HUMANISM, NURSING, COMMUNICATION, AND HOLISTIC CARE:
A Position Paper.

By

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Abstract: A position paper by the author and theorist proposing that Humanizing Nursing Communication Theory become the “benchmark” for effective nurse-patient communication in all areas of nursing practice.

Introduction: The Problem

There is a great need in the health care professions to provide holistic care (body, mind and spirit) to all clients, regardless of religious, ethnic, or cultural characteristics in a humane (non-judgmental and compassionate) manner. Major trends in today’s American health care systems emphasize certain business and management concepts. Efficiency, accuracy, and economy have become core concepts of health-care delivery. Efficiency and accuracy are expected in use of sophisticated medical terminology and highly skilled specialists who operate modern equipment. The very language used is often ineffective in aiding patients to understand the issues presented. Economy is necessary because of the spiraling costs and the increased expectations of citizens regarding accessibility of health care. In addition, major issues in our political, legal, and ethical systems focus on all phases of health care; who should receive it, who should decide what is received, who can provide the resources, who should have the right to start or stop treatments, and who should pay for it. Finally, according to the U.S. census bureau, (2004), the population of the United States is projected to increase by approximately 40% by 2050, and the world by about 45%. The pressures on the present health care system can be expected to increase exponentially in association with the population. With the impact of these trends, it becomes possible to overlook the purpose of the entire system; i.e., providing holistic and humane care to the client or consumer.

Across the proverbial table from the consumer is the nurse who is also frequently overlooked. This nurse represents the largest licensed professional health care provider group in America. In this health care area, the professional nurse traditionally has had the closest and longest interpersonal contact with patients, particularly when hospitalized, than any other health care provider. In this same health care system, it has been possible to overlook the fact that all the buildings, equipment and
sophisticated monitoring machines need to be operated by a human being...a professional nurse, practical nurse, or some type of nursing assistant within the organizational nursing system. Yet other health care professionals, as well as nursing colleagues, overlook the need to communicate with one another in a holistic and humanizing way. For example, Ulrich (2004) speaks of the “fear factor” nurses experience when other professionals use verbal abuse, refusal to answer questions, condescending voice intonation, and threatening body language in communicating. The Institute for Safe Medication Practices (http://www.ismp.org; and http://www.ismp.org/msaarticles/intimidationprint.htm) reports a survey indicating the role that intimidation plays in the safe administration of medications. Childers (2004) describes the hostile work environments in which professional colleagues behave as “bullies” Namie, a social psychologist and founder of the Workplace Bullying and Trauma Institute (http://wwwbullyinstitute.org), states that many nurses have just accepted working in a toxic environment with control-freak physicians and out-or-control supervisors....Bullies have long ruined their quality of life and driven many good nurses out of the profession.” Namie’s studies indicate 70% of the people targeted by a bully have to quit either because of health (33%) or as victims of manipulated negative performance reviews (37%). In a second report, plans are outlined for changing the culture are offered by the Institute for Safe Medication Practices. The plans involve long, expensive administrative processes to establish a zero tolerance policy, a reporting systems, conflict resolution and educational programs (http://www.ismp.org/msaarticles/intimidation2print.htm). Toxic work places are expensive and need to be addressed for nurses and other health care providers.

Health-care providers in general, and nursing as a discipline and practice profession in particular, are basically humanitarian—that is, concerned with and focused on the well-being of people. Yet an unfortunate trend, reported by both health-care consumers and providers, appears to be a growing lack of concern for one another. People frequently describe unpleasant encounters that leave them confused, insulted, iritated, and indignant when they seek care. Why this happens is not clear. It is noteworthy that an old and basic interpersonal communication model is operative:

Speaker → Message → Receiver

In this model, the person who initiates the communication is referred to as the “sender” and the person to whom the message is directed is the
“receiver.” Effective communication occurs when the receiver interprets the sender’s message in the same way the sender intended it. (Patton and Giffin (1977). See Table 1 for the ten characteristics of interpersonal communication. In the nursing context, the model looks like this:

Nurse & Other )
Health Care ) → Message → Patient/Client Providers ) (Bad News)

By the very nature of being a nurse or other health care provider, many messages to patients or clients may be characterized as “bad news.” Messages delivered by nurses frequently are about delayed meals, unpleasant and even painful procedures, and distressing revelations about illness. The age old pattern of “blaming the messenger” may be in effect and disrupt relationships. Clients confronted with their own unhealthy life style and poor health practices may be unable to understand or just reject the messages they receive. Yet, the more the health care costs, the greater the potential for consumer’s dissatisfaction. Health-care providers, especially nurses, are experiencing reality shock, burnout, anger dismay, and job dissatisfaction. They frequently choose to resign, resulting in high annual turnover and high inactivity rates among practitioners. Regretfully, there appears to be a trend for people to interact in a dehumanizing manner in the health-care system, and this trend can be expected to continue. In the 21st century, our society is moving toward a nationwide shift in the financing and lack of availability of health care resources, the increased numbers of clients, the increasingly complexity of care, as well as the lack of personnel in nursing and other heath care professions. (Johnson, 2000)

The dehumanizing processes can be counteracted by effective interpersonal communication, the key to humanizing relationships between people. To humanize means to recognize the individual’s human characteristics and to address the presented health care issues with dignity and respect. A concerted effort is needed by health-care educators, especially nurse educators, to guide students in a careful exploration of interpersonal communication processes that are known to promote humanizing relationships not only between the nurse and client but also between health care colleagues.

The critical data about the patient or client lie within this person and his/her family and/or key relationships. According to Tanner, Benner, Chesla and Gordon (2003), in their research about critical thinking of expert nurses, the concept of “knowing” the patient is unique to nursing discourse.
"Knowing nursing care plans, nursing diagnoses and standard protocols all derive from the rational model of practice, and cover over the significance of knowing the patient. Rational models of clinical judgment also assume that what is important to know about a patient can be explicitly stated and formalized in context-free processes and rules....Knowing a patient is highly specific, situated knowledge, and by it nurses never claim an inclusive all encompassing knowledge; ‘knowing a patient’ is always specific to what can be known in the nurse/patient/family interaction and clinical context.” (p 279)

Meaning, i.e., that which has importance, implications, significance, and value, is present in the communication occurring between nurses and their clients and families. Above and beyond the clinical information, the necessary data for humanizing and holistic nursing care lies within the patient, and it is through discourse between nurses and their clients that patterns of responses.

