PART II: The Communication Process in Nursing

4 Communication Skills 71
   Introduction 71
   Establishing rapport 74
   Listening 74
   Touch 79
   Questioning 81
   Information giving 86
   Written information 86
   Paralinguistics 88
   Empathy 89
   Key points 92

5 Barriers to Effective Communication 93
   Barriers to the therapeutic relationship 93
   Understanding influencing factors in the communication process 98
   Barriers in the nurse 103
   Barriers within patients 110
   Unequal power relationships 111
   Overcoming barriers 112
   Nursing theory and conceptual model use 115
   Key points 117

6 Conflict 118
   Introduction 118
   The nature of interpersonal conflict 118
   Common responses to conflict 122
   Dealing with conflict 125
   Using assertive skills 130
   Responses to conflict 132
   Conclusion 142
   Key points 143

7 Collaborative Communication 144
   Introduction 144
   Process of collaborative communication 145
   Barriers to successful collaborative communication 149
   Successful collaborative communication 150
## CONTENTS

Persuasion 152  
Negotiation 155  
Key points 157  

### 8 Communicating in Difficult Situations 159

- Introduction 159  
- Managing yourself in difficult situations 160  
- Breaking bad news 165  
- Bad news 167  
- Grief and bereavement 169  
- Cross-cultural communication 172  
- Key points 175  

### PART III: The Development of Therapeutic Communication Skills

#### 9 Values and Beliefs in Nursing 179

- Introduction 179  
- Values 179  
- Advocacy 183  
- Ethics in nursing 186  
- Nursing as a profession 190  
- Accountability 192  
- Key points 194  

#### 10 The Role of Self-Awareness in Developing Therapeutic Communication Skills 195

- Introduction 195  
- Developing awareness 195  
- What is self-awareness? 196  
- Communication models for increasing self-awareness 200  
- Benefits of self-awareness 206  
- Reflection 209  
- Developing professional confidence 217  
- Conclusion 221  
- Key points 222  

#### 11 Experiential Learning 223

- Introduction 223
Method of experiential learning in communication 225
Using a model of reflection 227
Key points 236

References 237
Index 259
PART I

The Theoretical Foundations of Communication in Nursing
Communication Theory

Introduction

The basis for communication lies in sharing a common existence with others but with each as a unique individual within the mix of human life. This represents the phenomenological view of communication as dialogue between self and others and although it should be considered in the context of other theories presented in this text book it provides a sound basis for the beginning of our discussion of communication (Craig 2001). Communication is something that we all do whether we want to or not, even if we hide ourselves away and cannot be seen, we are still communicating that we are unhappy or do not wish to see other people. We cannot prevent ourselves from communicating, even if we try not to speak to someone, our bodies will betray us and send a message to the other person. So we are all compelled to communicate at some level by using language and our bodies. However, communication does not always seem to work effectively. Why is this? Why do we walk away from encounters feeling angry, humiliated, frustrated and thinking to ourselves, ‘if only I had said…’. On the other hand why do we walk away from situations leaving others feeling like this? Indeed, how often are we actually aware that our communication has possibly engendered negative feelings in others?

The basis for communication lies in our common existence with others in a shared world that may be constituted differently in experience.
Exercise
To what extent are you aware of the impact of your communication behaviours on others? You may write down your thoughts on this before proceeding with the chapter.

Exercise
‘What is Communication’? Try to write down the first ideas that come into your head and keep them close by, as you will need to refer back to them as you read on.

It could be argued that communication is not actually communication unless it is intentional. When communicating, you need to consider and be aware of the effect your facial expression and tone has on another person. Your behaviour whether verbal or non-verbal, will influence how another person communicates with you because of the message that your tone and body language sends out. For example, if you are distracted and irritable because you have received a letter telling you that you have been caught speeding in your car and will have to pay a fine and get points on your licence, and this is evident in your facial expression and tone when you are speaking to a work colleague or patient about an unrelated matter, then it affects the interaction.

