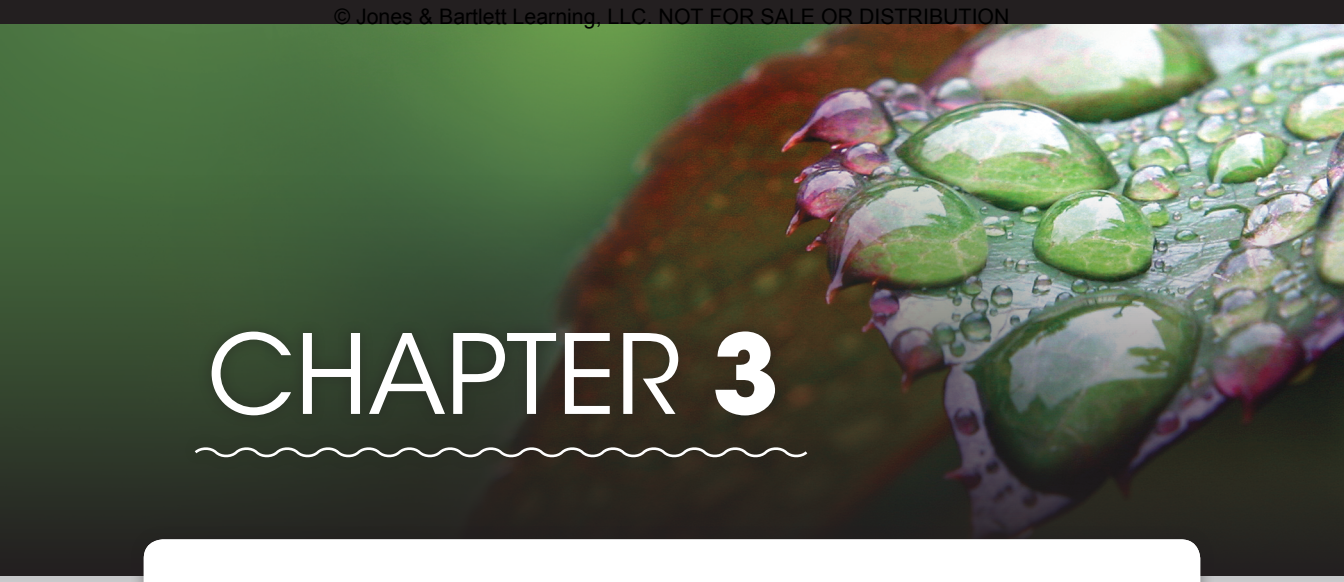
LEARNING OBJECTIVES

Upon completion of this chapter, you will be able to:

1. Discuss the concepts of active listening, empathy, and effective communication.
2. Identify barriers to effective communication.
3. Define differentiation.
4. Recognize what constitutes low versus high levels of differentiation.
5. Self-assess your level of differentiation.
6. Define boundaries and understand how boundaries determine appropriateness of behavior.
7. Understand triangles and how they can affect nurse–client relationships.
8. Describe effective communication practices and distinguish assertive from aggressive communication postures.
9. Develop practices for increasing self-awareness.
10. Pursue one personal wellness goal and chart progress.
11. Take action on one political or policy issue.

KEY TERMS

Active listening
Affirmation
Aggressiveness
Assertiveness
Avoidance
Boundaries
Centering
Contracting
Differentiation
Empathy
Hidden agendas
Refuting irrational ideas
Self-talk
Shaping techniques
Triangulation
Value clarification



CHAPTER 3

The Nurse's Role in Health Promotion

- Introduction
- Effective Communication
- Personality Traits and Communication
- Communication Barriers
- Techniques for Enhancing Communication Skills
- Facilitating Movement Toward Health and Wellness
- Summary

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Introduction

Definitions of health and health promotion, theories about how to undertake health promotion activities, and models for health promotion are all important foundation stones for the practice of health promotion. The final key element to successful health promotion practice is your ability to communicate with the client. As the person connecting a client to the health-promoting activities that seek to improve the client's overall health, your ability to assess needs, mediate problems, and motivate a client is crucial for success. Critical tasks include: (1) actively listening to the client; (2) communicating effectively with the client; and (3) educating the client.

Learning these tasks requires an understanding of how to identify social and familial communication patterns, not only in the client, but also in yourself. Listening, communicating, and educating are all bidirectional interactions that occur between you and the client. If you are not obtaining and processing input from the client, the client is unlikely to obtain and process the input from you.

In this chapter, we explain what constitutes effective communication between two people and describe how to mitigate obstacles to communication. We outline some social and familial factors that can limit or impede effective communication and offer strategies for getting around such obstacles. We will also address the internal factors that can prevent you from utilizing key communication methods so you can become aware of (and address) some of your own communication problem areas.

Effective Communication

Individuals, families, and communities turn to nurses to learn what steps to take to improve health. Doing so involves a process in which the person who has the required information (the nurse) communicates it to the client (an individual, family, or community). Sounds simple. It would be, were it not for the fact that communication is rarely simple. If you choose words or ideas that the client has trouble understanding, it is often difficult to tell where the communication breakdown lies. Some questions to ask yourself to unravel this puzzle are:

1. Am I assuming the client has a base knowledge that is lacking?
2. Are the ideas overly complicated or being communicated in an unclear or confusing fashion?
3. Is the client unable or unwilling to listen and learn in an active fashion?

In many instances, the problem may include elements of all of these issues.

Understanding how people communicate is a first step for you to take in learning how to teach clients more effective methods of listening, self-awareness, and self-expression, and how to identify barriers to communication. These techniques are all skills that you can develop and use to lay the groundwork for developing effective health promotion strategies.

What Is Communication?

Communication should be simple. You want to tell the client something or the client wants to tell you something. The process is complicated by the fact that information passed between two people is almost never composed of pure data free of encumbrances. Along with information, the person transmitting the information also gives a variety of messages, some conscious and intentional, some otherwise, that are received along with the information that the communication intends to pass along. These additional subtext messages may be transmitted by word choice, vocal tone, body language, or expression, and they may not always support the intended communication.

The recipient may also load the information *and* the messages with meanings not intended by the messenger. Most of us have played the game Telephone, where one person whispers a message to another, who then passes what he or she heard to a third person, and on down the line. The end result is usually greatly (and hilariously) different from the original message. This is the basic problem with communication: It is exceedingly rare for a recipient to obtain the *exact* information the messenger attempts to transmit without some sort of alteration occurring.

Communication Decisions

The act of message/information transmission is preceded by a variety of decisions—some made unconsciously—by the messenger. The most important of these decisions are:

1. *What information do I want or need to transmit to this person?* This decision includes smaller decisions about the amount of detail to be offered, whether there are points of information to be highlighted or suppressed, and it frequently involves an assessment of how urgent the transmission process is for both parties and what form the transmission process should take (e.g., "I need to tell Mr. Smith that his test came back negative, but it's not something he needs to do anything about—so I'll just send him an e-mail.")
2. *What words and tone will best accomplish the task of explaining this information?* In some cases, these decisions are made consciously (e.g., a speech, lecture, or prerehearsed conversation), while in others, choices are made unconsciously, in response to emotional impulses in the

moment. Or word choice might be made consciously, but tone is not, which can lead to conflicts between the information transmitted—for example, "I love you" stated in angry or bored tones transmits very different messages than the same words spoken in gentle or enthusiastic tones. Note that body language can have as strong an effect on transmission as tone, although the effect may not be as overt.

3. *How do I feel about transmitting information to this person?* A messenger who feels reluctance, unhappiness, guilt, anger, or other negative emotions related to the message being transmitted generally cannot hide these emotions unless a conscious attempt is made to recognize personal feelings and alter body language and expressions. If no such attempt is made, the *emotional subtext* (information about how the messenger is feeling) transmitted along with the verbal message may actually drown out or supersede the recipient's ability to receive the intended communication.

These decisions, and the subsequent transmission of information that occurs once they are made, are not the end of the communication event. On the other side of the bridge is the person for whom the message is intended—the recipient. In order for the communication to be completed, the recipient must also make a number of decisions:

1. *Do I want or need to obtain to this information?* The decision to listen to a message (or to ignore it) is often based on emotional considerations. A person who is stressed or distracted may simply tune out a communication, even one otherwise considered important, because of a need to limit the information overload being experienced. Alternatively, the person may perceive the information being transmitted as highly important and may drop everything in order to focus on the communication process—even when the person transmitting the information feels much less urgency about the need for communication.
2. *How do I feel about the information that has been transmitted?* The first decision represents the considerations around accepting information; this decision, which is similarly emotional in nature, is distinct from the first in that it focuses on *processing* the information that has been transmitted. A person can receive and comprehend information on an intellectual level, but may have trouble internalizing or coming to grips with the communiqué on an emotional level, particularly if the ramifications of what has been said create stress. A sudden loss, a frightening diagnosis or incident, and similar high-impact communications can cause the recipient to struggle with this particular decision.
3. *How do I feel about the person transmitting the information?* The previous two decisions are nearly always strongly affected by the recipient's feelings about the individual or source delivering the message. A trusted

or authoritative messenger will likely obtain more attention from the recipient regarding the message being communicated—although if there are too many positive feelings about the messenger, the recipient may focus on the messenger rather than the message! In contrast, an unknown or disliked messenger will receive less attention, or the message, once received, may be devalued—that is, regarded as unimportant or suspect.

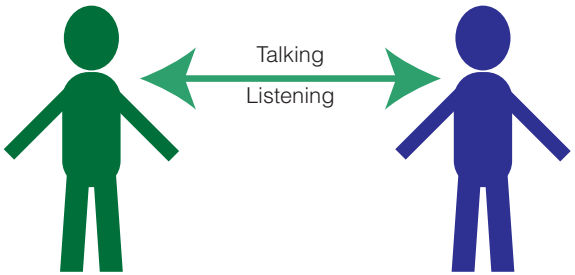
As an educator, you must take conscious control of your own decision making on both sides of the communication bridge. When transmitting messages to clients, word choice, tone, body language, and emotional subtext must be carefully considered—preferably in advance—so that the intended message is transmitted clearly and unambiguously. When interviewing clients or obtaining feedback, examine your decision-making process so that the client's information can be received without impediment.

Create a relationship in which you establish with the client a belief that you are trustworthy, knowledgeable, and competent. Helping the client to feel positive about you is one factor. Another is the capacity to model the type of behavior you wish to obtain from the client: active, engaged listening and learning. See FIGURE 3-1.

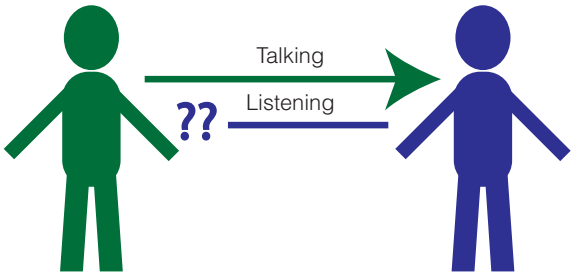
Active Listening

Effective, active listening is one of the most difficult skills to learn because it requires the listener (the recipient of communication) to do more than simply hear the message being provided by the messenger (Aled, 2007; Camillo Sdo, Nóbrega Mdo, & Théo, 2010; Piotrowski, 2005). Friedman, Bowden, and Jones (2003) note that **active listening** requires the listener show empathy, focus on the other person's needs and desires, and avoid interrupting the sender's communication. This requires a conscious and continual effort to suppress the natural desire to pay attention to the client's own needs, desires, and wish to communicate. It also necessitates rapid processing of the information being provided by the person to whom the client is listening. In the context of a high-stakes conversation in which two people are not in agreement about a matter of great emotional importance to one or both (what Patterson, Grenny, McMillan, and Switzler [2002] call a crucial conversation), the emotional considerations of obtaining the other person's agreement contradict the desire to listen—unless the listener deliberately sets aside the emotional response he or she feels and focuses on obtaining the information being provided by the other participant. Similarly, in a casual conversation where the matter under discussion is not important to one or both, the listener's attention may be prone to wander, and information is likely to be missed as a result.

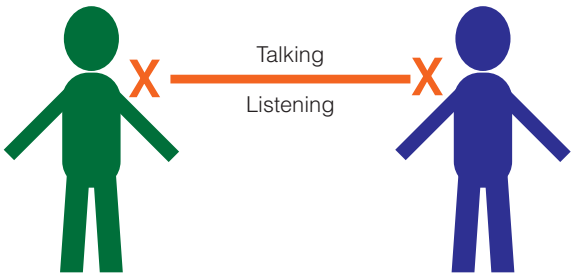
An active listener is one who exhibits engagement through expression, tone, and body language, responding to the messages sent by the communicating



Two people who take turns talking and listening are more likely to have effective communication about a topic.



If one person is continually talking, it is difficult to obtain cues that show the other person is listening. Over time, the "listener" may start tuning out much of what the "talker" is saying.



Complete communication breakdown. Even if one party is talking, the other is not listening. Or, neither party is talking. In either case, there is no communication occurring.

FIGURE 3-1 Communication is a two-way street

party in an appropriate fashion (feedback) that expresses an understanding and validation of the message (Friedman et al., 2003). Appropriate feedback acknowledges the content of the communication, whether spoken, unspoken, or both, and validation demonstrates that the content has been internalized and understood.

For example, imagine that you are helping a grieving client describe a recently deceased parent. You are leaning forward, looking directly at the client and saying, in a soft voice with a sympathetic tone, "I can see that talking about your late father makes you a feel sad." By doing these things, you have shown both that you heard what was said (feedback) and understood it (validation). In contrast, imagine that you say the exact same sentence in a dry, unemotional voice while sitting with your body turned away from the client, and your eyes looking at a computer screen instead of the client's face.

Although the same verbal response is offered, the message sent is very different. The feedback shows that you heard the message, but your body language does not validate the client's message. Your lack of engagement is obvious, and the client may respond accordingly by refusing to listen to you.

While simply modeling active listening for a client is a good way to establish positive feelings in the client (most people enjoy having a listener's full, unimpeded attention), it is also a good way to assess whether the client needs instruction in how to engage in similar behavior. A client who is not a skilled listener or who is stressed, fatigued, in pain, etc., may display inattentiveness, may not comprehend instructions or information being offered, or may speak continually without allowing you to respond. If your ultimate goal is to engage in health promotion activities with this client, then you must first take steps to ensure that the client is capable of receiving the instruction being offered.

Empathy can help make the client more receptive to your communication. **Empathy** means you communicate back to clients the feeling and meaning they express to you. There are five levels of communication.

Level 1: You do not focus on the client's communication and overlook expressed surface feelings.

Level 2: Your communication of client feelings is not congruent with what the client expresses.

Level 3: You paraphrase what the client said, but the meaning you provide is of a superficial nature.

Level 4: You believe you understand what the client is driving at and you add significantly to the client's expressions of feeling.

Level 5: You not only add significantly to the client's feeling expressions at more than one deeper level, you know you understand what the client is experiencing.

Example:

Client: "I don't like what the doctor told me."

Level 1 response: "Time for your walk now."

Level 2 response: "You'll learn to like what he says."

Level 3 response: "You don't like what the doctor told you?"

Level 4 response: "I see your face tensing up about what the doctor told you."

Level 5 response: "It's really upsetting when you hear something that isn't helpful to you."

