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A Study to Help Identify Problems Sophomore Students of Nursing Have in Establishing Initial Patient Communication

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A STUDY TO HELP IDENTIFY PROBLEMS SOPHOMORE STUDENTS OF NURSING HAVE IN ESTABLISHING INITIAL PATIENT COMMUNICATION

by

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A Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science in the Field of Nursing

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I certify that I have read this thesis and that in my opinion it is fully adequate, in scope and quality, as a thesis for the degree Master of Science.

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CHAPTER I

I. INTRODUCTION

Current magazines and books have recently contained articles concerned with interpersonal relationships, communication, and various ways and methods in which different types of interaction occur. Some authorities believe that the American society "...literally buzzes with people who are directly or indirectly concerned with the facilitation and improvement of communications."[1]

The field of medicine has recently been interested in the communication factor, and has been endeavoring to study the doctor-patient relationship.

Nurses have also been concerned with the nurse-patient relationship, particularly nursing educators. Nursing students are given knowledge of communication skills and opportunities to employ these skills.

A very important reason for including communication skills in nursing courses, according to Lockerby, is the need for the nurse to be sensitive to the unexpressed needs of her patients.[2] She goes on to say that "to give good nursing care.../one must/...develop more than

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[1]Jurgen Ruesch and Weldon Kees, Nonverbal Communication (Berkeley: University of California Press, 1959), p. 3.

[2]Florence K. Lockerby Communication for Nurses (St. Louis: The C. V. Mosby Company, 1958), P. 20.

manual dexterity and a working knowledge of basic principles."[3]

Because of the current trend to commercialization of communication there is a tendency toward unreal face-to-face contact, or impersonal relationships.[4] It is also felt by some that silent actions do not convey real ideas, and so are not considered as having any real communicative value.[5]

Thus it would seem that a sincere approach to the beginning conversation is most important for it is here that the climate for the ensuing relationship is set.

A relationship between a student of nursing and her patient must be established through some type of contact or communication. If the student is to be able to give safe, effective nursing care she must feel comfortable in the situation. In order for this to occur she must be able to establish a working relationship through either verbal or nonverbal methods.

The first few minutes of a conversation, or contact with a patient, will be the time when this relationship is established. At this point the type of nursing care given by the student may also be determined. It would seem that silent actions or nonverbal means of communication would be as important as verbal means of communication.

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[3]Ibid., p. 20.

[4]Ruesch and Kees, op. cit., p. 4.

[5]Ibid.

The patient can, to a degree, determine how the student feels about the assignment by facial expression and body movement. The student, in turn, can detect how the patient is responding to her nursing care by observing facial expression, body movement, willingness to cooperate by moving and turning, or by the patient pretending to be asleep.

The language used may not be the most musical to the ear, nor the most logical to the listener, but the immediate effect of what is said is important.[6] For this reason the student should be alert to what she says when first coming in contact with her patient. She should be aware also of her own facial expressions and body movements.

By the time a student of nursing has reached the stage in her education where she gives patient care it is felt that she has developed certain tools of communication. Among those with which she should be familiar are interviewing, listening, observing, and talking. These tools have been sufficient in her relationships with others in her own cultural group.

However, when one observes a student who ordinarily gives good nursing care fail to institute verbal or nonverbal communication, they may question if the student is sufficiently versed in, or familiar with, the tools of communication. The student may consistently complete her morning assignments ahead of her classmates, spend the majority of the assigned clinical hours sitting at the charting desk, and spend only a minimum of time with her patient. Upon inquiry it may be

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[6]Lockerby, op. cit., p. 26.

found that the student's response is: "I can't talk to that patient", or "He doesn't seem to want me around."

Does the student understand the purposes or goals of communication? Does anxiety perhaps instigated by stress, tension, or threat to the self-concept cause the student to withdraw from the patient? Were her first few minutes with the patient unpleasant? Could words chosen for beginning the conversation, or nonverbal communication of some type, have been inadequate or difficult for the patient to understand? Did the patient respond in some manner other than what the student expected?

Each student is an individual using the methods and tools of communication which are most effective, or comfortable, for her when conversing with her own cultural group. Words take on a specific meaning in one's own social and intellectual environment. The significance of a word, or its meaning, may change when one is in an unfamiliar situation.[7] This may be true particularly where one gives compassionate service and, in lieu of empathy, feels the strong bonds of sympathy which prevents the occurrence of understanding.

The instructor's responsibility for guiding the student so that her learning experience will help her become secure and interested in the initiation of effective and valuable student-patient relationships is very important. These experiences cannot be adequately planned in a climate of anxiety and frustration. It would seem to be a major responsibility of the nursing instructor to identify problems which

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[7]Dora V. Smith, Communication, The Miracle of Shared Living (New York: The MacMillan Company, 1955), p. 15.

beginning students have in establishing initial patient contact or communication. Methods could then be instituted into the curriculum to help the student resolve these problems.

II. THE PURPOSE OF THE STUDY

This study was undertaken to (1) help identify what problems students meet in establishing initial patient communication, (2) find out if information given to the student about the patient influenced the initial contact, and (3) find out if the student felt the initial contact with the patient had been successful.

III. STATEMENT OF THE PROBLEM

Beginning students of nursing are often faced with many anxiety producing problems. One of the problems which the young student faces in her nursing experiences is that of establishing effective patient communication.

The purpose of this study, therefore, is to help identify the problems which occur during the establishment of initial contact or communication which may tend to render the relationship ineffective.

IV. LIMITATIONS OF THE STUDY

The study was limited to thirty-seven sophomore students of nursing in a selected basic degree program in the western part of the United States. The findings are not considered as other than relating to the initiation of the contact or communication.

The timing was considered to be a limitation. It was felt that the reaction to the experience could vary with the recency and vividness of the experience. Thus an effort was made to have questionnaires available to the student immediately following each hospital experience. Some of the students returned the questionnaires the day of the experience, others returned them two or three at a time a week or two later.

Some of the disadvantages of the questionnaire method as suggested by Parten[8] were apparent in the study. The students who were most interested apparently responded more readily to the questionnaire.

The students completed questionnaires only on hospitalized patients to whom they gave nursing care.

V. DEFINITION OF TERMS

Establishment of Initial Contact or Communication. For purposes of this study the term establishment of initial contact or communication was defined to include (1) the first contact a student had with the patient, and (2) the first few minutes the student was with the patient during establishment of verbal or nonverbal communication.