This book is concerned with interpersonal communication in nursing, regardless of the medium through which it takes place. The emphasis is on the verbal and/or non-verbal language required to deliver the message in a manner that is patient-centred, respectful, genuine and therapeutic. This requires a level of awareness, not just of the specific nature and purpose of the message but most importantly it requires knowledge of one’s self. Communication is about interacting with people and therefore is at the core of nursing. For nursing care to be effective and therapeutic, the communication skills used by nurses need to be positive and patient-centred. This requires a continuing awareness by nurses as individuals of their contribution to interactions that they have not just
with patients but also with relatives, friends, other healthcare professionals and healthcare staff. Nurses spend more time with patients than any other healthcare professional and coordinate their care by communicating closely with other professionals. Without attempting to define all aspects of the nurse’s role, communication is without doubt an integral part of the nurse’s role. The collaborative skills required to do this well and effectively are discussed in Chapter 7.

**Defining communication**

This chapter explores communication as a concept; first, by reviewing non-nursing communication models frequently referred to when we think or learn about communication. Second, in order to consider communication in a context that we believe is unique to nursing, models of communication specific to nursing are also reviewed. However, before that let us look at various definitions of communication:

‘A process in which the individual implements a set of goal-directed inter-related, situationally appropriate social behaviours, which are learned and controlled’ (Hargie 2006: 13).

‘Human communication consists of the sending and receiving of verbal and nonverbal messages between two or more people’ (DeVito 2011). DeVito adds the comment to this definition that although this appears to be a simple process it is quite complex in reality.

‘Communication involves the reciprocal process in which messages are sent and received between two or more people’ (Balzer-Riley 2011: 6).

‘A useful way of thinking about interpersonal communication is as a series of messages – information – which you send out to other people and messages which you received from them, through seeing, hearing or touching one another’ (Petrie 1997: 6).

‘Communication is a universal function of man that is not tied to any particular place, time or context’ (Ruesch 1961: 30–1).
The diversity of these definitions in terms of their broadness or even vagueness highlights the complexity of the concept of communication and therefore, the difficulty in producing a comprehensive model and definition of communication that truly reflects its essence. In their definitions, of communication, Hargie (2011), Balzer-Riley (2011), Petrie (1997) and Hayes (1991) all use terms such as ‘interpersonal communication’ and ‘interpersonal skills’ interchangeably and are based on the fundamental belief that communication is an interpersonal process. Ruesch (1961) did not concur with this view. His definition described communication as a function, which implied that it is always purposeful. However, none of these definitions or models provides possible explanations as to why some communication is positive and some is not. Consider the following interaction.

Smiling and in a friendly tone, a nurse asks her nursing colleague, ‘Are you free to check the medication with me now?’ Her colleague is reading some notes and she looks and sounds irritated when she replies, ‘Yes, ok but it will have to be quick; the new admission will be here in fifteen minutes’. The first nurse seems confused by this reaction and says ‘If you are busy I will ask someone else’. Her colleague immediately says ‘No, no, I’m sorry if I seem irritable, it’s just that I was looking at the duty roster and I am working on my birthday.’

This type of interaction is quite a common between colleagues or friends and is an example of both intrapersonal and interpersonal communication. The colleague probably did look irritated but this was due to her own private thoughts in relation to having to work on her birthday and her face registered these inner feelings. However, the first nurse perceived the irritated expression as being directed at them. The problem is that often an individual’s intrapersonal communication is evident in their facial expression and a message is sent to the outside and is observed and interpreted by other people but this message is not or was never intended to be a message to another person. This is an example of unconscious communication that can have a negative effect on an interaction. The nurses communicated well in this example and nobody was left feeling negative about the interaction but often such interactions can cause friction and bad feeling among colleagues. Of course, the opposite is also possible, that is, communication...
that is successful and has a positive outcome can also be the result of communication that is unconscious.

**Concepts of communication**

Depending on the model structure and underpinning concept, communication can be regarded as both simple and a complex process. The Linear Model of Communication (Miller and Nicholson, 1976) may be considered as an illustration of simple communication. This is illustrated as follows:

\[ \text{Sender} \rightarrow \text{Message} \rightarrow \text{Receiver} \]

Berlo (1960) and Miller and Nicholson (1976) described communication as a simple activity in which a sender transmits a message to a receiver in order to bring about a desired response. Communication is said to occur in one direction only. The sender is responsible for not only the accuracy of the content but also the tone of the message. The message contains verbal and/or non-verbal information that will be interpreted by the receiver. The sender of the message will know that the receiver has interpreted the message accurately through feedback.

