when the return baby bath was about to occur.

The tape recorder was placed beside the equipment for the bath which was either on the patient's overbed table or on the bed. This was a feasible location, as the nurse and patient never strayed far from the baby and the equipment needed for the bath, therefore their voices were picked up quite well. Unfortunately when the baby was crying this also

was picked up clearly on the tape. The tape was turned on by the researcher once the mother or nurse entered the unit with the basin of water; the researcher then left the unit and waited outside the patient's room. This was done partly to explain to people wanting to enter into the room what was taking place and to ask them if they were willing to return a little later. If they said they could not wait they were free to enter the room. The researcher reentered the room when she heard the nurse or patient empty the bath water, at which time the researcher turned off the tape recorder. The quality of the tapes also depended on whether there was alot of other activity and/or noise in the room, which was especially problematic in a room shared with other patients.

Once the interaction was over, the researcher administered the questionnaires, the Relationship Inventory (RI) first and then the Patient Self-Disclosure Instrument (PSDI). The rationale for this sequence was that the Relationship Inventory is an instrument which measures the patient's perception of the interaction which has just taken place, whereas the Patient Self-Disclosure Instrument is a measure of the patient's general tendency to self-disclose. The Patient Self-Disclosure Instrument may distract the patient from her initial response to the interaction (Relationship Inventory). The researcher left the patient to fill out the questionnaires, returning to pick them up from the patient on the same day or, if this was not convenient

for the patient, on the following day. Five patients were discharged before they had filled out the questionnaire, 3 out of the 5 returned the questionnaire by mail (having been given an addressed and stamped envelope) as was requested.

## Data Analysis

### Content Analysis

Two of the instruments required content analysis. The Message Coding System and the Self-Disclosure Coding System (SDCS), were used to code the nurses' and the mothers' verbal communication respectively. Up to 9 minutes of an interaction were transcribed and then coded for the nurse's communication style and for the patient's self-disclosure. If an interaction was less than 9 minutes long, all of the interaction was written down. If it was longer than 9 minutes, the first 3 minutes, the middle 3 minutes and the last 3 minutes of the interaction were transcribed. The interactions ranged from 5 to 30 minutes in length. All the tapes were either transcribed by the researcher or the researcher checked the transcripts for their accuracy if they had been transcribed by someone else.

All data were coded by the investigator, but in order to enhance and test reliability, a training program and reliability check were developed. The investigator and a second coder were trained by discussing the category system and coding 3 interactions followed by a discussion of each. As a result of these training sessions the investigator

clarified both coding schemes. The investigator developed quidelines for the Message Coding Scheme (appendix II-b) and the Self-Disclosing Coding Scheme (appendix II-d).

In the Message Coding System the unit of content coded for nurses' communication style was the nurse's utterance. The utterance was scored according to its most person-centered component by category and then by subcategory within the chosen category.

In the Self-Disclosing Coding Scheme, used to analyse the mothers' communication pattern, the unit of analysis was the thought unit. For this study the unit of analysis was expanded beyond an independent clause. The unit of analysis also included responses to which a thought was implied based on what the nurse had just said previously:

e.g Nurse: "Are you feeling more comfortable handling the baby?"

Mother: "Yes" (implies - "Yes I am feeling more comfortable handling the baby.")

The results of the 3 cases were incorporated into the main data analysis but not into the tests of reliability.

Interrater and test-retest reliability were determined on both coding systems to estimate the investigator's consistency in coding the data over time. In referring to the percentage of interrater agreement Topf (1986) states that there is some consensus among behavioral scientists that an average of 70% is necessary, 80% is adequate, and

90% is good. Interrater reliability was determined on 20% of the remaining sample (excluding the 3 cases used in training process). One year after having completed the coding, the investigator recoded 10% of the sample as a means of assessing test-retest reliability.

Percentage agreement between coders on the Message Coding System was calculated for both category and subcategory. For the 3 training cases the percentage agreement for category between coders was 81%, 75.8% and 93% (mean 83%) and for subcategory it was 76%, 73% and 71% (mean 73.3%). For 20% of the remaining cases: the percentage agreement for the category was 76% and for subcategory it was 69%. For test-retest reliability the percentage agreement for category was 87% and for subcategory it was 81%.

The Self-Disclosing Coding System was tested for unitizing reliability (consistency in the identification of what is to be categorized across time and/or judges). The need to assess for unitizing reliability depends in part on the degree of observer inference required to identify the unit to be coded (Garvin, Kennedy, & Cissna, 1988). For example, as with the Message Coding System, when the unit of analysis is a person's turn at talk a low degree of observer inference is needed, and therefore unitizing reliability was not performed on the nurses' communication. In the Self-Disclosure Coding System the ability to identify the unit of

analysis was determined to be less clear and therefore it was assessed. In the 3 training cases the percentage agreement in identification of the unit of analysis (thought units and implied thought units) in the transcripts was 76%, 92% and 100% (mean = 89%). For 20% of the remaining sample the percentage agreement between coders was 84%. The percentage agreement for test-retest reliability on 10% of the sample was 88%.

Interrater reliability was calculated on the rating of amount of self-disclosure (percentage of self-references) yielding Pearson correlation coefficient of .9635 ($p<.01$) on 12 subjects. Test-retest reliability on the amount of self-disclosure yielded a correlation coefficient of .9374 ($p<.01$) on 6 subjects.

Given that the researcher acted as the coder of the data, measures were introduced to prevent bias. The interactions were identified only by code number and these numbers were hidden so the coding would not be influenced by the impression the nurse or the patient made on the researcher. The researcher did not tally the scores for all of the instruments until she had gathered all the data from all the sample subjects, except for those involved in the training project.

Statistical Analysis

The original plan for analysis was to conduct a two-way analysis of variance to determine whether self-disclosure

scores would differ between patients with high person-centered nurses and those with low person-centered nurses; and whether these differences in self-disclosure scores would differ in the same way for high and low levels of perceived empathy. The groups in the study were not found to be distinctly different for both independent variables. For perceived empathy 97% of the scores fell on the positive side of the scale, i.e. almost all of the nurses were perceived as being at least somewhat empathetic. For communication styles 98% of the scores fell approximately in the middle of the possible range in scores, making them neither extremely person-centered nor non-person-centered. Rather than create an arbitrary division between the scores (such as the mean for each of the variables) by which to define the comparison groups, a decision was made to analyse the data using a multiple regression technique. "Regression analysis is a statistical tool for evaluating the relationship of one or more independent variables X1, X2 .... Xk to a single, continuous dependent variable Y. It is most often used when the independent variables, cannot be controlled ...." (Kleinbaum, Kupper, Muller, 1988, p.36). A multiple regression technique serves to characterize the relationship between the independent and dependent variables by determining the extent, direction and strength of the association, and therefore will provide more information than the ANOVA will. It also can determine which of several

independent variables are important and which are not for describing or predicting a dependent variable. Multiple regression analysis can also control for the effect of other variables which might have an important relationship with the dependent variable. Therefore it could be used to determine whether communication style and/or perceived empathy were important in predicting the extent to which a patient would self-disclose while controlling for personal differences in self-diclosure as a trait.

Sample Size

"If either standard multiple or hierarchical regression is used, one would like to have 20 times more cases than IVs. ... However a bare minimum requirement is to have a least 5 times more cases than IVs ..." (Tabachnick & Fidell, 1989, p. 129). This study enters two independent variables into a standard reqression equation and has a sample of 61 subjects, which is ample in its ratio of variables to cases. When controlling for personal self-disclosure four variables enter into the hierarchical regression equation; this meets the minimum requirement for ratio of variables to cases.

# RESULTS

## Description of Sample

Background characteristics of the nurse sample are found in Table 1. The majority of the nurses' were 40 years of age or under (72%). The nurses varied in their number of years of nursing experience and most were diploma graduates. Background characteristics of the patient sample are found in Table 2. Most of the patients were between 21 and 30 years of age. The majority of the patients were married and had completed high school. The patients' reported ethnic backgrounds and occupations were quite diverse.

There was variation in the length of time the patient had known the nurse. Forty-three percent of the nurses were caring for the patient for the first time; 47% had had the patient the previous day; 8% had cared for the patient 2 or 3 days previously; 2% did not answer the item. Forty-six percent of the nurses had also given the patient the first baby bath demonstration.

Patients may vary in their willingness to participate in a return bath demonstration; some patients may feel pressured into it, while others may be eager participants. In this study 84% were "very interested", 15% were "interested" and 1% were "not interested".