Guidelines for communicating effectively with clients include:

1. Maintain eye contact and focus on what clients are saying and how they are saying it.
2. Mirror the degree of formality and word choice clients use.
3. Identify client feeling tone and use similar words when discussing a situation with clients.
4. Avoid simply sitting passively and listening. Actively and frequently respond to client communications.
5. Communicate client nonverbal expressions back to them.
6. Trust your feelings and be genuine in your communications.
7. Ask for specific details and instances, e.g., "Give me an example of what you mean," and "Tell me what you heard and saw so I can understand."
8. Only disclose personal information when it could benefit the client, e.g., how you felt when you experienced a situation similar to the one a client describes.
9. Point out what you observe about client behavior and how it is affecting your ability to be helpful to them: "When you don't answer or turn your back to me, it's difficult to understand you and how I could help."
10. State discrepancies in client verbal and nonverbal behavior, e.g., "You told me you're upset, but you're smiling."
11. State what clients are struggling to express, e.g., "I hear your anger about your situation and I'm going to help you with that."
12. Always communicate with respect; point out that clients know what is needed and by speaking with confidence about how you can teach clients to choose appropriate change goals and take action to accomplish them.
13. Explain what you can and cannot help with, e.g., "I can help you choose goals and learn ways to reach them, but I can't decide for you."
14. Encourage clients to problem solve by helping them specify reasonable goals, how they will know when they've met their goals, and when they plan to implement action toward their goals.
15. Teach clients to brainstorm by making comments such as, "Here's a piece of paper and a pen. Write down all the possible ways you could meet your goal."
16. Show clients how to evaluate alternate ways to meet their goals, e.g., "These are good ideas, but are there other ways you could meet your goal?"
17. Help clients to takes small steps to their goal, e.g., "It can be overwhelming to think about changing. Let's talk about how to break your goal into small steps that will be less stressful for you."

HEALTH PROMOTION CHALLENGE

Use the following statement by a community member to provide level 1, 2, 3, 4, and 5 empathic responses:

Client: "The school nurse is trying to force my daughter to have a whooping cough vaccination, even though the vaccine works no better than a placebo and even though my son died after receiving the vaccination. (Rage in her eyes). Is that fair? (Paces up and down the room). They might not let my daughter in school without the vaccination, but I'm not putting her in that position . . . not after my son (bangs her fist on the table). Do you believe it? These are people who are supposed to be concerned with health, and they're trying to force me to do something that killed my son!"

ACTIVE LISTENING TRAINING EXERCISE

A simple exercise to train yourself in active listening is to sit down with another student and practice giving information and then ask the other student to repeat what was heard before responding to it. Each of you must wait for confirmation before continuing. The benefit of this strategy is that it allows the originator of the message to correct misunderstandings, and it also slows the pace of communication down so that information is relayed in smaller, more readily processed packets. It also allows you time to consider the tone, body language, and expression used in communication. Practice active listening with at least two classmates and discuss your results with each other.

Personality Traits and Communication

No two people learn or communicate in the same ways. Learning and communication styles develop in an individual as a complicated interaction between personality traits (which themselves are determined by complex genetic, sociocultural, and environmental factors), life experience, and family and social environments. Modeling and teaching active listening can be a critical factor in helping clients change their communication style or pattern. Three other factors that are important to an individual's or family's communication style are the level of differentiation, the presence of (and respect for) clear boundaries, and assertiveness.

Levels of Differentiation

In the 1970s, psychiatrist Murray Bowen developed the concept of **differentiation** to define a person's ability to separate emotional stimuli from rational thought processes and actions (Bowen, 1972, p. 19). Bowen also used the term to explain the extent to which people intellectually distinguish themselves and their own needs from others in their emotional relationship system, e.g., a family (Miller & Winstead-Frey, 1982). The level of differentiation an individual displays reflects that person's capacity to identify and distinguish emotional input so that a response is undertaken, not in pure reaction to emotions, but with input from the rational, conscious mind as well.

The concept of differentiation draws on the fact that there are distinct emotional and intellectual systems in the brain. Each center responds virtually simultaneously to the same source of stimulus—a noise, a sensation, or a situation between people that links to a related experience, knowledge, or memory. For instance, if a person hears someone talking in a manner that reminds him of his father, he may think to himself, "Gosh, that guy sounds just like Dad." At the same time, he is undergoing physiological responses related to the experience of similarity between the speaker and his father, depending upon what emotions that experience triggers. If he has a difficult or distant relationship with his father, for instance, hearing someone who sounds like him may trigger a stress response—elevated heart rate, shallow breathing, sweatiness. If he has a close, loving relationship, he may have the opposite reaction—hearing a voice that reminds him of his father's may make him feel relaxed, happy, and confident. What matters is whether this person is able to act upon the intellectual recognition of the resemblance and comprehend that it is different from the emotional recognition of the resemblance—in other words, whether he is able to differentiate between the intellect and the emotions.

At a low level of differentiation, the intellectual center (which allows people to think about their lives and plan and control their behavior) is not well differentiated from the emotional center. People who are less well differentiated have a high level of fusion between their emotional and intellectual systems, which means that decisions and behavior are strongly influenced by emotional responses. Individuals with low differentiation are prone to acting impulsively, to reacting emotionally under stress, or to having difficulty foreseeing the consequences of their actions.

At a high level of differentiation, the intellectual center is well developed and screens stimuli from the emotional center. Individuals with high differentiation stay calm under high stress or in extremely emotional circumstances. This does not necessarily mean they are lacking in empathy or compassion, but simply that they are capable of discerning and separating an emotional response from an intellectual one. Let us suppose, for example, that the person

in the previous example has a poor relationship with his father, who is overbearing, hypercritical, and verbally abusive. He hears the voice and starts feeling nervous and stressed, but then says to himself, "Don't be silly. Dad is back home in Arizona. It's just someone who sounds like him." Because he is well differentiated, he is able to recognize and acknowledge his emotional response without letting it overwhelm him. If he were less well differentiated, he might become agitated or leave the room abruptly to escape the source of the emotional stimulus.

Although Bowen considered people to be on a continuum from low-level differentiation to high-level differentiation, it may be more useful to regard people as moving less well among various levels, depending on the amount of anxiety they are experiencing; in other words, an individual may function with a high level of differentiation under certain circumstances, but with a lower level of differentiation when under high stress or specific forms of stress. High levels of anxiety short-circuit the intellectual system and lead to overly emotional responses. Stress, fatigue, and burnout are associated with lower level of differentiation and may also be related to increased susceptibility to illness or infection (Callen, Mefford, Groër, & Thomas, 2010). Physiological correlates of high anxiety and lack of the relaxation response have been known for years. Some signs that are associated with low-level differentiation during stressful situations with clients include increased blood pressure, pulse, and respiration, and decreased ability to focus on the work at hand. Measures that enhance relaxation and decrease stress can enhance level of differentiation.

As a role model for health and wellness, learn to differentiate intellectual from emotional impulses, both in clients and in yourself, so that the guidance you offer is founded on knowledge rather than reaction. Use your understanding of the client's health and wellness value system and your own to develop a path that will be helpful to health promotion. On occasion, differences between you and the client in health-related ideas and goals may prove challenging and uncomfortable for you.

Support a high level of differentiation in yourself and the client by thinking through your responses and teaching clients to do the same. You will see this factor in action not only in clients, but also in colleagues, and even in yourself. For example, when experiencing anxiety, you or clients may overreact to a situation. When emotion and emotional systems take precedence over the intellect, self-talk similar to the following might occur: "Uh-oh, time to panic!" or "I can't handle this, I'd better get out of here" or "How dare she say that!" The task of the well-differentiated you is to recognize the emotional response for what it is, maintain a sense of groundedness as the situation unfolds, and avoid reacting to the client's emotions with an emotional response of your own.

Similarly, a well-differentiated you will be able to note your own emotional responses and take appropriate actions to prevent them from overcoming the intellectual response. For example, you can redirect emotional energies by breathing deeply before replying to a highly charged question, stepping out of a room for a time out to collect your thoughts, or even counting to 10 in your head.

Maintain awareness of your trigger points, those comments or situations that set off irrational reactions in you. This is a powerful method of preventing those buttons from being pushed. At a higher level of differentiation, the intellectual system screens noxious stimuli, and thoughts and perceptions may be more like the following: "Keep calm," "I can handle this," "What am I getting so excited about?" and "This isn't the end of the world; I can deal with this." It's helpful to think one or more of these comments to yourself even when you don't feel it because they can bring you out of an emotional state.

CASE STUDY Low versus High Levels of Differentiation

Jill is a new hire in the Portland City Hospital intensive care unit (ICU). Although this is her first staff position in an ICU, she trained for it in a teaching hospital that is renowned for its cutting-edge program that researches and develops new techniques. She was told when she was hired that her knowledge of the latest methods was something her supervisors wanted her to share with the hospital's veteran nurses.

Mary, an experienced staff nurse who has worked in this ICU for 15 years, was working with Mr. White, a man with pneumonia and Parkinson's disease, who was hospitalized on that unit. His family was visiting at the time, and his neurologist was also in attendance. Mr. White's muscles frequently became locked as an effect of his Parkinson's disease. Mary was performing a manipulation technique intended to help ease Mr. White's muscles so that he could change his position more easily, which would help his breathing. She used the technique she had been taught many years ago.

Upon entering the room where Mary was working, Jill saw that Mary was using a technique that she had been trained to avoid. Jill was taught that in the hands of an experienced person, the technique worked well, but if used incorrectly, it had the potential to injure a client. The alternate technique Jill had been taught was safer, but was sometimes less effective.

Because she was not experienced in its use, Jill could not assess whether Mary was using the technique correctly or not. How should Jill handle her concerns about Mary's technique?

A. Enter the room and say to Mary, "What are you doing? You're doing that wrong! Let me show you how to do it right."

(continues)

B. Leave the room quickly and go get a supervisor, telling her with great urgency that Mary's actions were endangering the client's welfare and requesting immediate intervention.
C. Enter the room and say to Mary, "May I watch? I wasn't trained to use that technique, so I'm interested to see what you're doing." Once she finished, Jill could plan to ask Mary to meet her for coffee so she could talk to Mary about the safety issues with her technique and offer to train her in a more updated method.
D. Enter the room, introduce herself, and simply observe what Mary does, taking unobtrusive notes. That way, Jill could document the client's well-being and intervene if Mary inadvertently injured him. Later, Jill could talk with a supervisor and describe her concerns—and suggest a training session between her and Mary to discuss the two different techniques.

Which of these responses reflect a low level of differentiation?
Which response is most professionally appropriate?

Analysis

Response A reflects a very low level of differentiation. It is a knee-jerk emotional response that demonstrates lack of forethought, lack of respect, lack of collegiality, and lack of consideration. Simply blurting out "You're doing it wrong!" to a senior colleague is not only unprofessional, but it is rude—and it creates a hostile environment in the client's sick room, in the presence of a physician responsible for the client's well-being. By responding in this manner, Jill may adversely affect:

- the client, who may be startled and disquieted by having his treatment interrupted so abruptly
- the family, who will likely be concerned at being told their relative is being mishandled
- the physician, who may have any of a number of negative responses depending on his relationship with Mary and his understanding of the technique she uses
- Mary, her coworker, whom Jill would have just criticized—perhaps unjustly—in front of both a client and a professional colleague

If Jill later must work with either this client and his family or either of these colleagues to engage clients in health promotion activities, her poorly differentiated response would probably affect their trust in her capabilities, and thus reduce her effectiveness.

Response B is not much better. While it may not have an impact on the client, his family, or his physician, Jill is suggesting to their mutual supervisor that Mary is doing harm to a client—which is founded on Jill's *emotional* response to seeing Mary's technique, not her reasoned response. Her accusation

(continues)

very likely is not true. The fact that Mary's technique is not *as safe* as the technique Jill knows does not mean it is *unsafe*, particularly when used by an experienced practitioner, which Mary is. Jill's reaction has created a problem where most likely none existed, and her response may cause workplace conflict between Jill and Mary or between Jill and her supervisor. Again, this will affect her colleagues' trust in Jill's capabilities during future collaborations.

Both response C and response D show high differentiation. Jill has concerns, but she does not react emotionally or with panic about the technique she sees Mary using. In both cases, Jill understands that she needs to trust in her colleague's experience and maintain her professionalism in the presence of the client, family, and physician. She thinks ahead to how she can address the situation in a way that will maintain collegiality and respect.

Of the two, however, response D is more professionally appropriate. Because client safety is the focus of Jill's concern, it is necessary that she formally present her issue and solution to the supervisor so that it can be resolved officially, not off the record, as Jill's solution in response C would do. By taking notes, Jill documents not only the situation, but also the technique she is observing—which may be useful down the line should Jill need to assess another practitioner's use of this unfamiliar technique in the future. Training between Jill and Mary may be mutually instructive, teaching Jill something she needs to know as well as bringing Mary's practice into line with current thinking.

HEALTH PROMOTION CHALLENGE

Evaluate your level of differentiation and set a goal for raising your level. Decide on a date for implementing your goal that's reasonable for you.

Boundaries

Boundaries are invisible crossing points where the self of one individual encounters that of another. In the physical sense, this is also sometimes referred to as "personal space," but boundaries are most commonly envisioned in non-physical terms; that is, they are felt as an emotional response to a perceived intrusion on the client's turf or a reduction of the client's personal dignity. Boundaries are often distinguished by the level of trust entailed in crossing them; that is, the rigidity or permeability of a boundary depends on the nature of the relationship between those individuals. The closer the relationship, the

more permeable the boundary tends to be. But boundaries can change in response to changes in relationship dynamics.

An example would be a situation in which someone confides embarrassing information to a trusted friend, who then reveals that information to someone else. By disclosing the confidence, the friend crossed the boundary of trust and friendship implicit in the act of confiding. Upon learning of the indiscretion, the first individual is likely to experience emotions of hurt, anger, embarrassment, and loss of trust in the friend. As a result of the indiscretion and the subsequent emotions, a formerly fluid boundary between this individual and the friend will likely become more rigid. A boundary based on a level of trust that has been breached is often extremely difficult to restore to prior levels.

Boundaries are also instrumental in determining appropriate behaviors between two individuals based on the roles these people play in relation to one another. For example, actions that may be appropriate between two people in a parent–child or a spousal relationship (tight hugging or cuddling, for example) are not considered appropriate between strangers or casual acquaintances.

A well-differentiated person has a strong sense of self, and recognizes consciously as well as unconsciously where the outer limits of his or her tolerance lie. A poorly differentiated person lacks this delineation of boundaries, and may often be lacking awareness of others' boundaries (as well as his or her own). The fusion trait described earlier as characteristic of people with low differentiation can be alternately described as poor awareness of boundaries.

In a nurse–client relationship, it is important that you are aware of boundaries and able to identify potential boundary conflicts. Failure to do so can disrupt your role as teacher and motivator, and in extreme cases can prove emotionally or even physically harmful to you, the client, or both. You will see personal sides of clients, but it is important to maintain professional boundaries and not reveal too much information about yourself (Helming & Jackson, 2009). Keep your focus on the client's needs and desires, not your own.

Assertiveness

A third important element of effective communication is assertiveness. **Assertiveness** is the ability to clearly and willingly express thoughts, feelings, or desires in a respectful and cordial manner. It means being able to define and stand up for reasonable rights while respecting others' rights, setting goals for wellness, acting on these goals by following through consistently, and taking responsibility for the consequences of actions. Assertive behavior, by definition, requires a high level of differentiation and solid self.

Assertiveness is a useful communication skill for several reasons. Assertive individuals can

- Keep interactions focused and goal oriented
- Let both parties in a conversation know where they stand and free up energy to deal with the situation as it really is, instead of wasting energy trying to decipher what the other person really means
- Role model and encourage similarly assertive behavior in others with whom they are communicating.

Do not confuse assertiveness with aggressiveness. Being assertive requires taking a risk by clearly stating what is expected from others and what they can expect from the nurse. *I* messages are used, e.g., "I would like to . . . " or "I suggest we settle it by . . . " or "I feel angry when I'm called lazy." In contrast, **aggressiveness** has an element of control or manipulation. *You* messages, such as "Why didn't you . . . ?" or "You should have . . . " or "I think you are crazy" prevail when aggressiveness occurs. An aggressive interaction is one in which one party seeks to exert power or control over another; aggression has no place in health promotion, where the goal is to motivate and educate individuals to work toward their own health improvement.

What Prevents Individuals from Being Assertive?