Communication. Communication is defined here as an interchange of empathetic thinking expressed through writing or verbal and nonverbal methods.[9] The verbal methods would be: interviewing, listening,

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[8]Mildred Parten, Surveys, Polls, and Samples: Practical Procedures (New York: Harper and Brothers, 1950), p. 95.

[9]"Communication Skills" (Provo, Utah: Brigham Young University College of Nursing, 1959), p. 1. (Mimeographed).

and talking. The nonverbal would include: facial expression, body movement, and observing.

VI. METHODOLOGY

The normative survey was the method chosen for conducting the study. A questionnaire was the tool for collecting the data.

The thirty-seven students filled out questionnaires each day they gave nursing care to a hospitalized patient. During the period of the study they were assigned one day each week for hospital experience, and given one patient for nursing care.

The data were categorized according to the questions and then subdivided into like responses. Thus responses to each question were grouped together and then subdivided into similar response groups.

VII. OVERVIEW OF THESIS

The remainder of the thesis is divided into four chapters. A review of literature is included in Chapter II. Chapter III contains the methodology of the study. The data are presented in Chapter IV. The summary of the data, implications for nursing education and recommendations for further study comprise the final chapter of the thesis.

CHAPTER II

REVIEW OF LITERATURE

An interest in the nurse-patient relationship was noted in the literature reviewed although very little material was found dealing with the student and her relationship with others. Most of the literature dealt with the nurse-patient relationship in psychiatry and did not deal specifically with the initiation of communication.

There were three studies reporting some information regarding the student-patient relationship, although not with the phase of initiation of communication.

One study, by Harris[1], identified anxiety producing situations for beginning students of nursing. One of these was noted to be when the student was afraid to meet new people. Another anxiety producing situation identified was that in which the student was concerned about what effect her conversation had on the patient.

In a study by Yasuda it was pointed out that "emotion-laden" situations were frequent problems which the young student encountered. Two other problems of importance were inadequate knowledge of the patient, and the student interpreting the patient's response as an

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[1]Margaret Maurine Harris, "An Investigation Into Anxiety Producing Factors in the Clinical Situation as Expressed by Beginning Students in a Basic Collegiate Nursing Program in the Western Part of the United States" (unpublished Master's thesis, University of Washington, Seattle, 1958), pp. 19-22.

attack on her nursing competency.[2]

The third study was a report of a project by Lockerby in which freshman students were apparently able to develop and use communication skills to advantage.[3,4] These student were first-year nursing students in a three year nursing program. Incorporated in the curriculum was a course in communications. The outgrowth of the project enabled Lockerby to write her book Communication for Nurses.

Lockerby did not state in her report, or the book, specific problems which the beginning student of nursing encounters when establishing the initial patient communication.

A review of other literature pertaining to communication was pursued in order to better understand the importance of communication between a nurse and her patient. It was felt that a review in this area would point up the problem of failure of communication. A comprehensive review of communication skills was not attempted.

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[2]Phylis M. Yasuda, "Some Factors Contributing to Interpersonal Relationship Problems Experienced by First-Year Nursing Students With Medical and Surgical Patients in a Selected General Hospital" (unpublished Master's thesis, University of Washington, Seattle, 1958).

[3]Henry W. Knepler, "Communication in Nursing Education," Nursing Outlook, 3:613-14, November, 1955.

[4]Florence K. Lockerby, "A Diploma School Adds Communication to the Curriculum," Nursing Outlook, 4:526-27, September, 1956.

[5]Lockerby, Communication for Nurses (St. Louis: The C. V. Mosby Company, 1958), 171 pp.

I. LANGUAGE AND COMMUNICATION

The importance of a language is naturally very great. "So intimate is the relation between a language and the people who speak it that the two can scarcely be thought of apart."[6]

For this reason, when considering the nurse-patient relationship, it seemed important to understand the purpose of language and the use to which it is put.

Edman has written:

> Language is, in one of its aspects, the most practical of human instruments; it is the indispensable means of communication between human beings in their daily and material affairs.[7]

Language, according to Peplau is used in conversation to express a concept, but may be used also in order to prevent communication from being effective.[8]

Hayes and Gazaway state that "...a human society depends upon communication for its existence."[9] In order for man to survive and progress and interact with others he must be able to understand the methods of survival and rules of interaction. He must be able to communicate to others by using his own language. Man's future is "...largely

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[6]Albert C. Baugh, A History of the English Language (second edition; New York: Appleton-Century-Crofts, Inc., 1957), p. 3.

[7]Irwin Edman, Arts and the Man, (New York: The New American Library, 1954), p. 54.

[8]Hildegard E. Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Sons, 1953), p. 294.

[9]Wayland J. Hayes and Rena Gazaway, Human Relations in Nursing (philadelphia: W. B. Saunders Company, 1955), p. 195.

under his own control...because of the gift of language."[10]

People communicate mostly by making verbal statements. Lockerby states that communication will happen only "...when the lines are open and reception compatible."[11] People communicate also by their actions, facial expressions, and body movements. Communication will occur only when the people involved are ready to perceive and evaluate the action. Ruesch and Kees believe that when the sender and the receiver "...can consensually validate an interpretation...communication has been successful."[12]

Nurses who work with hospitalized patients know the importance of the environment. The beginning of a contact is influenced by sound, lighting, the voice, posture, mannerisms, and attitudes--as well as the words which are spoken. These influencing factors can determine the duration, course, and content of the conversation.

Weiss felt that the patient reveals much about himself in his first contact with the nurse.[13] He may not be aware of this, but if the nurse is alert and observant she will note significant things about him. Bunker believes that each nurse-patient relationship is original and may become personal faster than other types of relationships

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[10]Norman L. Munn, "The Evolution of the Mind," Scientific American, 196:150, June, 1957.

[11]Lockerby, op. cit., p. 38.

[12]Ruesch and Kees, op. cit., p. 7.

[13]Olga Weiss, Attitudes in Psychiatric Nursing Care (New York: G. P. Putnam's Sons, 1957), p. 14.

if adequate communication is established. In this situation the patient would reveal much about himself. The nurse must know how to encourage the patient to express himself and not become uncomfortable in the situation herself.[14]

It is difficult sometimes for the nurse to approach a patient and just converse with him. Fries and McLellan state it in this way: "Some nurses who feel insecure in their approach to patients depend on various inadequate attempts at patient contact."[15] They state that the nurse will approach the patient with his medications, or treatments, in order to begin a conversation. Nurses use these two things as excuses for approaching the patient because they feel more comfortable in giving physical care. The patient would know the nurse had an interest in him if she would spend some time "just talking" with him, rather than being interested in completing another patient assignment.