Analyses were performed to see if any of the demographic factors were related to two of the variables

Table 1

Demographic Characteristics-Nurses

| Variables | % | n = 61 |
|---|---|---|
| Age | | |
| 21-30 years old | 41 | |
| 31-40 years old | 31 | |
| 41-50 years old | 15 | |
| 51-60 years old | 7 | |
| no response | 6 | |
| Years of Experience | | |
| < 1 | 12 | |
| 1-3 | 21 | |
| 4-8 | 16 | |
| 8-12 | 16 | |
| > 12 | 35 | |
| Educational Background | | |
| Nursing diploma | | 46 |
| Baccalaureate degree in nursing | | 26 |
| Masters degree in nursing | | 3 |
| Other | | 25 |

Table 2

Demographic Characteristics-Patients

| Variables | % | n = 61 |
|---|---|---|
| Age | | |
| under 20 years old | 3 | |
| 21-30 years old | 74 | |
| 31-40 years old | 20 | |
| 41-50 years old | 2 | |
| no response | 1 | |
| Marital status | | |
| single | 3 | |
| married | 84 | |
| living with someone | 13 | |
| Level of Education | | |
| Completed grade school | 2 | |
| Some high school | 5 | |
| Completed high school | 26 | |
| Attended university | 20 | |
| Completed university | 29 | |
| Other | 18 | |

Table 2 (continued)

| Variable | % |
|---|---|
| Patients' Occupation | |
| Service worker | 5 |
| Technical/semi-skilled | 7 |
| Sales | 8 |
| Clerical | 29 |
| Managerial/administrative | 10 |
| Professionals | 18 |
| Homemakers | 15 |
| Student | 3 |
| Other | 3 |
| No response | 2 |
| Patients' Ethnic Background | |
| English | 6 |
| Italian | 15 |
| Other European | 10 |
| Hispanic | 3 |
| Asian | 7 |
| Jewish | 7 |
| Black | 3 |
| Canadian | 31 |
| Other | 5 |
| No response | 13 |

under study. Chi square tests on several of the demographic factors (e.g. patients' and nurses' age, patients' educational and occupational background, nurses' education, and years of nursing experience) versus levels of perceived empathy (mean split) did not result in any signficant findings (p's>.05). One-way ANOVA's were carried out on several of the demographic variables (e.g. patients' age, level of education, ethnic background, interest in topic; nurses' level of education, and nursing experience, and familiarity or number of days nurse had cared for the patient) and self-disclosure (dependent variable) without any significant findings (p's>.05).

## Description of the Study Variables

The two independent variables in the study were communication style and perceived empathy. The Message Coding System used to analyse the nurses' communication styles has three major categories, each with three subcategories. The Relationship Inventory, which is a Likert scale ranging from +3 to -3, was used to measure perceived empathy.

Both the independent variables in the study proved to have limited range in their scores. For communication style by subcategory, 98% of the (mean) scores in the study fell between 3.0 and 5.6, out of a possible range of scores of 1 - 9. For communication style by category, 98% of the scores fell in the middle 2 quartiles (between 1.4 and 2.2)

out of the possible range of scores of 1- 3. Therefore the nurses' communication style scores were neither extremely person-centered nor position-centered. For the patients' perception of clinician empathy, 97% of the scores fell on the positive side of the scale. Therefore the vast majority of patients perceived their nurses to be at least somewhat empathetic in this study.

The dependent variable, patient self-disclosure was measured according to the amount of patient self-references yielding a percentage score: number of self-references divided by the number of thought units in the transcript. To control for personal differences in self-disclosure, data were collected using the Patient Self-Disclosure Instrument. In terms of self-disclosure as a personality trait: approximately 90% of the scores for "difficulty in self-disclosing" fell below the middle of the scale (<4.0); that is in general the patients in the study do not have difficulty self-disclosing on health matters. In terms of importance of self-disclosing on health matters, approximately 85% were above the middle of the scale (>4.0); that is, in general they feel it is important to self-disclose on health matters.

Table 3 shows the mean, standard deviation, and range of scores for the variables in the study.

Table 3

Descriptive Statistics of Study Variables

| Variable | M | S.D. | Range |
|---|---|---|---|
| Communication Style | | | |
| Subcategory | 4.1 | 0.5 | 2.8 - 5.7 [a] |
| Category | 1.9 | 0.2 | 1.4 - 2.5 [b] |
| Perceived Empathy | 1.6 | 0.8 | - 0.6 - 3.0 [c] |
| Self-Disclosure | | | |
| Self-references | 0.11 | 0.09 | 0.00 - 0.47 [d] |
| Difficulty | 2.8 | 1.0 | 1.0 - 5.9 [e] |
| Importance | 5.2 | 1.1 | 2.6 - 7.0 [f] |

NOTE. [a] 1 least person-centered, 9 most person-centered

[b] 1 least person-centered, 3 most person-centered

[c] -3 strongly unempathetic, 3 strongly empathetic

[d] possible range 0.00 - 1.00

[e] 1 not difficult, 7 extremely difficult

[f] 1 not important, 7 extremely important

## Test of Hypotheses

Analyses were performed using data on communication style according to both category and subcategory with no significant differences in the results for any of the multiple regression equations performed in this study. The findings presented in this chapter are based on scores by category for the communication style variable given that these ratings proved to be more reliable than those by subcategory.

Multiple regression analysis was performed to determine:

1. whether patients' self-disclosure is directly related to communication style (person-centeredness) and perceived clinician (nurse) empathy; and

2. whether perceived empathy is more important than communication style (person-centeredness) in predicting the extent to which a patient will self-disclose.

Multiple regression analysis was performed using the SPSSX REGRESSION procedure (SPSSX Incorporated, 1983). The squared multiple correlation ($R^2$) represents the proportion of variation in the dependent variable that is predictable from the best linear combination of the independent variables (Tabachnick & Fidell, p.135). There is an overall inferential test for multiple R (analysis of variance with an F ratio). There is also a significance test evaluating the unique contribution of each of the independent variables

(T-tests of the semipartial correlations). These express the unique contribution of an independent variable to the total variance of the dependent variable (Tabachnick & Fidell, p. 151). Squared semipartial correlations ($sr^2$) indicate the amount by which $R^2$ would be reduced if an independent variable were omitted from the equation (Tabachnick & Fidell, p. 180).

A standard multiple regression was performed with amount of self-disclosure (SD) as the dependent variable and communication style (CS) and perceived empathy (PE) as the independent variables, ($r^2$ = .2208, F(2,58) = 8.56566, p<.01). The unstandardized regression coefficient (B), the intercept, the standardized regression coefficients ($\beta$), the correlation between the independent variable and the dependent variable (corr), the squared semipartial correlations ($sr^2$), and the T values for the semipartial correlations are shown in Table 4.

In testing the unique contribution of each independent variable to the variance in self-references, perceived empathy was found to be nonsignificant. Only communication styles contributed significantly to the prediction of the amount of patient self-references. Altogether 23% of the variability in the amount of self-disclosure was predictable from scores on communication style and perceived empathy.

In assessing the first hypothesis: the nurse's communication style did contribute to the prediction of

Table 4

Standard Multiple Regression of Communication Style (CS) and Perceived Empathy (PE) on Amount of Self-Disclosure (SD)

$R^2$ = .2280

Multiple R = .4775**

Standard Error = .0780

| Variables | B | beta | corr | $sr^2$ | T df=58 |
|---|---|---|---|---|---|
| PE | -.0184 | -.1628 | -.1606 | .0265 | -1.411 |
| CS | .2061 | .4470 | .4489** | .2022 | 3.898** |
| Intercept | -.2602 | | | | |

** p<.01

self-disclosure. The more person-centered the nurse was the more the patient self-disclosed. Perceived empathy did not contribute significantly to the prediction of patient self-disclosure. A non-significant inverse relationship was found between perceived empathy and self-disclosure, providing no support for the hypothesis that the more the patient perceived the nurse to be empathetic the more the patient would self-disclose. Therefore the first hypothesis was only partially supported. Note: there was no correlation found between communication style and perceived empathy (r=.0048, p>.05).

In terms of the second hypothesis: only communication style was found to be significant (as noted by the test of

regression components, t-tests on the semipartial correlations); $sr^2$ was .2022 for communication style and .0265 for empathy. Therefore the second hypothesis was rejected, that is, communication style was more important in predicting the amount of patient self-disclosure than was perceived empathy.

When an extra predictor variable was added to the model to test for the interaction effect between the two independent variables, the t values (df=57) were non-significant for each of the variables (empathy t = -1.585, communication style t = .313, interaction t = 1.461) indicating overlap in variance between the variables. For the 3 variables in the equation R square was .2559, $sr^2$ for empathy and communcation style was .2280, $sr^2$ for the interaction was .0279. Therefore the addition of an interaction term did not contribute significantly to the equation (perceived empathy and communication styles on self-disclosure).