Clients and nurses alike often fear being assertive because they fear not being liked, being rejected, being retaliated against, and so forth. It is important to be aware of which of these fears (or others) may be preventing assertiveness and take action to dispel them. The same fears seem to operate regardless of gender. Women may be most fearful of rejection and tend to bend over backwards to please, but men also feel pressure to be strong and never show their feelings. Both of these reactions can be traced back to early family experiences in which girls are raised to be nice, not fight, not show anger, and (often) are judged on how they look or socialize, not on their competence in the task. As a result, many girls grow up to be women who underestimate their achievements, attribute their success to luck, and doubt their ability even when they are highly competent. Men assume they are competent and readily set out to prove it (Rivers, Barnett, & Baruch, 1979).

Early school experiences also influence the assertiveness of male and female nurses. Dweck (1975) found that teachers expect boys to be rowdy and inattentive about schoolwork, but girls are expected to be well-behaved, dutiful, and exerting their best effort. When boys fail, they are told to try harder (a motivation problem), but girls are just told they have done something incorrectly (which may be interpreted as a lack of ability).

Assertiveness appears to be situational. Some women feel more comfortable being assertive at work, while some men feel more comfortable being asser-

tive at home. Perhaps one of the few generalizations that can be made is that everyone has some assertiveness issue to deal with; no one is totally unassertive nor totally assertive. Assertiveness is a continuum.

CASE STUDY Assertiveness with Peers

Bob Smith was working to obtain his BSN. When assertiveness was discussed in a seminar, he shared the following comment: "Why is it that everyone expects you to be strong and handle every situation?" As the discussion group helped Bob explore the issue further, it became clear that Bob's female nursing peers gave him verbal and nonverbal messages to be strong and not show any uncertainty he felt about dealing with some nursing situations. It was suggested that Bob set up a time to talk with his female counterparts about how he felt and to share how difficult it was to always be the one who was expected to be strong and competent. The next week in class, Bob shared how he had met with his female peers and seemed surprised that they were surprised about how he felt. They decided to ask each time a stressful situation occurred how each one felt about taking responsibility in that situation. Bob reported feeling greatly relieved that "Things are now out in the open."

HEALTH PROMOTION CHALLENGE

Interview a nurse or nursing student of the opposite gender and find out which areas of assertiveness are a problem for him or her. Find a way to work together to help each other improve assertiveness skills.

Assertiveness and Stress

Development of assertiveness is also useful as a stress reduction measure. Individuals who are unable to express their thoughts and feelings directly or who feel unappreciated or exploited often report having psychosomatic complaints such as headaches or stomach problems. Assertive individuals often report increased feelings of self-confidence, reduced anxiety, decreased bodily complaints, and improved communication and response from others. There are a number of strategies to use to become more assertive, which we will describe later in the chapter, but one key to reduce anxiety and fear about being assertive is to regularly practice relaxation exercises.

RELAXATION EXERCISES

Progressive Relaxation: This exercise is especially for clients who are not tuned into tension in their bodies.

1. Lie down in a comfortable spot or sit in a comfortable chair.
2. Close your eyes. Follow steps 3–10, tensing for 5–7 seconds and relaxing for 20–30 seconds. Allow yourself to deeply experience bodily changes.
3. Tense all the muscles of your hands, forearms, and upper arms.
4. Let all the tension out of the muscles of your hands, forearms, and upper arms.
5. Tense all the muscles of your head, face, throat, and shoulders, including the forehead, cheeks, nose, eyes, jaw, lips, tongue, and neck.
6. Release all the tension in your head, face, throat, and shoulders.
7. Tense all the muscles in your chest, stomach, and lower back.
8. Release all the tension in your chest, stomach, and lower back.
9. Tense all the muscles in your thighs, buttocks, calves, and feet.
10. Release all the tension in your thighs, buttocks, calves, and feet.

Taking a Trip in Your Mind's Eye: Especially useful for clients who use imagery or can picture items easily.

1. Find a comfortable, quiet spot and assume a relaxed position.
2. Close your eyes.
3. Let your breathing begin to move lower in your body, moving toward your abdominal area. Each time you exhale, move your breathing lower in your body toward your abdominal area.
4. Take yourself on a trip in your mind's eye to a place that is comfortable and relaxing, somewhere you have been or somewhere you would like to be. See all the sights associated with your quiet, relaxing place. Hear all the sounds, smell all the wonderful smells, taste any tastes associated with your quiet, relaxing place. Fully experience all the sensations associated with your peaceful, relaxing place.
5. Totally immerse yourself in your quiet, relaxing place until you are ready to return, then gradually return from your trip, keeping the relaxation and calmnness with you for as long as you wish. Then, gradually open your eyes, feeling refreshed and ready to resume your day.

Assertiveness requires teaching the client to present himself or herself in a confident, self-assured manner. When body musculature is tense and constricted, a self-confident presentation is difficult. A relaxed body increases the probability that others will be approached in a direct, open manner.

Communication Barriers

Even when two persons have direct interactions, there may be a number of potential stumbling blocks. Health promotion is, at heart, about teaching, training, and supporting—all of which require the communication of key health promotion messages from the nurse to the client(s). If communication is ineffective, the messages are not transmitted or are transmitted incorrectly—and the health promotion effort likely will fail. In this section, we will talk about how to identify problem areas in communication, and what to do about them.

Dysfunctional Communication

Functional communication occurs when individuals or groups are able to discuss matters of concern in a respectful, mutually supportive manner. Each party takes turns expressing a position, each party listens to the other party's points, and they negotiate a position that both can find satisfactory because both parties care about reaching a compromise and working through differences. Emotionally mature, well-differentiated people may not always communicate in a functional manner, but most of the time, they do. Unfortunately, many people do not learn how to communicate this way, and resort to a variety of dysfunctional tactics (see BOX 3-1).

Box 3-1 Dysfunctional Communication

In messenger dysfunction, the messenger:

- Makes assumptions
- Has an unclear expression of feelings or wishes
- Uses bait-and-switch (starts with one message when a second message is what is on his or her mind)
- Offers judgmental responses
- Cannot define his or her own needs
- Presents incongruent messages (i.e., body language does not match verbal statements)

In recipient dysfunction, the recipient:

- Does not listen
- Disqualifies the message ("Yes, but …")
- Responds with insults or defensiveness
- Refuses to explore message or cuts off communication
- Refuses to validate message
- Brings up unrelated or tangential issues

Source: Friedman, M. M., Bowden, V. R. & Jones, E. G. (2003). *Family Nursing: Research, Theory, and Practice* (5th ed.), Upper Saddle River, NJ: Prentice Hall.

Listening Blocks

Make sure you're not engaging in any listening blocks such as:

- Comparing yourself to clients rather than listening to them.
- Trying to figure out what clients really mean rather than listening to what they say and observing what they do.
- Rehearsing your answer to the client rather than listening to what is said.
- Filtering out anything a client says or does that makes you feel uncomfortable.
- Judging what clients say or do rather than trying to understand and be helpful.
- Fantasizing instead of listening to clients.
- Focusing on your own feelings rather on the client's.
- Advising the client about what to do.
- Arguing with the client.
- Trying to be right rather than helpful.
- Joking or changing the subject rather
- than listening and observing clients.
- Agreeing with what clients say so they'll think your nice or pleasant.

The key to reducing the impact of such blocks is to train yourself to recognize they are occurring in you or the other person. To a certain extent, noting such tactics in another communicant helps resolve the issue by continually bringing the subject back to the matter under discussion. If use of these tactics appears to be habitual in a client (or in yourself), the pattern can be decreased or eliminated by increasing differentiation. Centering (see *Centering* later in this chapter) can also be helpful (McKay, Davis, & Fanning, 1983, pp. 1, 6–9).

Avoidance and Aggression

Avoidance in the context of communication means taking steps to prevent a message from being delivered, either by impeding the messenger from transmitting it, or more commonly, simply refusing to receive it. **Aggression** in communication can mean two things: (1) communicating in a manner that directs overt hostility, anger, or other negative feelings toward other parties, or (2) communicating in a manner intended to promote similar feelings in other parties. In the context of health care, both of these methods are usually undertaken as a way of diverting attention from a topic the avoidant/aggressive party does not wish to discuss. **Passive aggression** means expressing hostility or anger through passivity or silence—such as sullenly refusing to acknowledge a speaker or failing to do something that has been agreed upon as a way of annoying others.

In healthcare settings, avoidance and aggression are often seen in tandem and are particularly common in family settings. An avoidance/aggression

pattern may play out as follows: One family member may avoid a confrontation or wellness issue, which leads to buildup of resentment in other family members; this eventually fuels a blowup or angry outburst. Without intervention to break entrenched communication habits, family members may have feelings of guilt and recrimination that allow the avoidant person to return to their original pattern of avoidance, starting the cycle all over again.

Avoidant and aggressive behaviors are an outgrowth of an agenda that fundamentally seeks to establish power and control over a situation. Avoidance is a control behavior based in denial, e.g., *If I don't address this situation, I can make it not exist.* Aggression is a more direct expression of a desire for control; e.g., *Matters are not to my satisfaction, and I am going to make others uncomfortable in an effort to get my way.* Neither form of control seeking is healthy or helpful in a healthcare context, because they divert energy from the health issue for which an intervention takes place. You can reestablish a focus on the problem by simply acknowledging the underlying concern: "I know this is new territory for you, and it might be frightening. But let's agree to take it slow, and that you'll tell me when you are concerned or uncomfortable, and we'll get through it without any conflicts. OK?"

Distinguishing Assertive from Aggressive Messages

As discussed earlier, assertive messages start from the *I* position. You assert your stance as coming from your solid self, staking a territory in the conversation where you ask (not demand) your counterpart to meet you. "This is where I am. Please come join me," is the tenor of an assertive interaction. Of course, if

the counterpart in this interaction is also engaged in assertive behavior, he or she may simply respond with a similar proposition, staking a different position separate from yours. At this point, being well-differentiated people, you can negotiate to find common ground—a place in the middle that the two of you can agree upon. Or, if agreement is not an essential outcome, you can agree to disagree! As long as this is done in a respectful manner, the outcome is usually satisfactory for both parties.

Sometimes *you*-aggressive messages masquerade as assertive ones, e.g., "I think you're wrong!" or "I feel you ought to change" or "I want you to do as I say." In these messages, the speaker tries to control the listener by judging behavior or attempting to force change or action; these messages are aggressive and avoid the responsibility each person has for his or her behavior. Some *we* messages can also be assertive, especially if they imply collaboration, such as "We can meet and work this out."

Undifferentiated messages, such as, "Let's take our bath now," are not assertive or collaborative. They infantilize or patronize the object of the communication and lead to resentment and discord, rather than collaboration.

You-blaming messages are apt to put others on the defensive; for this reason alone they ought to be avoided. In addition, they absolve the speaker of his or her responsibility in the issue at hand. Examples of this type of aggressive statement are: "Why didn't you take care of that?" "Why can't you do it right?" "I think this is your fault," and "Why are you going around upsetting everyone?" Some assertive messages do use the word *you*, but there is neither blame nor coercion attached to assertive *you* messages (e.g., "Would you like to tell me your point of view?" or "I want to thank you" or "I thought I heard you say . . . ").

Recognize that while the point of your engagement in a conversation is to transfer your idea or thought to the other person, the other person in the conversation is simultaneously trying to accomplish the exact same goal. Communication is not one way—it must go in *two* directions in order to be effective. That means both parties must listen as well as talk. And listening is something that a surprising number of people do not know how to do. *I*-position statements in a conversation should also be interspersed with noncoercive, assertive *you* messages that show the other person that you are willing to listen—which is also conducive to helping this other person to relax and start listening to your message (Patterson et al., 2002).

Triangulation

Triangulation is a situation in which two people who are involved in a relationship of emotional significance experience anxiety or stress building up between them, and to alleviate this stress, one or both of the individuals calls upon another person, issue, or object to intervene or disrupt the conflict and thereby decrease discomfort (Bowen, 1972). Note that the creation of triangles

does not mean the source of stress is resolved, only that stress is disrupted for the immediate term; unresolved tensions do not generally go away following these disruptions, but may actually increase over time. Triangulation is therefore most often a way of deferring conflict, rather than solving it.

CASE STUDY Triangulation among a Husband, Wife, and Physician

Daniel is a 65-year-old man with multiple chronic ailments. He suffers from epilepsy, congestive heart failure, and late-stage Parkinson's disease. He is hospitalized with pneumonia, which requires intensive care. Daniel has a written do-not-resuscitate (DNR) order and has given his wife Annette a medical power of attorney to make decisions for him, both of which are noted in his file. Annette has explained to Daniel's own physician and to the nurses on the ward that Daniel does not like to make waves about his treatment, but that he has told her that he wants no heroic measures to be undertaken to keep him alive.

Overnight, after Annette has returned home, Daniel's blood oxygen levels start to deteriorate. The attending physician, who is reviewing Daniel's case for the first time, feels that Daniel should be intubated right away. In the doctor's opinion, intubation does not fall into the category of heroic measures. He speaks to Daniel, who is alert and awake at the time, and tells him what he wishes to do, and asks if intubation is acceptable to him. Daniel's response is, "You need to speak to my wife." When pressed to give a decision himself, he becomes agitated and refuses to communicate directly with the physician, who must then call Annette to come in to the hospital. After conferring privately with her husband, Annette steps out of the room and speaks with the physician in the hallway, explaining to him that Daniel is against the idea of being intubated, but feels unable to say so to the doctor. She then sits with the doctor and draws up a list of procedures that Daniel has told her are not acceptable to him.

Often, an individual brought in as arbiter between the two parties who are experiencing stress or tension in their relationship places his or her own interpretations or values on the message, which further muddies the intended communication from the first person to the second. This is the principal reason why avoiding triangles is important. Mixed messages often create misunderstandings and emotional disruptions that are not helpful in promoting health.

Triangles occur in all families as well as in other social and work situations in which there is high anxiety or stress. In a healthcare setting, we often see triangles in the context of the physician–client relationship. For example, a client may be anxious about getting answers from his physician, and may pull you into a triangle by asking or manipulating you to talk to the doctor on the client's behalf. Variants on this triangle are a nurse who questions her ability and triangles in the physician, or a physician who questions his ability to talk with the client about the client's impending death or other highly charged issues and triangles in the nurse to do his talking for him. Or, an adult child with an ailing parent forms triangles with the parent and caregivers, whether these are home health aides, nursing home staff, or a primary care physician. The parent may not want to complain about issues or discomfort to the care-

givers, and instead raises these issues to the son or daughter, who then brings them up to the caregivers.

If triangulation (or attempts at creating triangles) happens in the setting of health promotion, it should be regarded as an opportunity to help the client increase differentiation and promote more direct, better differentiated interaction between stressed individuals—often spouses or parents/children. When you act as a mediator between two individuals who are both present, the conversation need not turn into a triangle. By being a facilitator of healthy, straightforward interactions, you can help increase differentiation in clients, and possibly in yourself.

ASK YOURSELF

Suppose a client is not convinced losing weight will help him with his back problems, his hip problems, his lung congestion, and his blood pressure. What would you tell him? What written information might you provide?

Cultural Differences

Cultural differences in communication styles exist, and can become a barrier to communication if your expectations of how a conversation should be conducted conflict with the client's norms (Cuellar, Brennan, Vito, & de Leon Saintz, 2008). A variety of cross-cultural studies indicate that communication styles and mannerisms deemed appropriate in conversation vary widely. In an ideal world, people from all cultural backgrounds would have access to nurses who share their worldview, language, and cultural context, but this rarely occurs, particularly in a society as diverse as that of the United States. Various studies have shown that cultural disparities can lead to disparities in health care (Misra-Hebert & Isaacson, 2012). The remedy for this issue is for nurses (and other practitioners) to develop greater **cultural competence**—that is, skills in identifying cultural differences between themselves and their clients, and maintaining an attitude of flexibility when dealing with a situation in which the client's norms differ from their own.

Techniques for Enhancing Communication Skills

Techniques for Enhancing Assertiveness

Nurses may encounter clients who are not aware of how they come across to others. There are a number of strategies that can be used to provide feedback

about presentation of self. **Mirror practice** gives feedback about facial expression, posture, and whether words fit with gestures and body position. It can also be helpful in rehearsing assertive statements prior to trying them with the real-life person. This kind of rehearsal can build confidence so that assertiveness in the real-life situation is more likely.