Promotion of humanizing communication is also needed among nurses and other health care professionals. Lack of effective communication among nurses and physicians in intensive care units has been found to impact patient mortality and length of stay “as much as 1.8-fold.” Boyle and Kochinda (2004) report an experimental educational intervention which supported the idea that nurse-physician collaborative communication can be improved. In their review of the literature, Bowles, Mackintosh and Tom (2001) concluded there is no benchmark for effective nurse-patient communication. Yet they state:

“The importance of effective communication as a fundamental element of nursing has been acknowledged repeatedly...and regarded as integral to the provision of high quality patient focused nursing care. (p. 348)

Indeed, some nurses are noted to avoid close contact with patients, suggesting the need for nurses to protect themselves from instructional and professional cultures which inhibit and devalue nurse-patient intimacy. For some time, nursing students have been instructed in the use of a non-directive, “Rogerian” approach, a communication technique of psychological counseling, yet there is limited evidence of its’ effectiveness
The purpose of this paper is to present cohesive, basic introductory information, drawn from the disciplines of speech communication, interpersonal communication, and nursing in the hope of establishing and promoting a **benchmark of holistic and humanizing theoretical orientation for interpersonal communication between nurses, clients and others which is appropriate in all areas of nursing practice.** The core of holism is that living matter or reality is made up of organic or unified wholes that are greater than the simple sum of their parts. Humanizing, for the purposes of this paper, primarily means to be aware of the unique characteristics of being human and relating to the person with compassion and kindness. The author of this paper advocates the use of Humanizing Nursing Communication Theory (HNCT) by Duldt (1984) as a benchmark for effective nurse-client interpersonal communication in all nursing contexts. This theory is perceived as fitting into the philosophical perspective of existentialism, the systems model, and holistic paradigm. This theory is further classified as a symbolic interactionist theory and as a humanistic theory for nursing communication. (See Figure 1, Scheme of Paradigms.) It is believed to serve as a foundation for the specific therapeutic communication required of psychiatric nurses. The issues to be addressed in this paper are humanism, nursing, and communication from a holistic perspective as it is to be understood in HNCT.

**Humanism**

Humanism as a concept has not been clearly defined. Humanism, humanistic, humanitarian, and humanizing definitions are blurred and overlapping. Some propose humanism is an approach to life based on reason and our common humanity, excluding god or higher beings (British Humanist Association). In America health care professions seem to embrace humanitarian efforts to provide care to people of all religious beliefs and to nonbelievers in God or gods. Existentialist philosophers such as Jean-Paul Sartre (1957) and Kierkegaard (1957) focused on four major concepts: existence (being), choice, meaning (value), and nothingness (inevitable death); these concepts seem to be shared with many definitions of humanism.

Psychologists who are generally identified with humanist psychology have also struggled to define the term. Maslow (1968) notes that psychologists can profit from the study of existentialism to find “it to be not so much a totally new revelation, as a stressing, confirming, sharpening
and rediscovering of trends already existing in the ‘Third Force’ psychology.” For example, he notes that existentialism particularly emphasizes the concepts of identity and experiential knowledge (subjective experience serving as the basis of abstract knowledge). Geiger (1975), a physician, states, “even now, I am more comfortable defining the task as identifying dehumanization and fighting it, rather than identifying humanization and supporting it.” Howard (1975), in attempting to define humanization as a concept, notes a number of problems in conducting research on humanistic approaches. In operationalizing the concept, he asks:

“How do we judge actions that are defined by recipients as real but are false by other measures? If a practitioner feels neutral toward a given patient, but the patient feels loved by the practitioner, how do we determine whether the provider’s behavior is humanizing or dehumanizing in its consequences?” (p. 89).

Ultimately, however, Lee (1975) notes “At the heart of humanization is our image of man, how we value man and how we treat the individual.”

Historically, humanism as a philosophy can be traced to the 14th and 15th centuries. During this Renaissance period, scholars who have been identified with the humanistic movement were reacting to the prevailing view that humans could understand the world only by the revelation of God through the Bible. The humanists recognized a person’s ability to think, to reason, and thereby to improve one’s state in life. This view did not require one to reject religions or belief in a higher being. Rather, it focused on people’s ability to achieve excellence in the arts, literature, and other areas of learning. Out of this humanistic movement grew the humanities in academia—philosophy, literature, the arts, history, political science, and other disciplines commonly found in universities today. The essence of being human is highly valued; human capabilities and potential are shared experiences that supersede religion, culture, economics, politics, race, and so forth. In addition, the quality of life humans experience is valued. In health care and nursing, this emphasis is translated into the “here and now” caring, concerned, and thoughtful relationship that the care giver (nurse) establishes with the client. The care giver values one’s own ability to think, reason, and understand the client’s human existence; and the care giver also values and shares in the client’s state of being human.
The humanistic movement emerged again during the 1920s. A succinct statement of humanistic positions on relevant issues is found in the “Humanistic Manifesto” (Morain, 1980). Many of these statements seem to be viewed with alarm by conservative religious groups, who labeled the movement “secular” humanism. The humanists believe human need is the central issue in religion. Consequently, humanists oppose those authoritarian religions that advocate placing responsibility for human moral behavior and quality of life on God. Some religious writers urge people to accept the present state of affairs and negate attempts to change or improve the human condition. Ritual and religious dogma thus are placed above human needs and values; hence the polarization of beliefs by humanists and some faith communities of the Catholic, Orthodox, Christian, Jewish and/or other organized religious communities. However, many religious groups seem to share the humanistic perspective and incorporate it into their beliefs. **However, in order to avoid any confusion in these terms, I am formally announcing a change in the title of my theory from “Humanistic” to “Humanizing” Nursing Communication Theory.** Humanizing, as defined for my theory, is discussed next.

To humanize means to acknowledge all unique characteristics of the human being in order to build relations and to make contact between people; to dehumanize is to break down interpersonal relationships and lose contact between people. Leventhal (1975, pp 119-162) has provided a model of dehumanization and its consequences in illness. He defined dehumanization as “the feeling that one is isolated from others and is regarded as a thing rather than a person” (p. 120). The model involves normal information-processing systems as one perceives, interprets, and responds to the environment. He suggests that during illness, the information processing system malfunctions because of the illness-treatment information inputs so that depersonalization by one’s self and by others inevitably result. He proposes that these “dehumanizing experiences can be avoided or reduced if specific actions are taken to redirect the ongoing interplay between individuals’ processing systems and their environments” (p 120).

Of particular interest are the six factors of a dehumanizing experience that Leventhal developed from clinical material and the literature. He offers these as a starting point for consideration rather than a finished, complete set of elements for dehumanization.

1. Separation of the physical and psychological self.
2. Isolation of the psychological self.
3. Uncertainty and cyclic thought.
4. Planlessness and loss of competency.
5. Emotional distress, hopelessness, and despair.
6. Barriers to communication. (Leventhal, 1975, p. 121-122)

Important and relevant aspects of the human information processing system is that subjective or private experiences of the real world need to be validated or shared with others. This validation need is the heart of Festinger’s social comparison theory (1954). When something unusual happens, one typically turns to another and asks, “Did you see that?” In the ensuing discussion, information is exchanged about the way each experienced the event, and a consensus is usually achieved regarding the perceived event, its cause or importance. However, illness poses a threat that is magnified by the novelty of events, the strangeness of environment and people, and the ambiguity of outcomes. Attempts to obtain validation from others often fail because another’s symptoms may differ, and health-care providers tend to use unfamiliar language. Sometimes it is difficult for one even to communicate because of being “at a loss for words” to describe private experiences. Attributions of negative personality traits are readily made. Clients or patients can be labeled neurotic, nervous, or “cranks” by physicians and nurses, who in turn can be labeled by the clients or patients as cold, heartless, and unconcerned. Consequently, further efforts to communicate by either client or provider seem difficult and perhaps useless; the client inevitably experiences a breakdown in continuity and adequacy of health care sought.