Holmes believes it is much more comfortable for the nurse to avoid becoming involved with a patient and his problems.[16] It is easy for her to leave the patient when he needs her most because she is uncomfortable in the situation. If the nurse would stay with the patient as long as necessary or possible she could enhance the relationship and render it more effective.

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[14]Lucille J. Bunker, in an address to the EACT Section of the Utah State Nurses Association, October 23, 1958.

[15]Olive H. Fries and Mary Lou McLellan, "Helping Patients Get Well," Nursing Outlook, 7:654, November, 1959.

[16]Marguerite J. Holmes, "What's Wrong With Getting Involved?," Nursing Outlook, 8:250, May, 1960.

According to Bird it is important to have "...an aim, a definite purpose in mind, to know clearly what is to be accomplished by talking."[17] Here it is important to realize that the main purpose is to establish some type of communication so the patient will express himself, be comfortable in the situation, and be able to understand the nurse. Cobb and Patterson write that if the nurse cannot "...communicate effectively with the patient, he may develop undue anxiety, antagonism, and resistance to the research and treatment methods which ...strike him as bewildering and frightening."[18] Each patient will react to his illness in a different manner, and the nurse must treat each patient as an individual. She must initiate, or maintain, the conversation with this in mind.

The nurse must begin the contact in a manner which will be acceptable to the patient. She will need to be aware of the tensions which affect interpersonal relations.[19] Then she must be able to adjust to the situation as it arises and note each change which takes place during the contact.

Many individual men are unable to use language as a beneficial

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[17]Brian Bird, Talking With Patients (Philadelphia: J. B. Lippincott Company, 1953), p. 3.

[18]Beatrix Cobb and Mary G. Patterson, "Inservice Training in Interpersonal Relationships--An Experimental Approach," The American Journal of Nursing, 57:614, May, 1957.

[19]Barbara Faukes, et al., "How Skillful is Our Communication?," The American Journal of Nursing, 55:448, April, 1955.

factor in their own lives. In pointing this out McCarthy wrote: "...failure of communication causes a person to fear and distrust the world."[20] This may lead to loneliness for those who do not interact with others. Mosse is quoted as having written that loneliness is due to a failure of communications. This is the basic reason for loneliness and possibly also the reason for apprehension and misunderstandings.[21]

In his book on loneliness Mosse wrote that communication is a prime need for everyone.[22] He pointed out that "...the great challenge of human existence; the challenge of establishing contact and communication outside oneself..." is important because all human beings need to interact with others so they may become a part of society.[23]

If an individual cannot interact or converse with others he will not be able to understand them. If he can converse with others he may not recognize the terms used or phrasing employed. He will become bewildered and not recognize his role in the situation. He may hear only those terms which are familiar to him. Von Bekesy[24] remarked that sounds in which we are interested take precedence over those that concern us less. The patient, in conversation with the

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[20]Joe McCarthy, "Loneliness and Boredom," Cosmopolitan, 145:28 October, 1958.

[21]Ibid.

[22]Eric P. Mosse, The Conquest of Loneliness (New York: Random House, 1957), p. 51.

[23]Ibid., p. 54.

[24]Georg Von Bekesy, "The Ear," Scientific American, 197:72, August, 1957.

nurse, may hear and understand only those words which are most familiar to him.

Classe points out that:

> In conversation we do not ordinarily give attention to every sound. We recognize patterns through long familiarity with them, and we grasp the thought though we may miss and have to guess at a high proportion of the individual sounds.[25]

Smith has pointed out that the significance of a word, or its meaning, may change when one is in an unfamiliar situation.[26] The patient who is usually unfamiliar with medical terms will pick out only those words which have special meaning to him at the moment. He will then form his own ideas, but may become somewhat apprehensive when he discovers he misunderstood the meaning or significance of the conversation.

Before the student can give effective nursing care to her patient she must be able to communicate to him. She must have the ability to establish a good student-patient relationship. This comes about when she is able to express her own thoughts and ideas effectively. Connolly believes if a nurse can accept the patient and feel comfortable in the situation the patient will place his faith in the nurse and will share his feelings with her.[27] However, Holmes warns

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[25]Andre Classe, "Whistled Language of LaComera," Scientific American, 196:118, April, 1957.

[26]Smith, op. cit., p. 15.

[27]Mary Grace Connolly, "What Acceptance Means to Patients," The American Journal of Nursing, 60:1755, December, 1960.

that beginning students of nursing are rarely mature enough to deal effectively with patients, or assume full responsibility for their relationship with patients.[28] They need guidance and experience in being able to interview or converse freely with their patients.

To summarize, language and people are so closely related they cannot, in effect, be separated. Language is used by man to communicate ideas and feelings to others. If he cannot use his language effectively he may fail to establish adequate communication. This may lead to loneliness, apprehension, and misunderstandings. It is particularly important for the nurse to establish an adequate communication with her patient in order that he will understand and accept what is being done for him. She must do this so her nursing care will be as effective as possible for each individual patient.

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[28]Holmes, op. cit., p. 250.

CHAPTER III

I. METHODOLOGY OF THE STUDY

The method selected for conducting the study was the normative survey. A questionnaire was utilized for gathering the data. This method was chosen for the convenience it offered in reaching the student. Thus, the student would complete the questionnaire without having special interviews or conferences. Another reason was to insure a response to each question by the student every time she completed a questionnaire. In this way it was felt the answers would be more uniform in that a guide was given to the student. According to Good and Scates the questionnaire is useful for these two reasons.[1]

II. DESCRIPTION OF THE POPULATION

The thirty-seven students chosen for the study were all of the sophomore students of nursing enrolled in a basic degree program in the western part of the United States. The period of time covered by the study was two months.

The study had been planned to begin the second month of the fall quarter and would continue for two consecutive months. This quarter was the first one in which the students received nursing experience in a hospital situation. The student uniforms did not

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[1]Carter V. Good and Douglas E. Scates, Methods of Research (New York: Appleton-Century-Crofts, Inc., 1954), pp. 606-7.

arrive until shortly before the end of the second month of the quarter. Thus it necessitated beginning the study the last month of the fall quarter, and continuing it during the first month of the winter quarter.

