Manual for Nursing Communication Observation Tool (NCOT)

by

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NURSING COMMUNICATION OBSERVATION TOOL (NCOT)

by Bonnie Weaver Duldt

INTRODUCTION

This tool, the NCOT (see page 10), is designed to be used to observe any interpersonal communication occurring in nursing practice contexts in which you, as a nurse, interact with your clients, peers, leaders, and colleagues of nursing and other health care professions. Patterned after the work of Robert Freed Bales of the Center for the Behavioral Sciences at Harvard University (Bales, 1950, 1970, p. 92, 62; Patton and Giffin, 1978), Duldt and her associates have developed this instrument for collecting data for the Humanistic Nursing Communication theory. A set of twelve categories are identified, half of which are classified as humanizing and half as dehumanizing in nature. Each half is further divided into sets of "facts" and "feelings," which provide specific descriptions of each category of message.

PURPOSE

The purpose of this tool, the Nursing Communication Observation Tool (NCOT), is to assist you as an observer in collecting and analyzing data about interpersonal communications in your nursing practice, education or research.

MEASUREMENT

According to Duldt’s Humanistic Nursing Communication theory, the basic unit of measurement is the single communication "act" or behavior, which is any observable verbal or non-verbal interpersonal communication. You record your perception of three aspects of a single communication "act":

a. the message as being either fact or feeling,
b. conveyed with a humanizing or dehumanizing attitude, and
c. the pattern of interaction in which it occurs.

The specific content of the message is not recorded other than to identify it as either facts or feelings.
The unit of measurement, the message, may be verbal or nonverbal. The verbal message may be a fragment of a conversation, such as "Well" or "Hu-hum," indicating thoughtfulness or hesitation. The nonverbal may be a slow shaking of the head with a sideways glance. Together, these probably mean disagreement or "No." The message may be primarily verbal and three seconds in length. Or it may be divided into two or more themes, such as agreeing and giving information, all within in one time span. You may consider such messages as two separate messages so that the change in theme can be scored in the appropriate categories on the NCOT.

**RECORDING COMMUNICATION ACTS**

The process of recording is as follows. You record the frequency of acts by placing a mark, a "/", for each message in the column for the speaker, e.g., the client, and in the row for one of the twelve categories which seems to best describe the communication act as you understand it. You use the codes indicated at the top of the form for the patterns of interaction in a similar manner: "C" for communing; "A" for asserting; "N" for confronting; "X" for conflicting; and "S" for separating.

After a period of observation, the relative frequencies of the various categories can provide you information about the degree to which facts or feelings are being expressed, humanizing or dehumanizing attitudes are being communicated as well as the patterns of interaction occurring between two or more people.

**ANALYSIS OF DATA (Approaches)**

You can study these data to determine whether or not the nursing goals are being met and whether or not a change in attitude or pattern of interaction is indicated. For example, Rodri (1986) used the original version of this tool to study the communication occurring in the labor room between 20 laboring maternity clients on fetal monitors and their nurses. This study was designed to determine whether the nurses tended to be dehumanizing to the expectant mothers by "nursing the machinery" rather than communicating in a humanizing manner to the client in this critical life situation. Incidentally, the data analysis indicated direction in that the nurses had some, but not statistically significant (p = > 0.15), inclination to communicate in a humanizing manner to the expectant mother, rather than focus on the machinery.

**DEVELOPING OBSERVER SKILLS**

In learning to use this tool, it will be helpful for you, with several other nurses, to observe and collect data on a common experience, such as a videotape. Television offers another rich source of data. For example, after observing a five or ten minute segment of "Dallas," you and your colleagues might work together and compare your initial efforts. Through discussion, further data collection and comparisons, you all can become proficient in using and understanding the tool. You and two others may practice observing only for facts and feelings a few times, next only for the attitudes, and finally for the patterns of interaction. This will develop your
proficiency for each of the three aspects.

As you gain experience in using the NCOT, you will probably find yourself developing an increased sensitivity to the occurrence and effects of humanizing and dehumanizing communication. The television actors tend to talk slowly, and the interactions are exaggerated so that you can be amazed and delighted at the results. While such data as this cannot be "right," it does provide "approximately correct" data which enables you to make individual, subjective judgments about communication behavior generally and your own nursing communication behavior specifically.

You and your colleagues may want to become "specialists" in observing for one aspect only, pooling the data later for a composite of your observations. This approach is probably most helpful when initially learning to use the tool and working in groups of three or four within a larger group, such as in a class or workshop. This enables individuals to become familiar with the tool in small steps, and gives opportunity for comparison of decisions and discussion within the larger group, so that each individual's diagnosis of the communication acts is developed within a group norm. The "intra-rater reliability," or the degree of agreement you have with yourself in scoring one video on different times, is one way to meet reliability criteria often necessary in reporting findings.

RESEARCH APPLICATIONS

For research purposes, a group of observers may be initially trained in the manner described above. Later, opportunities need to be provided to practice observing nurse-client interactions similar to those expected in the research project. Research assistants can be trained to observe for one or all three aspects at once.

INTER-RATER RELIABILITY

By comparing the degree of agreement between all of the raters, the "inter-rater reliability" can be determined (Huck, et. al. 1974, pp. 330-335; Woods & Catanzaro, 1988, pp. 246-251). Reliability refers to the absence of errors in measurement. Inter-rater reliability refers to the degree of accuracy obtained when two or more people use the research tool. Reliability needs to be determined for each research study. The higher degree of concurrence in scoring, the greater the inter-rater reliability.

For students' course projects, the percentage of agreement between raters is sufficient for estimates of inter-rater reliability. Such estimates are determined by the following formula:

\[
\text{Percent of agreement} = \frac{\text{number of agreements}}{\text{number of agreements} + \text{disagreements}}
\]

The higher percentage of concurrence in scoring, the better estimate of the inter-rater reliability.
Empirical work still needs to be done to establish inter-rater agreement and agreement over time in categorizing messages. Work also needs to be done on content validation on the exhaustiveness and mutually exclusiveness of each of the categories. Judges would need to determine whether all of a set of relevant communications can be placed in unique categories as opposed to having some unclassifiable items and some items fitting multiple classifications.

**OBSERVER TRAINING PROGRAMS**

According to Emmert and Brooks (1970, p. 224) training of raters tends to increase reliability. Reliability is also increased when six or seven point scales are used, rather than two to five. And, the rater's reliability increases when the object being observed is divided into a group of aspects to be rated rather than rating of the whole. As a general principle, as the number increases from a single rater to twenty raters; thereafter additional raters seem to add nothing to the reliability coefficient (Emmert and Books, 1970, p. 225). To have .85 or above is generally a desirable inter-rater reliability. There is one objection to using raters. There is evidence in a variety of studies indicating that rater's biases toward the object being observed can influence their ratings (Emmert and Brooks, 1970, p. 225). So this needs to be considered when selecting raters.

**INCREASING SENSITIVITY TO OTHERS' FEELINGS**

Using the NCOT provides you with an opportunity to think about your own communication behaviors, and to discuss them with your colleagues, and to develop an awareness about the interpersonal meaning of your messages and how you are "coming across." You and each individual must ultimately determine for yourself whether you would like to change your own behavior. If you want to become a humanistic nurse, then as a nurse, you must decide whether or not you need to intervene to break a client's dehumanizing communication behavior and attempt to change the client's messages, attitudes, and patterns of interaction to a more humanizing mode.

**KNOW THE CATEGORIES**

Generally, you need to become familiar with the NCOT categories. The twelve categories are arranged in the two aspects of the message, facts and feelings, each within the six humanizing and six dehumanizing categories. The following description of each category will be helpful to you and your colleagues in training yourselves to observe and record communication data.¹

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**Humanizing Attitudes**

¹ As the NCOT is used in research, these categories need to be developed to include specific samples of dialogue.
Feeling Messages
1. **Communing**: trustful, dialogue, praises, encourages, supportive, intimate, gentle touch, eye contact.

2. **Shows tension release**: equality, warm voice tone, coping, responsive, faces speaker, open posture, use of humor, frequent eye contact.

3. **Agrees**: empathetic, warm, compliant, authentic, understanding, positive regard, smiles, nods, ignores inappropriate behavior, accepting. Promotes conflict resolution and problem solving.

Fact Messages
4. **Suggests, Made or Requested**: caring, initiates communication, coaches, makes requests calmly, allows choice.

5. **Opinions, Given or Requested**: authentic, self disclosure, uses appropriate names, comforting, positive.

6. **Information, Given or Requested**: allows choice, provides facts, clear directions, progress, individualizes, performs procedures with explanations.

**Dehumanizing Attitudes**

Fact Messages
7. **Information, Given or Requested**: directives, questions, demands, commands, categorizes, role-playing, performs procedures without explanations, withholds facts.

