INTERVIEW SKILLS TRAINING

FOR NURSING STAFF

A REPORT ON A PRACTICUM
SUBMITTED TO THE SCHOOL OF SOCIAL WORK
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BY

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I. OBJECTIVES

The primary objective in this practicum is to teach a professional group of health care providers- nurses, the basic skills of communication required to work effectively with health care consumers- their clients or patients.

Secondary specific objectives are:

1. To teach basic listening and attending skills using the microskills approach.
2. To clarify the participants' role as communicator with clients.
3. To maximize the use of videotape feedback in the learning process.
4. To introduce the systems approach to helping.
5. To teach participants to apply learned interview skills to clinical assessments.

The nursing profession relies on its technical skills for providing good health care, yet lacks initial and continued training in communication skills, which is important in assessing and caring for the "whole patient". Nuturance and good bedside manners do not in themselves constitute the skills required to fully understand the problems and needs of the patient. It has become increasingly evident that helping professions need to assess and treat individuals in the context or environment of the individual [Germain, 1973]. For example, this may involve understanding the individual's social needs, or family situation, or economic/employment problems, before

understanding diagnosis or recovery process. The vehicle for this understanding is communication.

Interview skills are the basic tools of the social worker. Indeed social workers spend more time in interviewing than in any other single activity. [Kadushin, 1983]. In the health care system, social workers are an integral part of the multi-disciplinary health care team. They are often called into patient situations when previous attempts at communication have failed, but where very basic communication skills would allow a wealth of information to flow to and from the patient. The intent of such communication is to assist in recovery from physical illness, mental illness, or stress due to illness. Some of the basic interview skills employed by the social worker can be taught to other care providers, to enhance their ability to assess, understand, and provide service to patients. This is the basis of the practicum: to teach nurses highly applicable interview skills through a custom-designed program.

The student expects to benefit as much as the participants might benefit. Having skills and imparting skill knowledge are two very different things, and it is the student's intention to learn to teach some of the skills used in everyday social work practice. Furthermore it is his intention to be able to measure the impact of teaching these skills.

Specific learning objectives are:

1. To learn and understand communication problems and needs in the nursing profession.
2. To custom design an applicable interview skills training program.
3. To employ a group shared learning process.
4. To evaluate the instruction.

It is the student's career goal to be an effective supervisor and administrator. The practicum experience is chosen to learn and test clinical supervision skills through teaching known skills to others. By employing a highly structured process, the methods for teaching can be more clearly evaluated, and applied to future supervisory experiences.

II. LITERATURE REVIEW

The client group here is comprised of members of the nursing profession, be they hospital nurses, community nurses, nurses in primary, secondary or tertiary care settings. We will examine the importance of and need for interviewing skills in the nursing profession, as the first focus of the literature review. The second focus will be on the methods and components of interview skills training.

Henceforth the term "client" refers to those people cared for or serviced by nurses, and is interchangably used with the term "patient". Client is the preferred term however, as it precludes the implication of illness, thereby widening our perspective of the nursing role.

Although the practicum experience takes place in a group setting, the literature on groups will be reviewed only to the extent that the group is an educational and mutual aid process, and to understand how to structure a group. Theory related to group therapy or psychoeducational groups is not applicable here.

1. Communication in Nursing

Communication is a natural human activity, essential to survival. Social learning theory tells us that how and what we communicate is learned primarily by listening to and observing others [Bandura, 1977]. However, many people learn communication styles which may serve them well in social situations, but are less than therapeutic in the helping relationship [Lore, 1981]. Here the adage that "good communicators are born, not made" is not entirely true; there are particular communication skills that are essential to the helping relationship, and can be learned [Edwards, 1981; Benjamin, 1981; Cross, 1974; Egan, 1986; Ivey, 1983; Kadushin, 1983].

Nurses must be in a position to serve clients and families, and to do so in a colleagial relationship with other members of the health care team. It is therefore necessary to be good communicators and to have an intelligent grasp of interviewing skills [Bernstein & Bernstein, 1980]. Interviewing skills are used primarily in the health care interview, with clients and their families. The functions of the health care interview can be summarized as follows:

1. To establish a relationship.
2. To define roles and responsibilites.
3. To collect data.
4. To process data.
5. To establish a contract (outlining mutually acceptable conditions for continued care).
6. To achieve compatible communication.

[Cormier, Cormier & Weisser, 1984]

Bernstein & Bernstein [1980] point out that the nurse may be the only individual caring for and about the client, who can serve as intermediary between the client, his or her family, and the health care team. This gives the nurse the unique role of patient advocate. Furthermore, the quality of the nurse's communication directly influences the quality of this relationship.

It is evident that the role of the nurse has shifted dramatically in the last twenty years or so [Bernstein & Bernstein, 1980; Edwards, 1981; Bellack & Bamford, 1984; Bradley & Edinberg, 1982]. Nurses who used to accept their subordinate role of carrying out doctors' orders are becoming an independent creative force in health care. Bellack and Bamford [1984] point out that the uniqueness of the nursing profession lies in the ability to care for the "whole patient". Nurses are now not only care givers but also care planners, involving teaching, collaborative and client advocacy roles.

As an illustration of caring for the "whole patient", Warden [1984] shows how nursing histories differ from

medical histories. Physicians focus primarily on detection of potential or actual pathologic condition for the purpose of arriving at a medical diagnosis and a plan for medical or surgical treatment. The information is obtained primarily as it relates to the client's current medical problems. Nurses on the other hand, focus on physiological, pyschological, cultural and developmental parameters that affect or are affected by the client's health status and functioning. They also focus on the client's ability to cope with actual or potential changes. All of this information serves as basis for formulating nursing diagnoses and for planning nursing care. The physician's diagnosis is disease-focused, and likely to be the same regardless of the client's status on the health-illness continuum, e.g. **diabetes**, whether the client is acutely ill in the hospital or healthy at home. Nursing diagnoses describe the client's **responses** to alterations in health status, and thus likely to change whenever the client's responses change, e.g. **ineffective breathing** pattern related to ketoacidosis, or **reactive depression** due to deteriorated condition.

The nurse advocacy role is further exemplified by Barry [1984]. Her thesis goes something like this:

Physicians, being the caring people that they are, are distressed when they realize the emotional hardships that their "cures" may impose on patients. Full awareness of this would

be impossible to bear. Hence a form of denial occurs, an unconscious protection as to allow them to carry on with their work. Awareness of the awful consequences of treatment is minimized as this coping mechanism kicks in. Nurses feel badly too, but at least they know they didn't **cause** pain. Ideally nurses can care for patients physically and support them emotionally. Given this healthy defense of physicians and if nurses are aware of this, they can begin to see their own importance to both physician and patient in monitoring the patient's response to illness.

Another important factor Barry [1984] notes is that while physicians may spend only minutes per day with patients, nurses spend hours. The physician may not observe developing problems because of the patient's attitude toward his or her physician- the authority figure whom patients are eager to please and for whom they are on their best behaviour. When hospitalized, the patient feels dependent on the doctor, and if he or she displeases the MD, the doctor may lose interest, not give the best care, transfer to another doctor, etc. It therefore becomes necessary to withhold all unessential, unpleasant information. Patients, Barry argues, don't have the same unconscious fear of abandonment by nurses, and therefore nurses are in the best position to be the patient's advocate. Nurses are able to monitor the response of the health care system to patient's needs, and able to monitor the patient's responses to the health care system's interventions. Therefore they should

be able to identify patients at risk for maladaptation and mobilize the health care system's resources to assist such patients in adapting to their changing physical condition. There really is no one else in the system to identify patients at risk for long term psychosocial maladaptation.

So we can see now that nursing actions encompass much more than meeting the client's physiological needs, as in the first level of Maslow's hierarchy [Bradley & Edinberg, 1982]. Their actions include 1) psychological activities, which affect the emotional well-being of the client,and 2) socioeconomic activities, which address the client as a total person within the environment. Psychological activities might include consolation, empathy, back rubs to reduce anxiety, and even psychotherapy. Discharge planning is the most salient example of socioeconomic activities. No doubt the physiological, pschological, and socioeconomic activities are interdependent and overlap.

Nurses have tended to judge themselves on their technical skills rather than on the types of human relationships they foster, and there is good reason for this. Bradley and Edinberg [1982] point out that physiological actions are the most easily defined and are most visible, while psychological actions are person-oriented and least visible. Physiological functions can be broken down into steps, and require a high degree of

psychomotor skill. They are routine and staff-centred in that they focus on the nurse's activities. Therefore they can be controlled, monitored, standardized, taught, and evaluated by superiors. Traditionally these high visibility tasks have been the basis for reward and promotion in the hospital setting, hence a tendency to overvalue these tasks.