Audio, digital, and videotape recorders also provide excellent practice in assertion. All provide clues about whether there are sufficient pauses, whether tone of voice is assertive, whether statements are made too quickly, if words are said with sufficient firmness and authority, and whether the issue is stated clearly and adhered to. Tape and digital recorders are also useful for recording (and providing instant replay about) one's ability to limit interruptions, express feelings appropriately, take a stand on an issue, disagree, admit a mistake, reward or thank another person, give positive criticism, say no, express distress about the way a relationship is moving, and ask for collaboration.

Some statements to record and evaluate for effectiveness are:

- I cannot talk to you now. I'll talk to you at two o'clock.
- I feel really angry about this!
- I have made up my mind on this.
- I see your point, but I disagree.
- I did make an error.
- Let's sit down and work this out together.
- No, I will not reconsider this; this item is not negotiable.
- I'm upset about our relationship and I'd like to talk with you about it.
- I appreciate your help.
- We agreed your report would be on my desk yesterday. What happened?

Another use of recorders is to keep relaxing or rewarding messages that can be played back at a later time. Some rewarding messages to consider recording for yourself or clients are:

- You are working toward wellness in a useful, helpful way. Congratulations on your effort.
- Keep up the good work.
- Congratulations on not smoking. Give yourself a hug or find someone to hug. Be proud of yourself. Allow yourself to feel good about your accomplishment.
- Congratulations on meeting your fitness goal. Treat yourself to a reward and be sure to allow yourself to feel good about your accomplishment!

Videotape feedback adds the extra information of

1. Eye contact
2. Body posture and positioning
3. Gestures
4. Facial expressions
5. Verbal responses that are too quick or hesitant

6. Conciseness of statements
7. Confidence of presentation

Probably the best use of videotape is to enable role-playing or review of situations, whether past or upcoming. Scripts can be written for two people and then recorded and evaluated according to each of the information components. TABLE 3-1 provides a completed guide for assessing an assertive presentation of self that has been videotaped.

HEALTH PROMOTION CHALLENGE

Use Table 3-1 to evaluate your assertiveness skills.

Table 3-1 Evidence-Based Health Promotion: Assertiveness Assessments

Nonverbal Presentation of Self	Examples/Comments
Frequent and direct eye contact	"I kept looking at the ceiling when talking."
Speaking loudly enough and firmly enough	"I crossed my arms and looked angry when talking about being pleased."
Open, direct body communication	
Gestures match words said	
Verbal Presentation of Self	
Remain on the point of discussion without changing topics	"I let her lead me away from my goal and we started talking about her sore leg instead of my raise."
Use *I* messages, e.g., "I can't help you now," "I feel angry when . . .," "I'd like to talk with you about . . .," "I don't like to be shouted at . . .," "I realize you're concerned, but please don't make decisions for me," "I did make a mistake," "Thank you," "I'd like to do a joint evaluation with you," or "I think we can work this out."	"I used the following blaming messages: I think you should give me a raise. I feel you overlooked me."
Refrain from using *You*-blaming messages; e.g., "You didn't . . .," "You should have . . .," "It's your fault that . . .," "You aren't doing that right."	
Goal(s) for a Role Play 1. Maintain eye contact. 2. Uncross my arms. 3. Tell my partner I feel angry instead of giving an inconsistent message. 4. Get feedback from partner.	

In the role-playing approach, one person tells the other about an upcoming or past situation. It is best to choose two-person situations, avoiding those with a long history of emotional overlay; strive for choices that are likely to end in a successful role-play, not in frustration because deep-seated issues are involved. For example, in an exercise that takes place between Angela and Chris, where Angela is seeking Chris's help in learning how to deal with aggressive clients or colleagues:

1. Angela gives Chris a description of what is to be said, which role each of them will take, how Chris should act to approximate the real-life situation, and how the interchange will end and begin. (A 3–5-minute script is suggested.)
2. Chris should be told that making it easy for Angela is not helpful. Being as aggressive or avoidant as a real-life person might be provides much better practice and will better prepare Angela for actual encounters.
3. Some directions that might be given are: "Be sure to try to make me feel guilty about saying no" or "Every time I try to stick to the issue, you change the subject" or "Use a really angry tone of voice, but tell me that you're not angry."
4. The goal of the role-playing exercise is to help Angela learn how to maintain emotional distance (differentiation) while sticking to her guns (assertiveness); if she loses her cool or becomes flustered, the two should take a break, discuss why Angela lost composure, and replay the exercise.

All of the procedures discussed are also appropriate when assisting clients to be more assertive and may prove invaluable if your initial interactions with the client show that lack of assertiveness is impeding effective communication.

Value Clarification

Value clarification can assist you and clients to develop larger portions of solid self and thus become more differentiated and open to health promotion actions. The process of value clarification is founded in effective communication, but that communication is not always between you and the client—it can also be between the client and him or herself. The steps of value clarification and their attendant processes are as follows (Kirschenbaum, 1976; Kirschenbaum & Simon, 1974; Raths, Harmin, & Simon, 1966):

Prizing

1. Prizing and cherishing. At this step in the process, nurses set priorities, become aware of what they are for or against, begin to trust their inner experiences and feelings, and examine why they feel as they do.
2. Clearly communicating the client's own values and actively listening to others' expressions of values.

Choosing

1. Choosing freely by examining values others have imposed on them.
2. Choosing thoughtfully between alternatives by examining the process by which they choose, and considering the possible consequences of each choice.

Acting

1. Trying out the value choice includes developing a plan of action and trying it out; contracts to act may be drawn up between the nurse and self or others.
2. Evaluating what happened when action was taken and making plans to reinforce actions that support their values.

CASE STUDY Assisting a Client to Clarify His Values

Theresa, a community health nurse, was working with Mr. Thomas, who was recovering from a heart attack. Mr. Thomas was overweight and showing signs of prediabetes. Although Theresa's first impulse was to tell him to lose weight, she restrained herself and decided to try value clarification instead. One of their conversations follows:

Theresa: What kinds of things about yourself concern you the most?

Mr. Thomas: I'm afraid I'll have another heart attack.

Theresa: Anything else?

Mr. Thomas: My wife's nagging; she's always trying to get me to stay on a diet, but at the same time, she bakes cakes and pies.

Theresa: Maybe the three of us can discuss this. [Theresa goes out to the waiting room and requests that Mrs. Thomas join the conversation.]

Theresa: Your husband was just telling me about your concerns about his staying on a diet.

Wife: The doctor told him to lose weight, and I try, but he's always sneaking goodies.

Theresa: Are you interested in losing weight, Mr. Thomas?

Mr. Thomas: Well, if it would make my wife happy … [poor differentiation]

Theresa: I'm wondering what would make *you* happy.

Mr. Thomas: Not having a heart attack again.

Theresa: What do you know about preventing a heart attack?

Mr. Thomas: The doctor says losing weight, exercising regularly, and eating more vegetables will help, but it seems like a lot to me.

Theresa: What if you could choose one of those to begin with; which would it be?

Mr. Thomas: Exercising. I've always been active in construction and baseball until this heart attack laid me low.

Theresa: Suppose we find an exercise plan for you and your wife agrees to exercise with you? How does that sound?

Mr. Thomas: Sounds good to me, but can you get her to stop nagging me?

(continues)

Theresa: I can teach you both how to support each other without nagging. We can start by using assertiveness skills such as *I* messages and other communication skills that have been found useful by some of my other clients. How does the plan sound to you, Mrs. Thomas?

Mrs. Thomas: OK, I guess.

Analysis

The conversation between Theresa and Mr. Thomas begins with the client's expressed desire to avoid another heart attack. By following up this expression with an open-ended invitation to the client to express other concerns on his mind, Theresa encourages Mr. Thomas to address other factors that may impede his success in this goal. While Mr. Thomas takes this as an opportunity to triangulate (blaming his wife for the lack of success in his dieting), it is evident that the mixed message of her nagging to stick to his diet coupled with baking sweets presents a real issue of concern to him. The nurse's act of bringing the wife into the room after the husband attempts to blame her for his inability to lose weight creates a barrier to triangulation by reintroducing direct communication between stressed parties. The triangulation does not stop completely—Mrs. Thomas's first act is to accuse her husband of sneaking goodies, deflecting blame from her own behavior—but Theresa's next response is effective in defusing the poor communication between the couple. Instead of getting involved in a wrangle over whether the wife is to blame for baking or the husband is to blame for eating what she bakes, she asks Mr. Thomas to express his wants—inviting him, in other words, to establish his *I* position. Initially, he does not take this opportunity, instead deferring to his wife, but Theresa redirects the question to once again obtain an *I* position from him. This time, he states his wants clearly. From here, Theresa now has the opportunity to give Mr. Thomas options on how to reach his stated goal. She offers Mr. Thomas a selection of choices regarding activities that can help him lose weight, and gives him control over which choice is most meaningful to him. When he picks exercise, she suggests an exercise program that involves his wife.

Bringing his wife into the selected program should provide Mr. Thomas with greater support in his weight loss efforts—support that his repeated comment about her nagging indicates he needs. The wife's limited, nonassertive verbal response may be a cue to lack of investment on her part. The husband has earlier complained that the wife sabotages his efforts at maintaining a healthy diet by baking cookies and pies, which the wife, in her turn, has accused him of sneaking. The disparity in their descriptions is significant and may point to a larger issue between them that has not been addressed—and that may be a continued obstacle to Mr. Thomas's success in losing weight.

If you were working with this couple, it would be important to note this and work to promote greater investment on the part of Mrs. Thomas. For example, asking Mrs. Thomas to agree to stop baking might not be realistic if baking is a hobby she enjoys. Asking her to bake less often, or to give her baked goods to friends, food pantries, or bake sales might be a way to negotiate a compromise—one which both Mr. and Mrs. Thomas can accept. Such a negotiation can reduce the sneaking of food and, in the long term, help support Mr. Thomas's efforts at weight loss. Discussion continues as the nurse proceeds through rest of the value clarification processes and makes plans with the couple to try out new behaviors and evaluate them.

HEALTH PROMOTION CHALLENGE

Read the case study that follows, choose a health promotion issue of importance to you, and follow the value clarification steps with at least one other student helping you through the process.

CASE STUDY

All students in a seminar were asked to write about an assertiveness issue that they wanted to work on and bring their papers to class (choosing freely). The instructor helped each student discuss when he or she might want or not want to be assertive in their situation (prizing and cherishing; examining alternatives and consequences of action). Students selected another student to pair up with to practice role playing the assertiveness situation. Some students decided to contract with one another to try out the situation in real life and to receive positive reinforcement from one another for doing so (trying out; contracting; reinforcing change). All students were encouraged to try their new assertive behaviors out in real life situations and to report back to the class by evaluating their performance (evaluating).

Techniques for Raising Self-Awareness

If you assess a client as lacking adequate differentiation or assertiveness, it is worthwhile to consider options for improving these qualities. A number of techniques have been developed to support an individual's abilities in this regard.

Centering

Centering refers to finding within oneself an inner reference of stability, a sense of self-relatedness that can be thought of as a place of inner being, a place of quietude within oneself where one can feel truly integrated, unified, and focused (Krieger, 1979).

Centering is a powerful, easily achieved skill (see BOX 3-2) for enhancing differentiation of self and thereby freeing individuals from becoming too emotionally entangled in life issues—what might be regarded as living in the problem rather than living in the solution. Centering is a practice that can benefit the nurse just as much as the client; when nurses are not centered, they are apt to feel fatigued, stressed, depressed, or angry when working with a client who lacks the ability to differentiate. Centering allows the nurse to be separate from, yet open to input from clients—which enhances effective communication.

Learning to reach one's center takes little time once the idea is mastered, but it can have an important impact on practice. Nurses have reported to the author the following ways of using centering:

- "I take a moment, go to the rest room, and get centered between clients."
- "I center myself as I'm walking down the hall on the way to my next client."
- "I center myself when I'm with the client; I ask the client to center herself or himself, and we do it together. I find we both have a lot more energy to concentrate on the tasks ahead when we do."

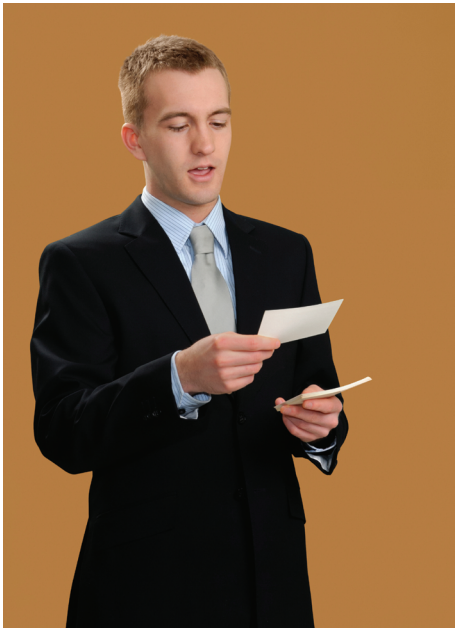
Box 3-2 Centering

Centering can be achieved while standing or sitting, but beginning efforts produce the best results in a sitting position.

1. Sit in a comfortable chair with feet flat on the floor and hands resting quietly in your lap; close your eyes.
2. Check out your body for tension spots and relax these areas as you exhale.
3. Inhale easily, filling your body with relaxation.
4. Exhale, moving your breathing to your center, about the level of your navel.
5. Continue breathing in this manner until you feel calm, integrated, unified, and focused.
6. (Optional) Picture the body surrounded by a protective shield that allows positive energy in, but keeps negative energy out. The shield may be conceived as a color, light source, or in a spiritual sense.

As the third example shows, it can be effective to teach clients to use centering. For example, clients may find it helpful to use prior to any anxiety-provoking situation in the hospital, at home, in social situations, or at work. The steps in centering remain the same. Directions given for the nurse can be copied or adapted for use with clients.

Affirmations



Affirmations are a self-care strategy that can reduce anxiety and stress and lead to calm, productive behavior. An **affirmation** is a positive thought you consciously choose to immerse yourself in. Examples include: "I refuse to let this bother me," "I can stay calm and focused," "I can handle this," "I'm handling this now," and "I'm taking deep breaths and getting calmer every second." For nurses engaged in health promotion, affirmations can be used both to strengthen the nurse's practice or as a means of reinforcing behaviors in the client.

Write or say the affirmation at least 20 times a day to counter the effects of negative thoughts and provide a sense of empowerment. Jot affirmations down on 3 × 5 cards and carry them in a pocket, post on the refrigerator or bathroom mirror, or set them on the car seat to read at stoplights.

Refuting Irrational Ideas

We all talk to ourselves in our thoughts and sometimes in words. This is called **Self-talk**. When our thoughts and words are positive and realistic they can be helpful, but when they are negative and irrational, they can create unneeded stress.

- Statements that "awfulize" an experience, e.g., thinking silence is a negative criticism or that a momentary pain is a sign of cancer or a heart condition.
- The belief that inactivity and endless leisure can lead to happiness.
- The idea that it is easier to avoid difficulties and responsibilities rather than face them.
- The thought that misery is due to external events that trigger emotion.
- The belief that it is possible to be perfect at all times.
- The idea that it is horrible when things are not the way they should be.
- The belief that people can't live without love and approval from others.
- The thought that we have no control over what we feel or experience.
- The idea that new situations must lead to anxiety and fear.
- The belief that good relationships mean constant giving and sacrifice.
- The thought that people are fragile and cannot accept the truth.
- The idea that worth is dependent on producing and achieving things.
- The belief anger is bad.
- The thought that rejection and abandonment will result unless we always try to please others.
- The idea that there is one perfect relationship and one perfect love.
- The belief that going after what is wanted or needed is a bad thing.