Hierarchical regression was used to determine the relationship between empathy (PE) and communication styles (CS) on self-disclosure as a situational construct (SD) while adjusting for initial differences between the mothers in self-disclosing (personality construct) on health care issues. Table 5 shows the unstandardized regression coefficients (B) and intercept, the standardized regression coefficients ($\beta$), the correlation between the independent

Table 5

Hierarchical Multiple Regression Controlling for Reported Importance(IMPT) and DIfficulty (DIFF) in Self-Disclosure on Observed Self-Disclosure(SD)

$R^2$ = .2881

Multiple R = .5368**

Standard Error = .0761

| Variables | B | beta | T df=56 | correl | sr square |
|---|---|---|---|---|---|
| DIFF | -.0223 | -.2446 | -2.137* | -.3038* | .0923* |
| IMPT | -.0039 | .0483 | .417 | -.0261 | .0006 |
| CS | .1888 | .4127 | 3.598** | .4489** | .1626** |
| PE | -.0210 | -.1855 | -1.603 | -.1606 | .0327 |
| Intercept | -.1802 | | | | |

* p<.05 ** p<.01

and extraneous variables on the dependent variables (corr), the semipartial correlations ($sr^2$) and R and $R^2$ after entry of all 4 independent variables.

With the extraneous variables "difficulty" (DIFF) and "importance in self-disclosing" (IMPT) on health issues entered first (step 1 and 2 respectively) communication style still contributed significantly to the prediction of self-disclosure (t value = 3.6, p<.01). Perceived empathy and importance of self-disclosing did not add to the

prediction of self-disclosure ($p>.05$). Personal difficulty in self-disclosure (DIFF) did contribute significantly to the prediction of self-disclosure ($P<.05$). There was an inverse relationship between difficulty in self-disclosing and observed self-disclosure; that is, greater reported difficulty in self-disclosing on health related matters was associated with less observed self-disclosure behaviour.

# DISCUSSION AND CONCLUSIONS

This study explored how interpersonal orientations are actualized in everyday interactions. More specifically, two communication styles representing two particular interpersonal orientations employed in nurse-patient interactions, were examined. The nurses' communication style was characterized as either person-centered or position-centered. The message that nurses transmit when they use a person-centered communication style as opposed to a position-centered response is that they are attempting to understand of the patients' unique viewpoint of a particular situation.

Based on symbolic interaction theory, it was anticipated that patients would respond to the two distinct communication styles according to their interpretation of the nurses' behaviour. Given the message being conveyed in each of the communication styles, it was thought that patients could be asked to interpret the nurses' communication style according to how empathic the patient found the nurse to be. Patients would then respond by self-disclosing to varying degrees.

This study presupposed that:

1. nurses would vary in their communication style

2. patients' perception of the nurses' communication style might or might not match the message the nurse was

trying to convey, so that both the person-centered approach and the position-centered approach used by the nurse could be interpreted by the patient as either empathic or not.

3. patients' interpretation of the nurses' communication style (perceived nurse empathy), rather than the actual communication style, would be more important in predicting the extent to which patients would self-disclose.

## Communication Style

Ninety-eight percent of the nurses in the study fell within the middle range of the Message Coding System. Therefore nurses were neither strongly person-centered nor position-centered. The levels in the middle category of the Message Coding System (Kasch & Lisnek, 1984) reflect the nurses use of rules and rationales and the provision of information about required health care. Studies using Matthews' schema for person-centeredness (Matthews 1962, Wallston et al. 1978) also found that nurses did not rate highly on person-centeredness. This study also supports Hills and Knowles (1983) findings that the major content of nurses' communication to patients consists of conveying information to patients.

## Relationship Between Communication Style and Perceived Empathy

No correlation was found between communication style (person-centeredness) and perceived empathy. A study by Stetler (1977) also found that high empathizers (as rated by

role playing patients) did not differ from low empathizers on various positive communicative behaviours.

Ninety-seven percent of the patients in this study rated their nurses as being empathic (positive rating). This is consistent with the findings in Forsyth's (1978-79) study, where 98% of the nurses were rated as highly empathic by their patients. Forsyth (1982-83), Rogers (1986), and LaMonica (1987) found that patients' ratings of nurses (nursing students in Rogers' study) were consistently higher than nurses' rating of themselves. Forsyth suggests that clients perceive all nurses as empathic whether they are or not. This phenomenon will be further examined later on in the discussion.

## Relationship between Communication Style, Perceived Empathy and Self-Disclosure

The most important finding in the study was that the more person-centered the nurse was in her communication style the more the patient self-disclosed. It is particularly meaningful because it is based on actual behaviour rather than perception or self-report of behaviours. The relationship was significant, despite the narrow range of nurses' behaviours, indicating that even moderate differences in nurses' communication style have an effect on patients' response.

However, contrary to symbolic interactionism, perceived empathy did not help to predict the degree to which a

patient would self-disclose. Several authors (Zderad, 1969; Ehmann, 1971; Squier, 1990) have described the purpose of empathy as a means of gaining an understanding of the patient. Therefore, there needs to be an examination of why perceived empathy did not play a role in the degree to which a patient self-disclosed. Three factors in the study design may have had an effect: self-report after the fact, the operationalization of empathy in practice and how self-disclosure was measured. These will be further discussed below.

Self-Report Measures

ten Have (1990) commented on seeking self-reported data relating to a recorded conversation, "It may be very hard for participants to reconstitute after the fact the moment-by-moment interweaving of meanings in interaction" (p.37). This indicates the difficulty of ascertaining what the patients' thoughts were, which prompted their specific responses, at the time of the interactions. In this study subjects were not asked to reconstitute specific meanings, but to give an overall interpretation of the nurse's behaviour after the fact. The interpretations did not correlate with either the nurses' or the patients' behaviour. It may be that the meaning given to the nurses' communication style is implicit in how patients respond or the degree to which they disclose, and the determination of recalled interpretations of the conversation may not be

necessary or reliable.

Self-report rating scales can be subject to response set biases. The social desirability response set "refers to the tendency of some individuals to misrepresent their attitudes by giving answers that are consistent with prevailing mores" (Polit & Hungler, 1987, p.256). This might explain why both variables "perceived empathy", as measured by the Relationship Inventory, and "importance in self-disclosing on health matters", as measured by the Patient Self-Disclosure Instrument, failed to predict the degree to which patients actually self-disclosed. Patients may have given responses which they felt were more acceptable or socially desirable, and therefore the instruments were perhaps less reliable in determining how these factors affected patient self-disclosure.

Tessler and Mechanic (1975) noted that when one is dependent, it is uncomfortable to accept the view that care is less than adequate. High empathy ratings may reflect the need by the patient to maintain a sense of confidence in health care providers. Patients may also be reluctant to criticize the nurses on whom they are somewhat dependent, for fear of retaliation, even if they have been assured by the researcher that the information will remain confidential. It is possible that the patients who felt themselves to be in a vulnerable position rated nurses more positively and they might also have been more reluctant to

self-disclose. Therefore a possible explanation for the lack of a relationship between perceived empathy and self-disclosure may be that within the given nursing situation a self-report measure may not have accurately measured the patient's perception of the nurse's behaviour due to a response set bias. This study might have taken the opportunity to control for certain response set biases in order to have had a more reliable measure of empathy.

Empathy as an Operational Construct in Nursing Practice

The findings may also be explained by the operationalization of the empathy construct within the particular nurse-patient interaction chosen for this analysis. Characteristics of the situation potentially influencing perceived empathy include: the short length of the relationship with the resulting patients' sense of the need to self-disclose and the particular circumstance of the new mothers' need for information.

A nurse, who was more person-centered in her approach, may have wanted to gain a greater understanding of the patient's particular situation. In doing so, she may have asked questions and sought clarification from the patient. At this early stage in the relationship, it seems plausible that nurses may have varied in their ability to reflect back to the patient the patient's experience at the time. It is possible that in a short-term relationship a patient who thought the nurse did not understand her situation fully

(not "highly" empathic) might tell the nurse more about her situation (further self-disclose).

The nurse, who was more position-centered in her approach, would have been less likely to seek out the patient's individual perspective. She might have presented herself as knowing what was best for the patient. It seems plausible that some patients might have accepted this approach. They might have felt that the nurse, based on her knowledge and experience, was in fact acting on their behalf. Other patients might have resisted the more position-centered approach and felt that their concerns were not being heard. As well, it may be that, in some cases, what the more position-centered nurses had to offer to the patient coincided with what the patient required at the time. At this point, a new mother, who was close to being discharged after a short hospitalization, might have been more interested in the nurse's perspective on how a baby "should" be cared for rather than exploring her own thoughts and feelings on child care. As a result, patients may have varied as to how satisfied they were with what the nurse was offering to them or how empathic they found their nurse. Some patients with the more position-centered nurses may, for whatever reason, have found their nurses to be "highly" empathic to their situation and they may have felt there was no need to self-disclose.

Thus self-disclosure may depend on the extent to which

the nurse encourages or discourages it and whether or not patients think further disclosure is required. This seems to exemplify the precepts of symbolic interaction theory, that is, an individual's response to another is based on a complex interpretive process. The individual is able to take diverse perspectives, including viewing the "self", the attitude of the other individual and the social context of the interaction, and transform them into a personal perspective.

At a more abstract level one could ask where self-disclosure fits into the empathic process. Does the nurse encourage patient self-disclosure so that she can be more empathic, or does an empathic nurse promote patient self-disclosure? This situation becomes somewhat ambiguous in interpreting the findings on the relationship between perceived nurse empathy and self-disclosure.

