REASSURANCE IN NURSING

JOHN KEVIN TEASDALE

A thesis submitted in partial fulfilment of the requirements of the Council for National Academic Awards for the degree of Doctor of Philosophy

June 1992

Sheffield City Polytechnic in collaboration with Pilgrim Hospital, Boston

REASSURANCE IN NURSING

JOHN KEVIN TEASDALE

ABSTRACT

The aim of this study is to identify the ways in which nurses can be effective in helping anxious patients to feel calmer or more secure. This subject is important to all nurses who work in close day-to-day contact with people under stress. The study uses the Inferential Model of Communication as its main theoretical foundation, emphasising the value of identifying the intentions of the communicator and the inferences made by the respondent. It establishes a Nursing definition of the verb "*to reassure*" as "*an attempt by nurses to communicate with patients who are anxious, worried or distressed with the intention of inducing them to predict that they are safe or safer than they presently believe or fear*".

The literature review reveals few research-based studies which explicitly refer to "*reassurance*", but many experimental studies of interventions designed to calm anxious patients. The inferential model helps to highlight the theoretical inadequacies of interventions based on "*information-giving*", and demonstrates the importance of the distinction between prediction and control in aversive situations.

Grounded Theory methods were used to collect and analyse a total of 351 Critical Incidents reported in writing by 202 nurses, and in tape-recorded interviews by a further fifty-one nurses and fifty-one patients. The incidents were drawn from the experience of nurses and patients in a wide variety of clinical settings, including general hospital, community, psychiatric and mental handicap settings. A set of descriptive categories was developed from this database to code all the incidents collected. The classification scheme was tested for inter-rater coding reliability, yielding agreement levels of ninety per cent or higher in most categories.

The results show that the nurses used five helping strategies - prediction, support, patient control, distraction and direct action. Of these, only the first two are always forms of "*reassurance*" as defined above. It appears that rational choice of a helping strategy requires nurses to compare their views of the aversiveness of patients' situations with the views of the patients themselves. Out of this comparative assessment, the study suggests that it is possible to predict which helping strategies are most likely to be effective in inducing patients to feel calmer, and which ones may have undesirable side-effects.

The study concludes by offering some suggestions for further research, arguing that the inferential model of communication has demonstrated its potential as a powerful tool for the analysis of nurse-patient communication.

ACKNOWLEDGEMENTS

I would like to acknowledge my thanks to the many people who have made it possible for me to complete this thesis. First to my wife, Sheila, for her constant help and support in long debates about the nature and value of reassurance. Secondly to my children, Jenny and Rose, who have had to put up with my long absences in front of the word processor. Next to my supervisors, Nigel Malin and Gerry Kent, for their invaluable criticism of work in progress, coupled with appropriate reassurance. I would also like to thank the following people: all the patients and nurses who kindly answered my questions; all those who freely gave time to assist in the reliability checks; the managers of Pilgrim Hospital in Boston and Mid Trent College of Nursing and Midwifery, who made it possible for me to conduct the research on a part-time basis; and the librarians at Pilgrim Hospital for the excellent service which they always provide.

DECLARATION

No portion of the work referred to in this thesis has been submitted in support of any application for another degree or qualification of this or any other institution of learning.

CORRESPONDENCE

If readers have any comments or questions about this thesis, I would be delighted to hear from them. My current work address is Pilgrim Hospital, Boston, Lincolnshire PE21 9QS. Tel: 0205 364801. My home address is Albion House, 15 Church Street, Heckington, Lincolnshire PE21 9QS. Tel: 0529 60695.

AUTHOR'S NOTE - Throughout this thesis, nurses are referred to as female and patients as male. The reason is clarity of expression and no sexism is intended.

PART ONE: INTRODUCTION, DESIGN AND METHODS

CHAPTER 1: INTRODUCTION

CHAPTER 1: INTRODUCTION

"*Reassure the patient*" is a phrase instantly recognised by every nurse. Qualified nurses frequently begin their teaching sessions by reminding students always to "*reassure the patient*"; the same words feature prominently in many nursing procedure manuals. It seems that giving reassurance is widely accepted as an important role of the nurse, yet very little is known about what nurses actually do when they try to "*reassure*" their patients. Do they simply say to patients, "*Don't worry, you will be alright*", or are the communication processes more complex than this? How do patients react to the nurses' interventions? What constitutes good practice in giving reassurance?