Goodman (1974) added to Ellis and Harper's guidelines for changing irrational thoughts into more rational ones. When **refuting irrational ideas**, keep the following points in mind:

1. One person cannot argue; it takes at least two.
2. Everyone makes mistakes.
3. To believe things aren't as they are is magical thinking.
4. Thoughts come first, then feelings; it is our interpretation of what happens, not the events themselves, that leads to emotions.
5. We can never know that real cause of many problems, so it's best to focus on the here-and-now.

TABLE 3-2 provides an example of the use of Ellis and Harper's format for refuting irrational ideas.

HEALTH PROMOTION CHALLENGE

Use Table 3-2 as a model to refute one of your irrational ideas.

Table 3-2 Evidence-Based Health Promotion: Refuting Irrational Ideas

Steps	Actions/Thoughts/Feelings
1.	*Activating event:* My family complains about me.
2.	*Rational ideas:* I know they're under a lot of stress now, so I should give them some slack.
3.	*Irrational ideas:* I can't stand hearing them whisper and point at me. I'm out of control and I may scream at them or punch them.
4.	*Main feelings:* Rage, anger, falling apart.
5.	*Refuting the irrational idea(s):* Refuting the irrational idea(s): I may feel horrible, but I'm not falling apart. I can handle it and stay calm without overreacting.
6.	*The worst thing that could happen:* The worst thing that could happen is I could scream and shout at them, but so what? I'm only human.
7.	*Good things that could occur as a result of this incident:* I'll learn how to handle myself in an upsetting situation without overreacting; even if I do overreact, I'll see that my family can handle that because I don't do it that often.
8.	*Alternate thoughts:* Maybe they're whispering about something or somebody other than me. I don't need to take everything so personally. Even if they are talking about me, I'm okay with it. I can handle being talked about and whispered about. I'm strong.
9.	*Alternate emotions:* Just by writing all this down helps me feel more in control of myself. I can't control anyone else's feelings, but I can learn to control mine.

Assertive Strategies for Dealing with Criticism

Criticism is a fact of life in any profession. Constructive criticism can lead to improvement; feedback from others can help you learn not to repeat the error. For nurses, the goal is to extract the growth-promoting aspects of criticisms from others and use them to grow. To do this, the nurse must dispel irrational beliefs that criticism means failure or wrongness. Sometimes criticism is accurate, but not constructive; other times, criticism is unjustified. However, to determine what beneficial features are present in a critique, the nurse must be willing to face the criticism and assess its validity from an intellectual (well-differentiated) position, rather than responding emotionally.

Three strategies for assertively responding to criticism are acknowledging, clouding, and probing (McKay, Davis, & Fanning, 1983).

Acknowledging

Whenever criticism is received, an assertive response includes **acknowledging** the critic's comment. Some examples are: "You're right, I am half an hour late for work," "You're right, I did misspell a lot of words," and "Yes, I am late in handing in this report."

Excuses and apologies are not part of an assertive response. Consider them automatic leftovers from childhood when excuses and apologies were demanded; parents and teachers expected an explanation and so one was offered—whether real or made up. As adults, individuals have the right to choose whether to give an explanation or not. Often, it is not advantageous to give an explanation because it provides further ammunition for the other person and does not present a picture of competence. Consider the two situations below; the first presents the individual as blame fixing, childlike, and incompetent. The second presents the individual as assertive and adult.

Situation 1: Nonacknowledging

Supervisor: You're late again! How long do you think I'm going to tolerate this?

Employee: Oh, I'm so sorry, the car broke down again and my husband wouldn't give me a lift.

Supervisor: You've always got an excuse, but this time I'm not buying it. I'm writing you up and docking you for 15 minutes.

Situation 2: Acknowledging

Supervisor: You're late again! How long do you think I'm going to tolerate this?

Employee: You're right, I am 15 minutes late.

Supervisor: I'm docking you for the 15 minutes.

The major difference between the two situations is that the nurse gives an excuse in the first instance and does not acknowledge error; in the second instance, the nurse acknowledges error and does not give an excuse. The supervisor lacks the impetus to make an accusatory statement and can simply state the consequence to be handed down—which limits the personalization and attacking nature of the response that is present in the first version.

Clouding

Clouding is an assertiveness technique to use when receiving criticism of a manipulative nature (Eshelman, McKay, & Fanning, 2008). To use this

technique, clients must listen carefully to determine which part of the criticism they agree with in part or in principle, but not to agree to change.

Situation 1: Agreeing in Part

Supervisor: You always have an excuse for not working overtime. What's the matter with you anyway?

Supervisee: Yes, I do have many reasons for not working overtime, but you know how it is when you have small kids at home.

Supervisor: You don't seem to care for your job at all.

Supervisee: I can see where you might conclude that, but it's not how I feel.

The initial critique offered by the supervisor is valid (even if rudely made); the supervisee does not work overtime much. However, the supervisee has valid reasons for refusing overtime; in agreeing, the supervisee has the opportunity to deflect the criticism by pointing out, gently, what the supervisor has overlooked—the fact that she/he has young children to care for. The second criticism, however, is unfair; working overtime (or not) has no relationship to the supervisee's commitment to the job. By suggesting that the supervisor's assessment may *seem* valid, but does not reflect the supervisee's *actual* level of commitment (I position), the supervisee again partly agrees and deflects the critique. Stating the *I* position here is key because the supervisor cannot contradict it; "This is how I feel" is a statement that only the person making it can assess for validity.

Situation 2: Agreeing in Probability

Supervisor: You know, this workstation is a disaster. You can't possibly work in such a mess. Why aren't you keeping it more organized?

Employee: Actually, my shift just started, but you may be right that the station needs to be organized better.

The supervisor's criticism is misplaced and rudely stated. The base concern, however, is valid—a poorly organized workstation is a hindrance to effective workplace functioning. Rather than entering into an argument over whether she should accept the blame for the problem, agreeing in probability with the (valid) underlying suggestion and letting the accusatory tone pass is the employee's best option; it is unlikely that the supervisor will pursue the point once it has been (apparently) accepted.

Situation 3: Agreeing in Principle

Faculty member: If you don't study more than you do, you're going to fail.

Student: You're right. If I don't study, I will fail.

The critique of the student's study habits might be valid, or it might not be; the faculty member is assuming that the student does not study enough, which may not actually be the case. The stated principle, however, is accurate: A student who does not study will likely fail. That is something the student

can agree with without accepting the (probably false) premise that he/she is not studying enough. Agreeing deflects further criticism.

Probing

Criticism is often used by others to avoid important feelings or wishes. Assertive **probing** assists in determining whether criticism is constructive or manipulative and clarifies unclear comments.

- The first step in assertive probing is to listen carefully and isolate the part of the criticism that seems most bothersome to the critic.
- The next step is to ask the critic, "What is it that bothers you about . . . ?"

Situation 1: Assertive Probing

Supervisor: You're not doing a very good job here. Your work is not up to par.

Employee: What is it about my work that bothers you?

Supervisor: Well, everyone else is working overtime, but you waltz out of here two out of three nights right at quitting time.

Employee: Why is it a problem that I leave on time when other people work overtime?

Supervisor: I don't like working overtime either, but the work has to be done. It's not right that you just work by the clock.

Employee: What is it that bothers you when I work by the clock?

Supervisor: When you leave, someone else has to finish your work. I want you to make sure your work is completed before you leave.

Employee: I see. Thanks for explaining the situation to me.

In this scenario, the problem as originally stated is not the actual problem at all. By continuing to question the supervisor for specifics, eventually the employee arrives at the *real* issue, stated in a way that he or she can accept, rather than an attack.

Additional Assertive Strategies

Broken Record

This approach is useful when others do not seem to hear or accept what is being said, or when an explanation would provide the other person with an opportunity to continue a pointless discussion. It is especially useful for saying no to others' unreasonable requests.

The process for using broken record includes the following steps:

1. Clarify exactly what the limits of what will be done are.
2. Formulate a short, specific statement about what is wanted; avoid giving excuses or explanations because they give the other person ammunition to undermine the original statement.

3. Use consistent body language that supports the statement, including maintaining eye contact, standing or sitting erect, and keeping hands and arms quietly at the side of the body.
4. Calmly and firmly repeat the chosen statement as many times as necessary until the other person realizes there is no negotiation possible. The first few times a statement is made, the other person may given an excuse or attempt to derive a different answer.
5. (Optional) Briefly acknowledge the other's ideas, feelings, or wishes before returning to the broken record statement, e.g., "I hear you saying you're upset, but I don't want to work any more overtime."

Situation 1: Broken Record

Nurse 1: I just got an opportunity to fly to Aspen to ski. Won't you help me out and switch vacation schedules with me?

Nurse 2: How great for you. No, I don't want to switch schedules.

Nurse 1: You mean you're not going to help me? What kind of a friend are you?

Nurse 2: I understand that you're disappointed, but I don't want to switch schedules.

Nurse 1: But I have to go to Aspen, and you're the only one who can help me.

Nurse 2: No, I don't want to switch schedules.

Nurse 1: Boy, you're really hard hearted. What happened to you? You used to be so nice, now suddenly, you're Wanda the Witch.

Nurse 2: I appreciate your difficulty, but I don't want to switch schedules. That's not going to change.

Content-to-Process Shift

When the focus or point of the conversation drifts away from the original topic, the content-to-process shift can be used to shift from the subject being discussed (the content) to what is occurring between the two speakers (the process), e.g., "We're off the point now, let's get back to what we agreed to discuss."

Content-to-process shift can involve self-disclosure of current thoughts or feelings, e.g., "I'm feeling uncomfortable discussing this now, and I notice we're both tense." This approach is especially useful when voices are raised and anger is present: "We seem to be getting into a battle about this." The trick is to comment neutrally about what is observed so the other person does not experience the comment as an attack.

Momentary Delay

There is a compelling aspect to many social situations. There is often the implied command from another person that a question must be answered right

away. Rather than being swayed by the emotion of the moment, take a deep breath and a momentary (or longer) delay. This procedure allows for further understanding and analysis of the pros and cons of each available response.

Situation 1: Momentary Delay

Supervisor: I'd like you to read the riot act to the aides; they aren't doing their work. You have to do something right now!

Nurse: [Takes a deep breath.] I'll need more information before I can act.

Situation 2: Momentary Delay

Supervisee: I think I deserve a break. I've been working nonstop for 7 hours, and if I wait any longer it will be time to go home!

Supervisor: You may be right, but I need to check the floor to make sure we won't be short-handed. Can you hang on for just a few more minutes?

Time Out

When the conversation reaches an impasse, but the discussion is an important one, the conversation can be delayed to a later time; time out is only assertive if a specific time in the near future is set to continue the discussion.

Situation 1: Time Out

Teenager: I think you're blaming me unfairly.

Parent: We've been talking about this quite a while now, and I don't think we're getting anywhere. Let's sleep on it and I'll see you at 9:00 a.m. tomorrow to talk then.

Joining and Circling the Attacker

The joining and circling the attacker approach is derived from the martial art of aikido, in which the attacked person accepts the attack and turns with it, letting the attacker pass in the direction he or she has chosen. According to Dobson and Miller (1994):

> One of the best ways to survive . . . is to . . . flow with them. Harmonize . . . Be the water, not the rock. The water has direction and flexibility. Eon by eon the rock is worn down, until halfway through eternity it has become a pebble. If the rock would turn with the force of the water, still retaining its place in the stream bed, the rock would lose nothing; the water would continue past. (p. 87)

As in the martial art, there is a pause the attacker takes just before a change in direction. That brief moment is when the attacker loses balance; it is at that precise moment that the defender takes charge and helps the attacker to a new,

firmer, less aggressive balance. Most attackers are spoiling for a fight. They are overextended, and they need the victim to fight back and preserve their tenuous balance. So if you yell at a yeller, that helps him stay upright. With joining and circling, focus of energy is, instead, on the resolution of conflict, and problem solving, and the restoration of harmony. In each attacking or conflict situation, there are six alternative ways to respond:

1. Do nothing
2. Use diversion, deflection, or humor
3. Join with the attackers
4. Withdraw
5. Parley
6. Fight back

Do Nothing This is an appropriate response when time is needed, when more information is needed to find out what is behind the attack, when the attacked person does not want to dignify the attack by reacting (it is not necessary to answer charges unless the nurse chooses to do so), or when the attack makes no sense. Doing nothing must be a conscious choice, not a response to fear, in order to be an assertive response.

Use Diversion, Deflection, or Humor An appropriate response is to deflect or redirect an attack. "Most attacks . . . come at you along a fairly straight line. By employing . . . surprise, you can break that line and cause the attack to misfire." Changing the subject ("I see you're wearing a new suit.") or giving absurd explanations can be used to create a diversion or deflection.

Situation 1: Using Deflection/Humor

Supervisor: You forgot to get that report in!

Nurse: You're right. I'm sorry I didn't follow through on our agreement.

Supervisor: That's no excuse! What were you thinking?

Nurse: I was planning my zombie attack preparedness strategies.

Supervisor: Um. What?

Nurse: I found it on the CDC's website. No, seriously. They have a page on zombie preparedness.[1]

Join with the Attackers Agree with the attacker's right to feel as he or she does. (This is aikido, confluence, flowing with being the water, not the rock.)

Situation 1: Joining the Attacker

Supervisor: What have you done? You're the—worst nurse I've ever seen!

[1] The CDC's zombie preparedness page is at http://www.cdc.gov/phpr/zombies.htm

Nurse: I don't blame you.
Supervisor: What do you mean, I don't blame you?
Nurse: It's not up to me to blame anybody for feeling the way they do. You're not happy, and I can't quibble with that.
Supervisor: [Puzzled] But you think your work is up to par?
Nurse: It can't be if you're not happy with it. My job is to work with you.
Supervisor: [Confused] I don't understand.
Nurse: If you don't think I should be fired outright, let's see if we can't work together on this thing and make it mutually acceptable. What are some of your complaints?

The nurse's use of surprise combined with joining the attack led to the supervisor losing his balance. The nurse has joined the supervisor and is helping him; the nurse does not take the attack personally, but objectifies the conflict. This leads to confusion. The nurse then takes the lead in identifying and resolving the problem in her relationship with the supervisor. Note that the supervisor must have a genuine issue with her work that is simply not well expressed; by taking this tack, the nurse provides an opportunity for better communication, both now and in the future.

Withdraw Withdrawal is an appropriate choice when all else fails and an escape route is open or when the time and place for discussion is wrong. To use withdrawal well, it must be completed clearly and with a single intention. Being unclear about the right to leave the scene can result in confusion. It is important to withdraw with certainty, knowing that it is each person's right to stay out of destructive involvements. Appropriate techniques for withdrawal include statements such as, "I can see we're not going to reach agreement on this, so we'll have to agree to disagree, as I have somewhere else I need to be right now," or "Unfortunately, there isn't time for us to hash this out, so I'm going to have to leave on that note."

Parley Parley is most effective when involved in a no-win situation in which the other person has defined the encounter as a contest. In this case, the nurse or client can remain centered and turn the conflict around, offering a reasonable way out for both parties. Some parleying comments are:

- "Shall we see if we can work out a compromise?"
- "Let's see if we can't iron out the problem."
- "Maybe we can figure out a way to solve both our problems by working together."

Fight Back Fighting back is the response of choice when there is no other option. It is a question of life or death, or it is a question of serious priority. Fighting back could include expressing anger directly or standing up to an insult.

Situation 1: Fighting Back

Surgeon: [He has just cornered the nurse in front of several other surgeons and physicians.] Listen, kid, my time is too valuable to spend chasing all over the place to find that room you assigned me to just because you're so inefficient you can't get the simplest things through your pinhead! And another thing, where is that new scalpel I ordered?

Nurse: Excuse me, I am not willing to be blamed for someone else's room assignment and I don't order scalpels. Now, we can argue, or we can try to solve the problem together.

Surgeon: I don't have to take this from you! I can have you fired!

Nurse: This is not productive. If you want to solve the problem, why don't you work on figuring out the room assignment and I'll find out about the scalpel. [She exits.]