Bradley and Edinberg [1982] indicate that psychological actions (low-visibility tasks) are less apparent to others, require cognitive or affective skills as opposed to psychomotor skills, and are not as amenable to routine and measurement. These tasks are client-oriented, interactive in nature and dependent on immediate changes in the client. They are less easily controlled by superiors, and traditionally less rewarded in the work setting. The philosophical orientation of nursing has in the past stressed meeting the physical needs of the patient, and so it follows that communication training has not until now been a high priority.

This is **not** to say that communication only occurs during low-visibility psychological activities. Bradley and Edinberg [1982] note that nurses are shifting emphasis from high-visibility tasks to an integrated approach that combines low-visibility skills with high-visibility skills. Nurses are also finding out that often the best therapeutic communication can be carried out while they are performing high visibility tasks. The home care nurse administering

pain medication to a dying patient can be applying sophisticated interview skills providing psychological support, while going about a routine injection.

What then, is the context for this new emphasis on communication/interviewing skills in the nursing profession?

The literature is giving much attention to the "nursing process" [Bernstein & Bernstein, 1980; Lore, 1981; Cormier, Cormier & Weisser, 1984; Bradley & Edinberg, 1982]. The nursing process is basically that of Assessment, Plan, Implementation, and Evaluation. **Assessment**, which incorporates the nursing history, is carried out to gain information about the client, in order to formulate goals and diagnoses. The skills needed to conduct the nursing assessment are: cognitive skills, interpersonal skills, and technical skills. **Plan** refers to setting priorities and goals for (and with) the client. This phase encompasses relationships with other health care workers as well as planning on paper. **Implementation** is the action phase of the nursing process, relying heavily on interpersonal and communication skills. The action here may be intellectual, interpersonal and/or technical. Finally, **evaluation** tells us how well the client responded to the planned action. Evaluation leads to further assessment and re-assessment, and thus the nursing process is dynamic.

Communication, according to Bradley and Edinberg [1982], is the common thread tying together the four phases of the nursing process. Furthermore, communication has content and relationship dimensions [Benjamin, 1981; Kadushin, 1983; DeVito, 1985; Ivey, 1983]. Neither is more important than the other, as Kadushin [1983] warns: "A good relationship is a necessary but not sufficient condition for good interviewing." (p. 3)

In the traditional role of nursing- focusing on the client's physical needs- the nurse/client relationship is primarily a complementary one, in that the nurse assumes a "one-up" relationship to the client. This role emphasizes qualities of nuturance and assistance, while the client role is one of dependence and submissiveness [Bradley & Edinberg, 1982]. Nursing is now moving closer to adopting the social worker/client relationship, which is more symmetrical than complementary. A framework to exemplify this concept is described by Szasz and Hollender [1956] and modified by Branch and Paxton [1976]. In it, there are three phases of the nurse/client relationship, each characterized by the client's states of illness and wellness. In Phase I the client is critically ill, the passive recipient of nursing care. The client is dependent, the relationship complementary. In Phase II the client is acutely ill but able to cooperate, moving from dependence to independence. The nurse becomes more of a teacher and enabler. The communication is still complementary, but now moving towards

symmetry. In Phase III the client is mildly ill (or completely well in a "preventative" care setting). The nurse and client are now in partnership, characterized by mutual participation and balanced communication. Both partners alternate in symmetrical and complementary patterns. Of course the phases described here are more on a continuum than discretely separate, but the idea is that communication must change as the client moves from a state of illness to wellness. Greater demands are placed on nurses in terms of complexity of communication required.

Although the Szasz-Hollender model was developed over thirty years ago, it has only been recently that the nursing profession has caught up to its implications for emphasis on communication skills. The profession has also come to the realization that the issue of symmetry/complementarity is just as important in relating to other members of the health care team [Bradley & Edinberg, 1982]. Several authors point to relationship building as key to the helping process [Rogers, 1951; Egan, 1986; Kadushin, 1983; Cormier, Cormier & Weisser, 1984; DeVito, 1985; Carkhuff & Anthony, 1979; Garrett, 1942].

Given the importance we now attach to the nurse/client relationship, what prevents it from flourishing? Cormier, Cormier and Weisser [1984] have summarized the work of authors who have examined barriers to communication in

health care. They list these problematic areas:

1. developing a systematic and precise interviewing style
2. defining the nature of the health care professional/client relationship and their respective roles
3. maintaining control of the interview
4. responding to the client's feelings or emotions
5. discussing personal or sensitive issues with clients
6. responding effectively to extreme emotional reactions of clients
7. dealing effectively with families, visitors and other health care team members
8. incorporating interviewing skills with health care skills in patient care

In addition, Bradley and Edinberg [1982] cite labelling as a common barrier to effective nurse-client communication, using the examples of the **hostile client**, the **good patient**, and the **good nurse** [p. 157]. These labels correspond closely to Virginia Satir's "communication styles" [1972] which are again referred to on page 21.

Some of these barrier issues will be more closely examined in part 2 of this review.

Notwithstanding the need for the nursing profession to adopt low-visibilty psychological actions, the use of touch by nurses deserves attention. As Lore [1981] points out, patients have generally accepted and understood the touching behaviour of nurses, as many nursing tasks involve the use

of touch. There are many styles of perceiving the world, including visual, auditory and kinesthetic [Lore, 1981; Ivey, 1983; Bradley & Edinberg, 1982]. This notion has been popularized in recent years by Bandler and Grinder [1975] who describe these modalities in terms of what channels people communicate in. Visual ("I **see** what you mean") and auditory ("It **sounds** like a good deal to me") are common and well understood. Kinesthetic communication ("I **feel** that I am **grasping** your meaning"), if properly identified as the client's communication channel, can be linked with therapeutic touch, to further strengthen the nurse/client communication. Nurses, in a sense, already have permission to touch patients. Therapeutic touch is already beginning to gain wide acceptance as a nursing modality, related to the ancient practice of "laying on of hands" [Bradley & Edinberg, 1982]. It is most effective in the areas of relaxation training and pain reduction.

2. Interview Skills Training

Interviewing is a particular form of communication. Communication, according to DeVito [1985] refers to:

> "...the act, by one or more persons, of sending and receiving messages that are distorted by noise, occur within a context, have some effect, and provide opportunity for feedback."[p.3]

This definition implies that there is both a sender and receiver of communication. The "effect" that DeVito refers

to can be cognitive, affective or psychomotor. He breaks down the "context" into component parts of physical (e.g. a room in which communication takes place), social-psychological (e.g. the social work interview), and temporal (e.g. time of day or year in which communication takes place). [DeVito, 1985, p.3; examples mine].

Glaser [1980] states that human communication occurs within the context of a system, and that behaviour is difficult to understand or to explain apart from the system it is in. Social workers have long been proponents of this concept.

DeVito [1985] outlines purposes of communication as: for personal discovery, discovery of the external world, establishing meaningful relationships, changing attitudes and behaviours, and for play and entertainment [p. 14]. We are most concerned with communication for the purposes of establishing relationships and for changing attitudes and behaviours. As earlier stated, communication has content and relationship dimensions. The content may be the same in two situations but the relationship different. DeVito [1985] suggests that many problems between people are caused by the failure to recognize the distinction between content and relationship levels of communication [p.21].

The basic elements of communication then, are: sender, receiver, message, feedback and context [Ivey, 1983;

Verderber & Verderber, 1983], although, as we have seen, DeVito [1985] has added the element of "noise", which will be relevant to our later discussion on components of training. The **process** of communication, according to Kadushin [1983], is one of encoding the message, transmitting the message and waiting for feedback, and decoding the message. This, he adds, goes on within the context of interpersonal relationships.

Interviewing is basically goal-directed communication. Jessop [1984] states that even informal interviews should have the goal directed purposes of: gaining information, giving information and/or motivating. Interviewing approaches, she says, can be either directive, in which the interviewer sets goals, controls the interview and sets its pace, or non-directive, in which the client controls the purpose and pace of the interview.