8. **Opinions, Given, Demanded, or Withheld**: Un-authentic self-disclosures, feedback; verbal outbursts, name-calling, commands, "tells off," manipulates, negative.

9. **Suggests, Given or Requested**: careless, abusive language, belittles, ridiculous, questions, tolerates, hits, kicks, carries out requests without speaking, directives.

Feeling Messages
10. **Disagrees**: tolerance, disregard, cold, rejecting, non-compliant, critical, withholds support, judgmental.

11. **Shows tension**: degradation, cold voice tone, helplessness, anger, turns away from speaker, closed posture, pain, struggle, limited eye contact.

12. **Alienation, Separation**: distrustful, monologue, makes excuses, demanding, defensive, withdraws, isolating, avoids touching.

**DATA ANALYSIS (Statistical)**
Observations of interpersonal communication behavior may be analyzed by tabulating the data according to each of the twelve categories. Judgments can be made by looking at the total percentage distribution for each individual and for all individuals observed. By making multiple observations, such as 20 observations of the same nurse or nurses interacting with patients, an NCOT profile can be developed of an individual nurse's behavior or that of a group of nurses, e.g., ICU or clinic nurses.

It is also suggested that combining categories percentages may provide greater insight in looking at the distribution of data. For example, you may combine categories 1, 2, and 3; 4, 5, and 6; 7, 8 and 9; and 10, 11, and 12. This can be done for the individual nurse and client and perhaps physician. In addition, these categories can be summed for a group total of all individuals involved. (Patton and Giffin, 1973, pp. 238-245.)

A "three-dimensional" view of NCOT profiles can also be described. If viewed as three sides of a box, descriptive trends can be identified, similar to those developed by Bales (1970) and briefly summarized by Patton and Giffin (1973, pp 59-65). See Figure 1, page 8.

You can describe the interpersonal communication behavior of a nurse's or client's Message as moving Forward and focusing on Facts (problem solving) or moving Backward and focusing on Sentiment (love, grief, joy, fear, anger, etc.); Attitudes moving positively and humanizing or negatively and dehumanizing; and Patterns of Interaction moving Inward (toward Communing or intimacy) or Outward (toward Separation or isolation). Bales identified twenty-six brief descriptions within this system to evaluate a members' contribution to group progress. Perhaps a similar system might eventually be developed for the NCOT if it would be of value in research and education.

**USING THE NCOT IN RESEARCH**

At this printing, the NCOT has been used in research by Dunn (1987). The purpose of the study was to test a selected relationship statement of Duldt's Humanistic Nursing Communication Theory by examining the effect of reminiscing on the communication behavior of elderly individuals living in nursing homes in Eastern North Carolina. The problem was to determine the effects of reminiscing (communing) on the degree of humanizing communication occurring in a group of elderly participants in comparison to a similar group who did not reminisce, but played bingo.

The sample (N = 20) was randomly drawn from a population of elderly (>65 years) individuals living in two separate but equal nursing homes. Ten were assigned from one home to the experimental group and ten from another home were assigned to the control group. Data were collected in a pretest-post-test design using Duldt's NCOT. Analysis of data by t-tests showed support of the following conclusions: Group reminiscence with elderly tends to increase their interpersonal interactions; there was less dehumanizing behavior; there was an increase in the subjects' ability to reminisce; and the participants reported feeling better about themselves.
USING THE NCOT IN EDUCATION

In a baccalaureate nursing leadership course, one of the goals was to increase the students' sensitivity to humanizing and dehumanizing uses of power (Spickerman, 1988). Approximately 65 first semester senior nursing students observed the film, "Group Productivity." With minimal orientation to the Humanistic Nursing Communication theory, they were instructed to record their observations on the NCOT while viewing the film.

Each student was provided a copy of the NCOT, and the instructor differentiated between humanizing and dehumanizing messages as well as facts and feelings. Some of the similarities and differences between the NCOT and Bales' schema for Interaction Process Analysis were considered. Each student was assigned one of the twelve communication categories for observation; six students observed each individual category. The committee leader in the film was cast in the role of "nurse" and the committee member as the "client" on the NCOT form.

After seeing the film, observations were compared. The students in their assigned groups generally concurred with a difference of one, not more than two citations. When observing the leader, wide discrepancies occurred in category 7, "Information given or requested," and in category 9, "Suggestions made or requested." The clues or descriptors in these two categories were not clear to the students. Why this occurred was not understood by the instructor. The students suggested they found some of the terms "overlapping and ambiguous." However, the majority of the students said that using the NCOT helped them analyze the communication which occurred on the film. Only one stated she "did not find the tool helpful."

The overall impression of the instructor was that the NCOT could easily be used to analyze communication occurring in a wide variety of settings. The film used in this class is excellent for that purpose. Two factors of importance were identified. First, the students were not familiar with the Humanistic Nursing Communication Theory, itself, and, under the time-frame imposed, the instructor was not able to elaborate. Second, the nonverbal communication in the film was powerful and obvious. However, this was not called to the students' attention; some may not have considered it while others may have done so.

Further study of the use of the NCOT is suggested by systematically comparing the effectiveness of the NCOT with other teaching strategies to achieve the educational goal.

References Cited


Rodri, Jo Anne, (1986). *Character of Communication Between Nurse and Laboring Maternity Patient*. Unpublished master's research project, School of Nursing, East Carolina University, Greenville, North Carolina.


Appendix

Figure 1. Adapted from Bales' view of three-dimensional space for determining a classification for nurse and client communication behaviors. (Patton and Giffin, 1973, p. 59.)

ABales has described group behavior in terms of three-dimensional space whose axes are labeled >up-down, = >positive-negative, = and >forward-backward= . These labels correspond to our speech idioms. In direction up are people we respect, look up to, and in direction down are submissive, powerless people, looked down upon. We like, enjoy being with, and feel warmly toward people moving in the Positive direction, and we feel unfriendly toward those moving in the Negative direction. If we see someone advancing group values and working toward group goals, we put him in direction Forward, while the deviant, un-accepting individual who impedes group progress we put in direction Backward.® (Patton, Bobby R. and Kim Giffin. (1973). Problem-Solving Group Interaction. New York: harper & Row, Publishers, p. 59.)
DULD'T'S HUMANISTIC NURSING COMMUNICATION OBSERVATION TOOL

<table>
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<tr>
<th>Project:</th>
<th>Date:</th>
<th>Nurse #:</th>
<th>Client #:</th>
</tr>
</thead>
</table>

Coding of Interaction: Communing = C; Asserting = A; Confronting = N; Conflicting = X; Separating = S

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<tr>
<th>MESSAGES</th>
<th>CLIENT</th>
<th>NURSE</th>
<th>OTHER</th>
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**HUMANIZING FEELINGS:**

1. COMMUNING: trustful, dialogue, praises, encourages, supportive, intimate, gentle touch, eye contact

2. SHOWS TENSION RELEASE: equality, warm voice tone, coping, responsible, faces speaker, open posture, use of humor, frequent eye contact.

3. AGREES: empathetic, warm, compliant, authentic, understanding, positive regard, smiles, nods, ignores inappropriate behaviors, accepting.

**HUMANIZING FACTS:**

4. SUGGESTIONS, MADE OR REQUESTED: caring, initiates communication, coaches, makes requests calmly, allows choice.

5. OPINIONS, GIVEN OR REQUESTED: authentic, self-discloses, uses appropriate names, confronting, positive, sincere feedback.

6. INFORMATION, GIVEN OR REQUESTED: choice, clear directions, progress, individualizes, performs procedures with explanations, provides facts.

**DEHUMANIZING FACTS:**

7. INFORMATION, GIVEN OR DEMANDED: directions, questions, demands, commands, categorizes, role-playing, performs procedures without explanations.

8. OPINIONS, GIVEN OR DEMANDED OR WITHHELD: un-authentic self-disclosures, verbal outbursts, name-calling, commands, telling off, manipulates, negative feedback.

9. SUGGESTIONS, MADE OR DEMANDED: careless, abusive language, belittles, ridicules, questions, tolerates, hits, kicks, carries out requests without speaking, gives directions.

**DEHUMANIZING FEELINGS:**

10. DISAGREES: tolerance, disregard, cold, rejecting, noncompliant, critical, withholds support, judgmental.

11. SHOWS TENSION: degradation, cold voice, helplessness, anger, turns away from speaker, closed posture, pain, struggle, limited eye contact.

12. ALIENATION, SEPARATION: distrustful, monologue, makes excuses, demanding, defensive, withdraws, isolating, avoids touching

Notes:
Theory: Humanistic Nursing Communication Theory

Theorist: Bonnie W. Duld, Ph.D., R.N.