The Compact Oxford English Dictionary (OED 1991) defines the verb "*to reassure*" as "*to restore a person to confidence*", and "*to confirm again in an opinion or an impression*". The implication is that one tries to "*reassure*" a person whose confidence has been shaken, whose beliefs have been undermined. People who are suffering from physical or mental illness often experience loss of confidence and feelings of anxiety, worry or distress. For nurses caring for these patients, any actions which will restore them to confidence are therefore important and merit a systematic analysis.

Surprisingly little research has been undertaken directly to investigate reassurance in nursing. Part of the reason for this may be that there is no general agreement over which words or actions constitute "*reassurance*". In an article in 1979 Heinz-Peter French considered published definitions of reassurance and concluded that:

> "Scanning nursing textbooks on the subject is a tedious and fruitless task. Even psychiatric nursing textbooks expend few words on it. Further, the concept is ill-defined as a nursing concept, and conflict on the subject among different professionals is only equalled by a lack of detail on the subject in the ordinary nursing literature." (French 1979)

Very little new work specifically on reassurance in nursing has been completed since French wrote his article. The present study is an attempt to remedy this

situation. It is a response to the challenge laid down by French to define reassurance as a nursing concept and to explore in a systematic way its use in patient care.

AIM AND OBJECTIVES

The aim of the study reported in this thesis is to identify how nurses can be effective in helping patients who are anxious, worried or distressed to feel calmer or more secure. This aim permits analysis of a wide range of helping interventions, including some which do not involve reassurance. In this way reassurance can be studied in context, contrasting it with other types of helping intervention.

The detailed objectives of the study are as follows:

1. To analyse reassurance as a nursing concept.

2. To review critically the literature on reassurance and related issues in health care.

3. To describe what a sample of nurses say and do when their patients are anxious, worried or distressed and the nurses are trying to calm them or to make them feel more secure.

4. To identify the factors which influence the effects of the nurses' interventions upon the patients.

PLAN OF THE THESIS

The study begins with a detailed definition of reassurance drawing on recent developments in the philosophy of language. There then follows a literature review which is necessarily wide-ranging, since there have been relatively few research investigations of reassurance itself. Using the definition and the evidence of previous research, a qualitative survey design was selected for this study. This design was chosen because it is suited to exploratory work in a relatively new area of nursing research, where even basic descriptions of nursing actions in the clinical area are severely limited in scope and depth.

The data comprise retrospective written and verbal accounts in which informants were asked to describe from personal experience critical incidents where nurses intervened to try to calm patients who were anxious, worried or distressed. Using these methods, accounts of incidents were collected in written form from an opportunity sample of 202 nurses, and in tape-recorded interviews from a further fifty-one nurses and fifty-one patients. The nurses were drawn from general, psychiatric, sick children's and mental handicap nursing, and the majority were trained nurses. They worked in both hospital and community settings. The aim here was to study reassurance and related issues from a *nursing* perspective, and to do this meant looking at the full range of environments in which nurses work.

It was very important to collect incidents from patients as well as from nurses, in order to understand all aspects of interactions. Slightly more than twenty-five percent of the taped interviews contained "*paired incidents*". These were incidents in which a patient and a nurse separately described the same incident. These paired incidents were particularly valuable for understanding and for illustrating both sides of an interaction.

The questionnaires and interviews generated a database of over 160,000 words describing 351 critical incidents collected from 304 informants. Qualitative methods tend to yield richer and more wide-ranging understanding of behaviour than quantitative approaches, but the bulkiness of the resulting data can make analysis particularly difficult. In this study, the "*constant comparative*" method of data analysis was used, following closely the description given by Glaser and Strauss (1967). They described a way of systematising inductive reasoning, arguing that too much attention in social sciences research has been paid to methods of verifying hypotheses which are relatively narrow in scope. They emphasised the value of the systematic generation of theory which is grounded upon a solid base of data.