Perhaps another outcome of perceived empathy might have been more appropriate than self-disclosure. Pike (1990) in a literature review on nursing studies on empathy refers to the following different views on the goals of empathy:

1. to establish a helping relationship in order to foster therapeutic personality change

2. to prompt the nurse to take action

3. to help the patient to realize his/her full potential

4. to provide comfort and emotional support by sharing

the patient's distress rather than have him or her carry it alone.

For this study situation, the effect of communication style and empathy might have been operationalized by the level of comfort the patient felt in caring for the baby or more specifically in bathing her baby.

It might be more beneficial to study empathy at a different stage of the nurse-patient relationship. For example at a later stage in the relationship, it might be easier for the patient to discern how well the nurse understands her/his situation; in addition, the goals of empathy might more likely be accomplished at a later stage.

Meaurement of Self-Disclosure

This study may have been limited by the decision to study the outcome variable of self-disclosure using only self-reference percent as a measure of self-disclosure. Although it is the most objective measure in the Self-Disclosure Coding System (SDCS), the two other dimensions of self-disclosure in the coding system, intimacy and affective manner of presentation, would have provided information on the quality of the self-disclosures. It is possible that the relationship between perceived empathy and self-disclosure according to these other parameters in the SDCS instrument, may have been different from that found in this study which examined only the amount of self-disclosures made by patients. Future studies investigating perceived

empathy and self-disclosure and using the SDCS should give careful consideration to the dimensions to be measured in the SDCS instrument.

Implications for Research, Practice, and Education

Recording actual conversations between nurses and patients provides an accurate record of the natural happenings that occur in nurse-patient interactions and allows the researcher to explore many facets of those interactions. However a natural study does have certain limitations. In a natural setting the researcher is unable to control for different factors in the study. Although there was limited variation in the range of scores in communication styles used by nurses, there was significant evidence of the effect of a more person-centered approach versus a more position-centered approach on nurse-patient interactions. Further studies might explore what are the antecedent factors and correlates of the use of various communication strategies. This might include investigating other characteristics of the nurse, the setting of the interaction, factors related to the patients, and the clinical objectives to be met.

Although perceived empathy did not help to predict self-disclosure, one cannot conclude that the patient's interpretation of the nurse's behaviour does not influence how the patient responds. Part of the problem appears to be how the individual's interpretation of another person's

behaviour can be ascertained, particularly given the circumstances of nurse-patient relationships. Further investigation is required, in the testing of symbolic interaction theory, as to methods that can be used to ascertain individual's interpretations of a person, event or situation.

Issues have been raised about how empathy should be defined and measured in clinical nursing practice. Should there be a different operational definition of empathy which would better fit into the clinical practice of nursing? Are there certain situations in nursing in which empathy should and can be more readily investigated, practised and learnt? Further study may be required to develop a clear description or definition of what empathy is within nursing practice; that is, exploration of empathy as it is taught in nursing schools, as it is practised in clinical settings and as it is perceived by patients. Further exploration is needed to identify factors which may influence the relationship between perceived nurse empathy and patient self-discosure. There also need to be studies that examine empathy in relation to its various possible outcomes in clinical nursing practice.

In this study nurses, in trying to influence the health beliefs and behaviours of the patient, were found to use different communication styles. The communication style was important in determining the degree to which a patient would

self-disclose. The more person-centered the nurse was in her communication the more the patient self-disclosed. Studies (Colten & Janis, 1982, Janis, 1983) have shown that patient adherence to a medical regimen is related to the patient's ability to engage in moderate self-disclosure. Squier (1990) has proposed a model in which the practitioner's empathic understanding of the patient's cognitive and affective view of illness will lead to greater patient adherence to a medical regimen and greater patient satisfaction. This study supports interactionist theories in nursing in that nurses who sought the patient's perspective (more person-centered) in the interaction gained greater access to patient information (self-disclosures), which might be necessary to help patients solve health care concerns.

This has implications in nursing education, in assessing students as to their predominant communication style and in teaching students communication strategies which are linked to the accomplishment of particular nursing objectives.

This study then underlines the importance of how communication strategies can be used as a resource to facilitate accomplishment of pertinent nurse/patient goals.

## Summary

Interaction is the major tool by which a nurse diagnoses and intervenes (King, 1981; Orlando, 1972;

Wiedenbach, 1963; Zderad, 1969). A common theme across the various nursing models is that nursing is individualized and based on a holistic view of persons. By encouraging patients to share information about themselves, the nurse gains an understanding of the person she or he is dealing with and how a particular event is affecting the patient. She or he can then devise a plan of care which is most appropriate to the patient's situation.

This study examined the day to day interactions occurring between nurses and patients. The conversations between first time mothers and registered nurses were recorded while mothers were bathing their newborn babies and the nurses were supervising them in this endeavour.

Symbolic interaction theory, upon which this study is based, posits that individuals do not merely respond to each other's actions, but respond according to their interpretation of these actions. Therefore, the researcher was interested not only in how patients responded to the different communication approaches that nurses used, but also how they interpreted their nurse's communication approach and how this influenced their response.

More specifically, this study measured the nurses' communication style according to Kasch and Lisnek's Message Coding System for its degree of person/position-centeredness. Patients rated their nurses' behaviour as to how empathetic they found the nurse to be during the

interaction, according to Barrett-Lennard's Relationship Inventory. Patient response was measured for degree of self-disclosure according to Chelune's Self-Dislosure Coding System. Patients were also asked to complete the Patient Self-Disclosure Instrument for "difficulty" and "importance" in self-disclosing on health related issues. This was to control for the possible effect of the patient's general tendency to self-disclose (as a personality construct) on patients' actual disclosure during the interview (situational construct).

The purpose of this study then was to explore the relationship between the nurse's communication style and the patient's perception of nurse empathy on patient self-disclosure. The following were hypothesed:

1. The more person-centered nurses are in their communication style and the more patients' perceive their nurses to be empathetic, the more patients will self-disclose.

2. Perceived empathy is more important in predicting the extent to which a patient will self-disclose than is communication style.

The sample consisted of all available and willing nurses and patients. Sixty-one nurses (all females) and patients participated in the study. The study found that the majority of nurses were neither extremely person-centered or position-centered but fell in the middle of the

scale, which meant they offered their patient information. The majority of patients found their nurses to be empathetic although there was variation in degree.

A multiple regression was performed with the following findings: There was a direct significant relationship between nurses' communication style and patient self-disclosure, while there was a non-significant inverse relationship between perceived nurse empathy and patient self-disclosure (based on beta t-test to determine unique contribution of each of the independent variables on the dependent variable). Therefore the first hypothesis was only partially supported as only communication style, and not perceived nurse empathy, helped to predict amount of patient self-disclosure. In terms of the second hypothesis, communication style accounted for more of the variance, than did perceived nurse empathy, and therefore communication style was found to be a more important predictor of patient self-disclosure than was perceived nurse empathy. Therefore the second hypothesis was rejected. In adjusting for initial differences between mothers in self-disclosing: communication style remained a significant predictor of actual patient self-disclosure; as well, general "difficulty" in self-disclosing was found to significantly predict actual self-dislosure, whereas "importance" in self-disclosing was non-significant.

The finding that patients' expressed interpretation of

the nurse's behaviour did not relate to patient response may reflect methodological difficulties in applying the theory rather than difficulties in the theory itself. It may be difficult to ascertain from some patients their interpretation of their nurse's behaviour. Patients' immediate behavioural response to nurses may more accurately reflect how they perceived the nurse at the time of the interaction, rather than a questionnaire asking patients to recall their interpretation of the nurse's behaviour. Factors such as guardedness in revealing what they really thought of the nurse and response set bias related to social desirability may have influenced how patients responded to the Relationship Inventory on how empathetic they found their nurses to be.

It is also possible that a different construct other than empathy, or empathy defined and measured differently, might have reflected more accurately the patients' interpretation of the nurses' communication style and been a better predictor of patient self-disclosure.

The study did find that communication style was important in predicting the extent to which a patient will self-disclose; that is, the more person-centered nurses are in their approach, the more patients will self-disclose. This has implications to the practice of nursing as it indicates that a certain communication style is more effective in promoting patient self-disclosure. The nurse,

in becoming more aware of the meaning of the experience to the patient, is better able to deal with the health concerns of the patient (Janis, 1983, Squier, 1990).

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# APPENDIX I

a. Patient Demographic Questionnaire

b. Nurse Demographic Questionnaire

c. Relationship Inventory

d. Patient Self-Disclosure Instrument

## Ia. Demographic Questionnaire - Patient

Research Number _____

Please fill in the spaces or circle the appropriate answer.

(1) Age _____

(2) What is your marital status?

(a) Single
(b) Married
(c) Living with someone
(d) Widowed
(e) Divorced
(f) Separated

(3) What is your ethnic background?