Phenomenon: Interpersonal Communication Between Nurse & Client, Peers and Colleagues

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**Theory:** Humanistic Nursing Communication  
**Theorist:** Bonnie Weaver Duldt  
**Phenomenon:** Interpersonal Communication between Nurse & Client, Peers, and Colleagues  
**Analysis by:** Monique Van Essendelft and Suzanne Woolard; edited by B. W. Duldt  

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<th>Concepts</th>
<th>Relationship Statements</th>
<th>Evaluation</th>
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| **DERIVED FROM PHILOSOPHY** (from humanistic and existential thought): | **1. Human Beings.** Man is a living being capable of symbolizing, perceiving the negative, transcending his environment by his inventions, ordering his environment, striving for perfection, making choices, and self-reflecting. | **1. The degree to which one receives humanizing communication from others, to that degree one will tend to feel recognized and accepted as a human being.** | **1. Parsimony.**  
Duldt=s theory is organized into consecutive elements. The elements are devised into subsets so that the assumptions are grouped with the discipline from which they are derived.  
The concepts= definitions are clear cut and to the point. The assumptions, concepts and relationship statements are all interlocking and relevant. As new concepts are introduced, they have importance in supporting her theory.  
The structure of the relationship statements in conjunction with the models offers a vehicle for statistical analysis and research designs. The relationship statements that she uses are in the form of correlational, deterministic or probable |
| 1. Human beings exist here and now--from which there is no escape. | **Characteristics of humans:** |  
| 2. Human beings are concerned with existential elements: being, becoming, choice, freedom, responsibility, solitude, loneliness, pain, struggle, tragedy, meaning, dread, uncertainty, despair, and death. | **a. Living:** able to function biologically and physiologically as an animalistic, viable entity. |  
| 3. All elements of existential beings are the communication imperative and salient issues to be dealt with in critical life situations. | **b. Communicating:** able to label things and to talk about them when they are not present. |  
| 4. Growth and change arise from within the individual and to a considerable degree depend upon one=s choice. | **c. Negativing:** able to talk about the symbolic negative (-1, no, none, not), make rules (laws regarding the A thou shalt not=s@), worry about what may not happen, and consider one=s own non-existence. |  

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8 April 19, 1996, Bonnie Weaver Duldt. C:\writing\hnct.wpd. (Converted to WP 6.0)
5. The nurse shares with the client all the characteristics of being human.

**DERIVED FROM COMMUNICATION:**

6. Survival is based on one’s ability to share feelings and facts about the environment and ways of coping.

7. The environment is a booming, buzzing world of strange sensations that must be sorted out to determine which are the most important; this sorting is achieved through communication with other people.

8. The need to communicate is an innate imperative for human beings.

9. Due to innate fallacies, human beings use and misuse all capabilities, especially the ability to communicate.

10. The way in which a person communicates determines what that person becomes.

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<tr>
<th><strong>d. Inventing:</strong> able to be aware of, know, and do things beyond his or her relationship to the environment.</th>
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<td><strong>e. Ordering:</strong> able to develop categories and hierarchies according to some value or theme; gives structure and system to one’s environment.</td>
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<tr>
<td><strong>f. Dreaming:</strong> able to dream of how things could be if all were perfect; expectations, hopes for the future.</td>
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<tr>
<td><strong>g. Choosing:</strong> able to consider numerous alternatives, implications for the future.</td>
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<tr>
<td><strong>h. Self-reflecting:</strong> able to think about and talk about self, reflect on one’s own behavior and understand self, body, behaviors, etc. Conscious of the existential elements (see Assumption #2).</td>
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2. To the degree that trust, self-disclosure, and feedback occur, to that degree humanizing communication or communing also occurs.

3. In the event one tends to experience dehumanizing communication— that is, monologal rather than dialogical communication, categorical rather than individualistic, and so on—then one tends to move outward (on the model) to the next pattern of interaction.

4. In an interpersonal relationship of trust, self-disclosure, and feedback, to the degree that dehumanizing communication attitudes are expressed by another, to that degree one tends to use assertiveness as a pattern of interaction.

5. To the degree that assertiveness tends not to re-establish trust, self-disclosure, and feedback, and to the degree that dehumanizing attitudes are expressed by another, to that degree one tends to move inward (on the model) to the next pattern of interaction.

2. **Scope:**

Duldt’s theory is a paradigm variation of the I-Thou theory by Buber, and of the Humanistic Nursing Theory by Pattern and Zderad. It differs in the following ways:

a. It defines the human being as applicable to nursing practice.

b. It provides easily testable relationship statements that are clearly stated.

c. It provides a structured body of knowledge that can be implemented into the educational cognates of a nursing education program.

Duldt’s theory is generalized in scope, not to say that it is simple. It is broad so that it can cover the area of communication. The specifics in her model speak to the nurse and some other person (specifically, nurse-client, nurse-peer, and nurse-colleagues) and their interactions.

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8 April 19, 1996, Bonnie Weaver Duldt. C:\writing\hnct.wpd. (Converted to WP 6.0)
<table>
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<th>11. Interpersonal communication is a humanizing factor that is an innate element of the nursing process (assessment, planning, intervention, and evaluation) and of the communication that occurs between nurses and clients, and nurses and professional colleagues.</th>
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<tr>
<td>12. Evaluation of a person's own communication skills is subjective; each individual must make his own decisions and choices about communication behavior and choose to change, depending upon his ability to utilize feedback.</td>
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<tr>
<td>DERIVED FROM NURSING:</td>
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<tr>
<td>13. The purpose of nursing is to intervene to support, to maintain, and to augment the client's state of health.</td>
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<tr>
<td>14. A human being functions as a unique, whole being responding openly to the environment.</td>
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<td>through the application of the degree one tends to use assertiveness as a pattern of interaction.</td>
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6. To the degree that confrontation tends not to reestablish trust, self-disclosure or feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to use conflict resolution as a pattern of interaction.

7. To the degree that conflict tends not to reestablish trust, self-disclosure, and feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to terminate the relationship by separation.

8. To the degree that humanizing communication attitudes occur in a relationship, in the event of separation, the relationship can be resumed to the same degree of closeness regardless of the separation.

The concepts are Operationalized in such a way as to provide a simplified means of testing and measuring abstract ideas.

The theorist builds, supports, and expands the concepts on previous works by Kenneth Burke (1966), Jourard (1971), Berlo (1960), Patterson and Zderad (1976); Yura and Walsh (1973), Kierkegaard (1957), A. Maslow (1954), Mead (1934), Rogers and Truax (1971), Sartre (1957), Patton and Giffin (1977), and others.

3. Limitations: This interpersonal communication theory is primarily applicable to relationships between two or three people, i.e., dyads or triads. Thus, it is believed applicable to the nurse-patient and perhaps a family member such as a parent or spouse. It is not applicable to groups, organizations or systems. This limitation is typical of existential and symbolic.
### 3. Nursing: the art and science of positive, humanistic intervention

In the changing health status of human beings interacting in the environment of critical life situations. Its elements are communicating, caring, and coaching.

### 4. Nursing Process: consists of

- a) assessing and diagnosing,
- b) planning
- c) implementing, and
- d) evaluating.

### 5. Health: one=s state of being, of becoming: of self-awareness. It is indicative of one=s adaptation to the environment.

### 6. Environment: One=s time/space/environment context.

### 7. Critical Life Situation: a situation in which there is a perceived threat to one=s health state, in which one=s existential humanizing communication from others--clients, peers, colleagues, and leaders.

### SPECIFIC ASSUMPTIONS TO THIS THEORY:

15. Health, satisfaction and success in a person=s life and work--in other words, that person=s state of being--is derived from feeling human.

16. Due to the bureaucratic and complex nature of the present health-care delivery systems, there is a tendency for clients and professionals to be treated in a dehumanizing manner and to relate to one another in a dehumanizing manner.

17. Humanizing patterns of communication can be learned and can enhance the nurse=s awareness of a sensitivity to the client=s state of being and of becoming.

9. To the degree to which a nurse uses humanizing communication, to that degree will be nurse receive interaction philosophical perspectives.

### 4. Applicability

Duldt=s theory provides a perspective of communication which can be useful in all situations in nursing practice.

The theory aids the nurse in coping with the negativity experienced in the practice of nursing.

This nursing theory can be utilized in conjunction with other nursing theories to provide a unique perspective of the communication dimension of interpersonal interactions.

Duldt=s theory is realistic in that it recognizes the dehumanizing aspects of communication with nurses, clients, and others. Her theory is an Ais@ rather than a Ashould be@ theory. It provides
18. The goal of the humanistic nurse is to break the communication cycle of dehumanizing attitudes and interaction patterns, replacing these with attitudes and patterns that humanize.

state of being is salient, e.g., in cancer, childbirth, accidents, and so on.