This problem of faulty communication and dehumanization can be solved, according to Leventhal (1975), but not by major institutional changes in the health-care system. Rather, Leventhal states, “To minimize self-depersonalization and dehumanization, it is necessary to alter the content and process of person-to-person interaction and not simply to change the labels applied to the participants” (p. 154). Leventhal’s position has particular relevance to nursing. One important aspect of the role of the professional nurse in operationalizing a humanizing perspective is being aware of one’s self as a person in the nurse-client relationship, sharing with the client all innate characteristics of being a human. Through the ability to communicate interpersonally in a humanizing manner, the nurse as a person has potential for providing positive influence upon the perceptions, beliefs, and attitudes of others. Greater awareness of one’s own interpersonal influence and communication skills can be deliberately used to intervene with predictable positive results rather than with lack of awareness and with random interventions without forethought, which tend to have unpredictable and variable results.
Nursing

Nursing is defined as a discipline and a practice profession. How are we now defining our discipline—our emerging discipline? According to dictionaries, a discipline as a field of study of human knowledge and inquiry. Generally each discipline is identified by the distinct perspective it uses in viewing human beings and the environment in which they exist. Late in the last century, Donaldson and Crowley (1978) stated that there is a critical need to identify a structure for nursing as a discipline in educational programs. In their review of nursing history, they identify three emerging themes that may serve as some structure. These are a concern for patterns and processes:

1. of life, well-being, and optimum functioning of human beings—sick or well;
2. of human behavior in interaction with the environment in critical life situation;
3. of change by which positive changes in health status are effected.

Donaldson and Crowley propose that these themes suggest boundaries for the discipline of nursing. Newman (1979) identifies criteria for nursing theories that are similar in theme. Note the key words human beings—the central focus of nursing.

Nursing is currently perceived as being in the process of becoming a field of study and a profession—an emerging discipline. There seems to be consensus among scholars that a theoretical body of knowledge is an essential element for both a discipline and a profession. Johnson (1974) notes the sparsely of theoretical and scientific giants in nursing heritage upon whose work the (then) present day nursing scholars might build; this was still true to a considerable degree at the turn of our century. Consequently, theories and models have been borrowed from other disciplines and professions to be applied with varying degrees of appropriateness to the nursing context. Efforts toward achieving a theoretical basis in nursing have occurred only in the past 30 years. It is proposed that nursing as an emerging discipline is just ending a “pre-conceptual” level of development in its theory building. Concepts must be defined before relationship statements can be developed. And relationships among concepts are the heart of a theory.

Prior to more recent efforts, nursing has borrowed from other disciplines. Nursing has even borrowed definitions of the major concept of nursing—the human being. The profession has employed definitions of
humans provided by biology, psychology, and sociology—biophysical psychosocial man, a definition is most often used in nursing texts. Incidentally, some nursing theories do not even define the human being. Generally, biology is the science of living organisms. Biologists define humans as homo sapiens, unique living creatures, and place them in a taxonomy of all living things. Biologists are concerned with how the body works, and they divide it into systems: circulatory, respiratory, urinary, and so on. Psychology is the science of mind and behavior, and psychologists focus on humans as individuals—behaving interacting, thinking, and emoting. They classify humans as normal, neurotic, psychotic, depressed, and so forth. Sociology is the science of development, structure, interactions and collective behavior in social institutions, and sociologists are concerned with humans living in groups, classified according to size, function, and so on.

In on-line dictionaries, each discipline is defined as a science or field of study having a particular territory of human knowledge. Nursing is still defined in dictionaries as a woman breast-feeding an infant and a person trained in caring for the sick especially under the supervision of a physician. It also is defined as “nursing” a grudge, an injury, or to “nurse one’s drink all evening.” Typically, nursing is not defined as a profession or a discipline. In summary, we have a long way to go in changing society’s definition of nursing as discipline and practice profession. (American Heritage Dictionary, 2000; Merriam-Webster Online Dictionary, 2004).

Among nursing scholars, no generally accepted definition of nursing is available. We can go from Florence Nightingale’s (1859) definition, “…nursing has to do…is put the patient at the best condition for nature to act upon him,” to Virginia Henderson’s (1960) definition:

“…to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength and knowledge; and to do this in such a way as to help him gain independence as rapidly as possible”

Chitty (2001) charts the themes in nursing definitions as these evolved over the past 150 years. Contemporary definitions of nursing include the concept of caring, to little avail because caring is one of the most elusive of all concepts to define. Many other definitions are specific to particular theories of nursing. More recently, the literature is showing a movement toward recognizing the unity and connectedness of rhythmic phenomena
such as the ebb and flow between health and illness. The dichotomy between health and disease is disappearing. Newman (3000) states:

“Things that we usually consider irreconcilable—the opposites—are like the crest and trough of a single wave; reality is not in the crest or the trough along, but in the unity of one inseparable activity….We create boundaries where there are none….A liberated person transcends opposites, like good and evil and life and death, moving to unity consciousness….At the highest level of consciousness, all opposites are reconciled. (p. 241).

Transformation or change occurs as nurses recognize patterns and intervene. According to Newman, nursing is coming to be viewed as a process of dialogue in which penetrates the consciousness of both nurse and patient, generating a unique meaning. The definition of nursing is expanded, but still there is no consensus.

So, with no consensus within the profession about the definition of nursing, one can be bold and leap into the fray with still another suggestion.

Nursing Defined.

The Theory of Humanizing Nursing Communication defines the following concepts: nursing, human beings (the client, and the nurse, colleague and peers), the nursing process, health, the environment, critical life situations and communication.

The Theory of Humanizing Nursing Communication defines the following concepts: nursing, human beings (the client, and the nurse, colleague and peers), the nursing process, health, the environment, and critical life situations. It is proposed that this theory and the following definitions be used to set a “benchmark for effective nurse-patient communication.” The definition of nursing is derived from the general guidelines as proposed by Donaldson and Crowley’s (1978) in which they identified three themes found in nursing history.

“Nursing is the art and science of positive, humanizing intervention in changing health states of human beings interacting in the environment of critical life situations” (Duldt, et al. 1984).
A set of three elements comprises the concept of nursing, i.e., communicating, caring, coaching. These are defined as follows:

**Communicating.** Communication, specifically, interpersonal communication, is a dynamic process involving continual adaptation and adjustments between two or more human beings engaged in face-to-face interactions during which each person is continually aware of the other(s); the process is characterized as being existential in nature, and involving an exchange of facts, feelings, and meanings. This theoretical concept specifically refers to communication between the nurse and client(s) (to be construed as including the family) as well as colleagues and peers. See the Appendix for the “Ten Characteristics of Interpersonal Communication. While communication often occurs by phone, rather than face to face, the non-verbal aspect of communication is omitted in these instances. Verbal communication has been found to account for only 15% and non-verbal about 85% of the total message. As one maintains eye contact with another, one set of nerve tissue is directly seeing another. One has direct visual access to the inner eye and retina—or is this the soul? Change occurs in this interaction.

**Caring.** Caring involves valuing and touching. The nurse values the client and is concerned about the individual’s well-being. Caring also involves touching in the sense of providing nursing care—the tradition sense of “laying on of hands.” This valuing and touching is generated by the nurse having an intentionally genuine feeling of being concerned and responsible for the client’s health state.

**Coaching.** Coaching refers particularly to the teaching aspect of nursing. The nurse plans and implements the teaching/learning process and provides support and encouragement to clients as they strive to meet health goals. Just as the football coach watches his team members and intervenes to help them be better players, so the nurse intervenes to help clients achieve a higher level of wellness or health. This dimension of nursing is available to the compliant as well as non-compliant client.