However, based on this model, for communication to be effective it is assumed that sender is very clear about the purpose of the message and what it is supposed to achieve and has also carefully considered the recipient when formulating the message. It is also assumed that, in this model, the recipient is an open-minded and willing participant in the interaction. These assumptions do not take into account other factors (intrinsic and extrinsic factors) that can influence the communication process. Intrinsic factors apply to both the sender and receiver and refer to personal and professional aspects of a person that may affect communication. Examples of these are values, beliefs, culture, goals, role and knowledge/education in relation to the topic of communication. Extrinsic factors relate to the immediate physical environment and the communication medium being used. DeVito (2011) described these factors as ‘noise’ that could distort the message being transmitted and distort the perception of the
receiver, such that the message is interpreted differently to the original meaning intended by the sender. DeVito (2000) described four types of noise:

- physical noise (external to the speaker, e.g., loud music or voices in the background);
- physiological noise (physical impairments that influence perception by the receiver);
- psychological noise (perceptions of sender/receiver being influenced by individual beliefs, values, biases, goals); and
- semantic noise (words have different meanings in different contexts).

The Linear Model of Communication is, therefore, limited and perhaps is most useful for identifying the basic components of simple communication, rather than for illustrating the complexities of communication between humans.

The Circular Transactional Model of Communication, based on the work of Bateson (1979) takes a broader view of the communication process (Figure 1.1). Communication comprises similar components as the linear model but the concept of communication is further developed by the indication that all

---

**Figure 1.1** Picture of circular transactional model of communication

communication is interpersonal, therefore, it takes place within the context of a relationship. This model acknowledges the key role that intrinsic and extrinsic factors outlined above or ‘noise’ play in the communication process but it also included the concepts of ‘feedback’ and ‘validation’ as fundamental for the development and continuation of successful or effective communication.

Both of these concepts will be discussed in Chapter 3 in relation to therapeutic communication. The transactional nature of this model lies in its recognition of communication as a reciprocal process in which communication is simultaneous and shared between people as ‘communicators’ rather than a ‘sender’ and ‘receiver’. The cyclical aspect of this model acknowledges that communication is not linear or one-way but is instead an ongoing dynamic process that is inherently complex.

Harms (2007) describes a multidimensional approach to communication that comprises of seven key themes:

1. An individual’s inner world is multidimensional and unique.
2. An individual’s outer world that influences their inner world to shape their daily life experiences.
3. Time is multidimensional comprising biological, biographical, historical/social, cyclical and future elements that influence behaviour and experience.
4. Experience is multidimensional and unique to individuals.
5. Adaptation is multidimensional and shapes individual or group responses to adversity thus allowing others to comment on/predict behaviour, risk, vulnerability and resilience.
6. Theorizing human development and adaptation should be multidimensional in order to provided human service responses that are appropriate and effective.
7. Human service responses must be multidimensional

This is an interesting model because it shows the origin of unique individual communication behaviour in the experiences of everyday life and the importance of considering the multidimensional approach when working with people and developing appropriate services (Harms 2007).
Hargie’s (2011) model of communication ‘A Skills Model of Interpersonal Communication’ contains many of the elements illustrated in the circular transaction model of communication and Harms’ (2007) model but in contrast it presents these elements as skills, suggesting that effective or successful interpersonal communication is purposeful and focused. These skills are identified as follows:

- person–situation context;
- goal;
- mediating processes;
- response;
- feedback; and
- perception.

The person–situation context refers to the individual or unique aspects of a person that contributes to an interaction. These aspects include the person’s values, beliefs, culture knowledge, skills, personality, age, gender, self-concept and self-efficacy (self-belief in one’s ability to succeed) and may influence their approach and style of response during an interaction. The situation itself in terms of not just the physical setting but also the parameters (roles and rules) will also directly impact how people behave and respond during an interaction.

The goal of the individuals involved in the interaction may be the same or it may differ to a greater or lesser degree. The achievement of the goal influences each participant’s behaviour and persistence. Success also depends on whether the goals are implicit or explicit, how important they are, whether they are task or relationship related, how compatible the goals of the people are and whether they are primary or secondary goals.