The results of the study comprise a set of descriptive categories which fully code the data obtained, and which make it possible to describe five strategies which the nurses used when they tried to help their patients to feel calmer or more secure. Some of these strategies were found to be consistent with the definition of reassurance already established, while other strategies were clearly not forms of reassurance. Further comparative analysis established a set of key findings about the ways in which different types of strategy interact with patients' preferences and with the context of care to produce different outcomes.

It is intended that the results of this study will help nurses systematically to improve their skills in communicating with anxious patients. Existing descriptions of nursing interventions in this area are inadequate because they are founded on *coding* models of communication, which lack explanatory power; the present study is designed to establish a new way of categorising helping interventions in nursing, consistent with the data collected and founded on the more comprehensive *inferential* model of communication. Further empirical research will then be needed to test the categories in a wider range of clinical situations and using quantitative as well as qualitative methods.

CHAPTER 2: DEFINING TERMS

"*Reassurance*" is a slippery concept, one which is used in different ways by different people. Uncertainty over its meaning was expressed as early as 1954 by the American psychotherapist Harry Stack Sullivan. In reviewing communication problems he noted that: "Reassurance might be termed a . . . technique for handling anxiety when it refers to a purposeful, skilled therapeutic move in interpersonal relations." However, he contrasted this definition with:

> "The use of reassuring verbalisms, which merely represents an attempt by the therapist to do magic with language, and is usually a matter of the therapist's reassuring himself rather than the patient."
> (Sullivan 1954: 217-218)

For empirical research to proceed further, the sources of this uncertainty over the meaning of reassurance must be identified and a working definition established. A key to the uncertainty over meaning was found in linguistics, particularly in the two fields of semantics and pragmatics. This chapter therefore contains a brief account of communication theory drawn from linguistics and the philosophy of language. The relevance of the theory presented will become apparent in the second half of the chapter, which deals with the application of the ideas to the concept of reassurance.

SEMANTICS AND PRAGMATICS

Noam Chomsky (1965) proposed a distinction between competence and performance in language use. He suggested that the grammar of a language is a description of the linguistic knowledge (*competence*) of native speakers of the language. Semantics is the branch of linguistics most closely concerned with competence. In contrast, *performance* theories deal with the way individual speakers (native or not) actually use language to communicate with others in

particular situations. Experts in linguistics and philosophers of language use the term "*pragmatics*" to describe performance theories. Leech (1983) neatly illustrated the difference between semantics and pragmatics when he focused on two uses of the verb "*to mean*":

> "*[1] What does X mean?* *[2] What do you mean by X?*
>
> Semantics traditionally deals with meaning in dyadic relation, as in [1], while pragmatics deals with meaning as a triadic relation as in [2]. Thus meaning in pragmatics is defined relative to a speaker or user of the language, whereas meaning in semantics is defined purely as a property of expressions in a given language, in abstraction from particular situations, speakers or hearers."
> (Leech 1983: 6)

A major development in pragmatics was announced by the publication of JL Austin's (1962) Harvard lectures, with the apt title of "*How to do things with words*". Austin argued that there is such a thing as a "*speech act*"; that in some circumstances the distinction between words and deeds is not tenable. For example, Austin argued that a declaration, such as the making of a marriage vow, is an "*act*". By saying the words of the marriage vow, one takes an action which changes one's status in the world. The words have a force of their own. Similarly, if one person says to another, "*I apologise for my behaviour*", the uttering of the words of itself constitutes an act of apology. Austin therefore argued that language can be used to perform actions - speech acts. He further divided speech acts into three types: locutionary, illocutionary and perlocutionary. A **locutionary** act is the act of making sounds. In linguistics it is part of the field of phonetics. An **illocutionary** act is an utterance which has a particular force. The utterance conveys the attitude or intention of the speaker towards the listener. A taxonomy was developed by Searle (1979), distinguishing five types of illocutionary act: assertives, directives, commissives, expressives and declarations. For example, if one says "*I believe the world is round*", one performs an

illocutionary act which has assertive force. If one says "*I order you to leave*", one performs an illocutionary act with directive force.