Egan [1986] has outlined four basic communication skills which helpers need in order to interact effectively with clients at every stage of the helping process. The essential skills are: attending, listening, empathy, and probing. Egan warns that helpers tend to overidentify the helping process with the communication skills that serve it, and cautions against what he calls the "appalling consequences" of overemphasis on the microskills of helping. Instead of being a fully human behaviour, helping gets reduced to bits and pieces [p.73]. This has major

implications for interview skills training, as we will see.

Priestley and McGuire [1983] view the helping interview as having two distinct kinds of activities: attending and influencing. Generally speaking, as a function of time, the need for attending skills decreases as influencing skills increase.

Ivey [1983] uses the term "intentionality" in refering to the goal directed helping interview. He describes intentionality as acting with a sense of capability and deciding from a range of alternative actions. Hence the "intentional individual" has more than one action, thought, or behaviour to choose from in responding to changing life situations. This process is the opposite of using only one skill, one definition of the problem, or one theory of interviewing.

Several authors outline in detail how helping interviews should or might be conducted [Kadushin, 1983; Benjamin, 1981; Ivey, 1983; Shulman, 1979; Cross, 1974; Garrett, 1942; Gordon, 1969]. Surprisingly enough, these interview structures vary little against the time period in which they were written and the professional background of authors. For exemplary purposes we will transcribe a formal structure proposed by Cormier, Cormier and Weisser [1984], intended for use in the health professions. Informal interviews, of course, may be adapted from this structure:

EXAMPLE INTERVIEW STRUCTURE

PHASE I: BEGINNING THE INTERVIEW

1. Building rapport.
2. Establishing interview structure.
3. Clarifying expectations.

PHASE II: MANAGING THE INTERVIEW

1. Obtaining information.
2. Giving information and instructions.
3. Acknowledging client feelings, incongruent communication, and defensive reactions.

PHASE III: TERMINATING THE INTERVIEW

1. Pre-summary.
2. Summary.
3. Follow-up.

Style in interviewing varies as much as do the personality traits of interviewers. Priestley and McGuire [1983] contend that while there is no commonly accepted standard for judging personal helping styles, it is helpful to have an awareness of one's own manner of working and the ability to change it to suit changing circumstances. Despite the lack of standard for measuring style, we can examine a few dimensions of style that surface in the literature.

Self-disclosure is more often thought of as a style of communication than as a technique [Egan, 1986; Benjamin, 1981; Kadushin, 1983]. Egan [1986] postulates that while

self-disclosure does not in itself "cure", it can release powerful healing forces in the client. It is not a goal in itself but rather a means of establishing and enhancing relationships. Awareness of self-disclosure in the helper can be gained through employing exercises like the Johari Window [Ivey, 1983].

Evans et al [1983] , state that self-disclosure serves three main puposes. It encourages the client **to share information** that is personally meaningful; it increases **trust** between the interviewer and client; and it enhances the client's ability to share feelings and personal information.

Glaser [1980] states that there is little evidence to determine the optimal degree of self-disclosure. Some researchers have discovered social norms governing the **appropriateness** of self-disclosure, however. Disclosing too much, too soon can have a negative impact on a relationship; a high rate of self-disclosure may be more than we care to hear. Conversly, a low rate of self-disclosure, not revealing **enough** about oneself even when self-disclosure is appropriate and legitimate, is more of a problem for interviewers. People remain private because they fear the consequences of self-disclosure.

Glaser [1980] outlines degrees of self disclosure: providing basic data (e.g.,"I live in Kenora"), revealing preferences ("I prefer wines from the Loire Valley"), describing beliefs ("Capital punishment is wrong"), and revealing feelings ("I love my kids").

Self-disclosure should be used only when the interviewer's response does not overshadow, deny or negate the client's communication. It should only be used after a good relationship has been established and even then in moderation [Evans et al, 1983]

Acceptance, of both self and others, is another important component of the helping process. Acceptance of others is central to Roger's client centred therapy [1951], as it is the understanding that a) what others believe or feel is their true belief, b) others have the right to believe or feel that way.

Another way to assess communication style is to look at how congruent it is. Satir [1972] defines congruence as how well the message fits with the internal feelings and beliefs of the message sender. We often think of congruence in terms of verbal behaviour being congruent with non-verbal behaviour. In Peoplemaking, Satir outlines four non-congruent response styles, based on the concepts of self-worth and stress. They are placating, blaming, computing

and distracting [p. 63]. She contends that an awareness of these styles of communicating helps the interviewer assess his or her style of communication.

Interviewing skills in the health care setting are paramount in gathering information for purposes of assessment. The nature of assessments varies from setting to setting, e.g., hospital, home care agency, outpatient programs. Bradley and Edinberg [1982] outline key factors influencing assessments. Time, they state, is nearly always a factor, particularly in acute care hospitals. As a result, assessments have tended to be reduced to checklists, which is convenient but does nothing to enhance the nurse-client relationship. Checklists amount to a (rapid) series of closed-ended questions; employing checklists is, by and large, a poor interviewing skill. External or environmental factors influence information-gathering techniques. Distractions should be minimized and privacy encouraged. Internal factors, i.e. the personal attitudes of the nurse and client, also influence assessments.

Moschel [1984] outlines three components of data collection which are key to our understanding of how good assessments are made. They are the sources, types and methods of data collection.

Sources of information can be primary, i.e. from the

client, or secondary: from the client's family or significant others, other caregivers, clinical records, and the clinician's own knowledge base.

Types of data can be subjective: information that can be experienced or perceived only by the client and not by the observer, or objective: behaviours, activities, events that can be observed or measured by another person by means of the five senses. Subjective data are what the client says, perceives, or feels (e.g. pain, weakness, blurring of vision, feelings of depression, and descriptions of one's home life). Objective data, on the other hand are factual in that they can be heard, smelled, touched, seen, or tasted (e.g. rash, respiratory rate, slouched posture). Objective data may often support subjective data, and vice-versa. While this differentiation between objective and subjective data may seem elementary, clinicians too often blur the distinction. It is important to note when objective and subjective data are discrepant, e.g. the client who denies problems but gives non-verbal messages to the contrary.

Moschel [1984] also differentiates between current and historical types of data. Using current data in conjunction with historical data provides more comprehensive information about a client's health status and is particularly useful in determining and understanding patterns of behaviour. There are several methods of data collection. In most situations, the largest portion of clinical data is gathered in the

interview. In health care other methods are: observation, inspection, palpation, percussion, auscultation and consultation [p. 17]

There are numerous identifiable skills connected to interviewing. For our purposes we will concern ourselves with the folllowing skills which can generally be referred to as "attending and listening skills": attending behaviour, active listening, perception, questioning, client observation skills, focusing the interview, and empathy.

Attending behaviour is a basic, rather simple skill, and one which social workers have long taken for granted, yet it has profound implications in the interview. Ivey and Gluckstern [1984] give us four dimensions of attending behaviour:

Eye Contact. Naturally the interviewer should strive to maintain eye contact, but also to note eye contact breaks on the part of the clients, giving clues to where the person "is at". The interviewer should be mindful of cultural differences vis-a-vis eye contact.

Attentive Body Language. The interviewer should be aware of his or her own style of body language.

Vocal Style. Changes in speech rate, volume and tone often indicate interest or disinterest.

Verbal Following. These are the natural responses which indicate to the client "yes I'm with you...go on please", in the form of "mm-mm", "go on", "yes..", etc. The interviewer never needs to introduce a new topic.

All of these behaviours should be congruent with our words and feelings [Glaser, 1980].

DeVito [1985] states that we spend most of our communication time in listening. We listen for enjoyment, for information and for helping. Listening as a helping behaviour enables the listener to check on the accuracy of his understanding of what the speaker has said and **meant**. The listener expresses acceptance of the speaker's feelings and stimulates him to explore further his feelings and thoughts. The techniques used in active listening are paraphrasing the speaker's thoughts, expressing an understanding of the speaker's feelings, and asking questions. Benjamin [1981] gives us the simple but effective "listener's test" which goes like this: **If** after listening you can state in your own words what was said, **and** tell the speaker in your own words the feelings she has expressed, **and** she accepts this as what did come from her, **then** you have listened and understood [p. 47].

Glaser [1980] states that non-attending listening behaviour often communicates disinterest, boredom, disagreement, or even hostility. Cormier, Cormier, and Weisser [1984] state most health professionals are aware of the importance of listening to patients, yet patients complain that the attending professional is too busy to do so. Instead of being willing to listen, the interviewer feels compelled to explain this lack of time.