Mediating processes refer to a combination of cognitive and affective processes that help the participants in the interaction to work through the encounter by identifying goals and acknowledging and responding to events. Cognitive processes are concerned with how individuals have a very personal way of using their knowledge and beliefs when thinking about things and this directly impacts on how they solve problems, make judgments or perceive situations generally. The affective
Index

Note: Page numbers in italics refer to figures and tables.

accents, 88
accountability, 192–4
advocacy, 184
Aggleton, P., 103, 116
Aiman, J., 111
Alberti, R.E., 142
Alligood, M.R., 27, 28
An Bord Altranais, 41, 59, 107
anger, 128, 132, 212
Anon., 170
anxiety, 19, 51–2, 162–5
appearance, physical, 74, 107–8
Arborelius, E., 114
Argyle, M., 71
Arnold, E.C., 8, 37, 41, 45, 46, 47, 51, 55, 59, 96, 98, 101, 103, 105, 116, 118–19, 120, 122, 123, 124, 125, 128, 129, 130, 131, 132, 138–9, 140, 195
assertiveness, aggressive
responses, 132–3; assertive
response, 135–42; barriers
to, 132, 136–7;
components, 131–2;
definition, 130; goals, 131;
manipulative response, 133;
passive response, 133–4;
reasons, 131; response
styles, 132–42; rights, 141–2, 141; specific
responses, 131
Attree, M., 13
awareness, concept, 198
bad news, 165–9; breaking,
165–6; withholding, 168–9
Balzer-Riley, J., 5, 6, 118, 120, 121, 130, 137, 138, 139
Bandura, A., 217, 220, 221
Barker, P., 42
Barnett, R., 212, 222, 229, 231
barriers, 93–117; to
assertiveness, 132, 136–7;
attitudes, values and beliefs,
109–10; to collaboration,
149–50; definitions, 93–5;
filters, 95–8; influencing
factors, 98–103; language,
110–11; listening, 103–5;
to the nurse–patient
relationship, 93–8, 103–10,
114; overcoming, 112–16;
within patients, 110–11;
personal factors, 95–8;
scenario, 95–6; touch, 109;
unequal power
relationships, 111–12
Basford, L., 190
Bateman, N., 183
Bateson, G., 8
Bath, P.A., 109, 111
Beckett, C.D., 145, 146
behaviourism, 199
beliefs, 109–10, 179–80
Benner, P., 224–5, 227, 230
bereavement, 169–72
Berlo, D., 7
Berry, J.A., 19
Betts, A., 114, 195
body language, 4, 71, 105, 132–3, 200, 201
Bowker, G.C., 181
Bowler, I.M.W., 109
Brajtman, S., 144
Brechin, A., 139, 211, 212, 213, 214, 214, 231
Brinkett, R., 121, 122
Buber, M., 50–1, 53
Bucksey, S., 79, 80
Bulman, C., 210
Burnard, P., 62, 96, 97, 104, 105, 196, 197, 198, 198, 199–200, 201, 203–4, 208, 209, 211, 222
busy nurse syndrome, 16, 26, 105–6

Callaghan, P., 62
Carroll, M., 210, 211
case meetings, 147–9
Chalmers, H., 103, 116
Chambers-Evans, J., 114
Chan, E.A., 19–20
CINAHL database, 65–6
Circular Transactional Model of Communication, 8–9, 8, 11, 13, 17, 100
Clark, J., 181
collaboration, 144–58, 192;
barriers, 149–50;
negotiation, 155–7;
persuasion, 152–5; process,
145–9; scenarios, 146–7,
148–9, 154–5, 156–7;
successful, 150–2
collusion, 168
Colyer, H.M., 190
Comforting Interaction-Relationship Model, 17–19, 54–5, 201, 224
communication, 3–5;
authoritative, 63; changing