Austin's third type of speech act, the **perlocutionary** act, may be defined as the act of achieving something by means of speech. For example, if one wants someone to leave the room, one may utter words with directive illocutionary force, "*I order you to leave*". If the hearer obeys the order and does what one intended, Austin would say that one has performed a perlocutionary act. However, Austin's formulation of perlocutionary acts does not stand up well to scrutiny from the perspective of human psychology. Austin appears to suggest that an utterance by one person and a response by another person may be categorised as a single "*act*". Moreover, he implies that there is a direct causative connection between the utterance and the response. This is an oversimplification. It is not supported by empirical experiments into cognitive response (see for example Love & Greenwald 1978 or Petty et al. 1981). In the real world, one can never be completely certain that one person's utterance has actually induced another person to act in a certain way. One can say that on the balance of probability this appears to have happened, but even then the connection between utterance and action is cognitively mediated in a complex way. The utterance is subject to a vast range of influences from the memory and perceptions of the respondent. We do not really know what happens between input and output in human communication, but we can be certain that there is no simple causative connection between the two.

However, although the notion of perlocutionary "*acts*" appears to be untenable, it is undeniable that the semantic meaning of some verbs in English explicitly includes a causative connection between utterance and response. For example, the verb "*to persuade*" is defined in the Compact Oxford English Dictionary (OED 1991) as "*to induce a person to believe something*". It is valid therefore to follow Austin in describing "*to persuade*" as a perlocutionary verb, since in semantic terms it describes the act of achieving something by means of speech. The concept of a perlocutionary verb is a useful way of categorising some English

words. Perlocutionary verbs can reasonably be used to describe situations in the real world in which a causative connection between utterance and response is believed to have occurred. An important question to be examined later in the chapter is whether "*to reassure*" falls into this category of perlocutionary verbs. However, before this can be done, it is important to understand how philosophers of language have taken ideas from semantics and pragmatics and synthesised them into a model of communication which expresses the complexity of the processes involved.

THE INFERENTIAL MODEL OF COMMUNICATION

The development of this pragmatic model of communication derives from the work of many people, most notably Grice (1957). However, the account presented here follows the description of the inferential model given by Sperber and Wilson (1986). In answer to the question, "*How do human beings communicate with one another?*", they argue that we conventionally use a coding model as the basis of our understanding of the process. Following this model, communication is a process which involves coding our thoughts into words and transmitting them as signals to a recipient, who then decodes them back into thoughts. Everyday metaphors such as "*putting one's thoughts into words*" or "*getting one's message across*" all derive from acceptance of the centrality of a coding/decoding approach to communication. Sperber & Wilson openly challenge this model:

> "The power of these figures of speech is such that one tends to forget that the answer they suggest cannot be true. In writing this book, we have not literally put our thoughts down on paper. What we have put down on paper are little dark marks, a copy of which you are now looking at. As for our thoughts, they remain where they always were, inside our brains." (Sperber & Wilson 1986: 1)

This is not to deny that coding does have a part to play in communication. Conceptual representations of thoughts may be encoded in language. Chomsky (1957) defined syntactic structures as codes which associate phonetic and semantic representations of sentences. Native speakers will be competent to encode and decode conceptual representations in the form of sentences in their own language. Yet this is not sufficient to explain communication. Consider, for example, the following sentence (developed from Sperber & Wilson 1986: 13):

Maxwell bought the Mirror

Semantically it follows all the rules of English, yet its pragmatic meaning is ambiguous. It may, for example, mean either of the following:

1. That a person named Maxwell bought the press enterprise called "the Mirror".
2. That a person named Maxwell bought a copy of a newspaper called "the Mirror".

If spoken instead of written, the sentence is open to yet another interpretation:

3. That a person named Maxwell bought a reflective glass mirror which had been referred to earlier in the conversation.

In fact, most readers or listeners in England at the present time would unhesitatingly understand the first interpretation as the most likely intended meaning. But this meaning cannot be deduced by the application of semantic rules: it has to be inferred from context, and from a shared context which is wider than that supplied by the utterance itself. This is the nub of the argument from pragmatics: that coding/decoding cannot fully explain communication, since it is primarily an inferential process.