8. Communication: a dynamic interpersonal process involving continual adaptation and

the nurse with an option for escape from negative patterns of communication and the potential to change relationships into humanizing interaction patterns and attitudes.

While Duldt=s theory is easily understandable for clinical

19. Interpersonal communication is the means by which the nurse becomes increasingly sensitive to and aware of the client=s state of being, of the dynamic relationship between the client and his or her environment, and of the client=s potential.

adjustments between two or more human beings engaged in face-to-face interactions during which each person is continually aware of the other(s).

Communication is a process characterized by being existential in nature, involving an exchange of meaning, concerning fact and feelings, and involving dialogical communing.

Two dimensions of communication are the

a) attitude with which one communicates and

b) skills or patterns of interaction one uses to communicate.

Humanizing communication involves an awareness of the unique characteristics of being

nurses, it is not widely used presently; it is relatively new and warrants further research for supportive for data.

Referring to the GRID (Duldt & Giffin, 1985, p. 231), Duldt=s adaptation of the definition of human beings in relation to the nursing process can be implemented into the curriculum of professional nursing.

The Manual for using the Nursing Communication Observation Tool (NCOT) has been published giving directions for collecting data for education, assessment and research purposes. The tool is validated by congruence of judgments of trained observers. The tool is
**Dehumanizing communication** ignores the unique characteristics of being human.

Based on the well known Interaction Process Analysis by Professor Robert F. Bales of Yale University.

5. Generalizability and agreement with known data.

Duldt’s theory, which fits in the symbolic-interaction model, pulls from disciplines other than nursing and utilizes these concepts to build this theory. Her theory implies a certain populations, experimental treatment variables, and methods of measuring these variables. (Duldt & Giffin, 1985, pp. 228-230).

Duldt’s theory has potential generally since it is a new theory and not widely tested, although efforts have recently been instituted. Her theory is congruent with other theorists, yet differs somewhat. For example, Pilette states that dialogue does not require special techniques. Duldt takes the

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### 9. Continuum of Attitudes

<table>
<thead>
<tr>
<th>Humanizing</th>
<th>Dehumanizing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialogue</td>
<td>Monologue</td>
</tr>
<tr>
<td>Individual</td>
<td>Categories</td>
</tr>
<tr>
<td>Holistic</td>
<td>Parts</td>
</tr>
<tr>
<td>Choice</td>
<td>Directives</td>
</tr>
<tr>
<td>Equality</td>
<td>Degradation</td>
</tr>
<tr>
<td>Positive Regard</td>
<td>Disregard</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Judgment</td>
</tr>
<tr>
<td>Empathy</td>
<td>Tolerance</td>
</tr>
<tr>
<td>Authenticity</td>
<td>Role-playing</td>
</tr>
<tr>
<td>Caring</td>
<td>Careless</td>
</tr>
<tr>
<td>Irreplaceable</td>
<td>Expendable</td>
</tr>
<tr>
<td>Intimacy</td>
<td>Isolation</td>
</tr>
<tr>
<td>Coping</td>
<td>Helpless</td>
</tr>
<tr>
<td>Power</td>
<td>Powerless</td>
</tr>
</tbody>
</table>

10. Patterns of interactions or
**Skills:**

**a. Communing:** Dialogical, intimate communication between two or more people; the heart of humanistic communication.

**Listening:** is the core of communing and involves making a conscious effort to attend to what another person is saying, particularly to expressions of feelings, meanings, and perceived implications.

The central tripod of communing is trust, self-disclosure, and feedback.

**Trust** is one person relying on another, risking potential loss in attempting to achieve a goal, when the outcome is uncertain; and the potential for loss is greater than for gain if the trust is violated.

**Self-disclosure** is risking opposite position and states that to maintain dialogue, it is imperative skills and attitudes in communing, for example, be learned, particularly in the health care professions.

Carkhuff and Truax theorized that training programs for health care professionals resulted in increased levels of empathy, respect, and genuineness; these concepts are included in Duldt's theory.

LaMonica identified positive attitudes as determinants of behavior; this is congruent with humanistic nursing. King and Gerwig drew on humanistic education and psychology of humanistic nursing education. (Duldt & Giffin, 1985, pp. 235-6).

Duldt drew from all these theorists= concepts and supporting data and implemented

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<table>
<thead>
<tr>
<th>Feedback</th>
<th>describing another’s behavior, beliefs and so on, regarding “here and now” events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Assertiveness</td>
<td>expressing one’s needs, thoughts, feelings or beliefs in a direct, honest, confident manner while being respectful of other’s thoughts, feelings or beliefs; Asserting with authenticity.</td>
</tr>
<tr>
<td>c. Confrontation</td>
<td>providing feedback about another plus requesting a change in his or her behavior; Confronting with caring.</td>
</tr>
<tr>
<td>d. Conflict</td>
<td>requires a decision over an issue in which there is risk of loss as well as possible gain, in which two or more alternatives can be selected, and in which one’s values are involved; Conflicting with</td>
</tr>
</tbody>
</table>

6. Relevant research.

A number of research studies tend to support the theoretical statements. These are listed on the following pages.

7. Importance to the discipline and profession.

The theory defines human beings specific for the scope of nursing, in a wholistic and existentialist manner. It also defines the roles and function of nurses.

The theory serves as a guide for research in the area of communication in nursing and potentially in other health care disciplines.
| dialogue.@ |
| e. **Separation**: occurs at the end of a relationship due to change, choice, or outside commitments; A separation with sadness.@ |
Supporting Research


- Identified some specific behaviors of nurses which increased client's trust in the nurse.

Eberhardt, Gary (1987). The relationship of hospice nurse and primary care giver behavior. (Master's research report)

- Identified some nursing behaviors which promote the development of trust of nurses by hospice care givers. Eberhardt & Duldt, (1988).

A Trusting the hospice nurse. American Journal of Hospice Care, 6(6), 29-32.


- Developed the initial form of the NCOT and used it to obtain descriptive data.


- Found differences in patients' and nurses' perceptions.

Longest, Robin. (1986). Analysis of non-communicative behaviors between nurses and patients on mechanical ventilators. (Thesis)

- Greenville, N.C.: East Carolina University School of Nursing. Descriptive of the reciprocity of interactions occurring between nurses and patients.


- Descriptive and supportive of Duldt's theory of anger (unpublished).


- Compared modes of handling anger in families with and without schizophrenia.


- Identified the anger dismay syndrome, a complex of communicative behaviors nurses tend to display when receiving destructive angry mode messages from others, especially from perceived superiors.
References


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Theory: Ethics of Humanizing Nursing Communication

Theorist: Bonnie W. Duldt, Ph.D., R.N.


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<table>
<thead>
<tr>
<th><strong>Assumptions</strong></th>
<th><strong>Concepts</strong></th>
<th><strong>Relationship Statements</strong></th>
<th><strong>Evaluation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Derived from Existentialist Philosophy</td>
<td>1. Human Beings: Humans are living beings capable of symbolizing, perceiving the negative, transcending the environment by inventions, ordering the environment, striving for perfection, making choices, and engaging in self-reflection.</td>
<td>1. The degree to which one receives humanizing communication from others, to that degree one will tend to feel recognized and accepted as a human being.</td>
<td>1. Parsimony</td>
</tr>
<tr>
<td>1. Human beings exist here and now--from which there is no escape.</td>
<td>Characteristics of Humans: <strong>a. living:</strong> able to function biologically and physiologically as an animalistic, viable entity. <strong>b. Communicating:</strong> able to label things and to talk about them when they aren't present. <strong>c. Negativing:</strong> able to talk about the symbolic negative (-1, no, none, not), make rules (laws regarding the Athey shalt not=s@) worry about what may not happen and consider one=s own non-existence.</td>
<td>2. To the degree that one respects one=s own and other=s personal theory of the world, to that degree one tends to behave ethically.</td>
<td>Not very parsimonious, but most statements are detailed and relatively complete, using terminology defined in contemporary vernacular.</td>
</tr>
<tr>
<td>2. Human beings are concerned with existential elements: being, becoming, choice, freedom, responsibility, solitude, loneliness, pain, struggle, tragedy, meaning, dread, uncertainty, despair, and death.</td>
<td>3. To the degree one respects and uses the traditional principles of autonomy, beneficence, justice, veracity, confidentiality, and fidelity in making choices, to that degree one tends to make moral decisions to resolve ethical dilemmas.</td>
<td>This theory of ethics is derived from the theory of Humanizing Nursing Communication, in most cases using the same assumptions, concepts, and similar relationship statements.</td>
<td>Maintains the symbolic interaction model as a worldview so that all statements are consistent within this model.</td>
</tr>
<tr>
<td>3. All elements of existential beings and the communication imperative are salient issues to be dealt with in critical life situations.</td>
<td></td>
<td>3. To the degree one respects and uses the traditional principles of autonomy, beneficence, justice, veracity, confidentiality, and fidelity in making choices, to that degree one tends to make moral decisions to resolve ethical dilemmas.</td>
<td>Structure of relationship statements are conducive to research and testing.</td>
</tr>
</tbody>
</table>

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8 April 19, 1996, Bonnie Weaver Duld. C:\writing\hnct.wpd. (Converted to WP 6.0).
4. Growth and change arise from within the individual and to a considerable degree depend upon one's choice.