behaviour, 58;
collaborative, 144–58;
concepts, 7–12; cross-cultural, 172–5; definitions, 5–7, 11–12; emotional engagement, 14–17,
223–4; facilitative, 63–4,
106–7; field competencies,
102; I-It and I-Thou, 50–1,
53; influences, 44–5;
interpersonal, 6, 13–14;
intrapersonal, 6, 44, 45;
intrinsic/extrinsic factors,
7–8, 9; mechanistic, 63;
models in nursing, 12–20,
15; multidimensional approach, 9, 13, 170;
nurse-focused, 16–17; one-
way, 13, 19; phatic, 62–3;
psychological factors,
45–52; range of, 99;
unconscious, 6–7, 16,
46–7, 71, 199, 201, see also
named models; non-verbal
communication; patient-
centred communication;
patient-focused
communication; therapeutic
communication
communication skills, 71–92;
empathy see
empathy/emotional
engagement; establishing
rapport, 74; information
giving, 86; listening see
listening; paralinguistics,
88–9; questioning, 81–5;
touch, 79–81, 200; written
information, 86–8, see also
non-verbal communication
Conceptual Frame of Reference
for Psychodynamic
Nursing, 29, 35–7, 35, 38;
exploitation, 36;
identification, 36, 37–8;
orientation, 35, 37–8;
resolution, 36
conceptual models, 27–8, 29–42, 115–16
confidence, professional, 217–21
confidentiality, 168
conflict, 118–43;
  accommodation, 123;
  aggressive responses, 132–3;
  assertive response, 135–42;
  avoidance, 122–3;
  collaboration, 123–4;
  common responses, 122–4;
  competition, 123;
  dealing with, 125–30;
  manipulative response, 133;
  nature of interpersonal, 118–22;
  passive response, 133–4;
  using assertive skills, 130–2
congruent behaviour, 49–50
Corbett, T., 106
Costa, M.J., 24, 103, 104, 106
counselling, 17, 90, 165, 170
Coyle, J., 56, 62, 104–5, 106
Craib, I., 170–1
Craig, R.T., 3
Cree, V.E., 110
critical action, 213, 213, 231–2
critical analysis, 212–13, 213, 229–31, 232
critical practice, 229–32, 235
critical reflexivity, 214, 214, 232
cross-cultural communication, 172–5
Daisley, J., 133–6, 134
Davidhizar, R.E., 173, 174, 220
Davies, M.M., 109, 111
Davis, M.S., 129
De Vito, J.A., 5, 7–8, 45, 76, 98, 108, 120, 121, 126, 149, 199, 201, 203, 204–5, 205, 208–9
Degazon, C., 190
Department of Health, 195, 206
Dewey, J., 209
difficult situations, 159–75;
  bad news, 167–9;
  breaking bad news, 165–6;
  cross-cultural communication, 172–5;
  grief and bereavement, 169–72;
  introduction, 159–60;
  managing yourself, 160–5
Dimond, B., 184
Dingley, C., 144, 145
distancing, professional, 25, 26, 50, 104
Doak, C.C., 111
documentation, 39–40
Dosanjh-Matwala, N., 173
Dowling, S., 139
dress, appropriate, 107–8
Driscoll, A., 113
Dunne, P., 211
Eckroth-Bucher, M., 195–6
education, 114–15
Edwards, A., 115
Edwards, S.C., 109, 111, 112
Ellis, R.B., 199
Emmons, M.E., 142
empathy/emotional engagement, 14–17, 49, 52–3, 54–5, 73, 89–92, 104, 223–4
empowerment, 34, 116, 213, 231–2
Engel, G.L., 169
ethics, 138–9, 186–7
ethnocentrism, 174–5
experiential learning, 223–36; interpretive approaches, 224–5; methods, 225–6; using a model of reflection, 227–36
eye contact, 66, 75, 76–7, 78, 140, 200

facial expression, 4, 6, 75, 105, 200
Fallowfield, L., 107
false reassurance, 16–17
families, involving, 113, 147–9
Fawcett, J., 27, 28, 29
feedback, 9, 11, 64–5, 76, 80, 203
Fewster-Thuente, L., 144
Fleischer, S., 74, 86
Fosbinder, D., 13–14, 224
Fossum, B., 114
Foster, J.H., 110
Francis, R., 144
Freedom of Information Act, 190
Freshwater, D., 90
Freud, S., 46–8, 53, 199
Fry, S.T., 191

Gallant, M.H., 115
Gardner, D., 151–2
Gates, B., 183
Gaudine, A., 187
genuineness, 49, 52–3, 54–5, 57, 73, 106, 181
Gibbons, M.B., 75, 107
Gibbs, G., 211, 226, 227, 227, 229
Giger, J.N., 173, 174
Gill, P., 62, 96, 97
Gillies, P.A., 173
Glasgow Coma Scale, 40
grief, 169–72
Griffiths, P., 41
Grypma, S., 175