The original two months had been selected because this was the period in which the students first came in contact with hospitalized patients and had to initiate a conversation with them. The first month of the fall quarter the students received some fundamental principles of communication. They had been given mimeographed sheets with some of the communication skills explained to them. During this time they were given lectures and participated in role-playing and group discussions to help them better understand the principles of communication.

During the two months of the study the students were also enrolled in some general education classes. The first month of the study they took a history course and a physics course, both of which were required by the university. During the second month of the study, which was the beginning of a new quarter, they took only a religion course in addition to their nursing courses.

Thirty-seven students were involved in the study during the first month. Six students withdrew from the school of nursing at the end of the fall quarter, leaving thirty-one students who were involved in the study the second month. One student withdrew from the university during the second month. This left thirty students participating the final month of the study.

During this two month period the students spent from six to twelve hours each week in the hospital giving patient care. Experience at this time also included some time in doctors' offices, outpatient clinic, recovery room, and the diet-therapy laboratory. When students were engaged in these experiences they did not answer the questionnaire. This was because they were not giving care to hospitalized patients, except in the recovery room. Patients in the recovery room were usually non-reactive, so in order to avoid confusion the students did not complete a questionnaire on these patients.

III. OBTAINING THE DATA

A questionnaire[2] was developed which contained seven questions. These questions were asked in the belief they would reveal information pertaining to one or more of the three purposes of the study. The basic areas of investigation in the questionnaire included (1) the first few minutes conversation, (2) how the student felt being with the patient, (3) making the initial contact, (4) situations which influenced the establishment of communication, (5) factors making communication successful or unsuccessful, (6) reasons for wanting or not wanting the same patient, and (7) information the student had about the patient.

It was felt that questions pertaining to (1), (2), and (3) would reveal how the student actually felt when making the initial contact and establishing the initial communication. Questions pertaining to

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[2]See Appendix.

(4) and (5) would give some indication as to problems which arose during the contact. The question pertaining to (6) was considered as a double check for the other five. If the student indicated wanting to keep the same patient for nursing care the other five questions should have positive responses. If she did not wish to care for the same patient some of the previous responses would be negative. The question pertaining to (7) was included in the belief it would reveal if information given to the student would influence the contact.

The director of the school of nursing was contacted and a request for a conference was made. During the conference the study was explained to her, and permission requested to have the sophomore students participate in the study. Permission was granted, and the director suggested contacting the three instructors who were in charge of the sophomore students.

A conference was arranged with the instructors and the study explained to them. They indicated a willingness to help with the distribution and collection of the questionnaires. It was decided to refer to the questionnaires as "Answer Sheets,"[3] and a box was labeled with this term for collection of the questionnaires. This box was placed in an area which the students passed each day. It was felt that they could place the questionnaire in the box and thus eliminate having one of the three instructors responsible for gathering the questionnaires. Additional questionnaires were placed next to the

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[3]See Appendix. These "Answer Sheets" will be referred to as questionnaires throughout the study.

collection box so students could obtain one when needed.

A time was arranged in one of the regularly scheduled nursing classes so that the study could be explained to the students. During this period the students received a copy of the questionnaire. The questions were read with an explanation of how and when to complete the questionnaires. They were told to fill out one sheet for each day spent in the hospital situation. There were no limitations set on how much the student should record on the questionnaire. Each student recorded answers in varying length--some very brief, others quite lengthy.

Time was provided for the students to answer the questions on each hospital-experience day during the period covered by the study. Learning experiences were planned so that ten to fifteen minutes, at the completion of the assigned time, were given each student. It was felt that this would insure the students answering a questionnaire after each hospital experience.

Each student was requested to place her initials on a space provided on the questionnaire. The purpose of this was to provide a method for checking to see if each student participated in the study, and as a means for follow-up in the event the students were not turning in the questionnaires. The average number returned per student was eleven. Four students returned eighteen questionnaires each. An interesting note is that one student returned only one questionnaire. This student was later found to have marked

interpersonal relationship problems and was referred to the university student counseling service. She eventually received some psychiatric assistance to help resolve her problems.

Extensive follow-up procedures were not deemed necessary as daily personal contact with the students during the second month of the study resulted in 73 per cent (363 out of 497) of the questionnaires being returned.

IV. METHOD OF ANALYSIS

Data from the questionnaires were organized according to the three basic purposes of the study. For the purposes of analysis the responses were divided into three categories. These were (1) positive reactions or responses, (2) negative reactions or responses, and (3) mixed or neutral reactions or responses. Analysis of the material was completed in the light of the purposes of the study.

V. SUMMARY

The method selected for conducting the study was the normative survey. A questionnaire was utilized for gathering the data.

The director of the school of nursing was contacted and in a conference the study was explained, and permission requested to have the sophomore students participate in the study. Permission was granted and the suggestion made that the instructors involved with the students in their nursing courses be contacted. This was done, and in a conference with the instructors the study was explained.

They indicated a willingness to help with the distribution and collection of the questionnaires.

Time was provided in a regularly scheduled nursing class to explain the study to the students. The students were provided time to fill out the questionnaires on each hospital-experience day during the two month period covered by the study.

Thirty-seven students were involved in the study the first month. Seven students withdrew from the school at the end of the first month, which was the end of the fall quarter. Thirty students were involved in the study during the second month.

Data from the questionnaires were organized according to the three basic purposes of the study. Analysis of the material was completed in the light of the purposes of the study.

CHAPTER IV

PRESENTATION OF THE DATA

This study was undertaken to determine (1) what problems beginning students of nursing have in establishing initial patient communication, (2) if information given to the student about the patient influenced the initial contact, and (3) if the student felt the initial contact with the patient had been successful.

A questionnaire was employed as the data gathering device. The basic areas of investigation in the questionnaire included: (1) the first few minutes conversation, (2) how the student felt being with the patient, (3) making the initial contact, (4) situations which influenced the establishment of communication, (5) factors making communication successful or unsuccessful, (6) reasons for wanting or not wanting the same patient, and (7) information the student had about the patient.

Data from the questionnaires were organized according to the three basic purposes of the study. For purposes of analysis the responses were divided into three categories. These were: (1) positive responses, (2) negative responses, and (3) mixed or neutral responses. Related comments included in the presentation of the information have been in most instances quoted directly from the questionnaires.