5. The nurse shares with the client all characteristics of being human.

Specifically Related to Ethics

6. Each person assumes full responsibility for outcomes of choices, for thoughts, feelings and actions.

7. "Reality" is out there and can be known through life experiences or situations.

8. The individual construes or interprets the experiences or situations so that a personal theory about the world is developed.

9. A personal theory of the world is developed throughout life which differs from

<table>
<thead>
<tr>
<th>d. Inventing: able to be aware of, know, and do things beyond his or her immediate environment, to invent things, and to change one's relationship to the environment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. Ordering: able to develop categories and hierarchies according to some value of theme; gives structure and system to one's environment.</td>
</tr>
<tr>
<td>f. Dreaming: able to dream of how things could be if all were perfect; expectations, hopes for the future.</td>
</tr>
<tr>
<td>g. Choosing: able to consider numerous alternatives and implications for the future.</td>
</tr>
<tr>
<td>h. Self-reflecting: able to think about and talk about self, reflect on one's own behavior and understand self, body, behaviors, etc. Conscious of</td>
</tr>
</tbody>
</table>

4. To the degree the nurse and patient explores the patient=s view of the world and are aware of the nurse=s own world theory, to that degree the interpersonal communication will tend to be ethical.

5. To the degree the nurse challenges those aspects of the patient=s personal theory of the world which are producing problems for the patient, to that degree the nurse is communicating ethically.

6. To the degree the changes occurring in the client=s personal theory of the world and accepts responsibility for the outcomes of one=s own actions, to that degree the nurse-patient interpersonal communication is therapeutic and ethical.

2. Scope

A paradigm variation of Buber=s Al-Thou,@ it offers an existential framework for the ethical analysis of moral health care dilemmas.

Contemporary approach in that it emphasizes the individual=s responsibility for one=s own choices, and the Aproof@ or Ajustification@ of these choices is the outcome.
<table>
<thead>
<tr>
<th>&quot;reality.&quot;</th>
<th>existential elements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Ethical justification of choices is found in outcomes--the way things turn out is the sole &quot;proof&quot; of right or wrong, good or evil.</td>
<td></td>
</tr>
<tr>
<td>11. Human beings are neither good or evil, but develop &quot;essence&quot; through the choices made and actions taken.</td>
<td></td>
</tr>
<tr>
<td><strong>Derived from communication:</strong></td>
<td></td>
</tr>
<tr>
<td>12. Survival is based on one's ability to share feelings and facts about the environment and develop strategies of coping.</td>
<td></td>
</tr>
<tr>
<td>13. The environment is a &quot;booming, bussing&quot; world of strange sensations that must be sorted out to determine which are the most important; this sorting is achieved through communication with other</td>
<td></td>
</tr>
<tr>
<td><strong>2. Roles</strong>: positions in society.</td>
<td></td>
</tr>
<tr>
<td><strong>a. Nurse</strong>: a human being who practices nursing, intervening through the application of the nursing process to develop a plan of care for a specific client or group of clients. The nurse possesses special educational and licensure credentials as required by society.</td>
<td></td>
</tr>
<tr>
<td><strong>b. Client</strong>: a human being who is experiencing a critical life situation, potential or actual, and is in need of the services of the nurse and is the focus of the nursing process. The client can also be seen to include the support system of the family, friends, and so on.</td>
<td></td>
</tr>
<tr>
<td><strong>c. Peer</strong>: a nurse having equal standing or status to another nurse.</td>
<td></td>
</tr>
<tr>
<td><strong>d. Colleague</strong>: member(s) of another profession with whom nurses coordinate and</td>
<td></td>
</tr>
<tr>
<td>7. To the degree the nurse helps the client analyze life experiences and discover meaning in critical, ethical dilemmas, to that degree the nurse communicates ethically.</td>
<td></td>
</tr>
<tr>
<td>8. To the degree the nurse respects the client's health and life decisions and assesses the client through the outcomes of such choices, to that degree the nurse communicates ethically.</td>
<td></td>
</tr>
<tr>
<td>9. To the degree the nurse cannot agree with the client's choices due to the nurse's own beliefs, rights, ethics or other valid reasons which set limits to the scope of one's practice, AND, the nurse reveals this to the client in a dialogical, humanizing and caring manner, to that degree the nurse behaves in an ethical manner, enabling other</td>
<td></td>
</tr>
<tr>
<td><strong>3. Limitations.</strong></td>
<td></td>
</tr>
<tr>
<td>Resolving ethical dilemmas involves focusing on the present situation and how one feels, the choices one makes, with moral justification lying in the outcome.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Applicability.</strong></td>
<td></td>
</tr>
<tr>
<td>Potentially useful in all clinical areas of nursing.</td>
<td></td>
</tr>
</tbody>
</table>

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| people. | collaborate in the practice of nursing, i.e., physicians, | arrangements to be made to provide the needed care and avoiding client abandonment. |

14. The need to communicate

is an innate imperative for human beings.

15. Due to innate fallacies, human beings use and misuse all capabilities, especially the ability to communicate.

16. The way in which a person communicates determines what that person becomes.

17. Interpersonal communication is a humanizing factor that is an innate element of the nursing process and of the communication that occurs between nurses and clients, and nurses and professional colleagues.

18. Evaluation of a person's own communication skills is subjective; each individual

| administrators, ministers, and other members of the health care professions and community service agencies. |

| Ethics for the Nurse=s Communicator Role: |

10. To the degree the nurse communicates using a board range of humanizing and dehumanizing attitudes and interaction patterns, to that
degree the nurse behaves ethically.

11. To the degree the nurse behaves ethically in providing authentic feedback so that the client tends to move toward a better health status, to that
degree the nurse tends to make morally correct choices.

12. To the degree the nurse engages in active listening so that the client tends to move toward a better health status, to that
degree the nurse tends to make ethical choices.
must make his/her own decisions and choices about communication behavior, choosing to change, depending upon one's ability to utilize situations.  

2) Provides authentic feedback.  

**c. Caring:**  
1) Provides personal care  

---  

**Derived from Nursing**  

19. The purpose of nursing is to intervene to support, to maintain, and to augment the client's state of health.  

20. A human being functions as a unique whole, responding to the world "reality" as perceived through one's own personal theory of the world.  

21. Health, satisfaction and success in a person's life and work--in other words, that person's state of being--is derived from feeling human.  

22. Due to the bureaucratic and complex nature of the services to those unable to care for themselves: caring Afor.@  

2. Conveys a concern for the individual: caring Aabout.@  

3. Maintains a warm, positive regard for others.  

4. Is an active listener, tolerant of ambiguity, and patient in waiting for change and growth.  

5) Is trustworthy, keeps promises, is loyal, and maintains confidentiality.  

6) Maintains an awareness and sensitivity to the work of searching for meaning in critical life situations.  

**Moral view of persons:**  
1. Respects own and other's personal theory of the world.  

2. Respects and often uses traditional ethical principles of **Ethics for the Nurse=s Coaching Role**  

13. To the degree the nurse coaches the patient using logic, critical thinking and argumentation skills to approach dilemmas of critical life decisions in health related situations, to that degree the nurse tends to make ethical choices.  

14. To the degree the nurse behaves ethically in providing authentic feedback so that the client tends to move toward a better health status, to that degree the nurse tends to make morally correct choices.  

**Ethics for the Nurse=s Caring Role**  

5. Generalizability and Agreement with Known Data.  

Consistent with expectations for outcomes in clinical case management and in administration of health care agencies.
<table>
<thead>
<tr>
<th>15. To the degree the nurse provides personal care to those unable to care for themselves, i.e. caring for, to that degree the nurse tends to make ethical choices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Humanizing patterns of communication can be learned and can enhance the nurse’s awareness of a sensitivity to the client's state of being and of becoming.</td>
</tr>
<tr>
<td>24. The goal of the humanizing nurse is to break the communication cycle of de-humanizing attitudes and interaction patterns, replacing these with attitudes and patterns which tend to humanize.</td>
</tr>
<tr>
<td>25. Interpersonal communication is the means by which the nurse becomes increasingly sensitive to and aware of the client's state of</td>
</tr>
</tbody>
</table>

### 4. Nursing Process:
- a. Assessing and diagnosing.
- b. Planning
- c. Implementing
- d. Evaluating.

### 5. Health: One’s state of being, of becoming, of self-awareness. It is indicative of one’s coping abilities.

### 6. Environment: One’s time/space/relationship context or situation.

### 7. Critical Life Situation: a situation in which there is a perceived threat to one’s health state, in which one’s existential state of being is salient, as in cancer, childbirth, |

### 6. Relevant Research.

No specific research in progress as of this date (Dec., 1995).
being, of the dynamic relationship between the client and his or her environment and of the client's potential.