This response focuses the surgeon on the problem and its solution, yet allows the nurse to stand up for her rights, which she has already decided are a high priority for her with this surgeon who has just attempted to humiliate her in public. The nurse might lose her job (an unlikely but possible resolution), but she has already decided she has no intention of continuing to work under these conditions. Most likely the job will not be lost, and conditions could improve as the surgeon realizes he cannot bully the nurse.

When the decision to stand up for the client's rights has been made, it is important to make several assessments prior to acting, including:

1. Does this person have something to lose by being aggressive? (If the answer is yes, the person may choose to reconsider this response and choose another, since the other person may be irrational in the interchange.)
2. What is the minimum amount of energy needed in this situation to make the point? (Use the minimum energy needed to restore harmony.)
3. What is the best time and place for the confrontation?
4. What is the best way to stop an attacker's advance?
5. What is the best way to focus the conflict on the problem and not on generalities or personalities?
6. What does the respondent want his or her face to say and how can he or she ensure it says that?
7. What does the respondent want his or her body to say and how can he or she ensure it says that?
8. What spatial relationship to the other person is most likely to end in harmony?

Multiple Attack

An attack from several other people feels intimidating. Examining the geometry of forces, it can be seen that due to the nature of the force exerted by the

attackers, they require one another's presence in order to continue the attack. Their forces create a balance due to focusing energy directly on the attackee. If the attackee keeps an attacker positioned between her or him and the rest of the attackers, the larger group will be unable to focus their attention on the victim, and the multiple attack will be defused. The nurse may still have to deal with the attacker nearest to the nurse's position, but handling one attacker is better than attempting to deal effectively with two or more.

Situation 1: Multiple Attack Sandra is a staff nurse who believes in wellness and health promotion. She tries to collaborate with her clients and help them to take responsibility for decisions about what happens to them. As a result, she spends more time talking with her clients than some of the other nurses. Her supervisor has noted her wasting time talking with clients a number of times and several physicians have demonstrated impatience waiting for her to make rounds or assist them.

Sandra is in a bind. She believes in what she is doing but knows she is being evaluated negatively. She knows this cannot go on indefinitely, so she moves in on a straight line to bring the attacks into direct confrontation. She calls a meeting of physicians and her supervisor to discuss the kinds of nursing plans she has implemented. Sandra centers herself, which helps her to remember the group is not there to get her. They are anxious about their work and worried about time pressures and being evaluated positively by their supervisors.

Ms. Bart, the nursing supervisor, is the most outspoken and demands that Sandra spend less time talking with clients and more time assisting physicians and completing her paperwork. Sandra pays attention to her breathing and keeps centered so she doesn't scream out, "Look here, I went to nursing school to learn these special skills I have, and I know that's the best way to practice nursing!" Sandra realizes that Ms. Bart, in the best tradition of attackers, has attacked with such force that she has almost lost her balance. Sandra decides to slide around Ms. Bart toward the other attackers. She asks for comments from the physicians, thanks them for their concern about clients, and asks if all the physicians agree with Ms. Bart about her spending less time providing care for their clients. The physicians disagree with one another and raise unrelated questions. Sandra refrains from becoming defensive and continues to go back to Ms. Bart's demands, keeping her between herself and the physicians. Sandra eventually offers to speak at the next grand rounds, sharing with the physicians her nursing interventions and outcomes for various clients they label as difficult.

Situation 2: Multiple Attack Sue Anderson, RN, is working with a client, Emily Weiss, who is constantly complaining that her teenage kids seem to be down on her lately. They argue about performing household tasks and

complain about her cooking and nagging. As a result, Emily feels cut off and resentful. Sue suggests a family meeting to bring the attacks into direct confrontation. Emily resists at first, until Sue does some role-playing with her to help her decide exactly what she wants to say to her family.

Emily practices centering herself prior to the family meeting and resists becoming defensive when the complaints start. Emily pays attention to her breathing, thanks them for being so candid, slides around the children's attacks, and keeps her husband between herself and the kids. Emily offers to stop nagging them in exchange for their agreeing to each cook one meal a week. The next week she reports to Sue that things are better around the house.

RESEARCH BOX 3-1 examines the relationship between assertiveness and aikido.

RESEARCH BOX 3-1 Aikido Principles and Assertiveness Training

- BACKGROUND: Self-defense classes aim to prevent violence against women by strengthening women's capacity to defend themselves; however, little research has examined the effects of self-defense training on women's attempts to fight back during actual attacks. This study investigated the relationship of self-defense or assertiveness training and women's physical and psychological responses to subsequent rape attacks.
- SAMPLE (N = 1,623).
- METHODS: Multivariate analyses.
- RESULTS: Victims with preassault training were more likely to say that their resistance stopped the offender or made him less aggressive than victims without training. Women with training before their assaults were angrier and less scared during the incident than women without training, consistent with the teachings of self-defense training. Preassault training participants rated their degree of nonconsent or resistance as lower than did nonparticipants, perhaps because they held themselves to a higher standard.

Source: Brecklin, L.R., & Ullman, S. E. (2005). Self-Defense or Assertiveness Training and Women's Responses to Sexual Attacks. *Journal of Interpersonal Violence, 20*(6), 738–762.

HEALTH PROMOTION CHALLENGE

Using Research Box 3-1, come up with at least three ways to use the findings and promote health of the nurse and/or client.

Hidden Agendas

Hidden agendas are unstated issues that are played out through interaction with others. Hidden agendas are excellent defensive maneuvers for low self-esteem. They protect against rejection by creating the desired impression at the expense of intimacy and authenticity. Nurses and clients use them to put up a smoke screen of carefully selected stories and calculated remarks. Clues that hidden agendas are operating include making the same point again and again while trying to prove something. The problem with hidden agendas is that they are obstacles to authentic, positive relationships. Therefore, it is important to assess the tendency for operating from a hidden agenda and take steps to devise self-instructions to counteract the pretense.

Eschelman, Davis, and Fanning (2008) list eight major hidden agendas:

1. *I Am Good.* Many of the statements from a person using this agenda demonstrate how caring and sensitive the person is; a fine character is created, but not an authentic self. No one is entrusted with the parts of the self that are less than wonderful. People who always present themselves as good, honest, loyal, generous, successful, powerful, strong, wealthy, self-sacrificing, etc., tend to bore other people, and an intimate relationship becomes difficult.
2. *I Am Good (But You Are Not).* In this agenda, the person attempts to raise his or her self-esteem by showing how stupid, incompetent, selfish, unreasonable, lazy, frightened, or insensitive others are. One nurse often complained, "Do you think I can ever get anyone around here to help me? I'm the only one doing the work!" This hidden agenda gives a temporary boost to self-esteem, but others feel threatened and put down and defensive maneuvers on their part soon follow.
3. *You Are Good (But I Am Not).* People who constantly flatter others have this agenda. More complex forms involve worship of smart, beautiful, or strong people. This agenda can also be used to ward off anger, rejection, and high expectations; who expects much of someone who is incompetent and self-berating?
4. *I am Helpless, I Suffer.* This agenda portrays the person as a victim who has suffered misfortune, injustice, and abuse. The implied message is that the person is helpless and not responsible for what happens. Variations include presenting a problem and then proving nothing will help resolve it, and sharing horror stories with another to form a bond of sympathy.
5. *I am Blameless.* This is the agenda of people who have innumerable excuses for their failures. The basic position is: "I didn't do it." (Variations include, "The doctor did it . . .," "The client did it . . .," "The family interferes . . .," and "My boss is the problem . . .") There is a basic

inability to accept responsibility for any actions that do not lead to success—although generally these people are happy to accept credit for success, whether it's due or not.

6. *I Am Fragile.* The basic stance is, "Don't hurt me; I can't take it." The person tells or shows others he needs protection from the truth. ("I don't want to talk about it; it upsets me," "You're giving me another of my headaches," and "This reminds me of my parents fighting; let's not get into it" are typical comments from this stance.) On most hospital units, there is one person who does not do his or her work but is not confronted by others because "She's fragile and couldn't take it."
7. *I Am Tough.* A variation is the super nurse whose communication is often a harried listing of things done or to do; the underlying message is "I work harder, longer, and faster than anyone." The purpose of the agenda is to ward off hurt and protect a fragile self-esteem.
8. *I Know It All.* This is the agenda of the perpetual instructor, constantly moralizing as a protection from reencountering early experiences of shame of being inadequate and ill-informed.

Eschelman, McKay, and Fanning (2008) suggest using self-instructions for overcoming hidden agendas. The statements can be said as mantras over and over again and can be taped to a bathroom mirror, the inside of a briefcase, or carried on 3 × 5 cards.

☐ Affirmations for Overcoming Hidden Agendas

"I'm a mixture of strengths and weaknesses; I can learn to be balanced."
"I don't have to put you down to make me feel good; I can feel good on my own."
"I can get attention for my strengths without making excuses."
"I experience joy as well as pain; I can allow myself to experience both."
"I'm responsible for what happens to me."
"I can learn to deal with upset."
"I can be safe without being tough."
"I can learn a lot from others if I listen, watch, and ask questions."

RESEARCH BOX 3-2 examines the identification of hidden agendas.

HEALTH PROMOTION CHALLENGE

Using the information in Research Box 3-2, identify at least three ways to use the findings to promote health.

RESEARCH BOX 3-2 Dealing with Hidden Agendas

» BACKGROUND: Most gynecologists lack the unique skills required for communication with female adolescent clients and with their parents. Years of clinical experience are required to develop communication skills that would facilitate the confidence of the young client during the first visit. Simulation-based medical education at the Israel Center for Medical Simulation (MSR) has become a powerful force in quality-care training for healthcare providers using empirical educational modalities, enabling controlled proactive experiential exposure to both regular and complex scenarios. Among the various MSR programs for various medical sectors, training programs have been developed to improve the skills of physicians, including primary care physicians and school doctors, in communicating with adolescents. This paper describes the first reported simulated client-based MSR training program for gynecologists in communication with adolescents who present with common complaints encountered in gynecology clinics.

» SAMPLE: Twenty gynecologists participated.

» METHODS: The researchers used eight individual simulated scenarios and conducted them at simulated physicians' offices which were equipped with audiovisual recording cameras and one-way mirrors for observation. Three physicians experienced in debriefing and in facilitating group discussions led the debriefing sessions, using the video recording of the simulated scenario following the simulation exercises. These discussions focused on communication techniques when facing adolescent clients with or without their parents, hidden agendas disclosed by using systematic physical and psychosocial reviews, the emotional load often associated with clinical problems, and the nonjudgmental and supportive approach to adolescent clients.

» FINDINGS: The clear recommendation that emerged from the high satisfaction of the program participants was to expand simulated client-based programs for gynecologists and to include it as an integrated part of the training curriculum in pediatric and adolescent gynecology.

Source: Beyth, Y., Hardoff, D., Rom, E., & Ziv, A. (2009). A simulated patient-based program for training gynecologists in communication with adolescent girls presenting with gynecological problems. *Journal of Pediatric and Adolescent Gynecology, 22*(2), 79–84.

Facilitating Movement Toward Health and Wellness

When you've established a high level of differentiation and professionalism, you will be able to use these attributes to create a method for facilitating clients' wellness without adversely impacting your own. This is an important consideration because being an effective role model is a key factor in teaching and motivating. A sure way to fail is to ask a client to do something that you yourself would find unpalatable or impossible; on the other hand, if you can show the client evidence that a strategy has been successful for you in the past

(whether in your own health promotion or in other clients' efforts), it encourages trust and effort.

A highly differentiated nurse with solid self can support consistent client involvement in the assessment, implementation, and evaluation of client goals and can teach clients to perceive life experiences as manageable and meaningful by increasing self-responsibility and commitment to action. Facilitating client assertive and creative behavior and assisting clients to differentiate themselves from you and significant others will promote behaviors that support health. Likewise, facilitating clients' social supports and evaluating the effect of change toward health and wellness, as well as resistance to and readiness for change, can aid in developing effective strategies. Use of contracting, self-assessments, belief scales, imagery, structured relaxation, affirmations, and other health promotion procedures can reinforce goals and strategies for the client.

Evaluating the Effect of the Proposed Change

Movement toward health and wellness requires change. One reason people resist change is because new habits or ways of thinking are unfamiliar. If movement toward wellness is viewed as a threat to current status, existing ways of life, job or money, familiar habits, or autonomy or free will, resistance to change can be expected. When facilitating movement toward health and wellness, ask the following questions:

- What other factors will be affected as a result of changing?
- What forces are operating to inhibit change at this time?
- What information or experiences are needed to change?
- What new procedures or experiences will need to be developed as a result of the change?
- Who is likely to suffer from the change?
- How will power, influence, custom, or lifestyle be affected by the change?
- How aware is the client of the need for change or of its purpose?
- Is the client sufficiently involved in planning for the change?
- What past experiences between the nurse and the client might be influencing resistance to change now?
- How open has the client been to the introduction of change in the past?

A factor to assess when examining client responsibility is the level of dissatisfaction with current lifestyle and the readiness for change. Clients who may be most ready to change include:

- A client who is constantly slightly depressed and lacking in energy and who has tried all medical treatments may be dissatisfied enough to be ready to try jogging or another form of exercise as a treatment.

- Another client who has tried all the fad diets available in an effort to lose weight may be ready to try a long-term weight management program if it seems enticing and if support is provided.
- A client who is in chronic pain that is not touched by strong medication may be willing to learn self-hypnosis or other noninvasive pain control measures.

Clients are most open to taking responsibility for health and wellness during childhood, when values may still be forming, and again between ages 35 and 45, when people enter the midlife crisis and begin to see they are alone, mortal, and are searching for internal, not institutional, validation. This and other times of crisis may provoke a move toward self-fulfillment and openness to change.

Decreasing Resistance to Change

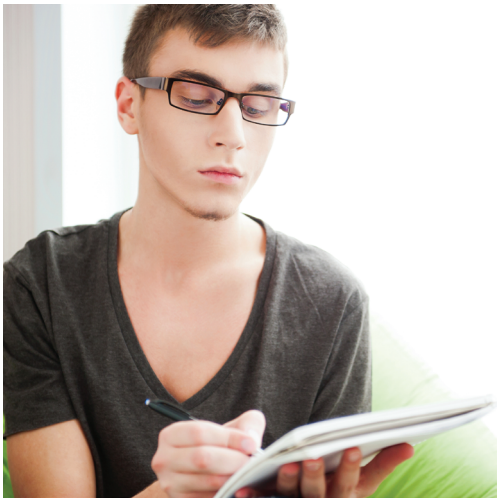
Once sources of resistance to change have been identified, steps can be taken to reduce it. If anxiety or threats are the source of resistance to change, teach clients to practice centering.

Resistance to change will be decreased if rewards for changing are given and problem solving is used. The first step in learning more effective behavior is to identify the behavior to be changed. Behavior is an action, not a feeling, attitude, or mood. Behaviors must be pinpointed and expressed in such a way that they can be counted. TABLE 3-3 shows examples of behaviors that can and cannot be counted.

Once the behavior is expressed in countable terms, baseline data can be gathered. These data consist of information gathered prior to treatment. The

Table 3-3 Examples of Behaviors That Can and Cannot Be Counted

Countable Behaviors	Noncountable Behaviors (General Behaviors or Internal States)
Jogging	Being neat
Brushing and flossing teeth	Being organized
Drinking fluids	Being motivated
Losing weight	Being depressed
Gaining weight	Being angry
Smoking a cigarette	Being guilty
Practicing relaxation exercises	Improving communication
Attending yoga class	Grieving
Eating complex carbohydrates	Being noncompliant



pinpointed behavior is counted or measured to see how often it occurs now. These data can be charted and hung in the client's home or elsewhere, and they can be recorded on the treatment chart, in the client's journal, or wherever agreed upon. Data from this before or baseline phase can be used later to check progress toward the goal. Behavior can be counted by

- Frequency
- Rate over time
- How long the behavior continues

The method used to count depends on the behavior. For example, the frequency method might be best for participating in relaxation exercises, the rate over time to measure weight gain or loss, and the duration method to measure jogging. A notebook, graph, chart, or journal can be used to gather baseline data.