Three hundred and sixty-three (73 per cent) of the 497 questionnaires were returned. The number returned by each student varied. Three possible reasons for this could have been (1) the student may

have spent the entire time covered by the study caring for hospitalized patients, (2) the student may have spent one month of the study working in clinics or doctors' offices, and (3) the degree of the student's interest in the study, as suggested by Parten.[1]

I. MAKING THE INITIAL CONTACT

During the initial contact in which the student attempted to establish communication with the patient she had some definite feelings about the situation. These could be classified as being positive, negative, or mixed-neutral feelings. The questions asked of the students were:

> (1) As well as you can recall, record the first few minutes conversation you had with your patient.
>
> (2) How did you feel about approaching this patient?
>
> (3) What were your feelings or reactions when making the initial contact with your patients?[2]

Positive Feelings

There was a total of 211 responses which were considered as positive in the initial contact. These are shown in Table I, page 27.

One hundred and one of the responses indicated that the student felt at ease and confident when making the initial contact. The responses indicated that the reasons the students felt at ease

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[1]Parten, loc. cit.

[2]See Appendix.

and confident after the initial contact were (1) the patient responded in a favorable manner, (2) the patient was friendly, and (3) the student felt the diagnosis or the patient would be interesting.

The students indicated in sixty-two responses that during the initial contact they were comfortable with the patient. No specific reasons were given, except "...he was talkative and comfortable to be around..." was the response most noted.

In twenty-six responses it was noted that the student felt capable when (1) the patient needed tender loving care, (2) the patient required special nursing care which the student was able to give, and (3) the student knew all of the procedures required in caring for the patient.

Seventeen responses were noted which indicated the student felt friendly toward the patient. No specific reasons were given in the responses.

In five responses the students mentioned being challenged. This occurred when the student felt the patient was "difficult".

Table II, page 28, indicates the positive feelings retained after the students had made the initial contact and had established some type of communication.

To summarize, the students, in making the initial contact and attempting to establish communication with the patient, reported experiencing positive feelings in 211 of the responses. These

TABLE I

POSITIVE FEELINGS EXPERIENCED BY STUDENTS
DURING THE INITIAL CONTACT

Feeling Experienced	Number of Responses
At ease and confident	101
Comfortable	62
Capable	26
Friendly toward patient	17
Challenged	5
Total	211

TABLE II

POSITIVE FEELINGS EXPERIENCED BY STUDENTS IMMEDIATELY AFTER THE INITIAL CONTACT

Feeling Experienced	Number of Responses
At ease and confident	96
Capable	62
Friendly toward patient	49
Comfortable	7
Satisfying	4
Challenged	0
Total	218

feelings, as seen in Table III, page 30, are shown in comparison to positive feelings retained immediately after the initial contact. The reasons responsible for these feelings, as indicated by the responses, were similar in both instances.

Negative Feelings

There were 150 responses which were considered as negative in the initial contact. These are shown in Table IV, page 31.

The responses indicated that the students felt apprehensive, in sixty instances, when making the initial contact, if (1) the patient had had an uncomfortable night, (2) there was a possibility of saying the wrong thing to the patient, (3) the patient worked in the hospital or was connected with the university, and (4) the patient might observe the student doing a procedure incorrectly.

In forty-three responses it was noted that the students were uncomfortable in a situation when (1) the patient seemed unappreciative, (2) the patient was demanding, (3) the patient complained continuously, (4) the patient felt sorry for himself, (5) the patient was unpleasant to the student, (6) the patient was either too old or too young, and (7) the instructor was present.

In the forty instances of negative responses one or more of these conditions existed: (1) the patient was critically ill, (2) the patient was severely handicapped, (3) the patient was deaf, (4) the patient was emotionally upset, and (5) the patient required care the student was unable to give.

TABLE III

COMPARISON OF POSITIVE FEELINGS EXPERIENCED BY STUDENTS DURING AND IMMEDIATELY AFTER THE INITIAL CONTACT

Feeling Experienced	Number of Responses	
	During	After
At ease and confident	101	96
Capable	26	62
Comfortable	62	7
Friendly toward patient	17	49
Satisfying	0	4
Challenged	5	0
Total	211	218

TABLE IV

NEGATIVE FEELINGS EXPERIENCED BY STUDENTS
DURING THE INITIAL CONTACT

Feeling Experienced	Number of Responses
Apprehension	60
Uncomfortable	43
Uneasiness due to patient condition	40
Uninterested in patient	7
Total	150

The student responses did not indicate the reasons for not being interested in the patient in seven responses.

Table V, page 33, reveals the negative feelings retained by the students after making the initial contact and establishing some type of communication.

A comparison of negative feelings experienced during the initial contact and those retained immediately after the initial contact is shown in Table VI, page 34.

To summarize, the students reported experiencing negative feelings in 150 of the initial contacts. Negative feelings retained by the students immediately after making the initial contact were similar in number to those experienced during the initial contact. The reasons for these feelings, as indicated by the responses, were similar in both instances.

Mixed-Neutral Feelings

There were two responses noted which were considered as mixed or neutral during the initial contact. These responses indicated the students did not have any feelings about the contact or the patient.

Seventeen responses indicated that immediately after the initial contact the student had some mixed or neutral feelings. These were due to a variety of reasons. The reasons usually indicated that the student had very limited contact with the patient. For example, the patient may have gone to surgery, x-ray, or physical therapy shortly after the student arrived on duty, and did not return to the hospital

TABLE V

NEGATIVE FEELINGS EXPERIENCED BY STUDENTS IMMEDIATELY AFTER THE INITIAL CONTACT

Feeling Experienced	Number of Responses
Apprehension	45
Uneasiness due to patient condition	36
Uncomfortable	33
Dislike of patient	14
Uninterested in patient	0
Total	128

TABLE VI

COMPARISON OF NEGATIVE FEELINGS EXPERIENCED BY STUDENTS DURING AND IMMEDIATELY AFTER THE INITIAL CONTACT

Feeling Experienced	Number of Responses	
	During	After
Apprehensive	60	45
Uneasiness due to patient condition	40	36
Uncomfortable	43	33
Uninterested in patient	7	0
Dislike of patient	0	14
Total	150	128

unit until after the student had completed the assigned hours.