(4) How much formal education have you had:

(a) Never attended school
(b) Some grade school
(c) Completed grade school
(d) Some high school
(e) Completed high school
(f) Some university
(g) Completed university
(h) Other (specify) _____

(5) What is your occupation? _____

(6) How interested were you in having the nurse assist you with your baby's bath?

(a) Very interested
(b) Interested
(c) Slightly interested
(d) Not interested

## Ib. Demographic Questionnaire - Nurse

Research number _____

(1) Age _____

(2) What is your marital status?

(a) Single
(b) Married
(c) Living with someone
(d) Widowed
(e) Divorced
(f) Separated

(3) Educational status:

(a) nursing diploma
(b) baccalaureate degree in nursing
(c) masters in nursing
(d) other (specify) _____

(4) Years of experience in nursing:

(a) less than a year
(b) 1 - 3 years
(c) 4 - 8 years
(d) 8 - 12 years
(e) more than 12 years

(5) Number of days you have cared for this patient, NOT including today is _____ day(s)

(6) The baby bath demonstration was performed by you:

(a) Yes
(b) No

Ic. Relationship Inventory (Barrett-Lennard,1962)

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to the conversation you have just had with your nurse during the return baby bath demonstration.

Mark each statement according to how strongly you feel that it is true or not true, in this relationship. Please mark every one. Circle only one of the following: +3, +2, +1, -1, -2, or -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.

+2: Yes, I feel it is true.

+1: Yes, I feel that it is probably true, or more true than untrue.

-1: No, I feel that it is probably untrue, or more untrue than true.

-2: No, I feel it is not true.

-3: No, I strongly feel that it is not true.

| | Strongly not true | Not true | Probably untrue | Probably true | True | Strongly true |
|---|---|---|---|---|---|---|
| 1. She respects me as a person. | -3 | -2 | -1 | +1 | +2 | +3 |
| 2. She wants to understand how I see things. | -3 | -2 | -1 | +1 | +2 | +3 |
| 3. She feels a true liking for me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 4. She may understand my words but she does not see the way I feel. | -3 | -2 | -1 | +1 | +2 | +3 |
| 5. She is impatient with me. | -3 | -2 | -1 | +1 | +2 | +3 |

| | Strongly not true | Not true | Probably untrue | Probably true | True | Strongly true |
|---|---|---|---|---|---|---|
| 6. She nearly always knows exactly what I mean. | -3 | -2 | -1 | +1 | +2 | +3 |
| 7. I feel appreciated by her. | -3 | -2 | -1 | +1 | +2 | +3 |
| 8. She looks at what I do from her own point of view. | -3 | -2 | -1 | +1 | +2 | +3 |
| 9. She is indifferent to me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 10. She usually senses or realises what I am feeling. | -3 | -2 | -1 | +1 | +2 | +3 |
| 11. She finds me rather dull and uninteresting. | -3 | -2 | -1 | +1 | +2 | +3 |
| 12. Her own attitudes toward some of the things I do or say prevent her from understanding me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 13. She cares for me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 14. Sometimes she thinks that I feel a certain way, because that's the way she feels. | -3 | -2 | -1 | +1 | +2 | +3 |
| 15. I feel that she disapproves of me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 16. She realises what I mean even when I have difficulty in saying it. | -3 | -2 | -1 | +1 | +2 | +3 |
| 17. She just tolerates me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 18. She usually understands the whole of what I mean. | -3 | -2 | -1 | +1 | +2 | +3 |
| 19. She is friendly and warm with me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 20. She just takes no notice of some things that I think or feel. | -3 | -2 | -1 | +1 | +2 | +3 |

| | Strongly not true | Not true | Probably untrue | Probably true | True | Strongly true |
|---|---|---|---|---|---|---|
| 21. I feel that she really values me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 22. She appreciates exactly how the things I experience feel to me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 23. She doesn't like me for myself. | -3 | -2 | -1 | +1 | +2 | +3 |
| 24. At times she thinks that I feel a lot more strongly about a particular thing than I really do. | -3 | -2 | -1 | +1 | +2 | +3 |
| 25. I seem to irritate and bother her. | -3 | -2 | -1 | +1 | +2 | +3 |
| 26. She does not realise how sensitive I am about some of the things we discuss. | -3 | -2 | -1 | +1 | +2 | +3 |
| 27. At times she feels contempt for me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 28. She understands me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 29. She is truly interested in me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 30. Her response to me is usually so fixed and automatic that I don't really get through to her. | -3 | -2 | -1 | +1 | +2 | +3 |
| 31. She feels deep affection for me. | -3 | -2 | -1 | +1 | +2 | +3 |
| 32. When I am hurt or upset she can recognise my feelings exactly, without becoming upset herself. | -3 | -2 | -1 | +1 | +2 | +3 |

Id. Patient Self-Disclosure Instrument (Dawson et al., 1984)

Subscale Items for Scoring

Personal Problems and Feelings = 6, 7, 8, 9, 10, 12, 13

Responses to Health Care = 1, 2, 14, 15, 16, 17, 18

Life Style = 3, 4, 5, 11, 19, 20, 21

PARTICIPANT'S OPINION: FORM I

Directions

The following is a list of items that some patients think are important for patients to discuss with their primary health professional, such as a nurse, doctor or social worker. In order to obtain the best possible care, how important do you think it is for patients to report about the following items? Read each item, decide how important it is, and circle the appropriate number to the right of the item.

If the item would be extremely important for patients to report, circle the number 7. If it would not be important at all for patients to report, circle number 1. Use the numbers 2, 3, 4, 5, or 6 to indicate the degree of importance between not at all important (1) and extremely important (7). Circle only one number for each statement.

| | Not Important | | | | | | Extremely Important |
|---|---|---|---|---|---|---|---|
| 1. Any new physical complaints | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Failure to follow advice given on previous encounters | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. The type and amount of exercise they get in an average week | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. How much alcohol they drink in an average week | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. How they relax | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Feeling badly about themselves and why | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | Not Important | | | | | | Extremely Important |
|---|---|---|---|---|---|---|---|
| 7. Whatever is most upsetting to themselves in their current life | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Sources of strain in their marriage or intimate relationships | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Feelings about their inadequacy in sexual behavior | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Being lonely | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. Difficulty in sleeping | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Suicidal thoughts | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Actions they have most regretted in their lives and why | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. Concern that the treatment is not helping them | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. Difficulty in understanding their health care professional | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Disagreement with their health care professional's advice | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Wish to see a consultant | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Feeling good about how they are doing | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. Amount and type of smoking they do | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Whether they feel they abuse their bodies | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. Their current health status and its relationship to their lifestyle | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

PARTICIPANT'S OPINION: FORM D

Directions

People differ in how difficult it is for them to discuss the following items. Please read each item and decide how difficult it would be for you to discuss the item with a health care professional, such as a nurse, doctor or social worker. Read each item, decide how difficult it would be for you to discuss it, and circle the appropriate number to the right of the item.

If the item would be extremely difficult for you to discuss, circle the number 7. If it would not be difficult at all for you to discuss, circle number 1. Use the numbers 2, 3, 4, 5, or 6 to indicate the degree of difficulty between not at all difficult (1) and extremely difficult (7). Circle only one number for each statement.

| | Not Difficult | | | | | | Extremely Difficult |
|---|---|---|---|---|---|---|---|
| 1. Any new physical complaints | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Failure to follow advice given on previous encounters | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. The type and amount of exercise you get in an average week | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. How much alcohol you drink in an average week | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. How you relax | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Feeling badly about yourself and why | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Whatever is most upsetting to you in your current life | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Sources of strain in your marriage or intimate relationships | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Feelings about your inadequacy in sexual behavior | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | Not Difficult | | | | | | Extremely Difficult |
|---|---|---|---|---|---|---|---|
| 10. Being lonely | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. Difficulty in sleeping | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Suicidal thoughts | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Actions you have most regretted doing in your life and why | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. Concern that treatment is not helping you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. Difficulty in understanding your health care professional | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Disagreement with your health care professional's advice | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Wish to see a consultant | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Feeling good about how you are doing | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. Amount and type of smoking you do | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Whether you feel you abuse your body | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. Your current health status and its relationship to your lifestyle | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

# APPENDIX II

a. Message Coding System

b. Guidelines - Message Coding System

c. Self-Disclosure Coding System

d. Guidelines - Self-Disclosure Coding System

IIa. Message Coding System (Kasch & Lisnek, 1984)

Category I

Strategies coded within the lowest major category subsume the individuality of the patient within the rules and norms governing patients. It contains communication strategies that deny or ignore the perspective of the patient, evaluate patient behavior in terms of deviation from rules and norms, and rely on the power inherent in the role of nurse for controlling patient behavior. At this level, there is no attempt to discuss the patient's beliefs or feelings, to supply extensive rationales for altering behavior, or to understand the behavioral act of noncompliance within a broader perspective. The ascending sublevels of this major category reflect the movement from a highly evaluative role-bound interpersonal orientation to reliance on the general rules governing behavior as the basis for regulating patient thought and action.