The ultimate indicator of effective listening is active responding. Often people assume they understand each other without bothering to check their assumptions out. Paraphrasing and perception-checking are skills that allow one to verify one's inferences. According to Glaser [1980], paraphrasing is "a restatement of both the content and feelings of another person's message". (p. 156), which gives that person information about the impact of his or her message. Misunderstanding can be eliminated by using paraphrasing more frequently. Paraphrasing takes the form of messages like "What I think you mean is...", "I hear you saying..." and "You feel (feelings) because (of events, experiences)".

A slightly more sophisticated form of feedback to clients is referred to as perception-checking. Glaser [1980] describes perception-checking as a process that involves describing to the sender the specific behaviours we are

receiving and the interpretations we are making. She delineates this skill into **sense data**- the sender information, **conclusion**- the receiver's inference, and **confirmation request**- the receiver's check for accuracy. As an example, perception-checking might be:
"When you didn't respond to my invitation for dinner (**sense data**), I thought you really didn't want to come (**conclusion**). Is that right?" (**confirmation request**)

Perceptions, rather than being an accurate record of events, are really no more than hypotheses on which we make predictions.

The language which we use in these skills should be, as Glaser [1980] calls it, the language of responsibility, better known as "I" messages. "I am upset when you don't repond" is more responsible than "It upsets me when you don't respond".

Finally, Glaser [1980] warns against "take-aways" as obstacles to paraphrasing. e.g. "I know exactly what you mean about writing reports. Last year I had to write one in three weeks and it nearly drove me crazy."

Moving up the hierarchy of skills we come to **questioning** as an interviewing skill. In any interpersonal communication, asking questions increases the probability that one will have more involved and detailed conversations

with people. Not only do questions let other people know that you are interested in them, but by asking questions, you become an active participant in the conversation without having to initiate new topics [Glaser, 1980]. In interviewing we must attend to the structure and technique of asking questions. Many authors refer to the use of **open** vs **closed** questions. [Ivey, 1983; Ivey & Gluckstern, 1984; Kadushin, 1983; Verderber & Verderber, 1983; Priestley & McGuire, 1983; Gordon, 1969; Egan, 1986]. Open questions are those that cannot be answered in a few short words. They encourage clients to talk and provide the interviewer with maximum information. Closed questions can be answered with a few short words or sentences. They have the advantage of focusing the interview and obtaining information. No doubt the interviewer has more control of the interview using closed questions, but he or she ends up doing most of the talking. The consensus in the literature is to use a meaningful combination of open and closed questions with regard for comfort and pace of the interview. Ivey [1983] states that, like attending behaviour, questions may encourage or discourage client talk. With questions, however, the stimulus comes more from the interviewer. The client is often talking from the interviewer's frame of reference.

Client observation skills are key to understanding client behaviour and to know when and how to intervene. Ivey

[1983] organizes this skill into three areas: client non-verbal behaviour, client verbal behaviour and client discrepancies. Client non-verbal behaviour is equally important to understand as the interviewer's non-verbal attending behaviour, in that most client communication of meaning is non-verbal. Client eye contact patterns, body language and vocal qualities should be observed. Client verbal behaviours to note are tendencies to focus on certain words through selective attention and verbal tracking. Discrepancies to note are the incongruities, mixed messages and contradictions. Often these discrepancies within themselves are the very reason clients have come for help.

Focusing is a skill that enables the interviewer to direct conversational flow towards areas the interviewer wishes to explore. As an example:

> **Client**: "I just received terrible news from my doctor. She thinks I have not managed my condition well enough and is sending me to a specialist in Winnipeg. I don't really want to go to a large institution and be asked questions by strangers..."

Ivey [1983] contends that there are several ways to respond to messages like this, depending on what focus the interviewer wants. Focusing on the CLIENT, the interviewer might respond:

"You sound upset. Could you tell me more about your feelings?" (reflection of feeling, open question).

Focusing on the MAIN THEME or PROBLEM, the interviewer responds with:

"Terrible news?" (verbal following, encourager) • or "Could you tell me more about why you need a specialist?" (open question)

The interviewer can use one or the other or both depending on the situation. Focusing on the person may lead the client to talk about more personal issues, whereas focus on the main theme or problem encourages the client to talk about what happened and the facts of the situation. Additional areas of focus might be: on OTHERS (the doctor, the specialists), on the INTERVIEWER, through self-disclosure or "I" statements, on CULTURAL/ ENVIRONMENTAL/ CONTEXTUAL issues, e.g. broader issues often not readily apparent, such as racial or sexual issues, institutional policy, patient-doctor relationships, etc, or MUTUAL ISSUES, e.g. the interviewer-client relationship.

Empathy is another integral skill in successful interviewing. Egan [1986] refers to it as an ability to enter into and understand the world of another person and to communicate this understanding to him or her. He views it on three levels: as Roger's [1951] "way of being", as a mode of professional contact with clients, and as a communication

skill that can be learned. The latter two levels can be taught and practised, but it is doubtful that empathy as a way of being is something that can be taught.

Knowledge of interviewing skills does not in itself guarantee a helping relationship between client and worker; we have already warned against on overemphasis on the microskills of help (see page 17). Workers invariably become part of the process and their ability to help is dependent on their degree of enmeshment with the client and/or the client's problem. Trute and Kuypers [1981] refer to these situations as process traps, usually the result of workers wanting clients to act in accordance with accepted social norms, before proceeding in the relationship. They are largely unaware of being caught in such traps. Equally dangerous, workers can fall into content traps, being too preoccupied with integrating and analysing verbal information for their required assessments, and missing important processes, e.g. client non-verbal behaviour.

Pitfalls in interviewing are strategies, styles or techniques that are non-therapeutic; they create distrust and interfere with client responses. This non-therapeutic communication leads to decreased self-worth of either the client or interviewer. Other common pitfalls in interviewing are described in Bradley and Edinberg [1982] and in Benjamin [1981].

Given our base of skill knowledge then, how do we go about teaching these skills?

Most literature on interview training methods based on discrete units of action comes from outside of social work but this literature has had a considerable impact on social work [Kadushin, 1983]. We will examine the microskills approach in some detail, as it appears to be appropriate to our practicum needs.

Microskills refer to discrete communication skill units of the interview that rest on a foundation of culturally appropriate attending behaviour. The skills can be conceptualized in a hierarchial structure as in Appendix D.1. Microskills cut across various themes, orientations and approaches to helping, but its best feature lies in its adaptation for teaching beginning interviewers [Ivey, 1983].

The teaching model for microskills is 1) warm-up and introduction to the skill, 2) example of the skill in action, 3) reading, 4) practice, and 5) self-assessment and generalization. The fourth step, practice, is probably the most important of these. The model for systemic group practice, proposed by Ivey [1983] is reproduced in Appendix D.2.

Research validation of the microskills approach was done by Kasdorf and Gustafson [1978], as quoted in Ivey [1983]. They report that the skills are clear and teachable, with consistent construct validity. One is able to demonstrate mastery of skills on videotape. Clients of students are noted to have changed their behaviour (verbal patterns, patterns of thinking), following their learning of microskills. The microtraining framework may be used to teach complex interviewing behaviour according to alternative theoretical perspectives/ counselling theories. Finally, the microskills approach allows for the student to retain his or her natural style.

The teaching of microskills is guided by the same principles held for working with clients, that is client dissatisfaction (or ambition) is directed into goal-setting activities, followed by skill teaching and eventually satisfaction or goal achievement. The client is viewed as a student more than as a patient. This is the opposite of the so-called psychoeducational model (illness- diagnosis- prescription- therapy- cure). [Ivey, 1983]

Egan [1986] states that the training of helpers involves four stages of skill development:

1. Conceptual understanding (or cognitive understanding) of the skills.

2. Behavioural-based feeling: by watching instructors model the skills and by doing the exercises students develop a behavioural rather than just a conceptual feeling for the skills. At this step, students are able to use skills in role playing.

3. Initial mastery: by practice with supervision. At this step students are able to use skills with specific impact on clients.

4. Further mastery: field experiences with supervision.

Egan [1986] stresses a competency-based, integrative approach to training of helpers. He says that helpers need to find **personal meaning** in communication skills and helping techniques, almost as an extension of the helper's humanity. Communication skills and helping techniques must serve the larger helping process, that is the **helping outcomes**. This basically means that helping does not take place when helpers communicate well; it takes place when clients manage their lives more effectively. Communication skills and helping techniques also need to be permeated by the values respect and genuineness, and this begins in training programs.