Sperber & Wilson (1986) argue that the inferential and coding models are in fact compatible, and that coding and decoding form a subsidiary part of the inferential model. The linguistic meaning of an uttered sentence partially encodes the speaker's meaning. It may be treated by an audience as an important piece of evidence about the speaker's intentions. However, the audience must always make additional inferences fully to recover the speaker's intended meaning.

The inferential model represents communication as a form of problem-solving. Thus I have certain thoughts about communication which I would like the readers of this thesis to understand and to believe to be true. My problem is to find ways of coding those thoughts into words and sentences from which you will be able to infer both my meaning and my intention. You in turn are a problem-solver. You have to decode the words and sentences on the page, and then infer my meaning and my intention from them, filtering out the ambiguities until you arrive at what you believe to be an accurate representation of my original ideas. If, instead of using a written medium, we were in face-to-face conversation, we would have much more data available from body language and vocal inflections from which to draw our inferences. We could ask questions in order to check the accuracy of those inferences. However, in both cases the problem-solving nature of the process would remain the same.

If one subscribes to an inferential model, one is left with the problem of explaining how hearers can filter out the many possible ambiguous meanings of utterances to derive the one which the communicator intended. Grice (1975) argued that communicators try to meet certain general standards when constructing utterances. The key principle for Grice was the Co-operative Principle, by which the communicator obeys certain maxims of quantity, quality, relation and manner when constructing utterances. The hearers can assume that under normal circumstances the communicator will have applied these maxims, and they can therefore use the maxims to infer the intended contextual meaning from the code. Sperber & Wilson (1986) modified Grice's ideas, arguing that the guiding

principle is better formulated as that of "*relevance*". The communicator must plan utterances so that they have maximum relevance to the hearers, meaning that they can be processed with the minimum of effort and that they have maximal contextual effects on the cognitive environment of the hearers. Whichever principle is accepted, the effect is similar; hearers assume the communicator has applied the principle in constructing his utterance, and therefore they can apply it in reverse to infer the intended meaning.

In summary therefore, linguistics distinguishes between semantic meaning, based upon an abstract grammar, and pragmatic meaning, which is meaning in context. Some verbs convey a perlocutionary meaning: they imply a direct cause/effect link between one person's words and another person's actions. In the real world, we know that such direct cause/effect links are an oversimplification. The coding/decoding model of communication is another example of this tendency to oversimplification. The inferential model offers a more satisfactory explanation of the complexities of human communication processes.

CONCEPT ANALYSIS

The application of these theories to the concept of reassurance must now be considered. The inferential model of communication implies that while a dictionary definition in semantic terms is a necessary first stage in establishing meaning, it is not sufficient for a full understanding of how concepts are used. It is essential to begin with semantics, but then to analyse usages of "*reassurance*" from a pragmatic viewpoint in order to elucidate meaning in context.

The Compact Oxford English Dictionary (OED 1991) gives three meanings for the verb "*to reassure*":

1. To restore (a person, the mind, etc.) to confidence
2. To re-establish, confirm (a thing) (to someone)
3. To reinsure

The definition of the noun "*reassurance*" reflects the same three-fold division:

1. Renewed or restored confidence
2. Renewed or repeated assurance
3. Reinsurance

The third form, "*reinsurance*", is not used in Nursing and therefore this discussion will concentrate on the first two definitions. In order to go beyond semantics to pragmatics, the researcher made an analysis of all occurrences in Nursing Times March-August 1986 of the verb "*to reassure*" and any of its related grammatical parts. From this analysis, two distinct ways of using the verb in health care settings were identified:

Usage 1: To reassure as an illocutionary verb.
Usage 2: To reassure as a perlocutionary verb.

Each of these usages will now be described, using aspects of the structured procedure for concept analysis described by Walker & Avant (1983). This will involve establishing the key defining attributes of each usage and illustrating these with a model case. The value of this procedure is that it obliges one to explore meaning in context.