Human Being Defined

The focus of nursing is the human being. Each profession defines the human being according to those characteristics of particular relevance to that discipline. Nursing, according to HNCT, is concerned about eight particular human characteristics uniquely relevant to the discipline of nursing. Thus, the human being is defined by Kenneth Burke (1966) as being 1) a living being, 2) capable of symbolizing, 3) perceiving
the negative (aware of one’s own non-existence), 4) transcending his
environment by his inventions, 5) ordering his environment (establishing
hierarchies), 6) striving for perfection, 7) making choices, and 8) self-
reflecting. These human characteristics are of relevance to nursing may
be described as a slightly different set of elements that define the whole
person. Each element is defined in the following paragraphs below: living,
communicating, negativing, inventing, ordering, dreaming, choosing, and
self-reflecting.

1. Living. Living refers to the living systems, enabling a human being
to function biologically and physiologically as a viable entity. This biologic
dimension is shared with other animal forms and includes bodily, life-
sustaining processes such as reproduction, assimilation, elimination,
mobility, oxygenation, and so forth. These processes are susceptible to
destructive events such as injury, infection, malfunction, and ultimately
death. Similar to other life forms, a human being displays an orderly,
sequential process of growth and development (and aging), influenced
to some degree by life style and environment, such as quality of nutrition,
cleanliness of air, amount of exercise, and so forth. As is true of all
mammalian species, a human being’s existence depends upon
interaction with members of one’s own species. Physiologic responses to
stimuli, such as flight-or-fight responses to danger or attack, are also
shared with other life forms. The human being also tends to share a sign
system of nonverbal communication, common to many other life forms,
such as sign systems indicating territory, rejection, and acceptance.
The capability of a person to communicate is of direct concern to nursing
care.

2. Communicating. Communicating refers to the ability of human
beings to label things and to talk about things not present. Human beings
are “symbol using, misusing” beings (Burke, 1966, pp. 3-24). As a
consequence, humans are able to build upon learned information, logic,
and perceptions of predecessors and contemporaries through written
and spoken language. Using symbols enables one to think abstractly, to
use logic and argumentation, to solve problems, and to describe
perceptions regarding phenomena observed about the physical
environment, about self, and about relationships with others. Humans are
particularly capable of expressing feelings arising from within as a
response to perceptions. These expressions take many forms, from crying
in grief or screaming in terror, to expression through music, paintings, and
other art forms.

3. Negativing. Negativing refers to the ability of human beings to
understand “nothingness” or “-1,” to talk about what is not existing, not
happening. According to current knowledge, animals do not seem capable of doing this and do not seem to know about their own non-existence or death. People are able to develop moral codes, rules of conduct, and laws governing relationships and functions of individuals as well as of the environment. Our children have a lot of “no-no’s” to learn. One can be aware of one’s own non-existence or death, and plan for the implications inherent in this fact. The hospice movement in nursing is a recognition of this human characteristic, and a human capability not recognized by other nursing theories. As one develops certain expectations of what can happen in the future, one also can be aware of the expected situation that might not happen. The pregnant woman can expect to deliver a healthy child, but worries about the possibility that the fetus may die or be born impaired in some manner.

4. Inventing. Human beings have a unique ability to invent tools. One extends one’s own physical capabilities through the use of these tools, such as transportation (airplanes, space ships), communication (radio, television, and computers) chemistry (fertilizers to increase food production, guns, and medications), technology (development of atomic energy, robots), and so on. However, a human being risks dangerous side effects in the quest of potential benefits. Some inventions have unanticipated effects, potential or real, as in the case of insecticides, cardiac by-pass surgery, genetically altered foods, cloning, etc. Thus, the ability to invent has profound implications for human health.

5. Ordering. Human beings have the ability of developing categories and hierarchies according to some value or theme. People give structure and system to the environment and tend to organize life, relationships, and the environment according to a particular perspective, goal, or criterion. One tends to practice one-ups-man-ship in relationships, and tends to seek power and status through control of others, of resources, of environment, or all of these. This sense of hierarchy tends to result in conflicts at all levels of human interaction, from the playground to the board room.

6. Dreaming. Humans have the ability to consider things as they “could” or “should” be if all were perfect. Each human being has hopes, expectations and dreams for the future. One tends to work and strive to that end. And human beings are continually experiencing frustration and disappointment as dreams become unattainable. The parents who work hard saving money to send their child to college experience a full range of disappointment and grief when the child becomes a drug addict and dies of an overdose. A politicians share their plans for a better world with the citizens, who vote for someone else. But we all dream on.
7. Choosing. Human beings have the ability to consider numerous alternatives, compare implications for the future, and select the alternative that tends to be most desirable according to selected values and criteria. Thus, human beings are able to make choices and control events in their lives. People are also capable of being highly motivated to achieve short-term as well as long-term, even lifelong, goals. And in the choosing, responsibility and accountability for the implications and results are significant factors. Responsibility for making choices regarding one’s health can be a matter of a long lived life or an unnecessarily early death.

8. Self-reflecting. Human beings are able to think and talk about one’s own self, one’s body, and one’s behaviors. Self-reflecting often involves the existentialist elements: being, becoming, choice, freedom, responsibility, solitude, loneliness, pain, struggle, tragedy, meaning, dread, uncertainty, despair, and death. Self-reflecting typically becomes salient during critical life situations.

These, then, are the eight characteristics which define the human being for HNCT. A significant factor in the concept of a human being is that both client and nurse, as well as peers and colleagues, are human beings first. Given individual variances, all the characteristics or elements of being human apply to both. In this very real sense, they are equal, yet each is unique in individual expression of these characteristics. It is this awareness of one another’s humanity that one communicates in a humane manner. One’s communication conveys a sense of kindness, mercy or compassion with a strong sense of ethical codes, principles and morality.

Roles in Society

People take many roles in society. The roles people take in the health care arena, according to HNCT are nurse, client, peer and colleague.

As one who is a nurse, the person intervenes through the application of the nursing process (assessing and diagnosing, planning, implementing, and evaluating) to develop a plan of care for a specific client or group of clients. The nurse possesses special educational and licensure credentials required by society, and functions cooperative and collaboratively with peers and colleagues.
As a holistic client, the person experiences a critical life situation in regard to one’s health (one’s state of being, of becoming, of self-awareness.) One may be experiencing a critical life situation in that there is a perceived threat to one’s health state and in which one’s existential state of being is salient, as in cancer, childbirth, accidents, and so on. There is a need for nursing services and nursing intervention. The definition of the client is to be inclusive of the person’s support systems, i.e., family, friends, etc.

As a peer, this person is another nurse who has equal standing or status to another.

As a colleague, the person is a member of another profession with whom nurses coordinate and collaborate in practice of nursing, i.e., physicians, administrators, and a variety of health care professions and community agencies. (A nursing peer might also be considered a colleague.)