Level I-A

At Level I-A the nurse employs compliance-gaining strategies that explicitly criticize or disregard the patient's feelings, motivations, or beliefs. Strategies coded at Level I-A coerce patients into modifying their behavior through the use of verbal punishment or through the overt display of power inherent in the role of caregiver.

Level I-B

Strategies coded at Level I-B also subsume each

patient's individuality within the implicit power relationship between nurse and patient. However, at this level strategies rely exclusively on the patient's recognition of the culturally sanctioned power inherent in the assigned status of the nurse and do not overtly induce fear of physical or verbal reprisal or punishment. The nurse regulates the patient's behavior through the use of commands, directives, imperatives, or sanctions without verbalizing any rationale or rule as a reason for modifying behavior. Strategies coded at this level state what the patient has to do, ought to do, or should do, and direct the patient how to act without explanation (eg., "I have discussed this in the past, and I want you to work out a solution to your problem. You can be as angry and uncooperative as you want, but sooner or later you will realize that you must comply.").

Level I-C

Strategies coded at Level I-C regulate the behavior of the patient through the use of some general rule relevant to the type of situation or behavior involved. These strategies are grounded in the social conventions governing action within a particular situation - affirmation of the rule system, categorical assertion of some general rule, statement announcing general goals of treatment, implication of behavior in terms of deviation from rules. Strategies coded at this level merely assert a belief, rule, or value

presumed to be operating in the situation and refer to how a specific class of people (patients) should act and behave in the situation. The regulatory force of appeal at this level is grounded in the assumption that patients can and should follow the rules and it is the nurse's primary role function to enforce them (eg, "It's always good to do what the doctor orders.", "You can continue to follow the rule, which all patients must follow to do well, or give up and suffer the consequences.").

Category II

In Category II the nurse implicitly displays an understanding of the patient's feelings, beliefs, and motivations; recognizes the patient's reasoning ability and autonomy; but does not elaborate the psychological features of the situation in regulating and advising the patient. Strategies coded within the category reflect increasing person-centeredness because they encourage patients to reason through the situation and grant them some autonomy in regulating their behavior. Persuasive rather than control strategies are the characteristic appeals coded within Category II.

Nurses relying on persuasive strategies are more inclined to elaborate the consequences of noncompliance or apply general principles (eg, appeal to commonly shared values) as the basis for regulating behavior. Strategies coded within this category present forms of reasoning

relevant to a generalized class of patient or to all patients within a particular clinical situation. Although patients are encouraged in some degree to use the facts relevant to the situation in understanding the need to modify behavior, at this level individual beliefs, intentions, or motives are not explicitly integrated into compliance-gaining strategies.

Level II-A.

Strategies coded at Level II-A offer the patients reasons for regulating their behavior beyond the categorical assertion of a general rule, but in an extremely truncated fashion. At this level the nurse begins to recognize the patient's power of reasoning by providing unelaborated reasons why each should adhere to the prescribed regimen. However, there is no indication that adaptation to the individual beliefs or feelings of the patient is a relevant goal and the reasons offered for compliance would be given to all patients faced with the same set of circumstances. Appeals to rationality and common sense, to gain agreement that noncompliance is a problem, and to make the needs of the nurse central would be coded at this level (eg, "Patients with high cholesterol are more prone to cardiovascular problems, so it would really help me if you would think seriously about going on a diet" .

Level II-B

Strategies coded at Level II-B offer the patient

several consequences of noncompliance and provide a more elaborated explanation of why those consequences are likely. The patient is asked to think about the consequences of compliance and non-compliance and to reason through the situation as a means of regulating personal behavior. Persuasion is explicitly recognized by the nurse as the appropriate means of using communication for the purpose of securing patient adherence. At this level the nurse provides the patient with a more elaborated rationale for regulating behavior. However, the psychological characteristics of the patient and others involved in the situation are still left implicit, and the explanations offered are tied to the features of the specific situation (eg, "Exercise can really improve the way you feel about your body, you can get to know your body better, and it raises your energy level. Many of my patients have started an exercise program, and they are doing well in keeping up with their weight loss goals.").

Level II-C

Strategies coded at Level II-C provide a rationale for compliance that integrates the general rules and norms relevant to the situation with the patient's own particular situation. At this level the active interpretive powers of the patient are explicitly recognized by the nurse and strategies are constructed to offer reasons adapted to the patient's particular situation. An explicit rationale is

offered that qualifies, individualizes, and specifies the norms and rules governing patient behavior. The nurse attempts to provide a more abstract explanation that the patient can internalize and adaptively apply in future situations (eg, "Abnormalities in calcium and phosphorous levels can cause bone demineralization, weakness in muscles, and aches and pains. Given the problem you have had with calcium deficiency in the past, it is important that you adhere to your dietary restrictions and prescribed medications. Your future participation in athletics may depend on how well you do.") At this level explanations and justifications are still tied to the patient's situation rather than to underlying psychological characteristics.

Category III

Strategies coded in Category III of the hierarchy recognize that the accomplishment of nursing goals is often contingent on treating patients as unique individuals. The subjective perspective of the patient becomes the basis for facilitating compliance. The nurse demonstrates the ability to integrate the institutional demands of the nursing situation with an understanding of the patient's own viewpoint and situation. Strategies coded within this category focus on the motivations and intentions underlying patient action rather than the overt behavioral act of noncompliance. The ascending levels are ordered according to the degree to which they reflect increasing recognition

and elaboration of the psychological perspective of the patient, ie, increasing person-centeredness.

Level III-A

At Level III-A the nurse implicitly recognizes that the psychological characteristics of the patient are a relevant feature of compliance-gaining situations. The nurse is also aware that the patient's beliefs and intentions can provide a basis for behavioral regulation since the causes of non-compliance are often ambiguous and unique to the individual patient (eg, "I know you have been depressed lately, but you still need to take your prescribed medication."). Although strategies coded at this level begin to seek out the patient's own reasons for specific actions ("Why don't you tell me what trying to stay on this diet has been like for you."), the relevance of the psychological qualities of the patient are not elaborated ("By lowering your cholesterol and losing some weight, you're going to feel much better about yourself.").

Level III-B

Whereas strategies coded at Level III-A provide only an implicit recognition of the relevance of psychological characteristics, strategies coded at Level III-B extensively use the beliefs and feelings of the patient as the basis for behavioral regulation. Strategies coded at this level provide elaborated reasons for complying that are adapted to the psychological perspective of the patient and help the

patient understand the potential relationship between psychological states and compliant and noncompliant behavior (eg, "Sounds like you are using food to help you cope with your anxiety caused by the pressure of your new job. Sometimes how you feel about things in your life can influence eating behavior. It seems important to you to be able to control things in your life, and I believe you can handle this new job and still maintain your weight loss goals if you set your mind to it.").

Level III-C

At Level III-C the nurse also focuses primary attention on the psychological characteristics of the patient. However, the primary goal implicit within the strategies coded at this level is to engage patients in constructing their own rationale for behavioral self-regulation. The nurse not only explicitly recognizes and elaborates the connection between the patient's psychological perspective and compliant and non-compliant behavior, but encourages the patient to think reflectively about the nature, causes, and consequences of non-compliant behavior. Strategies coded at this level encourage the patient to engage self-attribution, to verbalize thoughts about compliance, to elaborate intentions and motives that led to noncompliance, to create new levels of aspiration, to prepare for difficulties to be encountered in complying in the future, and to see the implications of their behavior in relation to others (eg, "I

know it is awfully hard to handle all of this, and sometimes you just must get tired of being sick, especially when it starts bothering those you love. Your children will understand in time what you are going through. They love you and want you to do well. Do you think that sometimes you postpone taking medication at mealtimes because your children are there also? I think if you tried to involve your children a little more, they would understand and try to help you, don't you think?").

## IIb. Guidelines--Message Coding System

I. Strategy is CONTROLLING: Nurse induces fear through show of power or threat of punishment. Imposes directives and general rules on patient.

Perspective: Disregards patient's feelings, beliefs or motivations. Based on nurse's or the hospital's perspective.

| MESSAGE | EXAMPLE |
|---|---|
| A. Induces FEAR through show of POWER or threat of PUNISHMENT. Reprimands the patient. Consequences would be sanctions which nurse/hospital would impose on patient. | "You can't go home until you show us you can properly care for the baby." "Don't be silly." |
| B. Directives: directs patient on how to act without an explanation (no rule or rationale). Questions patient if she has complied in carrying out an action. | "It's time to bathe the baby." "Clean the cord next." "Have you washed his hair?" You "must", "ought", "should" or "have to". |
| C. Asserting general RULE based on how a SPECIFIC CLASS of PATIENTS should act or behave in the situation (no rationale given). Imposing values and behaviours of the group, nurse or institution onto the patient without any rational. | "Generally babies are bathed every second day." "Most mothers like to have their babies close by." |

II. Strategy is PERSUASIVE: Persuades through giving patient rationale for (self-regulating) behavior. Rationale in the form of giving patient facts (information) and/or consequences (positive or negative) which would influence their following care.