Ivey and Gluckstern [1984] suggest that a post-training phase is needed to provide for the transfer and integration of microskills. Otherwise communication skills can drive rather than serve the helping process. Practical experiences provide forums for such transfer and integration.

Priestley and McGuire [1983] outline a similar framework for training, also emphasizing a competency-based

measure of performance. Any aspect of helping behaviour that may require improving should be formulated as specific learning goals. They should be as concrete as possible, achievable, and capable of being evaluated.

Goal-setting is a worthy task but often neglected. Glaser [1980] outlines a helpful method of goal analysis, for changing poorly defined ambiguous goals into specific behavioural performances. The procedure is one of writing down the goal, outlining the behaviours required to know when achievement has been reached, and recognizing achievement. She suggests one way of doing this is to think of someone who does **not** represent the goal, and to ask what specifically this person does.

In training, covert rehearsals (practising in the imagination) are normally followed by actual behavioural rehearsals, otherwise known as role plays [Glaser, 1980]. Behavioural rehearsal is probably a better term though as it implies rehearsing one's own behaviour rather than "playing the role" of someone else. Having said that however, we will continue with the well understood label of role play.

Cross [1974] says role playing provides the opportunity for individuals to experience the emotional elements involved in taking on roles they would otherwise never experience. It provides a means of enabling students to gain understanding of the feelings clients might have. A very

profound process goes on in role-playing in that students at first attempt to emulate the actions normally associated with roles, but eventually they find that the demands of these roles are absorbed into their own personal identities. They then become real incumbents of the roles. The rationale for using role plays in training is to provide students with a structured and supervised experience in interviewing in a situation in which adverse effects on clients cannot occur.

According to Lore [1981] learning is facilitated in an atmosphere which encourages active participation, free and open communication, and confrontation. It should be structured such that different ideas can be accepted and the learner's right to make mistakes is recognized. Openness of self should be encouraged to the extent that learners trust themselves and see themselves as originators of ideas. It is of paramount importance that the learner feels that his or her ideas, feelings, perspectives have value and significance.

Once learning is acquired, practice takes place. Glaser [1980] offers encouragement to the new learner by using the analogy of learning to ride a bicycle. As the learning rider puts the individual skills together in a coordinated way, he finds it awkward and unnatural at first. However with continued practice, mastery occurs and the individual skills are now fully integrated.

The last part of our literature review examines the educational group process. Shulman [1979] posits the notion of two clients: the individual and the group, and while the educational process of this practicum was largely that of teaching individuals in their workplace and individuals in the context of the group, there were expected group processes common to group work in general. The most salient of these is the mutual aid process, which has potential in every group according to Shulman, but is not guaranteed by simply bringing people together. Members bring to a group their own concepts based on past experiences of groups (school, committees, etc) and unfortunately many of these experiences were not altogether positive. The dynamics of the mutual aid process, that is the process through which mutual aid is offered and taken, are sharing data, sharing views, offering mutual support, creating a mutual demand, individual problem-solving, and rehearsal. Mutual experiencing of ideas and emotions may lead to the "all in the same boat" phenomenon, which Shulman defines as the healing process when one realizes that one is not alone and that others share the problems, feelings and doubts of others.

In the dialectical process members often present strongly held views precisely because they have doubts and need a challenging perspective. Mutual aid offers individuals a chance to discuss taboo subjects, given that

members may not be in touch with their own feelings if they believe these to be inappropriate. As members hear others speak of these emotions, it may cause them to experience openly the same emotions.

The group as a mutual aid system has implications for the role of the leader. Rather than seeing one's role as only providing help to clients within a group context, the leader also concentrates on the tasks involved in strengthening the members' ability to help each other.

Verderber and Verderber [1983] outline three main responsibilities of the leader: 1) To establish a climate, 2) To plan the agenda, and 3) To direct communication flow, giving each member an opportunity to speak, asking appropriate questions, summarizing frequently and maintaining necessary control.

DeVito [1985] adds that in addition to activating and maintaining group interaction, the leader must ensure member satisfaction by encouraging ongoing evaluation and improvement.

There are predictable stages of group development [Hartford, 1970; Toseland & Rivas, 1984; Yalom, 1970; Shulman, 1979]. The first is of course, planning. The worker assesses group needs, considers potential membership and sponsorship, and identifies the group's purpose. The

purpose of the group answers the question "What are we doing here together?" for members. It sets out how the group might conduct its work, and what its range of goals or tasks are. Toseland and Rivas [1984] state that clarity of purpose provides a base for group members to develop a bond and a means for establishing their common goals.

Ivey [1983] lists several considerations before starting skill teaching (e.g. setting, equipmant, timing, etc.). He remarks on a few aspects of particular importance: obtaining group expectations, "going with" as opposed to fighting resistence, noting cultural differences, and observing ethics (p. 305).

Individual member's attraction to a group will depend upon four major factors, according to Cartwright: 1) the incentive nature of the group, its goals, program, size, type of organization, and position in the community; 2) the motivation of the person, his or her needs for affiliation, recognition, security and other things he or she can get from the group; 3) the attractiveness of other persons in the group; and 4) if the group serves as a means for satisfying needs outside the group. [Hartford, 1970].

As group cohesion increases, the power of the group over the membership also increases. Motivation of members to participate in the group is influenced by cohesion, and

members of a cohesive group tend to show less anxiety [Hartford, 1970].

In the beginning stage of the group, the worker helps members to get to know each other. It is a period of orientation, characterized by a search for structure and goals [Hartford, 1970; Toseland & Rivas, 1984]. At this time there is great dependency on the leader and concern about group boundaries [Yalom, 1970].

In the middle, or working phase, the leader helps members to achieve individual goals and helps the group accomplish its task. He or she does so by preparing the meetings, structuring the group's work, helping members achieve their goals, monitoring and evaluating the group's progress [Toseland & Rivas, 1984].

In the ending phase the worker helps members to acknowledge that the group is actually ending and to express feelings about the end. He or she also evaluates the work, and helps to generalize the change efforts [Hartford, 1970; Toseland & Rivas, 1984].

3. Summary

The literature we have reviewed has centred on two themes: communication in nursing, and interview skills training. Communication in nursing has brought to light many aspects of the nursing profession worthy of incorporating into this kind of training program. This literature has clarified the unique role that nurses have in the health care system, that of being the client advocate. The Szasz-Hollender model is particularly useful in understanding the nature of the nurse-client relationship. Nurses can provide client-centred care within the medical model, and can often bridge the communication gap between doctors and clients. This is important for nurses learning the value of communication skills. The literature has also demonstrated the importance of communication skills in that good communication is required not only with clients, but also with families, physicians, administrators, and other members of the health care team. Using these theories of communication in nursing in practical teaching, like this practicum, is valuable because nurses need to value communication besides learning communication skills.

The literature on interview skills training is extensive and one needs to wade through the mire of repetitive material to find solid teaching programs. We settled on microskills training, which is a solid approach

but seemingly underdeveloped. The literature on communication styles is useful to this practicum, as learners need to be able to assess why they have "always thought" of themselves as good communicators, but wondered why. Learning about communication styles allows one to measure style against what skills are needed.

The literature on self-disclosure is also extensive but of limited value to this practicum. By our review, it would seem that self-disclosure is more of a style of communication than a skill.

The literature clearly emphasizes the value of listening in communication, and several authors we have cited have aptly broken down listening skills into teachable units. In addition, the emphasis on paraphrasing and perception-chaecking cannot be understated as necessary interview skills.

Finally, the literature on groups did not have high applicability to this practicum, because the practicum had clear goals, straightforward content and leader-directed activities. "Group process", per se, did not play a large part in the outcome of the practicum.

III. THE PRACTICUM

1. The Client Group

The practicum involved a didactic group process with nursing staff, each of whom came to the program voluntarily.

The program was originally advertised at the Lake of the Woods District Hospital, the Northwestern Health Unit and the Home Care Program in Kenora, with the assistance of the hospital's education department. A descriptive outline of the course was available to interested persons.

Originally 17 people from the hospital signed up for the program. The writer contacted and interviewed the hospital staff members to determine a) why they were interested in the program (i.e. their needs) and b) what were the most suitable times and dates for individuals. A number of time frames and structures were proposed.