Distinguishing Humanistic Perspectives in Humanizing Nursing

Humanistic philosophers historically exclude beliefs in a god or higher being (British Humanist Association, 2002), and so they include atheists and agnostics in their organizations. However, this is not true of nursing. According to the philosophical stance and code of ethics of nursing, all people seeking help are to be provided needed nursing services whether of some religious orientation or not. In addition, according to holistic perspectives, religion is differentiated from spirituality. Religion refers to specific faith traditions and unique theological, liturgical and scriptural orientations. The spirit is defined as a dimension of holistic humanity characterized by personal meanings that define one’s identity, vocation, life’s purpose, wellness, illness, and relationships with others. (Duldt, 2002, p. 20) All human beings have a spiritual dimension which may be expressed in religious practices, beliefs and behaviors. Thus, according to humanistic nursing communication theory assumption #3, “All elements of existential beings are the communication imperative and salient issues to be dealt with in critical life situations.” (Duldt, 2001) The nurse who communicates with clients according to HNCT deals with all salient issues the human being, including humanizing and holistic dimensions.
On the other hand, if the client or anyone communicates in a threatening, disrespectful and obscene manner to the nurse, it is the privilege and responsibility of the communicator to decide how to respond to another's dehumanizing approach. Having the options of the entire continuum, the nurse must decide whether to be humanizing or dehumanizing. See Figure 2 for the humanizing-dehumanizing continuum of attitudes. See also Figure 5, which combines the continuum of attitudes and the interaction patterns. Cultural and social rules are not to be ignored, nor is one's personal safety. If a nurse is approached by a sexual harasser, then to respond in a dehumanizing manner is not only an appropriate choice, but probably a very wise one. Each of us is responsible for our own communication choices in developing, continuing or discontinuing an interpersonal relationship. To behave in a dehumanizing manner in order to discontinue a relationship with someone who is abusive and harassing would seem to be most appropriate. One need only justify decisions based on how one feels, how one evaluates the relationship.

**Communication**

Communication, specifically, interpersonal communication, is a dynamic process involving continual adaptation and 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 meanings, concerning facts and feelings, and involving dialogue. There are two dimensions of communication. First, the attitude or spirit with which one communicates occurs on a continuum. Humanizing communication involves an awareness of the unique characteristics of being human; dehumanizing communication ignores these unique human characteristics. See figure 2, Continuum of Attitudes, for the list of elements. The patterns of interaction are the techniques or skills one uses to communicate. See Figure 3, Communication Interaction Patterns. There are many other of interaction patterns, such as solution-focused communication (Bowles, et. al. 200; de Shazer, 1985, 1988). The primary ones which seem most applicable to nursing include communing, (listening, trust, self disclosure, and feedback), asserting, confronting, conflicting (conflict resolution) and separating. These are the fundamental ones which need to be included in nurses' education. Trust, conflict resolution, and the ability to communicate in collaborative relationships is particularly highlighted in fostering peer and collegial relationships. (Baggs, Schmidt, Mushlin, et. al. 1999; Boyle and Kochinda, 2004). As time permits and future research findings reveal, there are many
other patterns of interaction in interpersonal communication which need to be identified and added to this list. These HNCT concepts are defined next.

Communing. Communing refers to dialogical, innate communication that occurring “between” people who are aware of each other’s presences. It is “being there” and “being with.” Communing is the element that makes nursing humanizing. Typically, the client is revealing something to the nurse which has not been told to anyone else. Communing includes four sub-elements: listening, trust, self disclosure and feedback. (See Figure 4.)

1. Listening. The core of communing is listening. It involves making a conscious effort to attend to what another person is saying, particularly to those expressions of feelings, meanings and perceived implications.

2. Trust. This 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.

3. Self-disclosure. The client is taking the risk of rejection in telling how he or she feels, thinks, experiences, etc. regarding the “here and now” or an existential event.

4. Feedback. This involves the nurse describing the client’s behavior, beliefs, and experiences, as self-disclosed by the client, plus giving the nurse’s evaluation of the facts, feelings and meanings that have been shared. The feedback needs to be authentic and ethical.

Clients frequently will trust the nurse to share something (self-disclose) they have not told anyone else, family member, friend, or doctor. The information may be very relevant to the health situation, but more often, it is not. Nevertheless, the clients are depending on the nurse to listen carefully and respect their trust. In return, the nurse needs to respond in a sincere, honest manner, giving an evaluation of the information provided by the client.

For example, one new mother very privately whispered to me her distress over her mother-in-law insisting the new baby be named something other than the mother’s preference. She was reticent to talk to anyone in the family, not wanting to disrupt relationships. My own honest response to her was to be understanding of her feelings, that one would expect her to feel that way. I also said that I believed, as the mother, her choice of the child’s name took precedence over anyone else’s, except
that the father’s choice should be taken into consideration, too. That was the way I had seen it work in other families. She verbally and non-verbally expressed relief and relaxed. Soon, she still had to deal with the husband and mother-in-law, but for the moment, she was relieved of distress. I didn’t hear any more about the situation, so I assumed the family were able to work it out later, after the mother had more rest and fewer hormones in her system.

Assertiveness. This means to state one’s position clearly. One expressing needs, thoughts, feelings or beliefs in a direct, honest and confident manner while being respectful of other’s thoughts, feelings, or beliefs. If humanizing, It is “asserting with authenticity.” For example, when the post operative patient is supposed to be out of bed and walking for the first time, nurses sometimes need to be assertive about the need to get up in order to convince the patient that it’s alright to be out of bed.

Confrontation. This is providing feedback about another’s behavior plus requesting a change. If humanizing, it is “confronting with caring.” The nurse occasionally needs to confront patients who are diabetics to take their insulin, to wear well protective shoes, to adhere to the diabetic diet, etc. (See Figure 2 for Concept Confrontation, a more extensive definition.)

Conflict. This 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. If humanizing, it is “conflicting with dialogue.” For example, people who share differing perspectives about an issue can do so in a gentle, democratic manner with obvious respect for one another, while others can disagree in a harsh, rejecting manner with considerable disrespect for one another.

Separation. This occurs at the end of a relationship due to a change, choice, or outside commitments. If humanizing, it is “separation with sadness.” For example, two friends may part because of graduation or moving away. Years later they can meet again and pick up the conversation where they left off. It’s almost as if no time had passed at all. In contrast, a person may want to get away from another and never come back, particularly if the other person is harassing or abusive.

Nurses’ Communication in a Humanizing Mode
To communicate in a humanizing mode, then, means to be cognizant of the unique characteristics of being human; to be dehumanizing is to ignore these characteristics. Humanizing nursing denotes the manner, attitude or spirit with which interventions are operationalized. Humanizing nursing is communicating and relating interpersonally to clients in such a manner that the client senses warmth and acceptance and can report feeling good about the care. Consequently, humanizing nursing does not occur in just one particular place. It happens between human beings, between a nurse and a client. Because nurses are human beings, it would logically follow that nurses themselves would be subject to this definition. Since both clients and nurses share this common bond, then the relationship between clients and nurses would logically be on an equal basis, each respecting the other and showing a concern for the other's individual feelings, needs, worth, and responsibility.

Two psychiatric nurses, Patterson and Zderad (1976) wrote a theory of Humanistic Nursing Practice which tells how to humanize nursing by describing this “between” or “in-touchness” experience that happens between a nurse and a client in a psychiatric care context. They have derived this theory from that well-known humanistic philosopher, Martin Buber (1970), author of I and Thou. Patterson and Zderad focus on the special phenomenon of interpersonal communication between people. This special, warm, genuine, open relationship is positively validating of individual worth. It is believed to be essential to “releasing” people to develop to their fullest potential, that is, “well-being” and “more-being” as Patterson and Zderad phrase it. This relationship may be that special part of nursing that is rewarding to nurses themselves. To feel good about oneself and to feel acceptance, importance, and positive regard “releases” clients to heal faster. The concept of humanism thus interacts with nursing. The primary purpose of Duldt’s Humanizing Nursing Communication Theory is to give substance to communicating in a humanizing manner—to help nurses in all areas of nursing practice deliberately achieve the “I-Thou”, the “in-between,” or the “in-touchness.”