Perspective: Acknowledges patient's autonomy & ability to reason but still focused on nurse's perspective & rationale. Does not take patient's psychological perspective, does not seek patient's point of view or rationale.

| MESSAGE | EXAMPLE |
|---|---|
| A. Rationale relevant to a <u>generalized class</u> of patients Nurse gives <u>limited</u>, <u>unelaborated</u> explanation or limited feedback. | "If you feed the baby just before his bath he could regurgitate." "That's right." |
| B. Rationale relevant to a <u>generalized class</u> of patients. Nurse gives a rationale which allows the patient to reason through the situation, i.e. gives sufficient data to think through the situation. | "The baby may cry during the bath and be jostled about, and on a full stomach he may regurgitate and perhaps choke." |
| C. Rationale relevant to <u>patient's particular</u> situation. Provides rationale which applies to patient's particular situation (NOT patient's psychological state) or rationale allows patient to adapt it to her own particular situation. | "The baby needs to be quiet for 1 1/2 hours after he feds so he can digest his food, so this will affect how you organize various activities around the baby's feeding time." |

III. Strategy focuses on motivations, intentions underlying patient action. Elliciting patient's reasons, thoughts &/or feelings. Takes patient's point of view. Encourages patient in gaining insight into self-regulating behaviour.

Perspective: Treats patient as a unique individual. The subjective perspective of the patient becomes the basis for facilitating compliance.

| MESSAGE | EXAMPLE |
|---|---|
| A. Seeks out patient's own reasons for specific actions but the relevance of the psychological qualities of the patient are not elaborated. | "Why do you think the baby shouldn't be bathed now?"<br>"I know your back is hurting you. It won't be much longer."<br>You "want", "think" or "feel". |
| B. Helps patient understand relationship between patient's psychological state & behaviour. | "You're tired so you want to bathe the baby later."<br>"The baby's crying is upsetting you and making it harder for you to remember everything." |
| C. Encourages patient to think reflectively about the nature, & consequences of her behaviour, i.e. examine for herself or gain insight about her (patient's) self-regulating behaviour. | "So you think your reluctance to bathe the baby now is due to your feeling tired?"<br>"Do you think the baby's crying is affecting your ability to remember what you're supposed to do next." |

## IIc. Self-Disclosure Coding System (Chelune,1975)

### Rationale

Self-disclosure is the verbal communication of personal information about the self. This coding manual was developed to provide a scoring system for self-disclosure dimensions, namely: amount of information disclosed about the self and the rate or density of personal information disclosed per time interval.

The scoring procedure entails tape-recording a subject's communications in an interview and transcribing these communications onto a written transcript. The written transcript is used in scoring the self-disclosure dimensions.

### Instructions for Coders

1. Rating of the responses will require your careful evaluation. Score only what is said or directly implied. Record your scores on the Coding summary Sheet.

2. Be as objective as possible and try not to allow your personal reactions influence your judgements.

3. You should assume that the coding categories are independent and not correlated. Thus a subject may score high on some dimensions but low on others.

### Coding Categories

#### Amount (A)

The overall amount of information communicated is

scored by counting the number of thought units of independent clauses within the maximum 9 minute time interval. The grammatical unit or "thought unit" is a non-reflexive clause, that is, one that can stand alone and does not distort the meaning of the rest of the sentence if it is taken away.

To assist coders in the scoring of this category a number of examples will be presented from Warriner's English Grammar and Composition (1963):

An independent clause expresses a complete thought and could be considered a sentence by itself and is, therefore, scored as 1 thought unit. A subordinate clause does not express a complete thought and must be attached to an independent clause and is not scored.

1. Simple Sentences are always scored as 1 thought unit.
   (a) He went to the store. (1 unit)
   (b) I am afraid of heights. (1 unit)
2. Compound Sentences are scored according to the number of independent clauses they contain.
   (a) The visiting dignitaries were met by the President,/ and they were entertained at the White House. (2 units)
   (b) Sally learned to knit during the summer, / and now she spends most of her time knitting socks for Bill. (2 units)
3. Complex Sentences are scored as only one unit.

(a) The look that she gave me was discouraging. (1 unit)

(b) I did not know the girl who spoke to me. (1 unit)

(c) What the announcer said was not clear. (1 unit)

(d) There is a man everybody admires. (1 unit)

(e) He runs as if he is afraid. (1 unit)

4. Compound-Complex Sentences are scored only for the number of independent clauses they contain.

(a) The visiting dignitaries, who landed at the National Airport, were met by the President, and he escorted them to the White House. (2 units).

Special Notes for Scoring Amount (A)

A. Independent clauses may be joined by coordinating conjunctions (and, but, nor, or, for) or by conjunctive adverbs (accordingly, also, besides, consequently, hence, however, moreover, nonetheless, otherwise, then, therefore, thus, still) and each clause should be scored as a thought unit.

B. Expressions used as introjections and that have no obvious information value should not be scored: "It wasn't fair. You know, I got the shaft." (2 units)

C. Occasionally words may be missing or implied in a subject's statements. A thought unit is scored when the subject of an independent clause is implied and conveys a thought different from the preceding clause.

e.g., "I don't worry if I make a mistake / but (I)

try to do better next time." (Score 2). The subject of the second clause, "I", is missing but, if present, would convey an independent thought different from the first.

e.g., "I try to be understanding / and don't tease people very often." (Score 2). "I" is implied in the second clause and conveys a different thought from the first.

e.g., "When I'm depressed I don't show people the full extent and mope around." (Score 1) "...and mope around." is a continuation of the first thought and is therefore <u>not</u> scored.

e.g., "When I'm depressed I try to think of something happy and remember all the happy things which have happened to me." (Score 1). The individual is implying" "...to think...and <u>(to) remember</u>..." --a participle.

D. Questions. The individual may pose questions which are:

1. directed toward the interviewer; or
2. directed toward themselves.

Score only those questions which the individual poses to himself as a form of self-reflection.

E. Special Uses of "That".

1. When "that", in the form of a demonstrative <u>pronoun</u>, is used as the <u>subject</u> of a clause, the clause

is scored.

e.g., "There are some people who can rattle on about nothing / and that bothers me." (Score 2).

2. "That" used as a relative pronoun (a substitution for "who" or "which") or as part of a relative clause is not scored.

e.g., "It makes me feel good when somebody does something that (which) makes me know that they care (relative clause). (Score 1).

Self-Reference (SR)

Not all information communicated by an individual belongs to the class of verbal behavior referred to as self-disclosure. True self-disclosure describes some personal aspect of the speaker. Thus, the amount of self-disclosure in a communication will be scored in terms of the number of thought units which describe the speaker in some way. These thought units will be referred to as self-references (SR) and will be the basic index of the amount of self-disclosure.

A self-reference (SR) will be operationally defined as a verbal response (thought unit) which describes the subject in some way, tells something about the subject, or refers to some affect the subject experiences (Powell, 1968; Rogers, 1960).

1. "I've done well in school thus far."
2. "I've done a lot of hiking this sommer."
3. "Living alone depresses me."

Special Note on SRs

A. Statements beginning with "I think ..." or "I know ..." must be judged carefully. Coders must evaluate whether the individual is expressing something about his/her self or about someone or something else. Score only those expressions which describe the speaker.

1. "I know the economy is in bad shape." (Not scored as SR).
2. "I don't think the reasons that they criticize are substantial." (Not scored as SR).
3. "I started thinking that maybe it was my fault." (Score as SR).
4. "I know what my strengths are." (Score as SR).

B. Reflexive third person references are scored as SRs.

1. "You (I) tell yourself (myself) that ..."
2. "You (I) really feel good when ..."

Self-Reference Percent (SR%)

The percentage of self-references will be calculated by the following formula: SR% = SR / A.

## IId. Guidelines--Self-Disclosure Coding System

### Thought Unit

If the patient's response is in sentence form use the guidelines given in the coding system.
If the patient's response is not in sentence form or is not an independent clause, (such as a single word response) BUT is in response to what the nurse has just said (implying affirmation, denial or reiteration of what the nurse has just said) THEN the patient's response will be scored as an implied thought unit (ITU).

eg. Nurse: "The baby likes you."
Patient: "yes." (implying--she does like me). Score as ITU.
Nurse: "Wash her back now."
Patient: "Okay." (implying--I will wash her back). Score as ITU.

Code the communication addressed to the nurse or to the baby, NOT to a visitor or husband or other health team member. If there is repetition in an utterance count it as one thought unit.

eg. "She's alright. She's fine." (ITU-1)

"Okay. I'll do that." (ITU-1)

"Use only one. I'll use one cotton ball." (ITU-1)

Sounds such as, "uhm", laugh, are not scored as a thought unit.

Questions are not considered as a thought unit, however, a sentence which ends with "eh?" is considered a thought unit.

eg. "She looks hungry, eh?"