Using Rewards to Increase Desired Behavior

The next step in increasing desirable behavior is to find out what is rewarding and depriving to the particular client. TABLE 3-4 shows reinforcers for a student who was chronically late to class. Clients, too, can be asked to make such a list. There are some nearly universal rewards, such as attention, smiles, praise, candy, or other sweets. If the client is unable to state a reward, a universal reward can be used or the chart can be read to find hints. Of course, giving sweets to someone with diabetes or who wants to lose weight would be self-defeating; if a reward is something that will worsen, not improve, health, then it should not be used. A reward also cannot be used if control cannot be established over when the reinforcement is dispensed. For example, if a family lets a child watch TV whether or not the child participates in family meetings, watching TV cannot be used as a reward for the child's participation in family meetings. If the client is hospitalized, more rewards can be controlled. If the client is at home, fewer rewards are under nursing control. It is wise to enlist the aid of families, other personnel, and whoever it is who dispenses rewards; the best way to do this is to reward them for helping by giving them attention, not scolding them when they do not comply, and by using whatever other things seem to be rewarding to them.

When operating from a health promotion/wellness framework, keep in mind that self-modification or client choice in applying behavior modification principles and voluntary changes in selected aspects of behavior is the focus, not changing the behavior of others through the manipulation of rewards and punishments (Pender, Murdaugh, & Parsons, 2010).

Table 3-4 Reinforcers for One Student

Positive, Rewarding Reinforcers	Negative, Depriving Reinforcers
Eating ice cream	Watching cartoons
Seeing a movie	Working overtime
Sleeping late on weekends	Being told I'm late
Talking with other nurses	Doing dishes
Going dancing	Doing reports
Reading mysteries	Eating cottage cheese

When to Reward Desired Behavior

To increase the occurrence of a goal-directed behavior, the reward must immediately follow movement toward that behavior. Giving praise 2 days after a client walked around the block is less likely to increase walking behavior than praising right after the walk.

In some cases it may be unrealistic or impossible to provide the reinforcement immediately following the occurrence of the goal-directed behavior. In that case, a written contract, wall chart, token system, or some other method can be used to indicate a reward is due. For example, a wall chart could be used to show participation in planned exercise. A mark could be used to indicate 30 minutes of TV time or crossword puzzle work that could be collected that evening or on the weekend for each time 30 minutes of exercise is accomplished. Or, clients can be given tokens to indicate completion of a behavior; a specified number of tokens can be used to purchase a reward.

Using Shaping Techniques

Some desired behaviors may occur at random or very rarely. In such cases, **shaping techniques** to reinforce approximations to the target behavior can be used. For example, telling the client the exact words to say and then praising the behavior, or asking the client to avoid smiling when talking are ways of shaping behavior. When shaping client behavior, nurses act as sculptors, helping clients to approximate the behavior that will be successful for them.

HEALTH PROMOTION CHALLENGE

Read the case study that follows and decide what else the nurse could have done to promote health.

CASE STUDY Helping a Client Start an Exercise Program

Mr. Sconce had just been discharged from the hospital and had been advised to begin an exercise program by his physician. The client revealed his anxiety about beginning such a program to the nurse, Ms. Joshua. The nurse began by listing the steps in an exercise program (learn how to take pulse, learn warm-up and cool down exercises, choose a suitable type of exercise, set up rewards and a way to chart movement toward exercise goal).

Next, the nurse demonstrated the steps, ignoring any statements of fear of failure and praising any positive attempts. (The use of the negative reinforcement of not commenting verbally or nonverbally on fears will extinguish that behavior in time, if used consistently.)

Ms. Joshua asked Mr. Sconce to copy what she did, and praised him for each step successfully completed. Ms. Joshua also enlisted Mrs. Sconce in the effort and both client and spouse soon were actively engaged in a walking program together. Ms. Joshua taught the Sconces how to make a contract with one another for changing behavior. FIGURE 3-2 shows the contract the Sconces used.

Use Goal-Setting and Self-Contracting to Promote Health

Whether working with clients, peers/family members, or self-contracts to achieve wellness goals, the **contracting** process remains the same.

Mutual Exploration of Goals

Questions to ask include:

- Is this goal realistic for me now?
- Why is this goal being chosen now?
- Has this goal been chosen before and what were the results, things learned, barriers encountered? Does this goal have a high personal priority or was it chosen to please others?
- How appropriate is this goal now?
- How specifically written is the goal?
- Has only one goal been chosen?

Identification of Actions Needed to Accomplish the Goal

What countable behaviors are involved in meeting the goal? (The more clearly and specifically actions are stated, the easier it is to evaluate progress toward the goal.)

☐ Establishment of Reward(s) for Movement toward Goal

What is reinforcing and realistic as a reward?

☐ Division of Responsibilities

What responsibilities are involved? Who is responsible for which ones? What specific assistance will the facilitator give the other person; e.g., encouragement, phone calls, assertive asking about how the wellness goal is going, weekly meetings to discuss the goal?

☐ Time Limit

What mutually agreed upon time limit is set to accomplish the goal and/or evaluate movement toward the goal?

☐ Evaluation of Movement Toward Goal

How will movement toward the goal be evaluated? By whom? When? What consequences will accrue as a result? What additional assistance does the goal writer need from the facilitator in order to move toward goal attainment? What barriers are interfering with movement toward the goal and how can they be surmounted?

☐ Modification, Renegotiation, or Termination of the Contract

If a goal is met, a new one is reset. If a goal proves inappropriate, a new goal is found.

FIGURE 3-2 provides one client's contract.

Facilitators for wellness goals can be nurses, but they can also be peers, family members, other health professionals, or anyone who agrees to learn and follow the procedure for contracting. Self-contracting can also be used, but research and empirical knowledge have shown that people with low self-esteem or little perceived control over what happens to them may not take responsibility for carrying through on a contract (Pender, 1982, p. 190).

Using Self-Assessments to Promote Wellness

A wellness/health promotion framework implies that the responsibility for the client's body/mind/spirit resides with the client, unless there is a life-threatening situation in which the client cannot decide. It also implies that a health or wellness goal chosen by the client may not have high priority for the nurse. For example, an obese client may have set a high priority on stress manage-

A Behavioral Contract for Mr. Adolph and Mrs. Edith Sconce

Wellness goal: To walk briskly for 30 minutes every day.

I, Adolph Sconce, promise to walk briskly with Edith Sconce 30 minutes every day for a period of 2 weeks, whereupon my wife, Edith, and I will treat ourselves to a movie. I understand that if I do not fulfill this contract, the designated reward (movie) will be withheld.

Signed:

(Client)

(Facilitator)

(Nurse)

(Date)

FIGURE 3-2 Sample Client Contract

ment, while the nurse thinks weight loss should be the first priority. A wellness framework assumes the client sets the goal, not the nurse.

Stepping out of the caretaking role may be difficult. However, consider the following. If the client takes self-responsibility for body/mind/spirit in one small issue, the process has been learned and it can be transferred to other issues, including those of high priority for the nurse. Also, if the nurse is able to demonstrate how success in attaining (life) goals can be accomplished, trust can be established and the client is more apt to agree to pursue a wellness goal of agreed-upon high priority. In some settings, such as the ICU, clients may not have a great deal of energy to invest in setting and striving toward wellness goals. It may not always be clear how health and wellness can be encouraged but even in these situations, clients can make decisions about when to have their bed, bath, what kind of juice to drink, and other simple choices.

A beginning step is to adapt nursing histories to fit a health promotion/wellness framework. Some questions that could be asked of clients on admission are:

1. What are the symptoms you are most concerned about?
2. What feelings and emotions are you concerned about?
3. What are the goals you would like to begin moving toward?
4. What are your strong points and special abilities?
5. What kind of help do you want from me?

6. What do you think is wrong with you?
7. Why do you think you are having this problem now in your life?
8. What does this disease (symptom, worry, etc.) mean in your life?
9. What would you have to give up or take on to get rid of this problem (disease, symptom, worry, etc.)?

The Health and Wellness Belief Scale

Another measure nurses can use to facilitate health and wellness includes assisting clients to examine their health and wellness beliefs. FIGURE 3-3 shows a health and wellness belief scale.

These questions can be used to find out how different people feel about health and wellness. Each item consists of a pair of statements, A and B. Select the statement for each pair which you most strongly agree with or think is true, not the one you think you should choose. There are no right or wrong answers; this scale is a measure of what you believe. For some items, you may find you believe both statements or neither one. In such cases, be sure to select the one you most strongly believe by checking one "agree" for each number. Try not to be influenced by your previous choice.

		Agree
1.	A. I carry the key to my own health and well-being in the way I choose to live. B. Health and illness are both luck and beyond my control.	____ ____
2.	A. Being healthy and well is a lifelong effort. B. If I wait, medical science will develop cures for all illnesses.	____ ____
3.	A. It matters little whether my healthcare practitioner pursues health and wellness as long as he or she looks after mine. B. I think it's important to steer clear of healthcare practitioners who are not pursuing their own health and wellness by not smoking, by keeping their weight down, etc.	____ ____
4.	A. No matter how hard I try, I think I'll probably still get ill (or won't be able to quit smoking or lose weight), so I might as well do what I want to do. B. I have faith in my ability to increase my health and wellness.	____ ____
5.	A. I think that if I'm going to be ill, I'm going to be ill. B. Trusting to fate about my health and wellness doesn't work. I find I have to take a definite course of action.	____ ____
6.	A. Staying healthy and well is a matter of hard work, and luck has little or nothing to do with it. B. Staying well is a matter of being born under the right condition and being in the right place at the right time.	____ ____
7.	A. Environmental factors have little effect on whether I get ill or not. B. Heredity is important, but I can take steps to counter it.	____ ____

FIGURE 3-3 Health and Wellness Belief Scale

8.	A. I can influence governmental decisions about health and wellness. B. Politicians, business people, and scientific experts make the decisions about my health and wellness.	____ ____
9.	A. When I devise a health or wellness plan, I am pretty certain I can make it work. B. I don't make long-term plans for health or wellness because I don't think they work.	____ ____
10.	A. Sometimes I don't think I can control my state of health. B. It is hard for me to believe that my state of health is always due to luck or chance.	____ ____
11.	A. I might as well decide my wellness goals by flipping a coin. B. Getting what I want in terms of health and wellness has little or nothing to do with luck.	____ ____
12.	A. With enough effort I think I can decrease the antihealth and antiwellness parts of my environment. B. I think it's difficult and perhaps impossible to decrease the antihealth and antiwellness factors in my environment.	____ ____
13.	A. A good health insurance plan ought to include incentives for staying healthy and well. B. A good health insurance plan should be inexpensive, covering catastrophes like chronic illnesses and heart attacks.	____ ____
14.	A. It doesn't really matter what I eat since health and wellness is unrelated to food. B. I should choose what I eat carefully, because it contributes to my health and wellness.	____ ____
15.	A. I should work at being physically and mentally fit because both contribute to my wellness and health. B. It doesn't matter whether I'm fit or not because health and wellness are due to luck and my doctor's prescription.	____ ____
16.	A. Stress is due to factors beyond my control. B. I can learn to reduce my stress level and thereby be healthier.	____ ____
17.	A. If I heal when I'm hurt or ill, it's because something outside me helped me to heal, like an antiseptic or medicine. B. I can learn to use my own healing potential and thereby enhance my health and wellness.	____ ____
18.	A. I think it's important to stand up for my rights when I feel others are trampling on them. B. It doesn't pay to stand up to others since they don't listen anyway.	____ ____
19.	A. I think it's important to question healthcare practitioners, lawyers, and anyone from whom I purchase a service because I share the responsibility for what happens to me. B. I assume doctors, lawyers, nurses, and other authorities know what I need better than I do.	____ ____
20.	A. Meeting new friends is a matter of luck and being in the right place at the right time. B. Meeting new friends is up to me to go places, introduce myself, and suggest we spend time together.	____ ____
21.	A. Pain is something that has to be endured, and it will pass. B. When I am in pain, I can take action to reduce my pain.	____ ____

FIGURE 3-3 (Continued)

The scale was modeled after Rotter's original work (1966) on internal locus of control or the degree to which people believe they have control over what happens to them. The purpose of the belief scale is to measure client responsibility for health and wellness, by measuring degree of internality. Those who score 21 are at a high point of internality.

Beliefs about health and wellness can influence the degree to which people take responsibility for their wellness. Numerous studies support the idea that people with strong beliefs about their ability to control destiny are more likely to be alert to information in the environment, place greater value on skills or achievement rewards, be more concerned about this ability (especially if the ability is lacking), and be resistive to subtle attempts to influence them. Rotter referred to these two basic stances as internal and external orientation. RESEARCH BOX 3-3 examines the use of locus of control with clients diagnosed with cancer.

RESEARCH BOX 3-3 Locus of Control and Well-Being in Older People Diagnosed with Cancer

» PURPOSE: To identify differences and similarities in health locus of control (HLC) and well-being between internalistic clients, recently diagnosed cancer clients, and healthy control subjects.

» SAMPLE: 110 clients with internal diseases, 196 cancer clients, and 80 healthy control subjects aged 60+ years

» METHODS: HLC was assessed with the Multidimensional Health Locus of Control Scales (MHLC), and well-being was assessed with the Positive and Negative Affect Schedule.

» FINDINGS: Clients with internal diseases scored highest on internal HLC. Scores on social externalism and fatalism MHCL subscales of internalistic clients were similar to those of cancer clients. Both client samples reported reduced positive affect. Higher levels of education, more social support, higher self-esteem, internal HLC, and daily functioning predicted positive affect in the total sample. In addition, an interaction effect of internal locus of control and daily functioning was found in cancer clients. There were no group-specific predictors of positive affect. Results suggest that high internal HLC is associated with positive affect in each of the three samples. However, an internal HLC only contributes to positive affect in cancer clients when they are in sufficient physical condition to exert control over their health.

Source: Knappe, S., & Pinquart, M. (2009). Tracing criteria of successful aging? Health locus of control and well-being in older patients with internal diseases. *Psychology, Health and Medicine, 14*(2), 201–212.

To request a copy of the entire study, contact Dr. Knappe at knappe@psychologie.tu-dresden.de

HEALTH PROMOTION CHALLENGE

Read the information in Research Box 3-3. What strategies would you take to promote health with this population?

People who are internally oriented are more likely to take responsibility for wellness; others are apt to let a healthcare practitioner or fate determine level of wellness. Most people fall along a range from externality (0: take little responsibility for their own wellness) to internality (21: take a great deal of responsibility for their own wellness).

Gender may be a factor in locus of control. In one study, males and normal-weight students showed higher affective motivation and overall intrinsic motivation compared to females and overweight students (Furia, Lee, Strother, & Huang, 2009). In another study that focused on healthy participants, overweight was associated with increased harm avoidance and decreased self-directedness in women but not in men (Suzuki et al., 2009). Some evidence suggests that acceptance is a promising approach for reducing body dissatisfaction in females, who are characteristically more dissatisfied with their bodies and may revert to over- or undereating as a result.

In a series of interviews, nine mothers related their beliefs and ideas about strategies utilized to maintain a perceived sense of wellness. The mothers used three main strategies: (1) obtaining help, (2) having a plan, and (3) taking time out. Discovery of a successful strategy led to a mother feeling greater confidence in the efficacy of her selected method, calmer, and in greater control.

Once the client completes the belief scale, a discussion about what the answers mean to the client's health and wellness can ensue. Writing down what is peripherally known can often clarify thoughts and feelings and can be the basis for change. When responses are discussed in a group, lively debates and (sometimes) changes in beliefs can occur.

Promoting Health in Multicultural Populations

When promoting health in multicultural populations, it is essential to understand traditional health beliefs, practices, and folk healers used by various population groups. To promote health across cultures, a nurse must attempt to enter the client's world to understand pertinent beliefs, values, attitudes, and feelings. The attitudinal aspects of transcultural nursing are the most difficult to learn because students must overcome their own ethnocentric tendencies and stereotypical beliefs (Andrews & Boyle, 2007).