Interpersonal Communication

There are important characteristics of interpersonal communication and particular ways to describe the communicative process that are helpful to understand in operationalizing a humanizing approach to nursing communication. Interpersonal communication concerns the face-to-face interactions between people who are continually aware of
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one another. Each person assumes alternately the roles of “speaker” and receiver of messages. This is a dynamic process that involves continual adaptation and adjustments of each person to the other. It might be considered analogous to the “slinky” toy in its circular construction and movement. As this dialogue “slinks” across time, there is no turning back; whatever is spoken cannot be taken back. The process of relating interpersonally with others is a basic key, not only to coping with reality in order to survive but also to living life to its fullest and most satisfying potentialities. Healthy interpersonal relationships provide for personal growth, development of self-confidence through self-acceptance, and beneficial cooperation through shared responsibility with other individuals. For most persons, it is essential to achieve a deeply satisfying, warm, personal relationship with at least one other person. There is a need to understand processes that provide growth, confidence, and cooperation under normal, healthy circumstances. To understand these processes in the event of illness and the “dis-ease” that accompanies it becomes not only a need but a necessity, particularly for individuals who function as professional health-care providers.

Certain characteristics of interpersonal communication are of particular relevance to being human and establishing satisfying, warm, personal relationships with others. These characteristics are as follows:

1. Interpersonal communication is a process that is essential in nature.
2. Interpersonal communication involves the generation and exchange of meaning, that is, a sense of what is important and what has implications for one’s future.
3. Interpersonal communication provides information about “outside the skin” reality or facts and about emotions aroused “inside the skin” or feelings.
4. Interpersonal communication is a dialogic or two-directional process in the sense that one alternately sends and receives messages.

The role interpersonal communication plays in our growth and development is to humanize. Through interpersonal communication processes with significant people, an individual, from infancy, becomes oriented to the physical and social world. Steward and D’Angelo (1975) state:

“The quality of our interpersonal relationship determines who we are becoming as persons. Interpersonal communication is not merely one of
many dimensions of human life, it is the defining dimension, the dimension through which we become human." (p. 23).

It is this author’s belief that humanizing nursing can be realized through a careful study of interpersonal communication, a humanizing process. This study needs to include the following set of elements which characterize interpersonal communication: process, existentialism and meaning, facts and feelings, and dialogue.

Process

Interpersonal communication is characterized above as being a “process” rather than a thing. This distinction is important—nothing is static. Berlo (1960) states:

If we accept the concept of process, we view events and relationships as dynamic, ongoing, ever-changing, continuous. When we label something as a process, we also mean that it does not have a beginning, an end, a fixed sequence of events. It is not static, at rest. It is moving. The ingredients within a process interact; each affects all of the others. (p. 24)

To analyze interpersonal communicate, one has to take picture, as it were, of a “slice” of time. One can capture the process on film. And even as one looks at the picture—or reads a book or views a movie—one is being changed by the meanings generated in the process. One can talk about process only with certain understandings about the limitations involved. Berlo states the logic of this:

We have no alternative if we are to analyze and communicate about a process. The important point is that we must remember that we are not including everything in our discussion. The things we talk about do not have to exist in exactly the ways we talk about them, and they certainly do not have to operate in the order in which we talk about them. Objects which we separate may not always be separable, and they never operate independently—each affects and interacts with others. This may appear obvious, but it is easy to overlook or forget the limitations that are
necessarily placed on any discussion of a process.
(Berlo, 1960, p. 26.)

The interdependency and mutual influence of all ingredients in the process need to be remembered continuously. The process of interpersonal communication is broken down for detailed analysis. The concept of process is not unknown in nursing. Many nursing theorists describe nursing practice as a process and generally discuss it in the manner suggested above by Berlo. General systems theory and adaptation theories would be good examples.

Existentialism and Meaning

Interpersonal communication also has been characterized as being existential in nature. Existentialism has been defined as focusing on an individual human being and that human’s state of becoming” in the “here and now,” that slice of time commonly referred to as the present. (Gill and Sherman, 1973). Existentialism looks at life as it is and tries to provide meaning to a complicated process of events.

The individual is in a state characterized by finite singularity (solitude, loneliness, and uniqueness), having choice and being responsible for acts. Searching for meaning, struggling to become what he is without rules or structure to point the way, human beings endure uncertainty. One is aware of the fact that life can be extinguished by chance at any moment. Coping with choice and struggling with work are persistent. And one is acutely aware of feelings of loneliness, dread, and alienation. These facts and feelings are the content of human interpersonal communication. This openness to the unlabeled and unclassified provides potential for greater meanings to be derived through interpersonal communication.

The theoretical basis for identifying meaning is revealed in Victor Frankel’s (1984, 1988) book, Man’s Search for Meaning. Frankel, a psychiatrist, proposes that when a person has a reason for living and a mission to complete, he/she can survive incredible adversities. He based his belief on his observations made when he was an inmate in a Nazi concentration camp during World War II. According to Frankl, meaning is the primary motivational force in human beings (1984, p. 121). Man needs something for the sake of which to live (1984, p. 122). Frankl noticed that those who survived the concentration camps were the ones who had a reason for living, a mission in life yet to complete. According to the dictionary (Nichols, 1999, p. 819), that which has meaning has
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significance, design, and is destined to be or do something of importance, influence, and intended to be. Tapping deep into a person’s spiritual dimension and activating whatever it is that has meaning for that person is the key to the nurse’s role. In his books, Frankl provides transcripts of dialogue demonstrating how this is done in his psychiatric interventions with patients. There may be many ways to do this, and it is proposed that using humanizing nursing communication is one.

Facts and Feelings

Facts are one’s statements concerning the phenomenologic world; through interpersonal communication, one gains validation of one’s perceptions of reality. Feelings come from within the individual and are by nature subjective. Individuals are the only judges of their feelings; no one can dispute one’s feelings. No one can dispute how one feels if, for example, one says one is unhappy. Our definition of existential human beings includes a humanizing dimension of inner emotions and feelings, in addition to the humanizing emphasis on a person’s ability to think, reason and deal with facts of the world. This dimension emphasizes the following concepts in describing a human being as an individual: existence, becoming, freedom, choice, responsibility, struggle, tragedy, despair, uncertainty, meaning, and dread. The dimension of being human is operationalized in communing, i.e. to converse intimately and to exchange facts and feelings about these facts.

Dialogue

The humanizing process has been described as being dialogic in nature, and generally it is defined as a two-way interaction in which each person participates by sharing information about oneself and being open to receiving similar information from another. The opposite of dialogic is monologic, or one-way communication—which tends to be didactic and dictatorial in nature, and thus tends to be dehumanizing. Dialogic communication is an essential characteristic of interpersonal communication. One existentialist philosopher, Martin Buber (1970) provides a theory in interpersonal communication is his book, I and Thou.

Generally, Buber, who was also a Jewish rabbi, assumes human beings to be in an existential state. Not only are human beings seen as symbolic, but communication is also of an immediate, “here and now” nature that involves freedom of choice. And it is assumed there is a
difference in relating to an object and to a person; awareness of this difference is necessary to entering into a meaningful interpersonal relationship.

Two types of relationships represent the dehumanizing and humanizing manner of communication; these are I-It and I-Thou. I-It is a monologic relationship in that I speaks to, about, or over an It. The I usually has some goal, and the communication generally involves strategy, defensiveness, deceptiveness, and evaluation. I withholds part of the self from the relationship. The communication concerns a specific time or space, and may involve technical language. Generally, this type of communication is reserved for talking to or about things or objects. When the I-It relationship is used for communicating with humans, a great flaw in interpersonal communication occurs. Growth and development are limited when a person is treated as an It.