USAGE 1: "*TO REASSURE*" AS AN ILLOCUTIONARY VERB

This usage corresponds with the second definition: "*to re-establish, confirm (a thing) (to someone)*". The key defining attributes derived from analysis of occurrences in Nursing Times are as follows:

1. A nurse infers that a patient is anxious, worried or distressed.
2. The nurse infers the source of the patient's concerns.
3. The nurse selects a communicative intervention which she believes will induce the patient to predict or infer that he is safe or safer than he presently believes or fears.
4. The nurse carries out her planned intervention. She may use <u>any</u> form of communication, verbal or non-verbal, which she believes will induce the patient to respond as she intends.

These defining attributes accord with the inferential model of communication. The nurse's utterances may have any variety of illocutionary force which she believes will influence the patient: they may be assertive, commissive, directive, expressive or even declarative. However, in this usage, the descriptive verb "*to reassure*" tells us nothing about the outcome upon the patient of the nurse's intervention. The emphasis is on the <u>process</u> - what the nurse says or does - not on how the patient responds.

A MODEL CASE

A patient fears he has lung cancer. The results show that there is no malignancy. The sister says to the patient: "*I have good news for you, your tests are all clear. Look, here is the printout of the results. The consultant and I have both reviewed*

them and you definitely do not have lung cancer." The sister writes a note in the patient's care plan: "*Reassured the patient that his test results were clear.*"

To "*reassure that*" is a frequent, though by no means infallible, indication of an illocutionary usage. The words following "*that*" generally describe the source of concern which the nurse's utterances addressed. The sister's use of "*reassured*" tells us what she did, but it does not tell us how the patient responded. Thus with no change to the verb she could have written either of the following versions of the sentence:

a. "*Reassured the patient that his test result were clear, and he expressed enormous relief.*"
b. "*Reassured the patient that his test results were clear, but he refused to accept what I said.*"

Therefore this verbal usage is truly illocutionary, since it focuses on process and is compatible with either a successful or an unsuccessful outcome.

OPTIMISTIC ASSURANCE: AN ILLOCUTIONARY VARIANT

Sullivan (1954) in the words quoted at the start of this chapter disparaged the use of "*reassuring verbalisms*" in an attempt to "*do magic with language*". He was referring to the automatic and isolated use of optimistic assurances such as "*There's no need to worry*" or "*You'll be alright*". Writers such as Hays & Larson (1963) have even gone so far as to define "*reassurance*" solely in terms of these optimistic assurances. They assert that the verb "*to reassure*" necessarily implies the use of a more limited range of interventions than the ones described in the model case above. Hays & Larson would interpret the sister's note in the care plan as meaning simply that she uttered an optimistic assurance such as:

"*You've nothing to worry about*". The key defining attribute here is the selection of a verbal intervention, most frequently with assertive illocutionary force, which expresses an exclusively optimistic view of the patient's situation.

It is undeniable that "*to reassure*" is sometimes correctly used to describe the limited range of utterances which Hays & Larson describe. However, it is also undeniable that the verb is used in the broader sense described in the model case. Both are illocutionary in form, but the defining attributes of the broader usage include the option of uttering optimistic assurances among the range of interventions from which the nurse may select. Because of this, the restricted usage should be classified as a variant of the broader illocutionary usage. This analysis goes part of the way towards explaining the source of the confusion which has arisen over the meaning of "*reassurance*". However, as well as two forms of illocutionary usage, there is also a perlocutionary usage to take into account.