In conclusion, the students indicated positive feelings in 211 responses while making the initial contact and establishing some type of communication. Immediately following the initial contact the students had positive feelings as indicated by 218 responses.

Negative feelings were experienced in 150 responses during the initial contact. One hundred and twenty-eight negative responses were noted immediately following the initial contact.

There were two responses indicating mixed or neutral feelings during the initial contact, and seventeen responses indicating mixed or neutral feelings after the initial contact.

Table VII shows a comparison between positive, negative and mixed-neutral feelings during and immediately following the initial contact.

TABLE VII

COMPARISON OF POSITIVE, NEGATIVE, AND MIXED-NEUTRAL FEELINGS DURING AND FOLLOWING THE INITIAL CONTACT

Type of Feeling Experienced	Number of Responses During	After
Positive	211	218
Negative	150	128
Mixed-Neutral	2	17
Total	363	363

II. EFFECT KNOWLEDGE OF PATIENT HAD ON INITIAL CONTACT AND ESTABLISHMENT OF COMMUNICATION

The responses indicated the students were given or sought information about the patient before making the initial contact. The question asked of the student was:

> (7) What preparation, or special information, did you have about your patient before you cared for him or her?

This information included something about the patient and/or his diagnosis. In 279 responses the students indicated some knowledge of the patient. In thirty-one of the responses the students did not have any knowledge or preparation regarding the patient. In fifty-three of the responses it was not indicated if the student did or did not have some information about the patient.

Initial Contact Influenced By Information

In 328 responses it was indicated that information gained about the patient influenced the initial contact and establishment of communication. In most instances the responses did not indicate in what way the information affected the contact. One response noted that information about the patient's illness "...nearly scared me out," but went on to state it was not too bad after the initial contact had been made.

Four responses indicated that information about the patient helped in knowing what to say. One in particular mentioned caring for a patient who had cancer but did not know her diagnosis. The response indicated that the student was guided by the information she had been

given, and she felt she helped the patient accordingly.

In summary, 328 responses indicated that the initial contact or establishment of communication was influenced by information about the patient. In most instances it was not indicated in what way the information had affected the contact.

Initial Contact Not Influenced By Information

In twenty-nine responses the students indicated that information gained about the patient did not influence the relationship.

Influence On Initial Contact Uncertain

In six responses the students did not know if the information had affected the initial contact. One response stated: "It didn't help but didn't hinder either."

In conclusion, in more than three-fourths of the responses it was noted that information given to the students about the patient influenced the initial contact and establishment of communication. In only thirty-five of the responses did it appear that the initial contact was not influenced, this is noted in Table VIII, page 38. In most instances the responses did not indicate what way the information affected the contact.

III. FACTORS IN SUCCESSFUL OR UNSUCCESSFUL COMMUNICATION

During the time in which the students gave nursing care to the patient a communication of some type was established. This was

determined by asking the student these questions:

(1) As well as you can recall, record the first few minutes conversation you had with your patient.

(2) While you were caring for this patient did any situation or problem arise which greatly influenced the establishment of communications? (That is, make it easier or more difficult to establish communication?)

(3) At the completion of the assignment, what factors made you feel that your patient communications had been successful? What factors made you feel it had been unsuccessful?

There were factors noted in the responses which could be identified as indicative of a successful or an unsuccessful communication. These have been classified as positive (successful) and negative (unsuccessful) communications. In some responses it was difficult to determine if the communication had been successful or unsuccessful, and in these instances they were classified as mixed or neutral communication.

TABLE VIII

EFFECT OF INFORMATION ABOUT PATIENT ON INITIAL CONTACT

Influenced	328
Not influenced	29
Effect not known	6
Total	363

Positive Communication

Two hundred and seventy-eight communications were noted in the responses as being positive. Those factors which were considered as indicative of a positive communication are shown in Table IX, page 40. (Some of the responses listed more than one factor, and these were counted separately.)

The responses indicated that if the patient conversed freely with the student it was considered a positive communication because this made the student feel the patient was comfortable in her presence. There were 115 responses indicating the patient conversed freely.

If the patient talked of his work or family the student felt the communication had been positive. In many of these responses it was noted that the student recorded statements similar to this one: "He seemed to like the interest I showed in his occupation and family."

In 165 responses it was noted that when the patient expressed thanks and was cheerful and co-operative he conveyed the feeling of acceptance of the student.

In one response it was noted that a patient, unable to speak and not responding well to other people, moved with ease and willingness after the student had made the initial contact. This made the student believe the patient had confidence in her as a nurse.

It is interesting to note that in nine responses it was suggested that the patient "understood" the student. No reasons were given for this, although the responses indicated the students considered it a factor contributing to a positive communication.

TABLE IX

PATIENT FACTORS INDICATING
POSITIVE COMMUNICATIONS

Indicating Factor	Responses
Conversed freely	115
Expressed thanks	78
Co-operative	54
Cheerful	33
Expressed confidence	26
Understanding	9
Total	315

When the responses indicated the communication had been positive there was a tendency to want to care for the patient again. The reasons given for wanting the same patient are shown in Table X, page 42.

In summary, communications which were considered positive by the student responses were those in which the patient conversed freely, thanked the student for care given, expressed confidence in the student as a nurse, understood the student, and was cheerful and cooperative. The responses indicated the student wished to care for the same patient again when the communication had been positive.

Negative Communication

Twenty-six communications were noted in the responses as being negative. Those factors which were considered as indicative of a negative communication are shown in Table XI, page 43. (Some responses listed more than one factor, and these were counted separately.)

Thirty-five responses indicated that if the patient was deaf or not talkative the student considered it a negative communication.

If the patient was apprehensive the responses indicated the communication was felt to be negative. There were thirty-four responses indicating the patient was apprehensive. In these instances the patient was reported to be facing surgery, worried about personal matters, and concerned about members of his family.

In one response a student indicated changing the conversation several times because the patient insisted on talking about personal problems and worries. The student felt the patient should not discuss

TABLE X

POSITIVE REASONS FOR WANTING TO CARE FOR THE SAME PATIENT

Reason for Wanting Patient	Number of Responses
To know the patient better	65
Liked the patient	51
To help the patient	52
Patient a challenge	42
Patient required attention	25
Patient a nursing-need study	5
Total	240

TABLE XI

PATIENT FACTORS INDICATING
NEGATIVE COMMUNICATION

Indicating Factor	Number of Responses
Deaf or untalkative	35
Apprehensive	34
Disturbed or nervous	28
Visitor interruptions	10
Not confident in student	10
Wanting to be alone	9
Unco-operative	5
Totals	131

her problems with other people.