TABLE 3-5 contains some of the explanatory models for health and illness in various cultural communities.

Table 3-5 Traditional Models of Health and Illness

Cultural Group	Beliefs
Brazilians	Illness may be attributed to divine intervention, fate, changes in temperature, food ingestion, activity, or strong emotions (Hilfinger Messias, 1996).
Guatemalans, Salvadorans, Nicaraguans	Illness may be the result of an imbalance among the individual, the environment, and outside forces, including the evil eye, ghosts, a witch's curse, and other similar agents, that may affect health and illness.
Cubans	The germ theory is accepted, but stress, extreme nervousness, evil spells, and voodoo-type magic may also explain illness (Boyle, 1996).
Mexican Americans	Ill health is an imbalance between the individual and the environment; emotional, social, physical, and spiritual factors can account for sickness (De Paula, Lagana, & Gonzalez-Ramirez, 1996).
Puerto Ricans	Illness may be attributed to heredity, lack of personal attention to health, punishment from God for a sin, or evil or negative environmental forces (Juarbe, 1996).
African Americans	Illness may be natural (caused by stress; drinking or eating too much; fighting with friends or neighbors; impurities in air, food, or water; cold air or winds; or punishment from God), or unnatural (caused by evil influences induced by witchcraft that require a voodoo practitioner) (Spector, 1991).
Asian Americans	The forces of yin and yang, and the five elements (wood, fire, earth, metal, water) are employed. Yin conditions include cancer, pregnancy, and postpartum care and are treated with yang foods such as chicken, beef, eggs, and spicy foods. Yang conditions include infections, hypertension, and venereal diseases and are treated with pork, fish, fresh fruits, and vegetables. Acupuncture, acupressure, meditation, acumassage, moxibustion, cupping, coining, herbology, shamanistic rituals, and Western medicine may be used. Mild illnesses may be attributed to organic causes, while more serious diseases are believed to be caused by supernatural forces including spirit attacks, soul loss, and other metaphysical manifestations that can only be treated by a shaman who uses rituals such as tying strings around the wrist to symbolically keep protective spirits within the body (Chan, 1992).
Native Americans	All things are connected (Joe & Malach, 1992). Health is closely linked to spirituality. The focus is on lifestyle and behavior. American Indians and Alaska Natives may see no conflict in using both Western medicine and traditional medicine practices (Lyon, 1996).
Pacific Islanders	Illness is related to the breaking of rules for how one is to live and is related to both the spiritual and physical worlds.

HEALTH PROMOTION CHALLENGE

Choose one culture that is dissimilar from yours. Devise a plan for learning more about how to understand beliefs, discover what is wrong, why it happened, and what should be done to promote health based on a client from that culture.

Taking Action on Political and Health Promotion Policy Issues

National and local political and policy issues affect the practice of nursing. They provide the larger picture for practice focused on health promotion. Avoid assuming that because healthcare reform has passed that all problems with health will be solved. The list of health promotion issues that follows will still require input and action from you:

1. Hypertension, overweight/obesity, and diabetes are on the upswing in children. What health promotion actions need to be taken to reduce these increases (World Health Organization, 2010)?
2. Fewer than half of all Americans exercise regularly (Kruger & Kohl, 2007). What health promotion actions need to be taken to increase this number?
3. The United States is one of two countries in the world that allows drug advertising on TV. What health promotion actions need to be taken to disallow these ads?
4. Firearms injuries remain a leading cause of death in the United States, particularly among youth (Branas, Richmond, Culhane, Ten Have, & Wiebe, 2009). What health promotion actions need to be taken to reduce this cause of death?
5. *Healthy People 2020* posted a list of objectives for promoting health in America. These objectives still require input from citizens, including nursing students, and assistance in implementation.

HEALTH PROMOTION CHALLENGE

Choose one of the Healthy People objectives (or find one of your own). Devise an action plan, take action, and report your findings to at least three other nursing students.

Facilitating Health Promotion via the Internet

Many clients now use the Internet to obtain information about their condition and medications and to obtain support. Is the Web now positioned to

replace health professionals or provide important information for them? To help decide, read RESEARCH BOX 3-4.

RESEARCH BOX 3-4 Is the Internet Replacing Health Professionals?

» BACKGROUND: People with mental disorders often report unmet medicines information needs and may search for information on medicines from sources including the Internet, telephone services, books, and other written materials.

» OBJECTIVE: This study aimed to identify and describe the sources of medicines information used by people with and without mental disorders.

» METHODS: A cross-sectional postal survey was mailed to a nationally representative sample (n = 5,000) of Finns aged 15–64 years in spring 2005. Completed responses were received from 3,287 people (response rate 66%), of whom 2,348 reported using one or more sources of medicines information during the past 12 months. Of those who reported one or more sources of medicines information, 10% (n = 228) reported being diagnosed with or treated for a mental disorder. The main outcome measures were the sources of medicines information used by people who did and did not report being diagnosed with or treated for a mental disorder.

» RESULTS: Among respondents with and without a mental disorder, physicians (83% vs. 59%), pharmacists (56% vs. 49%) and client information leaflets (53% vs. 43%) were the most common sources of medicine information. After adjusting for age, gender, level of education, working status, and number of chronic diseases, respondents with mental disorders were more likely to use client information leaflets (OR 1.47, 95% CI 1.06–1.98) and the Internet (OR 1.64, 95% CI 1.02–2.64) as sources of medicines information than respondents without mental disorders.

» CONCLUSIONS: The results indicate that physicians and pharmacists are the most common sources of medicines information among people both with and without mental disorders. However, client information leaflets and the Internet were more commonly used by people with mental disorders. There may be an opportunity for clinicians to better exploit these sources of medicines information when developing medicines information services for people with mental disorders.

Source: Pohjanoksa-Mäntylä, M., Bell J., Helakorpi, S., Närhi, U., Pelkonen, A., & Airaksinen, M. S. (2010, March 12). Is the Internet replacing health professionals? A population survey on sources of medicines information among people with mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 46*(5), 373–379.

To request a copy of the full study, e-mail: Division of Social Pharmacy, Faculty of Pharmacy, University of Helsinki, Helsinki, Finland, marika.pohjanoksa@helsinki.fi.

HEALTH PROMOTION CHALLENGE

After reading Research Box 3-4, devise a health promotion tip to provide to clients.

The Web provides an inexpensive, relatively easy, and accessible format for health promotion. For information on the use of the Internet to reduce stress, read **RESEARCH BOX 3-5** concerning a website stress reduction program.

RESEARCH BOX 3-5 Workplace Use of Website Stress Program

- BACKGROUND: In web-based health promotion programs, large variations in participant engagement are common. The aim was to investigate determinants of high use of a worksite self-help web-based program for stress management.
- METHODS: Two versions of the program were offered to randomly selected departments in IT and media companies. A static version of the program including a health screening tool, diary, and information about stress was offered to the control group. Additional materials, i.e., interactive, cognitive-based and classical stress management exercises, and a chat room, were offered to the intervention group. Baseline data regarding participants' demographics, health (self-ratings and biological measures), lifestyle, work-related factors, and group membership were analyzed to study determinants of employees' participation in the program during a period of 12 months. Multiple logistic regression analysis was used.
- FINDINGS: Intervention group membership, being a woman, having at most a secondary education, regular physical exercise habits, and having positive expectations of the program were significant predictors of high use. The findings demonstrate that the interactivity of a web-based program is an important factor for determining participation in a web-based worksite stress management program.

Source: Hasson, H., Brown, C. & Hasson, D. (2010). Factors associated with high use of a workplace web-based stress management program in a randomized controlled intervention study. *Health Education Research*. http://her.oxfordjournals.org/cgi/content/abstract/cyq005

HEALTH PROMOTION CHALLENGE

Use the information in Research Box 3-5 to identify important elements in a website health promotion program.

Summary

Effective communication is a necessity in health promotion. Active listening can enhance client learning and success in the client's health promotion goals; it includes thinking of the client's needs and avoiding disruption of the client's flow of communication and using an interested tone of voice and a positive body language. Empathy is the communication of at least as much feeling and meaning as the client communication. High differentiation implies the ability to respond to clients without reacting impulsively or irrationally, but by remaining calm under high stress. To be helpful to clients, it is important to maintain clear and rational boundaries. Assertiveness is the ability to clearly and willingly express thoughts, feelings, or desires in a respectful and cordial manner. Communication barriers include dysfunctional communication and listening blocks. Triangulation is a two-person situation in which one or both individuals calls upon a third person, issue, or object to intervene or disrupt the conflict as a way to decrease discomfort. Clarifying values is a process that can help clients move toward higher levels of health. Centering is a way to find the client's inner reference of stability. Affirmations are a self-care strategy that can reduce stress and lead to calm, productive behavior. Refuting irrational ideas is a method of helping clients to take responsibility for their behavior. Hidden agendas are obstacles to authentic, positive relationships. Evaluating and decreasing resistance to change are two ways to implement change. Shaping techniques are ways to reinforce approximations to a health promotion goal. Contracting is a method to help clients reach their health promotion goals.

REVIEW QUESTIONS

1. A person with a high level of differentiation is most likely to:
   a. Act impulsively
   b. Stay calm under high stress
   c. Have a high capacity for aggressiveness
   d. Engage in self-talk
2. Using *I* messages is a form of:
   a. Assertiveness
   b. Aggressiveness
   c. Self-talk
   d. Dysfunctional communication
3. Calling on a third person to disrupt a conflict between two parties is known as
   a. Affirmation
   b. Setting boundaries
   c. Centering
   d. Triangulation
4. Finding an inner reference of stability within oneself is known as
   a. Balancing
   b. Centering
   c. Yoga
   d. Goal setting
5. Which of the following is an affirmation?
   a. I can do this.
   b. I will stay calm.
   c. I will not let this bother me.
   d. Both a and b.
   e. All of the above.
6. Which of the following is not a strategy for assertively responding to criticism?
   a. Acknowledging
   b. Apologizing
   c. Clouding
   d. Probing
7. What is the purpose of the belief scale?
   a. To measure client responsibility for health and wellness
   b. To refute irrational ideas
   c. To decrease resistance to change
   d. To use rewards to increase desired behavior

EXERCISES

1. Use FIGURE 3-4 Health Wellness Self-Assessment, and Figure 3-3, the Health Wellness Belief Scale, and see where you stand. Choose at least one health wellness goal to pursue for the next 6 months. Share your findings with at least three students and ask for feedback and support in achieving your goal. Find another student who agrees to work as your health/wellness buddy to provide support for you and vice versa.
2. Evaluate your level of differentiation and devise a plan to become more differentiated. Share your plan with at least one other student and ask for feedback and support.
3. Evaluate your level of assertiveness. Develop a program to help yourself become more assertive. Share your plan with at least one other student and work together to help support each other in becoming more assertive. Keep a diary of your progress and reevaluate your assertiveness skills each month. If needed, add more assertiveness approaches to enhance your assertive behavior.

Directions: Read the statements for each dimension of wellness; circle the number which most appropriately resembles the importance of each statement to you and your well-being and current interest in changing your lifestyle:				
1. I am already doing this. (Congratulate yourself!)				
2. This is very important to me and I want to change this behavior now.				
3. This is important to me, but I'm not ready to change my behavior right now.				
4. This is not important in my life right now.				
Nutritional Wellness				
I maximize local fresh fruits and uncooked vegetables in my eating plan.	1	2	3	4
I minimize the use of candy, sweets, sugar, and simple carbohydrates.	1	2	3	4
I eat whole foods rather than processed ones.	1	2	3	4
I avoid foods that have color, artificial flavor, or preservatives added.	1	2	3	4
I avoid coffee, tea, cola drinks, or other substances that are high in caffeine or other stimulants.	1	2	3	4
I eat high-fiber foods daily.	1	2	3	4
I have a good appetite, but I eat sensible amounts of food.	1	2	3	4
I avoid crash diets.	1	2	3	4
I eat only when I am hungry and relaxed.	1	2	3	4
I drink sufficient water so my urine is light yellow.	1	2	3	4

FIGURE 3-4 Health and Wellness Promotion Self-Assessment

I avoid foods high in saturated fat, such as beef, pork, lamb, soft cheeses, gravies, bakery items, fried foods, etc.	1	2	3	4
I use a reverse osmosis water filtration system or drink distilled water to ensure safe drinking water.	1	2	3	4
Fitness and Wellness				
I weigh within 10% of my desired weight.	1	2	3	4
I walk, jog, or exercise for more than 20 minutes at least 3 x/week.	1	2	3	4
I seem to digest my food well (no gas, bloating, etc.).	1	2	3	4
I do flexibility or stretching exercises daily and always prior to and following vigorous exercise.	1	2	3	4
I am satisfied with my sexual activities.	1	2	3	4
When I am ill, I'm resilient and recover easily.	1	2	3	4
When I look at myself nude, I feel good about what I see.	1	2	3	4
I use imagery to picture myself well and healthy every day.	1	2	3	4
I use affirmations and other self-healing measures when ill, injured, or to enhance my fitness.	1	2	3	4
I avoid smoking and smoke-filled places.	1	2	3	4
Stress and Wellness				
I sleep well.	1	2	3	4
I have a peaceful expectation about my death.	1	2	3	4
I live relatively free from disabling stress or painful, repetitive thoughts.	1	2	3	4
I laugh at myself occasionally, and I have a good sense of humor.	1	2	3	4
I use constructive ways of releasing my frustration and anger.	1	2	3	4
I feel good about myself and my accomplishments.	1	2	3	4
I assert myself to get what I need instead of feeling resentful toward others for taking advantage of or intimidating me.	1	2	3	4
I can relax my body and mind at will.	1	2	3	4
I feel accepting and calm about people or things I have lost through separation.	1	2	3	4
I get and give sufficient touch (hugs, etc.) daily.	1	2	3	4

FIGURE 3-4 (Continued)

Wellness Relationships and Belief				
I have at least one other person with whom I can discuss my innermost thoughts and feelings.	1	2	3	4
I keep myself open to new experiences.	1	2	3	4
I listen to others' words and the feelings behind the words.	1	2	3	4
What I believe, feel, and do are consistent.	1	2	3	4
I allow others to be themselves and to take responsibility for their thoughts, actions, and feelings.	1	2	3	4
I allow myself to be me.	1	2	3	4
I live with a sense of purpose.	1	2	3	4
Wellness and the Environment				
I have designed a wellness support network of friends, family, and peers.	1	2	3	4
I have designed my personal living, playing, and working environments to suit me.	1	2	3	4
I work in a place that provides adequate personal space, comfort, safety, direct sunlight, fresh air; limited air, water, or material pollutants; or I use nutritional, exercise, or stress reduction measures to minimize negative effects.	1	2	3	4
I avoid cosmetics and hair dyes that contain harmful chemicals.	1	2	3	4
I avoid pesticides and the use of harmful household chemicals.	1	2	3	4
I avoid X-rays unless serious disease or injury is at stake, and I have dental X-rays for diagnostic purposes only every 3 to 5 years.	1	2	3	4
I wear protective clothing when exposed to the sun for more than 15 minutes (light-skinned) or 45 minutes (dark-skinned)	1	2	3	4
I use the Earth's resources wisely.	1	2	3	4
Commitment to Wellness and Health				
I examine my values and actions to see that I am moving toward health and wellness.	1	2	3	4
I take responsibility for my thoughts, feelings, and actions.	1	2	3	4
I keep informed on the latest health/wellness knowledge rather than relying on experts to decide what is best for me.	1	2	3	4
I wear seat belts when driving and insist that others who ride with me also do.	1	2	3	4
I ask pertinent questions and seek second opinions whenever someone advises me.	1	2	3	4
I know which chronic illnesses are prominent in my family and take steps to avoid incurring these illnesses.	1	2	3	4
I work toward achieving a balance in all wellness and health promotion efforts.	1	2	3	4

FIGURE 3-4 (Continued)

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