8. Communication: a dynamic interpersonal process involving continual adaptation and adjustments between two or more human beings engaged in face-to-face interactions during which each person is contin-

19. To the degree the nurse is trustworthy, keeps promises, is loyal, and maintains confidentiality, to that degree the nurse tends to make ethical choices.

which each person is continually aware of the other(s). A process characterized by being existential in nature, involving an exchange of meaning, concerning fact and feelings, and involving dialogical communicating. It contains the humanizing and dehumanizing set of attitudes on a continuum and a set of patterns of interaction.

9. Continuum of Attitudes:
   Humanizing....De-Humanizing
   Dialogue           Monologue
   Individual         Categories
   Holistic           Parts
   Choice             Directives

20. To the degree the nurse maintains an awareness and sensitivity to the client=s work of searching for meaning in critical life situations, to that degree the nurse tends to make ethical choices.

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| Equality | Degradation |
| Positive Regard | Disregard |
| Acceptance | Judgment |
| Empathy | Tolerance |
| Authenticity | Role-playing |
| (of feelings) | |
| Caring | Careless |
| Irreplaceable | Expendable |
| Intimacy | Isolation |
| Coping | Helpless |
| Power | Powerless |

**Humanizing communication** involves an awareness of the eight unique characteristics of being human; **dehumanizing communication** ignores these eight characteristics.

**10. Patterns of Interactions (skills):**

a. **Communing:** dialogical, intimate communication between two or more people; the nature or essence of humanizing or humanistic communication.

**7. Importance to the Discipline and Profession.**

Represents a first effort in developing a theory of ethics for nursing alone and not dependent upon biological or medical ethical approaches. Potential for making a significant contribution. Only time will provide answers.

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8 April 19, 1996, Bonnie Weaver Duldt. C:\writing\hnct.wpd. (Converted to WP 6.0).
**Listening**: is the core of communing and it involves a conscious effort to attend to what another person is saying, particularly to expressions of feelings, meanings, and perceived implications.

**The central tripod** of communing is trust, self-disclosure & feedback.

1) **Trust**: one person relying on another, risking potential loss in attempting to achieve a goal, when the outcome is uncertain; and the potential for loss is greater than for gain if the trust is violated.

2. **Self Disclosure**: risking rejection in telling how one feels, thinks, and so on, regarding here and now events.
3. **Feedback**: describing another’s behavior, beliefs and so on, plus giving one’s evaluation or feelings.

**b. Assertiveness**: Expressing one’s needs, thoughts, feelings or beliefs in a direct, honest, confident manner while being respectful of another’s thoughts, feelings or beliefs; Asserting with authenticity.

c. **Confrontation**: providing feedback about another plus requesting a change in his or her behavior; Confronting with caring.

d. **Conflict**: requires a decision over an issue in which there is risk of loss as well as possible gain, in which two or more alternatives can be selected.
and in which one=s values are involved, Aconflicting with dialogue.

e. Separation: the end of a relationship due to change, choice, or outside commitments; Aseparation with sadness.
Definitions of Theoretical Concepts

CONCEPT: Communing

DEFINED:

1. A dialogical, intimate, humanizing communication which occurs between two or more people (Duldt, et. al., 1984).
2. To talk together intimately (Webster).
3. Derived from the Latin term, "communicare," meaning to share (Webster).
4. Synonyms include talking, thinking, pondering (Webster).

OPERATIONALIZATION:

1. It is a subjective event which happens "between" people;
2. It involves being aware of the other person's presence;
3. It is "being there" and "being with."

SCOPE:

1. Elements include trust, self disclosure, and feedback (Duldt, 1984, 1985).
2. Humanizing attitudes (spirit, temper, stance, disposition, prejedgments or interpersonal orientations) which include the following: dialogue, individuality, holistic, choice, equality, positive regard, acceptance, empathy, authenticity, caring, irreplaceability, intimacy, coping, and power. (Duldt, 1984, 1985.)

LIMITATIONS:

Dehumanizing attitudes in communicating. These attitudes include: monologue, categories, parts, directive, degradation, disregard, judgment, tolerance, role playing, carelessness, expendable, isolation, helplessness, and powerlessness.

ACCOMPLISHES, ROLE AND FUNCTION:

1. It is the "humanizing" factor of communication which enables one to become capable being sensitive of other's feelings and interpersonal orientations.

ANALOGY: Just as a tripod provides stability to a camera in photographing a scene, so trust, self disclosure and feedback provide the foundation for communing, which is like "getting a picture of another's view of reality."

AUTHORITY QUOTES:
1. "Relation is reciprocity. My You acts on me as I act on it....Inscrutable involved, we live in the currents of universal reciprocity" (Buber, 1970, p. 67.)

2. "In spite of the inherent differences between science and the humanities, there exists the capacity for the science of caring that approaches human problems from both directions. The science of caring cannot be completely mental with respect to human values. It cannot remain detached from or indifferent to human emotions--pain, joy, suffering, fear, and anger....(it) integrates the biophysical sciences with the behavioral sciences, and so necessitates a recognition and utilization of the humanities (Watson, p. 5).

THEORIES:

2. Duldt's Humanistic Nursing Communication Theory (pp. 43-49).

RESEARCH:

Requires qualitative research methods, and there has been limited work in this area. In nursing, Patterson and Zderad (1976) probably have come the closest to achieving this goal in testing their theory of humanistic nursing.
CONCEPT: Trust

DEFINED:

1. Entrusting one's self to others and believing in being safe (Duldt, et. al, 1984, 1985).
2. A firm belief or confidence in the honesty, integrity, reliability, justice, etc. of another person or thing (Webster).
3. Derived from the word, "trust," meaning firmness or true (Webster).
4. Synonyms includes faith, reliance, loyalty, dependence and conviction (Webster).

OPERATIONALIZATION: Trusting conditions in an interpersonal relationship includes:

1. One person relying on another;
2. risking potential loss;
3. in attempting to achieve a goal;
4. when the outcome is uncertain;
5. and the potential for loss is greater than the potential for gain if the trust is violated.

SCOPE:

1. Self disclosure and honest feedback are central to the process of trust development.
2. Includes the Johari Window:

   ![Johari Window Diagram]

LIMITATIONS:

1. Defensive feelings of fear lead to distrust, stereotyping, the need for excessive ground rules or norms, excessive politeness, use of strategies and building facades.
2. Also includes making decisions for others, avoiding feelings, giving advise, and impersonal talk.

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ACCOMPLISHES, ROLE AND FUNCTION:

1. Growth in skills for developing and maintaining interpersonal relationships through verification of one's own self-concept.
2. Increases one's ability to cope.
3. Increases tolerance of ambiguity and acceptance of a variety of opinions.

ANALOGUES AND METAPHORS:

An interpersonal "cliff-hanger,"

AUTHORITY QUOTES:

Luft: Misery in a relationship is to expect trust and get tolerance.

THEORY:

2. Paradigm proposed by Kim Giffin:
   1. Trust of the speaker by the listener (Ethos, credibility).
   2. Trust of the listener by the speaker (Psychological safety; speech confidence).
   3. Trust of self as a speaker.
   4. Trust of self as a listener.
3. Duldt's Humanistic Nursing Communication Theory (pp. 43-49).

RESEARCH:

1. Set of elements identified by semantic differential:
   a. Reliability (dependability, will take action);
   b. Expertness (knowledge, credibility); and
   c. Dynamism (degree of openness and frankness).
2. Boyd, in a survey of nine spinal cord injury patients, found the certain behaviors displayed by the nurse tended to increase the patient's report trust of the nurse. See abstract, p. 56.
3. Eberhardt found primary caregivers in hospice care settings tended to trust the hospice nurse who displays certain behaviors. See abstract, p. 57.
CONCEPT: Self Disclosure

DEFINED:

1. Revealing the "real you" to others through facts about yourself.
2. It involves risk and feelings of anxiety because of possible rejection.
3. It is a "story" with risk and ego involvement.
4. Derivation of self is from Latin word, "sibi," meaning separate, set apart. Disclosure is derived from the Old French term, "desclore," meaning to bring into view or make known (Webster).
5. Synonyms include revealing, divulging, telling, or betraying one's self (Webster).