USAGE 2: "*TO REASSURE*" AS A PERLOCUTIONARY VERB

This usage corresponds semantically with the first of the dictionary definitions: "*to restore (a person, the mind etc) to confidence*". The key defining attributes are exactly the same as those of the broad usage of the illocutionary verb, but with the addition of a fifth attribute which refers to outcome:

5. The patient feels calmer or more secure as a consequence of the nurse's intervention.

A MODEL CASE

Returning to the model case of the patient who fears he has lung cancer, the patient looks at the test results with the sister and then smiles with relief. He tells the sister: "*That's wonderful news, now I can stop worrying.*" The sister writes a note in the patient's care plan: "*Reassured the patient by showing him that his test results were clear.*"

Here the sister was using "*to reassure*" as a perlocutionary verb, implying that "*I successfully induced the patient to predict that he was safe*". The construction "*to reassure by doing something*" generally signals the perlocutionary usage, implying a successful outcome. Thus the construction: "*Reassured the patient by showing him that his test results were clear, but he refused to believe me*", is awkward. It would be more usual to preface the sentence with, "*Tried to reassure the patient.*" Leech (1983: 204) states that this is a good test of a true perlocutionary usage, since "*try implicates that the illocution failed to achieve its intended perlocutionary effect.*"

OTHER GRAMMATICAL FORMS

As might be expected, the other grammatical forms derived from the verb "*to reassure*" also reflect the difference between perlocutionary and illocutionary usages. The noun, "*reassurance*", is unusual in that it may be used with perlocutionary effect to describe a state of mind, rather than an activity. Thus Gregg (1955) used it in this way when she stated that:

"Reassurance is experienced by a patient when he finds he is respected and understood by the nurse who assists him to recognize and develop his own resources and thereby restore his confidence in himself."

However the more frequent way of using the noun, as with all the other grammatical forms, is to describe the activity of reassuring someone. Thus, in the model case previously cited, the sister could have written: "*I gave the patient reassurance about his diagnosis.*" Taken out of context, this is very ambiguous. Possible meanings are as follows:

1. It may be a perlocutionary usage: the sister's intervention induced the patient to feel calmer than before.
2. It may be a broad illocutionary usage: the sister used a range of verbal and/or non-verbal interventions in an attempt to calm the patient.
3. It may be the restricted illocutionary variant: the sister gave the patient an optimistic verbal assurance about his diagnosis.

Without additional contextual information it is impossible to know which usage is intended. Moreover, the form of the phrase tends to suggest a simple coding model of communication, giving the misleading impression that "*reassurance*" is some type of commodity which can simply be "*given*" to a recipient.

"REASSURANCE" IN THIS STUDY

For the purposes of the present study, unless otherwise stated, the phrase "*to reassure*" and its related grammatical forms will be employed in their broad illocutionary usage. Therefore "**to reassure**" is defined here as:

an attempt by a nurse to communicate with a patient who is anxious, worried or distressed with the intention of inducing him to predict or interpret that he is safe or safer than he presently believes or fears.

This definition is compatible with the inferential model of communication, viewing the nurse's task as that of a problem-solver. The nurse has to establish whether a patient is feeling anxious, worried or distressed, and to infer the source of any such concerns. She then has to construct an intervention which she believes will alter the way the patient views his situation. She also has to monitor the patient's reaction and perhaps modify future interventions as a result. The interest of this study lies in how nurses go about doing these things in everyday clinical practice, and how their patients react. This is an investigation into illocutionary acts, not illocutionary verbs; it is an enquiry into the reported actions of nurses, rather than an exploration of the semantics of "*reassurance*".

However, linguistic analysis is a necessary precursor both to a literature review and to the design of an empirical data collection process. It has revealed that the source of the slippery nature of "*reassurance*" arises from the fact that the word can shift seamlessly from perlocutionary to illocutionary usages, and can even shift in meaning within illocutionary usage. This has implications for anyone who uses the word, requiring the user to take particular care that the precise intended usage can be inferred correctly from the context. As will be seen in the literature review, much of the argument over whether or not it is therapeutic to "*reassure*" patients arises from the fact that many writers have failed to clarify the usage to which they are referring.

CHAPTER 3: LITERATURE REVIEW

CHAPTER 3: LITERATURE REVIEW

Although many nurses and doctors have written about reassurance in health care, there have been very few empirical investigations of this topic. Therefore to establish the context for the present study, it is necessary to examine the wide range of helping interventions which health professionals can use. The difficulty with this is to know where to set the limits. One key word leads on to another and a vast number of studies will indirectly cast light on reassurance in health care. However, by using the key attributes identified in chapter two for the illocutionary verb "*to reassure*", it is possible to identify the most relevant themes in the literature. The key attributes were:

1. That a nurse infers that a patient is anxious, worried or distressed.

2. The nurse infers the source of the patient's concerns.

3. The nurse selects a communicative intervention which she believes will induce the patient to predict or infer that he is safe or safer than he presently believes or fears.