The purpose of the interviews was partly to gain the above information, and partly to provide information to individuals who were unsure of the nature and content of the program. This process was initiated in early December 1986

at a time when people tend to set their winter "extra-curricular" schedules. Advance notice was also important in terms of shiftworkers re-arranging their schedules. Following this process, a schedule was determined according to the preferences of those interviewed. As it happened, the schedule was too inconvenient for the Northwestern Health Unit to participate to the extend they had originally intended, so they only sent one staff nurse. Other interested recruits eliminated themselves either because of scheduling problems, or because they had determined that the program was not suitable to their immediate needs. By the time the program started in late January 1987, the group consisted of one public health nurse, one community program nurse (psychiatric day treatment program), and six hospital staff, for a total of eight committed participants. Each were required to sign a sheet of paper indicating their availability for sessions and commitment to the program. {Appendix A.1}

Nursing staff from the two community programs were salaried individuals, who were granted educational leave for the program. Two of the hospital staff nurses were unit head nurses, also granted educational leave. The rest participated in the program on their own initiative, and had juggled their shifts to attend the program on their days off.

Group members came from a variety of backgrounds, experiences and education. One women was in her fifties; the rest were all in their thirties, with at least ten years of nursing experience. The hospital staff represented several nursing units.

The following table lists the written reasons participants gave for their interest in the program, before it began {per form, Appendix A.1}. This list represents only those individuals who eventually did participate in the program.

TABLE 1: REASONS FOR INTEREST IN PROGRAM

"Briefly indicate what it is you most wish to improve:"

- Interviewing skills and avoiding traps; how others perceive me; handling co-workers and patients who are difficult.

- Want to be able to clarify my role with clients, and to give the information I need; also wish to be able to react appropriately to crises.

- Communication skills; how not to be defensive; listening; screening for high risk mental problems.

- Interviewing skills with patients and parents; interviewing of staff in performance appraisals; selection interviewing; problem solving interviews ("I think I talk too much and don't listen enough")

- Would like to improve my interview skills in general, but mainly geared to the psychiatric client.

- More comprehensive assessments; how to establish meaningful relationships with patients and to "notice" things about patients like others do.

TABLE 1 (Cont'd)

- How to get through to others as I am unsure if others understand me; home communication.

- Often when assessing patients they will give me one story-facts- and then change them when speaking to a doctor. I would like to improve on getting the "true" facts from the patient and be able to document them clearly and concisely.

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2. Supervision

The practicum was planned, coordinated, and carried out by this writer. All group sessions were solely led, with the exception of the afternoon of the first session when assistance was provided by a hospital social worker in demonstrating interview techniques. The practicum was supevised by Peter Hettinga, a social worker who is director of community mental health programs and hospital social services. Dr Hettinga was readily available at all times and had access to the videotapes of each session. The practicum was sponsored and supported by the Lake of the Woods District Hospital.

3. The Program

The practicum was a two-phase program, involving a structured course and individual help in implementing skills learned in the course, to a closed group of nursing staff. All sessions of the course took place in the Training Centre of the hospital, overlooking the Lake of the Woods . The Training Centre was fully equipped with audio-visual equipment, tables and chairs, with few distractions. Individual help took place in the work setting, "on the job". Otherwise, some individual help was provided over the telephone.

In planning and establishing the course, applicants' expressed needs were taken into account {see Table 1 above}, interview skills training material was reviewed, and the writer's personal experience as a medical social worker was drawn upon. Overall course objectives, as listed in section I of this report, were struck. As well, individual session objectives were struck, based on one or two "themes" per session. From an adult learning standpoint, the course had these underlying objectives:

1. To be interesting and stimulating, unlike traditional schooling.
2. To be relevant and immediately applicable in the participants' work setting.
3. To be flexibly structured so that group members share responsibility for individual, group, and program success.

The course was 35 hours, divided into five 7-hour days over a three month period. The two week intervals between sessions allowed for skill practice and opportunity for participants to receive individual help. Each day's program contained a variety of lectures, exercises, discussions, role plays, videotape feedback, and review of case material brought in by participants. The course content was custom-designed according to the writer's perception of what the group needed (based on group composition and expressed needs). The group composition was known two weeks prior to start-up, at which time the content was modified and the first two sessions planned in detail. The rest of the sessions were planned in detail as the course progressed, given the response from the first two sessions and the individual help between sessions. In the planning process, several optional exercises were planned in order to keep the program flexible enough, well timed and to offer participants choices as we went along. The planning was as much part of the practicum experience as the teaching itself.

Videotaping was used extensively during the course; in fact the camera was always rolling. Taping had a dual purpose: it provided immediate feedback for role plays, and it served as a record of the course, for those who might have missed sessions, and for supervision purposes.

The first three sessions offered skills training and practice to the participants. The fourth session was devoted almost entirely to assessments. This was a culmination of all the previously learned skills in that it provided a relevant format in which to integrate these newly-learned skills. During the fourth session, participants were given background theory regarding data collection and assessments in general, so that together with interviewing skills, they would be able to improve their ability to assess clients. It was felt that any more skills taught beyond the third session would be an overload. The fifth and final session was loosely structured so as to remain flexible to the group needs, leaving room for leftover issues from the first four sessions.

The general themes of each session were as follows:

SESSION 1:	Goal-setting (assessing present skill level and determining individual needs) Attending and Listening skills
SESSION 2:	Giving and getting feedback Attending and Listening skills (cont'd)
SESSION 3:	Focusing the interview (Questioning & responding; Avoiding traps)
SESSION 4:	Assessments
SESSION 5:	Problem situations as identified by the group; Communication styles
SESSION 6:	Evaluation

A more detailed outline of the program is listed in Appendix B. Individual session objectives and formats are in Appendix C.

The interviewing skills were taught using the microskills approach [Ivey, 1983; Ivey and Gluckstern, 1984]. The model for building these skills is an adapted version of **Ivey's Hierarchy** [Ivey, 1983, p. 5]. This hierarchy is reproduced in Appendix D.1. The hierarchy can basically be divided into attending skills, and higher order skills, like influencing, confrontation, etc. The course content stuck mainly to the basic attending and listening skills due to the time contraints of the program, the needs of the participants, and the educational levels of participants. Even if it were possible to teach "higher order" skills (i.e. with more time), it is doubtful that they would be very applicable to the participants' job requirements. The only skill taught that might be considered higher order was that of focusing, and even it was only touched upon.

Specifically, the group learned and practised these skills, more or less in the following order:

1. Active listening/ Attending behaviours
2. Listening with understanding

3. Client observation skills
4. Paraphrasing/ Perception checking
5. Giving and getting Feedback (for skill improvement)
6. Empathy
7. Establishing relationships with clients
8. Questioning
9. Focusing (to an extent)
10. Reflection of meaning (to an extent)

The course was also interspersed with values clarification exercises, adapted from Simon, Howe & Kirschenbaum [1978].

Pre-planned lecturettes were given on these topics:

Content and relationship in communication
The value of self-disclosure
Systems theory (the family system; the health care system)
The nursing process
Nursing vs. medical viewpoints
Data collection
Communication styles
Working with people who are: shy/resistent
defensive
suicidal
strongly opinionated

Unscheduled topics arose during the program, some of which were dealt with at the time; other topics were either deferred to the last session, or were considered by the group leader to be irrelevant to the course. The topics which were immediately dealt with deserve some mention here however.

Issues regarding cultural and language barriers with native clients continually arose in the group. The leader undertook a brainstorming session exploring those differences and ways which the helping process might be adapted. Although no conclusive or definitive answers evolved, understanding and awareness of the issues was increased.

The group also became interested in human behaviour issues that emerged from discussions and processing of exercises. Participants were often interested in not only **how** people behave, but **why** they behave as they do. For example, following an exercise in observing non-verbal communication, discussion took place regarding the strength of non-verbal messages, and how people learn this style of communication in the first place. Whereas they may have previously thought of a non-talking client as non-communicative, they now realize how their own behaviour as helpers might actually be **contributing** to the client's maladaptive communication behaviour. Participants were

interested in exploring the reasons behind observable behaviour, and so as time permitted they were given this writer's best explanations.

As confidentiality and trust built up in the group, members were interested in applying communication theory and skills to resolving interpersonal staff issues and other workplace issues (e.g. resolving ward conflict). Again, directed discussion was incorporated whenever it was considered congruent with program goals.

The overall approach modelled by the instructor was one of optimism and positive feedback. In fact, during feedback following skill practice in the sessions, participants were encouraged to give **only** positive feedback (focus on strength). Participants were encouraged to give feedback only when individuals requested it, and individuals were encouraged to ask for it! Accurate, non-evaluative feedback was emphasized; it had to be concrete, specific, and brief. By adopting these conditions for feedback, participants gave themselves more permission to explore and develop their skills, without worrying about making mistakes. The use of videotape feedback eliminated the necessity for anyone to point out mistakes or need for improvement anyway. The form used by the role play observers, for purposes of feedback, is in Appendix D.3.