OPERATIONALIZATION:

1. To tell how one feels about something "here and now," selecting topics appropriate to the situation.
2. Self disclosures MUST RECEIVE SUPPORT AND MUST BE COMPLETE.
3. Emotional disturbances loses its power when it loses its privacy.

SCOPE:

1. Cultural bias exists against self disclosure; seen as a "sickness."
2. Cultural "permission" to self disclose is given within the medical mode; self disclosure is seen as a medical set associated with illness.
3. Resistance to self disclosure may be due to flight from
   a) self knowledge;
   b) fear of intimacy;
   c) flight from responsibility and change;
   d) fear of rejection.
4. The over-disclosure is not discriminating in different relationships and may be demanding more of your care, time, feelings and attention than you are ready to offer.
5. The under-discloser distrusts others and appears emotionally self-sufficient, but, of course, it not.

LIMITATIONS:

1. It is not forcing one to talk.
2. It is not social chit chat or exhibitor in nature.
3. It is not "history" involving facts or relating things that happened so that the person is hidden.

ACCOMPLISHES, ROLE AND FUNCTION:
1. It invites others to involve themselves with you.
2. If authentic, it tends to create intimacy.
3. It tends to stimulate interactions and involvement with others.
4. Once established, it tends to dispel disputes and is disarming.

ANALOGY:

1. A bridge, not a barrier, in interpersonal relationships.
2. It is like opening doors and windows to air out a house.

AUTHORITY QUOTES:

1. Mower: Too little results in mental illness. Two types of symptoms: Type I are tension, anxiety, depression and fatigue. Type II are suicide, withdrawal, blaming others, business, daydreaming, and drugs.
2. Jourard: Concealment saps energy, increases stress, dulls awareness, causes use of facades, stereotyping, rigidity and loneliness.
3. Kaplan: "It is not abandonment of autonomy. To cherish privacy is not saying you are rejecting others."
4. Alvin Toffler has noted that the transient, temporary nature of relationships restricts an individual's adaptive potential and creates the danger of "future shock."

THEORY:

1. Duldt's Humanistic Nursing Communication Theory.

RESEARCH:
CONCEPT: Feedback

DEFINED:

1. Feedback is reflecting or simply describing another's behavior. It involves thinking about the behavior in which another is engaged, reacting to this behavior, and then telling the other person how his behavior strikes you. Descriptive facts plus feeling of evaluation.
2. A process in which the factors that produce a result are themselves modified, corrected, strengthened, etc. by that result (Webster).
3. Derived from the Old English term, "fedan," meaning to provide food for or give food to (Webster).
4. Synonyms are not noted in the dictionary, but probably include evaluation and performance review in a management sense.

OPERATIONALIZATION:

1. Each group member interprets another's behavior in his or her own way; no consistency is necessary.
2. Feedback concerns only the dimension of another which one chooses to reveal.
3. Indirect feedback is ambiguous, global, and usually not helpful: for example, "Some of us here feel that you...."
4. Direct feedback is making explicit statements describing one's reaction to another. Generally, the more specific and limited in scope, the more helpful. For example, "I feel uncomfortable when you say that because...."

SCOPE:

1. Reflected appraisals shows one just as he or she is exposed.
2. To confirm or validate another is to indicate the other person is normal.
3. To dis-confirm or invalidate another is to suggest that he or she may hold a discrepant belief, may be distorting perceptions, or, in the extreme, may be unhealthy or unimportant.
4. To promote growth, feedback is best provided in a climate of support and respect.

LIMITATIONS:

1. Excludes the last part of confrontation, i.e., the challenge to change. People have the right to choose if they want to change as a result of receiving feedback.
2. People have a right to refuse feedback; it may not be wanted. The person may not be "ready" for it.
3. It is not a personal dumping.

8 April 19, 1996, Bonnie Weaver Duld. C:\writing\hnct.wpd. (Converted to WP 6.0).
ACCOMPLISHES, ROLE AND FUNCTION:

1. It enables one to learn how he or she appears to others and what impact he or she has on interpersonal relationships.
2. It is useful for self evaluation and for making decisions regarding self-change.
3. It tests our self-image. Supportive feedback from valued or significant others is necessary to achieve a satisfactory self-image.

ANALOGIES AND METAPHORS:

1. Like looking in a mirror to see how you are "here and now."
2. Transfer of part of the electrical output of an active circuit back to the input, either as an unwanted effect or in an intentional use, as to reduce distortion (Webster).

AUTHORITY QUOTES:

K. Giffin: Maturity is a process of relating to others by self-disclosing and seeking feedback, and changing one's behavior as necessary and/or appropriate. It is a process of confronting one's self when thinking about the feedback received.

THEORY:

1. A theory of feedback does not appear in the literature, although it appears to be an essential part of psychological well-being, and is essential to most psychological therapy and counseling (Tubbs and Baird, p. 10.)
2. Duldt's Humanistic Nursing Communication Theory.

RESEARCH:

1. Levitte and Mueller found that as the size of a group increases, feedback decreases, conflict and hostility increases, and communication accuracy decreases.
2. Osgood found that two-thirds of the meaning of language is derived from the evaluation or feeling element; the remainder is derived from potency and activity in semantic differential studies.
CONCEPT: Assertiveness

DEFINED

1. Standing up for personal rights and expressing thoughts, feelings, and beliefs in direct, honest, and appropriate ways which do not violate another person's rights (Jakubowski, in press, a).
2. Stating confidently without need for proof; to state or declare positively (Webster's).
3. Derived from the Latin term, "assertus," meaning "to join" (Webster).
4. Synonyms include pushing, militant, affirmative, and confident (Webster).

OPERATIONALIZED:

1. Non-verbal behavior:
   a. Eye contact firm, but not a stare-down.
   b. Body tense and strong but normal stance; not dominating, as in using finger-pointing or fist shaking; not pleading or and-wringing.
   c. Voice patterns clear, fluent, matter-of-fact in tone rather than too soft or loud or condescending.
2. Verbal behavior:
   a. "Thank you, the food is delicious, but I don't want any more." (When offered more a third time.)
   b. "Excuse me. I would like to finish what I was saying without interruption, please." (When interrupted.)
   c. "I would like to visit with you more, but I need to complete some work now." (When someone stays too long.)
   d. "I have five minutes to talk with you now, and then I must go to another appointment." (When you don't want to be imposed upon, yet you don't want to be rude.)

SCOPE

1. Responsible use of assertive skills in a manner that others are treated fairly.
2. Help others to become more assertive.
3. Risk is involved. If your assertive attempt is successful and effective, you may have a) loss of another's affection and respect or b) appear foolish, unwise and selfish.
4. Responsibilities include the following:
   a. Avoid over-reacting to every imposition on one's rights.
   b. Avoid being assertive just to be assertive: "grandstanding."
   c. Do select when, about what, and with whom to be assertive and to be responsible for the consequences, both positive and negative.
LIMITATIONS:

1. Aggression, which violates other's rights and demeans others to achieve personal goals. Your goal is really to dominate, win, and force. Other's don't "count." Based on the need to control others, and fear of being controlled. Often it is characterized by long periods of non-aggressiveness and then explosive aggressiveness. Interpersonal reaction of others ultimately is:
   a. failure to establish close relationships, and
   b. continually being on guard against others' counter-aggressiveness (overt and overt) through calculated acts designed to irritate, subvert, and sabotage.
2. Non-assertion violates self by deferring, apologizing, and denying preferences and rights. It shows lack of respect for others' coping abilities to take "No," to take responsibility, and to adapt. The goal is appeasement of others and avoidance of conflict. The effect is an increasing sense of hurt and anger, depression, and psychosomatic illness. Interpersonal reactions of others is to feel guilty if they inadvertently take advantage of non-assertiveness, to feel pity, to feel irritation, and finally feel disgust for the non-assertive person.

ACCOMPLISHES, ROLE AND FUNCTION:

1. Increases one's own sense of self-respect.
2. Increases self-confidence and decreases the need of approval of others.
3. Gains the respect and esteem of others.
4. Achieves need satisfaction and respect for preferences of both parties to a greater degree.
5. Increases one's control over self.
6. It increases the probability of more satisfying relationships with others.

ANALOGIES AND METAPHORS:

1. "Staking out one's territory."
2. "Claiming one's own space."

AUTHORITY QUOTES:

THEORY:

1. Duldt's Humanistic Nursing Communication Theory.

RESEARCH:

8 April 19, 1996, Bonnie Weaver Duld. C:\writing\hnct.wpd. (Converted to WP 6.0).
CONCEPT: Confronting

DEFINED:

1. Using information a person gives you and pointing out the inconsistencies.
2. A challenge to another to improve interpersonal relationships.
3. An attempt to involve one's self with another.
4. Derived from the Latin terms, "confrontare" (meaning "together") and "frons" (meaning forehead), which together mean to stand or meet face to face or to oppose boldly (Webster).
5. Synonyms include meet, face, and encounter (Webster).