Hancock, H., 192–3
Hanks, R.G., 184
Hannigan, B., 209, 210, 211
Hargie, O., 5, 6, 10, 11, 83, 85, 104, 118, 130, 131, 136, 152–3
Harms, L., 9, 10, 170
Hart, C., 190–1
Hayes, J., 6
Health Information and Quality Authority (HIQA), 42
Henderson, V., 181, 182
Hindle, S.A., 44, 45, 95, 96, 109
Holland, K., 29, 30
Holmberg, L., 19–20
humanistic model, 48–50, 199

Iggulden, H., 32, 40
illiteracy, 111
information, written, 86–8
interpersonal processes, 13–14, 224
interpersonal skills, 101, 101, see also Skills Model of Interpersonal Communication
ISBAR (Introduction/Identify, Situation, Background, Assessment, Recommendation), 146–7, 149, 151
Ito, M., 116

Jackson, A., 42
Jakobsson, L., 19–20
Jarrett, N. J., 107
Jenner, E.A., 23
Jensen, S.K., 211
Johari Window, 201–4, 202
INDEX

Johns, C., 211, 212, 218  
Jones, D.C., 173  
Jones, L., 234  
Jorm, A.F., 110  
Joy, C., 211  
Kagan, S.H., 25  
Kalb, K.B., 107–8  
Kantcheva, D.A., 195–6  
Keating, D., 103, 114  
Kim, H.S., 28  
Kipnis, G., 145, 146  
Kirkham, M., 109  
Kreigh, H., 163  
Krujijver, J.P.M., 19, 224  
Kubler-Ross, E., 169, 170  
Kunyk, D., 90  
Lambert, V.A., 116  
Lang, N., 181  
language, as a barrier, 110–11  
Langwitz, W.A., 52  
Lea, A., 174  
Leadership Qualities Framework (LQFR), 207, 207  
Lee, P., 39  
Leininger, M., 173  
Liaschenko, J., 189  
Lindemann, E., 169  
Linear Model of Communication, 7–8, 11, 13, 19, 93, 200–1, 224  
listening, 74–9; active, 74–6, 78, 80, 105, 107, 129, 171; to answers to questions, 83–4; attending, 106; as a barrier, 103–5; clarification, 75; and ethics, 186–7; false, 77, 78; feedback, 76; paraphrasing, 76, 83; scenarios, 77–8  
Llewellyn, P., 184  
Luft, J., 201, 202  
Martin, G., 23, 25, 26  
Maslow, A.H., 48–9, 53–4, 55, 57  
Mason, C., 41  
Mason, D.L., 193  
Mavundla, T.R., 110  
McCance T., 55, 64  
McCartan, P., 137  
McCormack B., 55, 64  
McCrae, N., 41  
McDonald, H., 184  
McIntosh, W., 136, 137  
McQueen, A., 14  
McSherry, R., 193  
Melia, K.M., 23  
Michie, S., 114  
Miller, G.R., 7, 93  
Milstead, J.A., 121, 122, 125, 127  
Milton, C.L., 192  
Morrall, P., 112  
Morrissey, J., 62  
Morse, J.M., 13, 14, 15, 17–19, 20, 54, 89, 90, 91, 92, 201, 223, 224, 225  
mortality, 172  
Moser D., 162  
multidimensional approach to communication, 9, 13, 170  
Murphy, K., 41  
Nadzam, D., 151  
Nash, C., 214  
needs, hierarchy of, 48, 53–4  
Negarandeh, R., 184
negotiation, collaborative, 155–7
Newell, R., 210
NHS Modernization Agency Leadership Centre, 206, 207
Nicholson, H.E., 7, 93
non-verbal communication, feedback from, 11; influence, 4; with ISBAR, 147; paralinguistics, 88–9; percentage of message, 71; touch, 79–81, 109, 200; when breaking bad news, 166, see also body language; listening
Notara, V., 42
Nottingham model, 39
nurse-focused communication, first-level (spontaneous), 16, 224; second-level (learned), 16–17, 224
nurse–patient relationship, barriers, 93–8, 103–10, 114
nursing, definitions, 180–3, 183; knowledge, 236–7; as a profession, 190–2
Nursing and Midwifery Council (NMC), 42, 100–1, 102
nursing theory, 21–43; conceptual models, 27–42, 115–16, 223–5, see also named models; definitions, 22–7; as a guide to communication behaviour, 29–42; philosophy, 28; potential to guide communication practice, 28; in practice, 27–8
O’Brien, L., 106
O’Donovan, M., 227
Onyeukwu, C., 110
Orchard, C.A., 145, 150
Orem, D.E., 29, 32, 33, 34, 43, 116, 201
O’Shea, J., 201
Oxford English Dictionary, 184, 197
paralinguistics, 88–9, see also voice, tone and pitch
partnership, 115–16, 201
patient care meetings, 147–9
patient-centred communication, 14–16, 15, 17, 20, 24, 26–7, 52–8
Paton, B.I., 42
Payne, S.A., 107
Pearce, P., 193
Pearson, A., 29, 30, 32, 36, 37, 115, 201
Peplau, H.E., 13, 18, 29, 35, 36, 37, 42, 43, 59, 89, 103, 115, 199, 222
Percival, J., 136
Perko, J., 163
Permanente, K., 145
Perry, B., 75
person-centred theory, 49–50, 181
personality, id, ego, superego, 46
personality tests, 205
persuasion, collaborative, 152–5
Peter, E., 189
Petrie, P., 5, 6
Pinkery, S., 213
Poroch, D., 136, 137
portfolios, examples, 233, 234
power relationships, unequal, 111–12
prejudice, as a barrier, 109–10
professional distancing, 25, 26, 50, 104
projection, 46–7
Queendom.com, 205
questions, closed, 83, 84, 85; listening to, 83–4, 105; open, 82–3, 84, 85