In twenty-eight responses the students indicated negative communications because the patient was (1) disturbed, (2) nervous, or (3) quite ill. The responses did not indicate if the patient had been disturbed or nervous before the initial contact, and had remained so during the contact.

Interruptions due to visitors and telephone calls contributed to ten negative communications. The reasons indicated by the students were that they were unable to re-establish an effective communication after the interruptions.

In ten responses the students indicated that the patient did not have confidence in them. Some of the reasons were (1) the patient questioned what the student said or did, (2) the patient could not understand the student, (3) the instructor was present, and (4) the instructor did all of the talking or reassuring.

In nine responses the patient wished to be left alone. No specific reasons were given by the students.

Five responses indicated the patient was unco-operative. The student felt the communication had been negative because the patient did not do what the student thought he should.

When the responses indicated the communication had been negative there was a tendency not to want to care for the patient again. The reasons given for not wanting the same patient are shown in Table XII, page 45.

To summarize, communications which were considered negative by the student responses were those in which the patient was deaf or

TABLE XII

REASONS FOR NOT WANTING TO CARE
FOR THE SAME PATIENT

Reasons	Number of Responses
Patient not challenging	34
Did not like patient	10
Could not help patient	6
Wanted to talk to others	6
Student could not learn	4
Totals	60

untalkative, apprehensive, disturbed or nervous, had visitors, did not have confidence in the student, wanted to be alone, or was unco-operative.

Mixed-Neutral Communication

There were fifty-nine communications in the responses which were identified as being mixed or neutral by the students. Factors indicative of both positive and negative communication were present. In one response a student stated: "In some respects it was successful and in others unsuccessful. She talked some to me, but she also cried a lot and was nervous."

When the responses indicated the communication had not been successful or unsuccessful there were mixed reasons in regard to wanting to care for the same patient again. Reasons listed were combinations of those found in both the positive and negative responses. There were sixty-three mixed-neutral responses relating to caring for the patient again.

In conclusion, there were six main factors identified by the students in their responses which were indicative of a positive communication. Seven factors were identified as being indicative of a negative communication. In mixed-neutral communications there were factors present indicative of both positive and negative communication.

If the communication had been positive the student responses indicated a tendency to want to care for the patient again. When the communication was negative the responses indicated the students did not want to care for the patient again. In mixed-neutral communications the

responses did not indicate specifically if the student wanted or did not want to care for the patient again.

IV. SUMMARY

This study was undertaken to determine (1) what problems beginning students of nursing have in establishing initial patient communication, (2) if information given to the student about the patient influenced the initial contact, and (3) if the student felt the initial contact with the patient had been successful.

Each student made an initial contact with her patient by conversing or establishing some type of communication. During this contact the student experienced various feelings. These were classified as being positive, negative, or mixed-neutral feelings.

Immediately after making the initial contact and establishing some type of communication the responses indicated that the students had feelings similar to those experienced during the initial contact.

Information given the student influenced the communication in 328 of the contacts. In most instances the responses did not indicate in what way the information affected the contact.

Some factors noted in the responses could be identified as indicative of a positive or a negative communication. Some of the positive factors were when the patient (1) was co-operative, (2) expressed thanks, (3) was cheerful, (4) talked freely, and (5) had confidence in the student. Some of the negative factors were when the patient (1) was apprehensive, (2) was disturbed or nervous, (3) was deaf or untalkative,

(4) was interrupted with visitors, (5) did not have confidence in the student, (6) wanted to be alone, and (7) was unco-operative.

If the communication had been positive the responses indicated the student would like to care for the patient again. If the communication had been negative the student did not usually wish to care for the patient again. In mixed-neutral communications they did not state their preference.

There were twelve main problems which the students encountered when establishing the initial contact or communication. These problems made the establishment and maintenance of communication more difficult for the student. These problems arose when the patient was (1) uncomfortable, and the student was afraid she would irritate him by conversing with him, (2) very ill, and the student was concerned with disturbing the patient, (3) demanding, which prevented the student from being comfortable in the situation and decreased her desire to communicate, (4) complaining, which again made the student uncomfortable in the situation and reluctant to be with him, (5) unappreciative, which made the student feel inadequate, resentful, and uninterested in being with the patient, (6) too young or too old, which made the student uncomfortable and afraid to relax, especially if the patient were near the student's own age, (7) unpleasant to the student, which made the student uncomfortable and afraid to say anything for fear the patient would be more unpleasant, (8) feeling sorry for himself, which made the student uncomfortable because she could not handle the situation, or say the

correct thing, (9) discussing his personal problems, which made the student embarrassed, and uncomfortable because she felt he should not be discussing them with anyone.

Other problems occurred when the student (10) was afraid of saying or doing the wrong thing, and would possibly appear inadequate or uninformed, (11) did not like the patient, and did not have any desire to converse with him, and (12) was not secure in her knowledge or skills, and concentrated more on the procedure than initiating or maintaining a conversation.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY OF STUDY

This study was conducted for the purposes of determining (1) what problems beginning students of nursing have in establishing initial patient communication, (2) if information given to the student about the patient influenced the initial contact, and (3) if the student felt the initial contact with the patient had been successful.

A survey of literature disclosed two prior studies dealing with the phase of establishing student-patient relationships.[1]

This study was conducted by utilizing a questionnaire for collecting the data. These questionnaires were distributed to all of the sophomore students of nursing enrolled in a selected basic degree program in the western part of the United States.

The basic areas of investigation in the questionnaire included: (1) the first few minutes conversation, (2) how the student felt being with the patient, (3) making the initial contact, (4) situations which influenced the establishment of communication, (5) factors making communication successful or unsuccessful, (6) reasons for wanting or not wanting the same patient, and (7) information the

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[1]Yasuda, loc. cit., and Harris, loc. cit.

student had about the patient.

Data from the questionnaires were organized according to the three basic purposes of the study. For purposes of analysis the responses were divided into three categories. These were: (1) positive responses (2) negative responses, and (3) mixed-neutral responses.

Three hundred and sixty-three, or 73 per cent, of the questionnaires were returned.