Self-References

A self-reference (SR) will also include a verbal response in which she discloses her PERSONAL beliefs regarding her baby, babies in general and care that baby(s) require.

eg. "I thought that babies slept most of the time."

"I think he (baby) should be put on a set routine right from the beginning."

"Because she (baby) sleeps so much, I think I should feed her everytime she wakes up."

Exclude routine steps in the task at hand.

eg. "I can wash her face now."

"I don't use soap on her face."

If the patient's response to a nurse's question is a SR but she only responds with a "yes" or "no" (or something equivalent to that - "okay", "right", "uh hum") then score it as an implied self-reference (ISR).

eg. Nurse: "Are you right handed?"
Patient: "Yes." (ISR-1)

Use of "we":
Determine if the patient is referring to herself, the baby or both the baby and herself.

eg. "We get along just fine." (SR-1)
"We're new at this." (SR-1)

If there's a repetition of a SR in an utterance count it as one.

# APPENDIX III

Verbal Explanation - Nurse

Thank you for allowing me the time to present my research project. The study is part of the requirement for my attainment of my Masters degree in Nursing. It is exploring nurse-patient interactions. I cannot give you much more details, as it might affect the study's validity but once the study is completed, I will send you a full description of the study and its findings. Your involvement in the study will remain strictly confidential, the interviews will be numbered and your names will not be attached to the data. The purpose of the study is to explore nurse-patient interactions, to ascertain how patients respond, and therefore it will have practical implications for nursing. The situation I have chosen to examine is first time mothers returning a baby bath demonstration to a nurse. If you agreed to participate, I would arrange with you an audiotape recording of the teaching session. The interaction should be as natural as possible. Carry on as you normally would. I would really appreciate your participation in this study. I will be approaching each of you individually to determine if you are interested in participating. Thank you once again for your time.

Verbal Explanation - Patient

My name is Nancy Woo. I am a Masters Nursing student. I am involved in a research project, which is part of the requirement for attaining my Masters degree . It is a study on nurse-patient interactions. I was wondering if I could have a few minutes of your time to tell you about my project. ...(wait for patient's response)... . The purpose of the study is to explore nurse-patient encounters, to determine what nurses can do to improve their care of their patients. I would like to have the patient's point of view in this matter. I will not be studying any of the details of what you say, only the general way the nurse talks to you and you respond. The results will be helpful to both nurses and patients. Your input will remain strictly confidential, your name will not be attached to any of the data, it will be coded with a number, and it will not influence the care you receive in the hospital. The study involves taping an interaction between you and a nurse, in which she is helping you with the return bath demonstration. The interaction between you and the nurse should be as natural as possible, try to ignore that it is being taped. I would then ask you to fill out four questionnaires, which should take about 10 minutes each to complete. Would you be willing to participate in this study? ... (wait for the patient's response) ... . Thank you for your time and patience in allowing me to discuss my project with you.

# APPENDIX IV

McGill University

School of Nursing

Topic of Study: Nurse-Patient Interactions
Researcher: Nancy Woo
Telephone Number:4 484-3431

Written Consent Form - Nurse

The research project is a study of nurse-patient encounters. The purpose of the study is to determine what nurses can do to improve nurse-patient interactions. I understand that if I agree to participate, I will allow the interation that occurs during a baby bath return demonstration between a patient and myself to be tape-recorded.

I further understand that:

The tape will be identified only by code number. The content of the interaction will be held in strict confidence, that is, no one except for Nancy Woo and her research coworkers, will be able to hear the interaction. My participation is voluntary.

I am free to withdraw my consent and to discontinue my participation in the project at any time without explanation by contacting Nancy Woo.

There is no risk to me or to my job in having the tape recording made. In no way will the tape be used to judge me personally or my nursing care individually and my employer will not have any access to data.

I also understand that while I will not directly benefit from participating in the study, the information gained may be useful in guiding nurses towards more effective interactions with their patients.

I understand that the results of this research will be given to me if I request it.

The study and this consent have been explained to me by Nancy Woo and my questions at this time have been answered satisfactorily.

_____ _____

Participant's Signature Date

_____

Witness

Université McGill

Ecole des Sciences Infirmières

Projet d'Etudes: Interaction entre Patient et Infirmière
Chercheur: Nancy Woo
Numéro de telephone: 484-3431

Formule de consentement écrit - Infirmière

Ce project de recherche est une étude des relations patiente-infirmière. L'étude vise à déterminer ce que les infirmières peuvent faire pour améliorer l'interaction avec leurs patients.

Je sais que, si j'accepte de participer à ce projet, je dois autoriser l'enregistrement sur bande sonore de l'interaction qui aura lieu au moment où la patiente reprend à son compte la démonstration du bain de son bébé.

Je sais en outre que:

.La bande sonore sera identifiée par un code numérique.

.Le contenu de la bande sonore sera strictement confidentiel, c'est-à-dire qu'il ne sera accessible qu'à Nancy Woo et aux membres de son équipe de recherche.

. Ma participation est libre.

. Je pourrai retirer mon consentement et cesser ma participation au projet en tout temps en prévenant Nancy Woo.

. La bande sonore ne pourra en aucun cas être utilisée contre moi ou nuire à mon emploi, soit pour me juger personnellement, soit pour évaluer mes soins professionnels.

. Mon employeur n'aura pas accès à ces données.

. Même si je ne bénéficierai pas directement des résultats de cette recherche, ma participation à ce projet par l'information précieuse qu'elle fournira, sera utile à l'amélioration des interactions entre patients et infirmières.

. Les résultats de cette recherche me seront communiqués sur demande.

Le projet d'étude et les termes de mon consentement m'ont

été expliqués par Nancy Woo. Elle a répondu à mes questions de manière satisfaisante.

Dans les conditions mentionnées ci-dessus, je m'engage à participer à ce projet.

_____ _____

Signature du participant Date

_____

Témoin

McGill University

School of Nursing

Topic of Study: Nurse-Patient Interactions
Researcher: Nancy Woo
Telephone number:484-3431

Written Consent Form - Patient

The research project is a study of nurse-patient encounters. The purpose of the study is to determine what nurses can do to improve nurse-patient interactions. I understand that if I agree to participate, I will:

(a) allow the conversation that occurs while I am bathing my baby between a nurse and myself to be tape recorded;
(b) complete 4 brief questionnaires about myself and the conversation which will take about 20 minutes to complete all together.

I further understand that: All information is confidential and my identity will not be revealed. The taperecording and my written responses will be identified only by code number.
The content of the conversation will be held in strict confidence, that is, no one except for Nancy Woo and her research coworkers, will be able to hear the taped conversation.
My decision whether or not to participate will not affect the care or services I receive here. My participation is voluntary.
I understand that while I am encouraged to answer all questions, I am not obliged to do so.
I am free to withdraw my consent and to discontinue my participation in the project at any time without explanation by contacting Nancy Woo.
I also understand that while I will not directly benefit from participating in the study, the information gained may be useful in the future in guiding nurses towards more effective interactions with their patients.
The study and this consent have been explained to me by Nancy Woo and my questions at this time have been answered satisfactorily.

_____ _____

Participant's Signature Date

_____

Witness

Université McGill

Ecole des Sciences Infirmières

Projet d'Etudes: Interaction entre Patient et Infirmière
Chercheur: Nancy Woo
Numéro de telephone: 484-3431

## Formule de consentement écrit - Patient

Ce projet de recherche est une étude des relations patiente-infirmière. L'étude vise à déterminer ce que les infirmières peuvent faire pour améliorer l'interaction avec leurs patients.

Si j'accepte de participer à ce projet, je sais que je devrai:

a) Autoriser l'enregistrement sur bande sonore de l'interaction qui aura lieu lorsque je donnerai le bain à mon bébé en compagnie de mon infirmière.

b) Répondre par écrit à quatre brefs questionnaires sur moi meme et sur l'interaction. Le tout devrait être terminé en 20 minutes environ.

En outre, je sais que:

- Toutes ces informations seront confidentielles.
- Mon identitée ne sera pas revélée.
- La bande sonore et mes réponses écrites seront identifiées par un code numérique.
- Le contenu de la bande sonore ne sera accessible qu'à Nancy Woo et aux membres de son équipe de recherche.
- Ma décision de participer - ou mon retrait - n'affectera en rien mes soins.
- Ma participation est libre.
- Bien que l'on m'encourage à répondre à toutes les questions, je n'y suis pas obligée.
- Je suis libre de retirer mon consentement et de cesser ma participation au projet en tout temps sans explications, en contactant Nancy Woo.

. Même si je ne bénéficierai pas directement des résultats de cette recherche, ma participation à ce projet par l'information précieuse qu'elle fournira, sera utile à l'amélioration des interactions entre patients et infirmières.

Cette étude et ce consentement m'ont été expliqués par Nancy Woo. Elle a également répondu à mes questions de manière satisfaisante.

Dans les conditions mentionnées ci-haut, je m'engage à participer à ce projet.

_____ _____

Signature du participant Date

_____

Témoin