OPERATIONALIZED

1. Occurs when one person (A) deliberately or inadvertently does something that causes or directs another person (B) to avert to, reflect upon, examine, question, or change some particular aspect of one's (B's) own behavior.
2. Procedure
   a. Getting confrontee's attention: "I have something important to tell you."
   b. Give behavioral facts: "This is how you have been behaving..." or "This is what you said...".
   c. Tell how the confrontee's behavior makes you feel: "It annoys me and is distracting when you do this. I don't like it."
   d. Give interpretation or hypothesis of what the perceived behavior means: "It seems almost as if you want to prevent me from doing my work." (optional step)
   e. Request a change in confrontee's behavior: "I wish you would stop."
3. Reactions to confrontation by confrontee:
   a. Defensiveness
      > To be confronted also.
   b. Counterattack
   c. Acceptance of how confrontee is experiencing by the confronter. Openness to temporary disorganization to deal with an identified area of conflict and to resolve it.
4. Evaluation of effectiveness measured by:
   a) the degree of positive growth and change in behavior; and
   b) by the degree of interpersonal closeness which develops when the confrontation is successful.
5. Cautions:
   a. If the issue is of major importance, confrontation will tend to fail if the confrontee is coping with too many other problems at the moment.
   b. Do not continue with the confrontation when the Confrontee states he/she is not ready for this now. A more appropriate time can be arranged.

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SCOPE

1. Includes only salient, timely, "here and now" behavior of importance to both parties. Includes confronting behavior, action, inaction, attitudes, or moods.
2. Includes a concern for another.
3. Confrontee must be aware of own biases for or against the confrontee.
4. Confront behavior primarily; be slow to confront motivation.
5. Vehemence of confrontation and behavior confronted are to be proportional to needs, sensitivity, and capabilities of the confrontee.

LIMITATIONS:

1. Confronting to punish, dominate, or control.
2. "Telling off" someone.
3. "Wolf-packing" or having too many people confront one person at once; may be necessary for individuals who refuse to acknowledge the confrontation or "non-engagement."
4. Long winded interpretations of another's behavior.
5. Confronting aspects which are unchangeable, e.g., skin color, race, etc.

ACCOMPLISHES, ROLE AND FUNCTION:

1. A direct challenge by "calling one's game."
2. An asocial response which withholds acceptance and support.
3. A powerful force for interpersonal growth.
4. The goal is a behavior change in the confrontee.

ANALOGIES AND METAPHORS:

1. Adler: "spit in one's soup: he can continue eating, but it won't taste as good."

AUTHORITY QUOTES:

THEORIES:

1. Duldt's Humanistic Nursing Communication Theory.

RESEARCH:

Notes:

8 April 19, 1996, Bonnie Weaver Duldt. C:\writing\hnct.wpd. (Converted to WP 6.0).
CONCEPT: Conflicting

DEFINITION:

1. To be antagonistic, incompatible, or contradictory; to be in opposition; clash.
2. Sharp disagreement or opposition, as of interests, ideas, etc.; clash.
3. Emotional disturbance resulting from a clash of opposing impulses or from an inability to reconcile impulse with realistic or moral considerations.
4. Synonyms: fight (any contest), struggle (implies great effort), contention (heated verbal strife), contest (struggle for supremacy in some matter).
5. Derived from Latin word, "conflictus," meaning to strike together.

OPERATIONALIZATION:

1. Arguing, bickering, quarreling, fighting, name-calling and generally competitive behaviors.
2. Becomes disruptive when behaviors include aggression, withdrawal, ego-defensive (fantasy), projecting, sublimating, rationalizations, repressing, identifying, scape-goating or blaming others.

SCOPE:

1. Constructive type:
   a. Recognize that it exists; expect it; it is necessary to effective problem solving discussion if participants can learn to disagree productively.
   b. In reaching consensus on the best alternative solution or decision, the group needs first to hear different views, to give fair consideration and critically evaluate each view. Focus of discussion is on issues and involvement tends to be sincere.
   c. Occurs best in cooperative, open climate where ideas can be expressed without punishment.
      d. In groups in which conflict occurs constructively, there is a greater tendency for wise decisions to be made because in sharing ideas, the decision tends to be better than any one member could make.

2. Disruptive Type:
   a. Occurs when members of the group do not perceive conflict to be constructive
   b. Interpersonal climate in the group is competitive, i.e., perceived by members to be a win or lose situation.
   c. The group usually lacks a common goal; no sense of direction or team spirit.
   d. There is frequent use of disruptive behavior.
   e. Members tend to be "frozen" to their own point of view and to be unwilling to consider others' as having value or credibility.
f. Focus of discussion slips from issue to personal attacks as viewpoints polarize.
g. Little satisfaction is experienced by members in the solution or decision made or in the interpersonal relations experienced.

LIMITATIONS:

1. Explicit aggression and violence.

ACCOMPLISHES, ROLE AND FUNCTION:

1. Constructive type:

a. Promotes growth and development in that it motivates people to build new, creative solutions.
b. Acts as a cathartic if the group can look at the source of conflict and process how it developed to increase self learning for the members.
c. In problem solving discussions, conflict:
   1) broadens understanding of the nature of the situation, problem, and its implications;
   2) allows more alternative suggestions from which members can choose;
   3) allows satisfaction of healthy, spirited interaction and high involvement interpersonally.

2. Destructive type:

a. Is pathological in that it acts as a threat to individuals and tends to narrow their perceptual processes, leading to an increase in defensive behaviors.

ANALOGIES AND METAPHORS:

AUTHORITY QUOTES:

THEORIES:

1. Cognitive dissonance explains motivation to resolve conflicts.
2. Social comparison theory explains the need to validate perceptions.
3. Duldt's Humanistic Nursing Communication Theory.

RESEARCH:

1. Variables: Some variables which influence conflict development are differences in members' norms of references, values, beliefs, and attitudes. Any change perceived by members is a potential source of conflict.

8 April 19, 1996, Bonnie Weaver Duldt. C:\writing\hnct.wpd. (Converted to WP 6.0).
CONCEPT: Separating

DEFINITION:

1. To set or put apart into sections, groups, sets, units, etc.
2. To release from military service or dismiss from employment.
3. To part company; go in different directions; to cease to associates.
5. Derived from the Latin word, "separatus," meaning to separate.

OPERATIONALIZATION:

1. To separate your self physically from another by barriers (desks, walls, time or distance).
2. May be due "drift," such as changes in residence, job, or interests.
3. May also be due to "choice" because the other person (or group) is experienced as being un-supportive, un-attractive, or un-friendly, thus dehumanizing.
4. May be due to drift or choice, but separation from a close friend a unfortunate part of the separation. It is a humanizing separation if you meet your friend again, even years later, and it seems as if the separation had not occurred.

SCOPE:

1. Refers primarily to the degree of closeness experienced in interpersonal relationships.
2. Behavioral components include the:
   a. degree to which one is in close proximity to another by chance or by preference;
   b. frequency of eye contact when communicating;
   c. degree to which one holds similar beliefs and attitudes of another;
   d. tendency to evaluate positively or negatively the other's performance, product, possessions or characteristics;
   e. tendency to benefit or not one who reciprocates interpersonal closeness or separateness.

LIMITATIONS:

1. The sorting of objects into categories.
2. The separation of chemicals in solution.

ACCOMPLISHES, ROLE AND FUNCTION:

1. Separation is used to end a relationship.
2. The degree of separation by space identifies the interpersonal relationship to be intimate, personal, social, or public.
ANALOGIES AND METAPHORS:

AUTHORITY QUOTES:

1. "...everyone has around himself an invisible bubble of space that contracts and expands depending on several factors: his emotional state, the activity he's performing at the time, and his cultural background...a kind of mobile territory that he will defend against intrusion (Hall and Hall, p. 216).

THEORY:

2. Duldt's Humanistic Nursing Communication Theory

RESEARCH:

1. Festinger, Schachter, & Back (1950): a study of proximity, friendship choice, and interpersonal contact in a housing development. Architecture of buildings was found to influence the number of contacts people have, depending upon placement of exits and entrances, stairways, mailboxes, etc., and consequently the number of friendship choices available.
2. White (1953): The presence or absence of a desk in a doctor's office significantly alters the patient's "at ease" state. With the desk separating the doctor and patient, only 10% of the patients were perceived "at ease"; without the desk, 55% were "at ease."
3. Hall (1969): Intimate space, 6-18 inches, is for lovemaking, comforting, protecting or fighting. Personal space, 18-30-48 inches, is for friendly relations. Social distance, 4-7-12 feet, is used for acquaintances, co-workers, and formal business and social events. Public distance, 12-15+ feet, is used for formal occasions, especially by public figures.