II. SUMMARY

The responses indicated various feelings experienced by the students when making the initial contact and establishing communication with the patient. In most of the beginning contacts the students felt confident and at ease. Immediately following the initial contact the responses indicated that the students retained most of the positive feelings. During the initial contact there were 211 responses which indicated a successful communication.

Some negative feelings were also experienced by the students during the initial contact. In most of these instances the students felt apprehensive. The students retained many of the negative feelings immediately following the initial contact. There were 150 responses which indicated negative communication.

Mixed-neutral feelings were noted in the minority of responses. These were usually when the student did not have any feelings about the contact or the patient.

In 328 responses, out of 363, it was indicated that information about the patient had an influence on the initial contact and establishment of communication. In most of the responses the students did not indicate in what way the contact or communication had been affected.

There were factors noted in the responses which could be identified as indicative of a positive (successful) or negative (unsuccessful) communication. In some responses it was not determined if the communications had been positive or negative. In these instances they were classified as mixed-neutral communications.

If the response indicated a desire to care for the patient again the communication had usually been positive. When the communication was negative the responses indicated that the students did not wish to care for the patient again. In mixed-neutral communications the responses did not indicate one way or another about caring for the patient again.

There were twelve main problems which the students encountered when making the initial contact and establishing some type of communication.

III. CONCLUSIONS

The responses indicated that the students considered those communications positive in which (1) she did not feel threatened, (2) she cared for a patient who was talkative, cheerful, co-operative, and appreciative, (3) she had to concentrate only on her

manual nursing skills, and (4) the contact or communication went in the direction she wished it to go.

The responses indicated that the communications considered as being negative were ones in which (1) the student felt threatened, (2) the patient did not converse freely, (3) the patient was not cooperative or appreciative, (4) the patient expressed being insecure or apprehensive, (5) others were present (especially the instructor), and (6) the contact or communication did not go in the direction the student wished it to go.

The study revealed that the students were interested in caring for the patient again if the student felt comfortable in the situation. If the students were uncomfortable they did not usually desire to care for the patient again.

A major reason for desiring a new patient was the need for a challenging patient. This is interesting because of the fact that a challenging patient, as indicated by the responses, was someone who was on bedrest, required special treatments, and received medications. It was difficult for the students to converse with the patient unless the student had a specific reason for being with him.

It was felt that the students did not recognize their own problems in communicating with others. If they were comfortable in a situation no problems were noted and communications were considered positive. If the students were uncomfortable in the situation problems were noted and communications were considered negative.

In many instances the patient may have been demanding and complaining in an effort to convey to the student his needs which he himself did not recognize. Some of the students, however, did not recognize the clues as they were trying to meet their own needs of acceptance, satisfaction, and achievement. These findings concur with those of Harris and Yasuda.

IV. RECOMMENDATIONS

The following recommendations are an outcome of the study:

1. That a similar study be undertaken in other clinical areas as the student advances in the nursing program, and comparisons made to determine if students continue to identify problems which make the establishment of initial student-patient communication difficult.

2. That a study could be done to determine if students recognize their own limitations in communicating with others.

3. That a similar study be done in which the investigator could use the information in an individual conference.

4. That a similar study be done to include observation of the student in the situation by the investigator.

5. That a similar study be conducted in which an analysis of the individual student responses be considered.

6. That the importance of clues expressed by patients be stressed in communications courses for beginning students of nursing. A section of this course should be set up for discussing situations in which individual students feel uncomfortable in the initial patient contact.

7. That the first nursing course include instructions for the students to help them communicate specifically with deaf, handicapped, and critically ill patients.

8. That students be helped to understand that a negative response from the patient is not necessarily a reflection on the

nursing competency of the student.

9. That students be helped to understand that a contact may be successful even though the patient is demanding or is not talkative.

10. That the instructor use the information for individual conferences in giving guidance to the student.

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APPENDIX

APPENDIX

RESEARCH ANSWER SHEET
(Questionnaire)

1. As well as you can recall, record the first few minutes conversation you had with your patient.

2. How did you feel when with the patient?

3. What were your feelings or reactions when making the initial contact with your patient?

4. While you were first caring for this patient did any situation or problem arise which greatly influenced the establishment of communications? (That is, make it easier or more difficult to establish communication).

5. At the completion of the assignment, what factors made you feel that your patient communication had been successful? What factors made you feel it had been unsuccessful?

6. Would you prefer a new patient tomorrow, or this same patient for several days? Why do you feel this way?

7. What preparation, or special information, did you have about your patient before you cared for him?

Did it help in your relationship?

Where did you get the information?

ABSTRACT

LOMA LINDA UNIVERSITY

School of Graduate Studies

A STUDY TO HELP IDENTIFY PROBLEMS SOPHOMORE STUDENTS OF NURSING HAVE IN ESTABLISHING INITIAL PATIENT COMMUNICATION

by

Constance J. Bethers

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

June, 1962

ABSTRACT

The purpose of this study was to determine what problems beginning students of nursing have in establishing initial patient communication. A questionnaire was utilized to obtain the data.

The responses revealed that various feelings were experienced by the students when making the initial contact and establishing a communication with the patient. In most of the beginning contacts the students felt confident and at ease. Immediately following the initial contact the responses indicated that the students retained most of the positive feelings.

Some negative feelings were also experienced by the students during the initial contact. In most of these instances the students felt apprehensive. The students retained many of the negative feelings immediately following the initial contact.

There were factors noted in the responses which could be identified as indicative of a positive (successful) or negative (unsuccessful) communication. In some responses it was not determined if the communication had been positive or negative. In these instances they were classified as mixed-neutral communications.

It was noted in the responses that when the students were comfortable in a situation no problems were noted and communications were considered positive. If the students were uncomfortable in the situation problems were noted and communications were considered negative.

There were twelve main problems which the students encountered or experienced when making the initial contact. These were when the

student (1) was afraid of irritating the patient who was uncomfortable, (2) did not want to disturb a very ill patient, (3) did not desire to communicate with a demanding patient, (4) was uncomfortable and reluctant to be with a complaining patient, (5) felt inadequate and resentful when the patient was unappreciative, (6) was unable to relax because of the patient's age, (7) uncomfortable and afraid because the patient was unpleasant, (8) could not handle the situation or say the correct thing when the patient felt sorry for himself, (9) was embarrassed because the patient discussed his personal problems, (1) did not wish to appear inadequate or uninformed, (11) did not like the patient, and (12) concentrated on procedures because of insecurity in nursing knowledge or skills.