Prepared case material and role plays were used during the first session, but following that the participants brought in their own more relevant case material, noted between sessions as they practised new skills.

Strong emphasis was placed on goal-setting at the outset of the course, with much time devoted to the group process as well as to individuals who sought help with this. Logs and other recording practices were encouraged to track goal achievement, but the actual responsibility to work towards those goals, to modify them and record progress, was left to individuals.

The second phase of the program was providing individual help to participants. The extent of this help was dictated entirely by participants. As it happened, five of eight participants took up the offer of help; a sixth person had asked but was unable to arrange a convenient time to meet her instructor in the workplace. Help ranged from supervised visits to telephone and other informal one-to-one consultation e.g. before and after course days, in and around the hospital. All of the visits to the workplace were pre-arranged. During hospital client interviews, the nurse would typically introduce her instructor, and inform the client of the reason for a third party observer. The instructor wore a hospital photo identification card, having previously cleared hospital policy and procedure on confidentiality.

Most staff members had specific concerns regarding their interviewing skills, and these were usually discussed before going into the interview. Where concerns were non-specific or unclear to the instructor, the goals of the interview were reviewed beforehand. Some interviews were formal, i.e. assessment interviews; others were less formal, like interviewing emergency room or pre-op patients. Interviews varied in length, purpose, and intensity. For example, we conducted an interview during a public health nurse's informal fourth visit to a geriatric client on a "maintenance schedule", and we interviewed a middle-aged man who presented in Emergency with symptoms of heart failure. All interviews were processed following the intervention, and many interview situations were brought to the rest of the group for further group processing and generalization.

4. Progress Recording

As previously mentioned, the course sessions were drawn up on paper, in detail {Appendix C}. Following each session, the course outline was modified by the instructor, according to what **actually** happened, i.e. where optional exercises were deleted or where discussion of a particular topics

arose. Since this information was recorded on computer diskettes, information changes and retrievel were made easy. In addition, following each session, notes were made vis-a-vis the instructor's evaluation of the session.

Progress of participants was, by design, entirely the responsibility of participants. They were given methods for recording progress, during the first session's lesson on goal-setting.

IV. EVALUATION

1. Evaluation Criteria

The main thrust of the evaluation was in attempting to measure how the program impacted on skill levels of participants. In essence the only true method to evaluate this is to assess change in the clients interviewed by these participants. Since this was neither possible nor feasible, we undertook to assess the participants on three levels.

The participants were given a self-perceived interview questionnaire before and after the program {Appendix E.1}, designed to measure their competence in interviewing. Improved abilities in interviewing would show higher scores on the post-program measurement.

The **Index of Self-Esteem** was also given before and after the program. Since self-esteem is associated with competence, then improved competence would be reflected in higher scores on this measure.

A subjective evaluation instrument was completed by participants following the program. It was designed to

measure subjective responses of participants to their own goal achievement as well as to program goal achievement.

The criteria for this student's evaluation is a positive self-assessment of teaching and supervisory abilities, based on the ojectives set before the program, as well as a positive assessment by participants of both the course and the instructor.

2. Instruments and Procedures

The use of self-esteem and self perceived competency measures in this practicum was the result of discussions with the practicum supervisor and subsequent review of his doctoral thesis at the University of Minnesota [Hettinga, 1978]. This study of interview performance competence was based on the notion that skill attainment such as interviewing performance directly involves the development of a professional self, and that self perceived competence and self esteem are critical dimensions of professional self-dependence. Consequently the level of competence attained in a skill domain is directly related to self perceptions of competence in the skill domain and self esteem of the learner.

The self perceived interviewing competence dependent variable in Hettinga's thesis was measured by a questionnaire made for his study. The questionnaire was originally derived from an interviewing performance frame of reference, and systematically structured. It was used to ensure that all students achieve the required level of competence in interviewing performance. From this frame of reference, the questionnaire derives its validity. His 30-item tailor made questionnaire was specific to the situation his students were in.

The self perceived interviewing competence questionnaire used here {Appendix E.1} is based on this thesis, and was adapted to the nursing situation. It is a 15-item questionnaire structured to incorporate appropriate interview skills, to which respondents must indicate their level of agreement on each item (five point scale from strongly disagree to strongly agree). Its content validity was not tested.

The Hudson Index of Self Esteem is a standardized scale of twenty-five items [Bloom & Fischer, 1982]. It is an accurate and reliable measure of self esteem designed specifically to be used as a repeated measure. This scale is reported to have high face, concurrent and construct validity. However, due to measurement error, changes of five points or less between administrations do not reflect real changes in the respondents' level of self esteem. The Index

of Self Esteem is reproduced in Appendix E.2.

The subjective evaluation was designed by this writer. It is intended to capture the participants' subjective evaluation of their own goal achievement as well as program goal achievement. This evaluation instrument measures the program along the categories of content, learning methods, and instructor performance. It measures individual goal achievement by asking respondents to specify their original objectives and to comment on the extent to which these objectives were met. The subjective evaluation instrument is in Appendix E.3.

3. Evaluation Results

The formal evaluation made use of three instruments: the Index of Self Esteem (ISE), the self-perceived interview competence questionnaire, and the subjective evaluation form.

a) Index of Self Esteem

Table 2 shows the pre- and post-test scores for the eight participants. Individual score differences range from 0 to +15, with a mean difference of +7.5. Differences of five points or less do not reflect real changes in the respondents' level of self esteem.

TABLE 2: INDEX OF SELF ESTEEM

Partic. #	Pre-Test	Post-Test	Difference
1	87	94	+7
2	96	103	+7
3	88	103	+15
4	113	123	+10
5	104	104	0
6	107	108	+1
7	99	109	+10
8	105	115	+10

Six of the eight respondents had raised self esteem on the post test.

b) Self perceived interviewing competence

Table 3 shows pre- and post-test scores of the eight participants, as well as differences. Seven individuals scored higher on the post-test, ranging from a 2 point difference to a 14 point difference. One individual (participant # 4) scored one point lower than on the pre-test; her pre-test score was high (= 51) given that the mean of pre-test scores was 44.25. On the Index of Self-esteem,

this particular individual had scored herself highest among all eight participants.

TABLE 3: SELF-PERCEIVED INTERVIEW COMPETENCE

Partic. #	Pre Test	Post Test	Differences
1	40	49	+9
2	54	57	+3
3	47	49	+2
4	51	50	-1
5	41	45	+4
6	36	50	+14
7	43	55	+12
8	42	50	+8

The mean difference of scores for the group was 6.4 points. Although we cannot draw conclusions from this instrument, it appears that course participants perceived themselves as more competent interviewers after the program than they did before.

When the two tables are compared on a participant-by-participant basis, no apparent anomalies occur.

c) **Subjective evaluation**

The subjective evaluation was constructed for this program in particular and measured participants' responses to material and presentation. Perhaps more importantly it asked participants to review and analyse their own objectives and outcomes, to determine if these objectives were met. This was felt to be far more important than whether or not they liked the program.

To review, each participant went through a process in developing, achieving, evaluating and re-evaluating objectives. This process began during sign-up time in December 1986. At that time, when asked **Why do you want to take this course?**, responses were typically of a general nature, e.g. **to improve my interview skills**. After each interested person was contacted and interviewed, they were asked to sign a committment to the program {Appendix A} and again answer the question **Briefly indicate what it is you most wish to improve**. Based on information they had received during the interview, respondents now gave somewhat more specific objectives. We have already listed the responses in Table 1, page 43. During the first session of the course, a half day was spent developing and refining objectives, until they were clear, attainable and measurable. A few individuals needed to go home and work on their objectives, and in consultation with the instructor, managed to establish meaningful objectives. Each was

encouraged to develop only one or two objectives. As an example of the process, one objective which began as: **I want to spend more time communicating with staff and patients** became two separate objectives, one of which was: **I want to spend at least five minutes with at least one new admission each day, for purposes of getting to know that person.** This participant then established a recording procedure on which she daily charted her progress. Mid-way through the program she realized that she was achieving this objective, and then revised it, adding: **without any paper in my hand, and without simultaneously doing a procedure.** Her other objective related to time spent with staff: **spend more time communicating,** actually became: **To determine if another staff member has understood me, by asking for specific feedback after giving a message.** This she had planned to do at least once per ward meeting, and to record progress.