Rains, S.A., 155
Reber, P.A., 150
Redman, B.K., 191
Reed, P., 182
Reeves, S., 150
Reynolds, W., 89, 90
Rich, K., 179
Riley, J.P., 25
rituals, 25–6, 28
Roberts, L., 79, 80
Robertson, E., 113
Rogers, C.R., 48, 49–50, 52, 55, 181, 199, 202
Rolfe, G., 227
Rönndahl, G., 110
Roper-Logan-Tierney (RLT) model, 29, 30–2, 31, 32, 39; activities of living (ALs), 30–2, 39, 116; case study, 40; documentation, 39–40
Roper, N., 29, 30, 31, 43, 115
Rosenblatt, C.L., 129
Rowe, J., 202
Ruesch, J., 5, 6
Rutherford, M., 181
Rutty, J.E., 181–2, 182
Sahlsten, M.J., 156
SBAR (Situation, Background, Assessment, Recommendation), 145
Schmitz, G.S., 220
Scholes, J., 231
Scholz, U., 220, 221
Schön, D., 209
Schutz, S., 210
Schwarzer, R., 220
Scott, P.A., 89, 90
Seager, W., 196, 197
self, defined, 198–200; unconscious, 6–7, 16, 46–7, 71, 199, 201
self-actualization, 48, 54, 55, 57
Self-Care Deficit Nursing Theory (SCDNT), 29, 32–4, 39
Self-Care Nursing Theory (SCNT), 116
self-efficacy, 220–1
sexual identity, 203
sexual orientation, 110, 203–4
Shaw, H.K., 190
Sheppard, M., 13
Sidell, M., 104, 105, 233
silence, 75, 129, 166, 171, 172
Simons, J., 113
Sims-Williams, A.J., 25
skills, assertive, 130–2; interpersonal, 101, 101, see also communication skills
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Model of Interpersonal Communication</td>
<td>10–12, 13, 17</td>
</tr>
<tr>
<td>Slevin, O.</td>
<td>190</td>
</tr>
<tr>
<td>Smith, F.</td>
<td>39</td>
</tr>
<tr>
<td>spirituality, 79, 172, 203</td>
<td></td>
</tr>
<tr>
<td>Stanford Encyclopedia of Philosophy</td>
<td>196, 199</td>
</tr>
<tr>
<td>stereotyping, as a barrier,</td>
<td>109–10</td>
</tr>
<tr>
<td>Stockwell, F.</td>
<td>173</td>
</tr>
<tr>
<td>Suikkala, A.</td>
<td>63–4, 106–7</td>
</tr>
<tr>
<td>sympathy, 14–15, 56, 91</td>
<td></td>
</tr>
<tr>
<td>Takase, M.</td>
<td>190</td>
</tr>
<tr>
<td>task-oriented care, 22–4, 24–5, 25–6, 106–7</td>
<td></td>
</tr>
<tr>
<td>Taylor, B.</td>
<td>132, 133, 142</td>
</tr>
<tr>
<td>therapeutic communication,</td>
<td>58–66, 90, 103, 113, see also experiential learning; self-awareness; values</td>
</tr>
<tr>
<td>Thompson, D.</td>
<td>25–6</td>
</tr>
<tr>
<td>Thompson, H.J.</td>
<td>25</td>
</tr>
<tr>
<td>Thompson, J.E.</td>