I-Thou is a dialogic relationship in which two human beings stand in relation to one another, experiencing what is between them. This relationship involves meeting, confronting, and encountering with total commitment and genuineness. There is an awareness of the other’s being and a readiness to receive the other into one’s own experience. Time and space are forgotten as one genuinely listens with the realization that thou is saying something new about the nature of Thou. In the I-Thou relationship, one can live through an event from the standpoint of another person. If the response becomes calculated, then the relationship becomes an I-It. It is through the I-Thou relationship that meaningful interpersonal relationships can develop which involve love, not eros (love object) but agape (love relation). The I-Thou relationship concerns the spiritual aspect of human beings, that bit of the supremely humanizing being, the image of God or God residing in each human; it is this spiritual aspect of each one standing in warm, positive regard for another and communing. The effect of the I-Thou relationship is to achieve a feeling of rest and peace in being accepted and understood by another without reservation, evaluation or classification. (Buber, 1970)

Drawing from existentialist thought and from Buber’s I-Thou theory of interpersonal communication, Patterson and Zderad (1976) developed the Theory of Humanistic Nursing Practice, a theory of humanizing nursing for psychiatric practice areas. These theorists note that nurses deliberately approach nursing practice as a short-term, existentialist experience. They note that nurses experience with clients and patients special existential moments in life that may be labeled peak experiences, such as “creation, birth, winning, nothingness, losing, separations, and death” (p. 7).
They emphasize human beings as symbolic beings, noting that words are “the major tools of phenomenologic description” (Patterson and Zderad, 1976, p. 8). The individual can be the only source of self-description “in this situation.” They indicate that the purpose and aim of nursing is:

...the ability to struggle with other men through peak experiences related to health and suffering in which the participants in the nursing situation are and become in accordance with their human potential (p. 7).

The primary relationship statement of Patterson and Zderad’s (1976) Humanizing Nursing Practice theory is the transaction, the dialogic “reciprocal call and response” interactions occurring between the nurse and client. Both participate in the “lived dialogue” interdependently, yet both are subjects and are independently generators of meaning. The “between” that occurs in this relationship concerns the awareness of meaning generated, and the “being with and doing with the patient.” Patterson and Zderad (1976) note that this existential involvement is short-lived and suggest that “…it is more realistic to think of humanistic nursing as occurring in various degrees.”

According to the clinical research of Shaver (2001, 2002), when one is ill and hospitalized, one can suffer psychospiritual crisis.” This is experienced as loss of self-empowerment and control. One suffers from loss of relationships and isolation. The person is alone with his (or her) illness. There is no longer control of his body or control of his time and place in the world. The person may want to be at home with family and friends but his body had failed him. He no longer felt safe. He feels his life unstable and, given the health issue, he is probably experiencing anxiety about death.

According to Shaver, the goals of intervention for one suffering psychospiritual crisis includes:

1. Restoration of a sense of self and wholeness and restoration of relatedness;
2. Relational healing by sharing stories and being a real person again;
3. Reorienting on a locus of control by empowering the person with knowledge of what is being done to
or for him, understanding of the disease-oriented language, and
4. A reminder to “let go and let God” be in charge.

The interventions suggested by Shaver (2001b, p. 10) for one suffering psychospiritual crisis include the following:

Reflective listening;
Validation of the person;
Silence presence;
Creating a “safe” space; and
Unconditional love.

This means the nurse is a leader in coping with suffering. You lead the person out of suffering psychospiritual crisis toward wholeness. You don’t have to “fix it” right now or “do something.” You just need to be there, actively listen to the person’s concerns, and in the process of this, you validate the importance of this person to you, to his family and friends, and to the his faith community as appropriate. Don’t interrupt. You are there, understanding and accepting of his feelings and his physical state. You dispel isolation and loneliness not only by “being there” and “being with” but also, when it seems appropriate, by talking about significant relationships this person has with his family, friends and, if appropriate, with the his faith community and religious beliefs. You help him see the world as a safe place again. If appropriate, the nurse might consider a referral to a chaplain, priest, rabbi, or whomever is appropriate.

In summary, Buber’s (1970) I-Thou and Patterson and Zderad’s (1976) “lived dialogue” occurring in the “between” provide theoretical perspectives and serve to clarify and explain the concept of dialogue as it occurs in and relates to humanizing perspectives of nursing. Frankel’s (1984, 1988) writings speaks to the importance of meaning in life; clients self disclose their goals and purposes with nurses and others though interpersonal communication. Shaver (2001, 2002) provides specific directions for interpersonal communication with one who is suffering a psychospiritual crisis, which is a common encounter for nurses. These theories also serve to restate important characteristics of interpersonal communication that are identified thus far in Humanizing Nursing Communication Theory.
Research and Development of Interventions for Change.

While there are many areas of nursing communication calling out for future investigations, it is certainly a need for the identification of additional patterns of interaction occurring in communications of the nurse and others. For example, one area has to do with the communication occurring between the nurse and the physician in areas other than ICU. It would logically follow that if improved communication between physicians and nurses in the ICU influences the patient survival rate and number of days in the hospital, then the communication between these key individuals may also make a similar difference in the outcomes of patients on a general medical-surgical unit or anyway where. If the interpersonal communication occurring between these key individuals is in jeopardy, the program of health services as well as the public images of these professionals is also in jeopardy. The collaboration, believed to be a variation of communing, occurring at this level in the health workplace culture could cause the work of both professional roles flourish.

Another area needing further investigation is dealing effectively with complaints of patients and their families. A social worker, de Shazer and others (1985) have developed and implemented “solution focused brief therapy.” People complain about many issues, and it is difficult to identify what kind of help would be appropriate to help them. Some individuals may present a list of complaints while others focus on one complaint of an issue that seems to dominate their lives.

“Complaints are maintained by the clients’ idea that what they decided to do about the original difficulty was the only right and logical thing to do. Therefore clients behave as if trapped into doing more of the same. (Watzlawick et al. 1974) because of the rejected and forbidden half of the either/or premise,” (p. 25)

Bowles, Mackintosh and Tom (2001) conducted a hallmark study applying solution focused brief therapy in the nursing context. Re-labeling it solution focused communication, they evaluated a short educational course for staff nurses and found this pattern of interaction may be appropriate to nursing. There are many interaction patterns in this model of therapy which can be useful to nursing. For example, the “miracle question” bypasses complaining and goes directly to the client’s description of the goal. The client is asked to suppose that during the
night, while sleeping, a miracle happened, so that the problem is gone. "When you wake up in the morning, you don’t know it happened. So what would be different? How would know the miracle had happened? “ The response to this question describes what needs to change. The “crystal ball” question is similar in that the individual describes how life would be without the problem, what would change. An assumption of the approach is that change is inevitable. This pattern of interaction encourages the individual to think about change and to expect change. According to Newman (2003), there is support in the literature for the synthesis of caring, wholeness, pattern, transcendency and transformation. In accord with Newman, this author proposes that HNCT may be used with numerous other theories to provide a better perspective of human holism.