This example typified the laborious task of setting and refining objectives. On the subjective evaluation form they were asked: **What was your main objective established early in the course, when we did the goal-setting exercise?** and **To what extent have you accomplished this objective?** Four respondents specifically indicated how their objectives were met. e.g. "The feedback I had requested from my head nurse has indicated my assessments are more complete". Two others gave responses indicating generally their heightened **awareness** of communication problems and solutions. The

other two respondents gave very general answers: **I see considerable improvement** and **I feel I have greatly improved my communication skills.**

The question was asked: **What has helped or hindered you achieving this objective?** Responses centred around the theme of increased awareness of one's effect on others in communicating. Of interest here, when the course began, there was a universal complaint from the participants that while they would love to spend more time communicating with clients and their families, and to practise interviewing skills, there simply was not enough **time**. In completing this evaluation only one out of eight respondents mentioned time as a hindering factor. During verbal evaluative feedback in the last session, participants indicated they had come to the realization that time invested in establishing positive working relationships with clients paid off and actually saved time in the long run. Even after the first session, the complaints of "no time" dropped off remarkably as participants tried on new skills.

Participants were asked: **Please comment on the value of + individual help you received from the instructor.** Responses here were generally unspecific but somewhat positive: **I was nervous at first with you there watching me, but it helped me the next time I did an assessment.**

Participants were asked to evaluate the content items

on a scale of one to five, with 1 = of little or no benefit, and 5 = of great benefit. More than 95% of the responses fell in the 4 to 5 range. Of 15 listed content items, the most highly valued items were: Active listening, Perception-checking, Feedback, Focusing, and Goal-setting. The least favoured items were: Working with native patients, nursing function vs. medical function, assessments, and systems theory. It is interesting to note that favoured items tended to be practice-oriented, while unfavoured items were theoretical in nature and were presented in the traditional lecture mode.

The most favoured learning methods were role plays and group discussions, while the least favoured was homework. Very little formal homework was assigned due to the negative reaction received following the first session. Although participants did "homework" by practising interviewing skills on the job, homework that required time at home was resented.

Participants favourably commented on the value of role plays and videotape feedback, yet voiced their discomfort in using these learning methods. Two participants did indicate that they never got used to role playing and seeing themselves on tape, but they did not actively resist during the course.

Participants were asked to rate the instructor on timing, style and manner of presentation, knowledge of material, preparedness, flexibility to group and individual needs, and availability for individual help. Seven respondents felt the presentation was well timed and paced, while one thought it was too slow. Style/ manner of presentation, preparedness, and knowledge of material all were rated high, while flexibility to needs and availability for help were rated moderately high.

General comments received on the subjective evaluation were varied and interesting. If one could generalize these comments, they were reflective of the insights participants gained of themselves and others. This was despite the fact that the whole concept of self awareness was reduced to a couple of short exercises that were minimally processed. The program was far more skill-oriented than person-oriented. Some example comments were:

Made me aware of habits that I had which are barriers

Made me realize that I'm not always right; others have feelings, beliefs, customs, etc that I must respect

(I'm a) better listener using the different methods of active listening and made me empathize more and understand

Made me feel more confident

Cannot and should not try to change others' opinions without first listening and letting them know I understnad what they are saying; I can allow others to lead.

I value my own way of doing things now and I have more

to offer in my job and family life

(I'm a) more effective caregiver whether I have 2 minutes or 30 minutes to spend with a patient. Better understanding of personal limitations and my type of communication.

Three respondents were strongly critical of the instructor allowing one individual in the group to go on at length about her personal experiences, which were not always relevant to the program. While I have no intentions of excusing myself, I feel an explanation is in order. I knew this individual long before the practicum began, and I was less than excited about her application. She often interrupts and dominates conversations with non-productive stories. During the first session she set an objective to not interrupt people, which was great. After a few hours of restraint however, she did interrupt and I called her on it immediately. She managed to hold out for one more session, then as she felt more comfortable in the group, her old behaviours resurfaced. Unfortunately I tended to let her go on, not wishing to be negative, as I thought perhaps the group did enjoy her anecdotal ramblings. Not until I read the evaluations did I realize my lack of control was not appreciated. It is regretful that I did not process the matter in the group, or follow my own instincts more closely.

d) Evaluation of objectives

In terms of the program objectives, stated on page one of this report, all were achieved. The primary objective was to teach the basic skills of interviewing. The microskills approach, framed within the context of systems theory, was successfully employed. The program helped clarify the participants' role as communicator, as we have seen in the participants' evaluations. Videotape feedback was used throughout the program. Finally, interview skills were applied to assessments, both in the classroom set-up, and in the field.

In terms of my own evaluation, the four learning objectives listed in section I of this report (p. 3) have been met. The first objective was to learn and understand communication problems and needs in the nursing profession. Having worked in hospitals for seven years, I have had much contact with nurses on multi-disciplinary teams as well as personally. However, until this practicum experience, my understanding was limited to my outside observations. I was often distressed to have to spend time communicating with patients on issues which I felt nurses could resolve, with a few basic interviewing skills. From reading nursing literature, I learned about the nursing process, about high and low visibility tasks and about the nurse-client advocacy relationship- concepts I had not previously considered in any depth. Through the practical experience, I learned more

fully about personal and institutional barriers to effective interviewing skills in nursing. Nursing defies comparison with social work. The largest profession in health care is also the most bureaucratic and oppressive, but put in an historical context, nursing is progressing rapidly as an independent rather than an adjunct profession. Since our hospital is not a teaching hospital and lacks educational incentives for staff, we are probably less advanced in utilizing the nursing process, but there is evidence of increased independence. The practical experience has taught me that nurses have abilities to help clients which are hindered by staffing problems and subsequently, time constraints.

The second learning objective was to custom design an applicable interview skills training program. This was accomplished by much planning and consultation. It was also more difficult than anticipated because I found it was not possible to rely on my own interviewing skills. The course was almost entirely designed from the literature, in order to break down the skills into teachable, and learnable components. I virtually do not know where and how I happened to learn interviewing skills. Experience did pay off however, in being able to supervise role plays and individual help.

The third objective was to employ a group shared

learning process, which was accomplished. The fourth objective was to evaluate the instruction as I was most concerned whether my teaching could have an impact on the students. Although evaluation has taken place, in hindsight I wish it had been more scientific, either by employing controls and/or validating my interview competence questionnaire.

V. CONCLUSIONS

It is evident that there is a need for interview skills training in the nursing profession. Schools of nursing do have courses labelled communications, but they tend to be general and do not normally have practice components. To provide interview skills training, one needs to know and understand nursing as a profession, and the health care system. Social workers probably are as good as interviewers found anywhere, but it is difficult to teach outside of one's profession, especially in a custom-designed program.

How-to books on interviewing skills are legion. Some are good, some are bad. They tend to contain predictable exercises (like the Johari Window) and offer advice on skill-building in several different ways. The microtraining literature is well developed and tends to be more reasonable than most methodologies. While breaking down the skill units it still manages to have wide applicability. Now manuals are being published together with audio-visual training materials.

The power of videotape in learning these skills is to the advantage of teachers and students alike. Certainly in this course, videotape was effectively used and appreciated.

It was also evident that a combination of group and individual learning is invaluable in interview skills training. Often the theory, and even the role played skills learned in the classroom required modification in the field, and this process occurred time and time again during the individual help sessions. Though it was difficult to resist theorizing, nothing could replace the hands-on experience.

Over and above skill-building, other important processes went on that were not predicted. The group enjoyed processing the role plays and furthering their discussions to generalized issues. Due to these discussions many opinions that the participants had about people and situations were moderated. "Strong views" wwere weakened by the group process. In addition, the participants began to view their clients differently, as being part of their family systems, with all the needs and concerns similar to their own family systems. They saw their work in more client-centred than staff-centred terms.

It is definitely not a good idea to assign homework, or at least to label it as such. There was plenty of opportunity on the job to practise.

If this practicum were to be replicated, it would be worthy of applying research methodology. The impact of teaching skills can really only be measured by measuring client changes in behaviour, or at the very least client satisfaction.

The initial planning stages of the practicum were painfully detailed, but the applicant screenings were well worth it, evident in the absense of dropouts. We probably could have had more registrants, but they would not have been as committed and certain of being able to apply learned skills.

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