<td>145</td>
</tr>
<tr>
<td>Thompson, N.</td>
<td>127</td>
</tr>
<tr>
<td>Thorsteinsson, L.S.C.H.</td>
<td>13</td>
</tr>
<tr>
<td>Tidal Model</td>
<td>42</td>
</tr>
<tr>
<td>Tierney, A.J.</td>
<td>115</td>
</tr>
<tr>
<td>Timmins, F.</td>
<td>24, 131, 136, 137, 138, 141, 181, 201, 211 touch, 79–81, 200; as a barrier, 109</td>
</tr>
<tr>
<td>transference/counter-transference</td>
<td>46–7, 53</td>
</tr>
<tr>
<td>Tschudin, V.</td>
<td>179, 187</td>
</tr>
<tr>
<td>Turner, M.</td>
<td>155</td>
</tr>
<tr>
<td>Uitterhoeve, R.</td>
<td>101, 104</td>
</tr>
<tr>
<td>unconscious self, 6–7, 16, 46–7, 71, 199, 201</td>
<td></td>
</tr>
<tr>
<td>Underman Boggs, K.</td>
<td>8, 37, 41, 45, 46, 47, 51, 55, 59–60, 96, 98, 101, 103, 105, 116, 118–19, 120, 122, 123, 124, 125, 128, 129, 130, 131, 132, 138–9, 140, 195</td>
</tr>
<tr>
<td>Uys, L.R.</td>
<td></td>
</tr>
<tr>
<td>Vaartio, H.</td>
<td>184</td>
</tr>
<tr>
<td>Valentine, P.E.B.</td>
<td>136</td>
</tr>
<tr>
<td>validation, 9, 11</td>
<td></td>
</tr>
<tr>
<td>values, 179–83; accountability, 192–3; advocacy, 183–6; as a barrier, 109–10; ethics, 138–9, 186–9; nursing as a profession, 190–2</td>
<td></td>
</tr>
<tr>
<td>Van Amelsvoort-Jones, G.M.M.</td>
<td>173</td>
</tr>
<tr>
<td>Velsor-Friedrich, B.</td>
<td>144</td>
</tr>
<tr>
<td>voice, tone and pitch, 4, 66, 71, 88–9, 132–3, 136, 174</td>
<td></td>
</tr>
<tr>
<td>Ward, M.</td>
<td>42</td>
</tr>
<tr>
<td>warmth, 49, 52–3, 54–5, 73, 181</td>
<td></td>
</tr>
<tr>
<td>Washer, P.</td>
<td>87</td>
</tr>
<tr>
<td>Watson, J.</td>
<td>225, 230, 232</td>
</tr>
<tr>
<td>Wheeler, N.L.</td>
<td>37, 38, 56, 62–3, 113</td>
</tr>
<tr>
<td>Wilkinson, S.</td>
<td>13, 107</td>
</tr>
<tr>
<td>Williams, A.</td>
<td>74</td>
</tr>
<tr>
<td>Williams, B.</td>
<td>56, 62, 104–5, 106</td>
</tr>
<tr>
<td>Williams, K.</td>
<td>110</td>
</tr>
<tr>
<td>Willis, L.</td>
<td>133–6, 134</td>
</tr>
<tr>
<td>Wimpenny, P.</td>
<td>41</td>
</tr>
<tr>
<td>Windsor-Richards, K.</td>
<td>173</td>
</tr>
<tr>
<td>Wiseman, T.</td>
<td>91</td>
</tr>
<tr>
<td>Wisssow, L.S.</td>
<td>26</td>
</tr>
<tr>
<td>Wollett, A.</td>
<td>173</td>
</tr>
<tr>
<td>Wright, D.</td>
<td>144</td>
</tr>
<tr>
<td>Zion, A.B.</td>
<td>111</td>
</tr>
</tbody>
</table>