**Holistic Care.**

It is proposed that nurses communicating in a humanizing manner is a necessary factor in achieving holistic health care and improved collaborative professional relationships. Writing from a humanizing point of view, there are certain assumptions one makes about communicators as people, as human beings. First, one assumes that individuals not only receive and interpret stimuli, but also play an active role in selecting stimuli to which they will respond. Humans are born into a “booming, buzzing” world of strange sensations. Visual images, varying pressures and temperatures, degrees of moistness and hardness, and strange sounds impinge upon the sensory system. The early years of life are given to sorting out these sensations. Humans learn that physical needs will be met when certain people are present. Certain pressures, temperatures, and images come to be indicators that certain events are or will be happening. Sounds become meaningful as words are repeated over and over. Humans soon begin to behave in a manner that has an influence on this environment: crying, babbling, and vocalizing tend to elicit signals of warm acceptance from people. As individuals develop, they continue to attach more discriminating meaning to the phenomena they perceive, and they develop greater skills in controlling their interpersonal world. Cultural surroundings and behavior of significant people in their lives enrich individuals; experiences and expectations of interpersonal relationships. Through dialogic communication with others, people learn to adapt to the environment to meet their human needs. Individuals live through interactions with other people. Although humans interact with objects, animals, and other aspects of their total environment, these interactions are relatively unimportant in comparison with the interactions or interpersonal communication experienced with other people. It is
proposed that the way humans communicate with others is what individuals become. It involves the total being, the whole or the holistic person, i.e., body, mind and spirit.

Second, one assumes that the more people can be aware of their own motives and communication patterns of interaction, the greater degree of control they can have over their interpersonal communication rather than being controlled by them. The nurse calls the pathologist to politely request results of a test and receives a gruff answer. The nurse has a choice; to be angry and upset or to remain polite and pleasant in dealing with the next person. The nurse chooses the latter because she or he does not want to be controlled. One cannot make the nurse angry unless the nurse allows it. As human beings, it is possible to think and act rather than simply to react.

Third, having a humanizing theoretical base and perspective places emphasis on choice and freedom. A person can choose to delay reactions to phenomena or interactions until due consideration has been given and a course of action has been selected. To the extent people can control and select their behavior, to that degree people are free. And this freedom involves a responsibility to oneself and to others for the consequences of one’s choices and actions. Some people so completely take their interpersonal communication for granted that they seldom think of studying it. By the time individuals reach adulthood, communication has become very much like a reflex action, and people simply accept its existence.

Finally, it is proposed that the study of interpersonal communication is necessary to promote awareness of ones’ skills as communicators, and it should foster both personal and professional development in at least three areas: knowledge, social decision making, and self-expression. By understanding the interactive-ongoing process of interpersonal communication, it becomes possible to alter certain elements with predictable effects. This requires knowledge of theory and practice: “why” certain behaviors work and “how to” skills in operationalizing the behaviors effectively. Criteria of excellence here are not as well defined as in some fields, and absolute rules are nonexistent. Each individual must make one’s own social decisions and choices about communicative behaviors. One would hope that nurses, as holistic beings, would be mainly of gentle spirit and allow the client some extra space because of being distressed about health issues.

Nursing is an important profession in society. Barbara Blakeney, First Vice President of the American Nurses
Association, stated in an interview that we have a message to the world.

“We do so much more than you realize. We are much more valuable than you know. A great deal of what we do has to do with rescuing....We are successful because something doesn’t happen. How do you measure that?” (Manthey 2003).

Blakeney suggests this should be a measure of good nursing care. School nurses cut from budgets result in things happening that shouldn’t. Yet, the truly special services nurses provide inherently are humanizing in nature, and nursing represents a significant humanizing force within the health-care system.

It is proposed that more emphasis needs to be placed on this seemingly latent asset in the very nature of nursing. Humanizing nursing is communicating a concern for the individuals feelings, needs, and self-image, particularly in relation to implications arising from changing health states and coping capabilities. This communication behavior of the nurse must convey interpersonal warmth, genuineness, and caring. Elements of humanizing nursing include authenticity of feelings as well as facts, validation of the client as a communicator of value, and caring about the client as a person in a manner than promotes coping and independence.

One aspect of the role of the professional nurse in practicing humanizing nursing is being aware of his/herself as a variable in the nurse-client relationship. It is proposed that students and practitioners of nursing need to be sensitive to their own feelings and encouraged in the development of this self-awareness. To the extent one is aware of one’s own feelings and thoughts, to a greater extent one tends to become sensitive to others. People who become nurses need to be particularly sensitive to others’ feelings and experience, and nurses also need to be skilled in communicating this awareness and sensitivity to others.

This author believes theory and research in interpersonal communication are highly relevant to efforts to operationalize holistic perspectives in nursing and to humanize health care. To the extent that a humanizing approach occurs in the nurse-client and nurse-colleague-peer relationship, to that extent health care will tend to be more effective, more holistic. It is also proposed that such health care will tend to cost less, not only in terms of dollars spent, but also in terms of needless repetition of efforts and decreased need for technology. As we move into the 21st century, nursing educators, students and practitioners can be
expected to continue to seek ways of combining humanizing and holistic beliefs into holistic health care practices within the increasingly complex health-care system and society.

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Author’s Note

This manuscript is a composite of publications which span 25 years and it draws together a broad statement of humanizing nursing communication theory. As deemed appropriate, information has been updated with contemporary applications. However, the humanizing nursing communication theoretical statements have not been changed except as supported by research. The primary change was the addition to “listening” to the set of element defining communing.

The Nursing Communication Observation Tool (NCOT) was developed as a research tool to test the relationships statements of Humanizing Nursing Communication Theory. In the few studies in which it has been used, it has proved successful. The NCOT manual and tool are available on my website.

It is imperative that I give recognition to the many colleagues and students who have stimulated my thinking and inadvertently contributed to the development of this work. It gives me great satisfaction and pleasure to share these thoughts to those who are concerned with interpersonal communication in nursing.

Bonnie W Duld-Battey, PhD, R.N.
May 7, 2004
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Humanizing ------------------------------------- Dehumanizing
Figure 3. Communication Interaction Patterns.
Figure 4, Tripod of Communing.
Figure 5. Communication Interaction Patterns and Continuum of Attitudes
Figure 6. Communication Continuum of Choices

Communication spans the entire continuum, from dehumanizing to humanizing.
Table 1. Ten Characteristics of Interpersonal Communication.

The following characteristics are presented to stimulate discussion and help identify the dimension of interpersonal communication as opposed to other dimensions such as small group, organizational, and mass communication.

1. Communication is unavoidable and inevitable when people are aware of one another.

2. In interpersonal communication, both the sender and the receiver of meaning must be present.

3. Each person assumes roles as both sender and receiver of messages in interpersonal communication.

4. The choices that a person makes reflect the degree that person’s interpersonal communication competencies.

5. In interpersonal communication, the sender and the receiver are interdependent.

6. Successful interpersonal communications involves mutual needs to communicate.

7. Interpersonal communication establishes and defines the nature of the relationship between the people involved.

8. Interpersonal communication is the means by which we confirm and validate self.

9. Since interpersonal communication relies on behaviors, we must be satisfied with degrees of mutual understanding.

10. Interpersonal communication is irreversible, unrepeatable and almost always functions in a context of change. (Patton & Giffin, 1981, pp. 12-20)
Table 2. 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
   b. Counterattack
   c. Acceptance of how confrontee is experience 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.

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. Duld t's Humanistic Nursing Communication Theory.
RESEARCH: (None)