4. The nurse carries out her planned intervention using any form of communication, verbal or non-verbal, which she believes will induce the patient to respond as she intends.

Thus, by definition, a patient must be in a state of **anxiety, worry and distress** to be in need of reassurance. For the purposes of this study, the words *"anxiety", "worry" and "distress"* are used interchangeably to describe an unpleasant emotional state experienced by an individual when he perceives an event as aversive or potentially aversive. In order to help a patient who is experiencing such an emotion, a nurse must draw on her knowledge of the patient's

susceptibility to anxiety, of the factors which induce him to perceive an event as aversive, and of his preferred coping styles. She must then select a **helping intervention** which she believes will induce the patient to behave as she thinks necessary or desirable. This intervention may be an attempt to reassure the patient, or it may be something quite different. All that can be said is that the nurse intends to help the patient in some way by means of her intervention. It is in keeping with the overall aim of this study that this broad range of interventions should be reviewed and not simply those which involve reassurance. In making her choice of intervention, the nurse will be influenced not only by her view of the patient's situation, but also by her view of her own place in the hierarchy and by the policies and procedures of the **organisation** for which she works. Therefore, taking these ideas as a logical framework, the literature review is organised in three main sections:

1. ANXIETY AND THE PATIENT
2. THE RANGE OF HELPING INTERVENTIONS
3. NURSES AND THE ORGANISATION OF HEALTH CARE

Each section includes a description of current theories and a critical review of relevant research studies.

SECTION 1: ANXIETY AND THE PATIENT

This section defines the meaning of "*anxiety*" in this study; it describes how anxiety may be measured, reviews research into events which patients commonly find aversive and examines theories about the functions of anxiety. The section ends with a review of research into nurses as assessors of anxiety.

DEFINITION

John Bowlby (1975) noted that words such as "*anxiety*", "*alarm*" or "*fear*" may only be used legitimately with reference to the emotional state of an individual. In Bowlby's terms, it is misleading to speak of "*an anxiety*" or "*a fear*" as if these exist as entities in their own right. Cullberg is consistent with Bowlby in regarding anxiety as:

> ". . . experiences of discomfort, tense expectation, insecurity, helplessness escalated to panic, feeling of catastrophe. Possible tendencies towards repugnance, nausea, and other negative symptoms." Cullberg, quoted in Gyllenskold 1982: 21)

The above definition is used in this study, and the term "anxiety" is here synonymous with all forms of worry, distress or fear experienced by a patient, whether or not the source of these feelings is known to the patient. Defined in this way anxiety is an aversive emotion, but one which is thought to have a protective arousing function. Selye (1956) proposed that when an organism is faced by environmental demands it will respond by trying to achieve a restored balance or homeostasis. Selye called this response the "*General Adaptation Syndrome*" (GAS). The first stage of this is a response of alarm at the demands of the stressor. Selye regarded anxiety as the emotional mechanism of the alarm response. The second stage is resistance, an attempt to adapt the aversive situation to oneself, or to adapt oneself to the aversive situation. This coping stage may require prolonged toleration of arousal. If the attempt at resistance is successful, anxiety will dissipate. If it is unsuccessful, the third stage of physical or psychological exhaustion will overtake the individual. Although the theory may be criticised as mechanistic, behaviour patterns predictable from the GAS have been reported in children (Bowlby 1971), in people with psychological problems (Malan 1979), and in adults suffering from cancer (Weisman1979).

MEASURING ANXIETY

All emotions are subjective experiences, and therefore very difficult to measure. However, helping interventions can only be evaluated if valid before/after measurements of anxiety can be recorded. Attempts have been made to develop objective measures based on observation of behavioural changes associated with emotional states. The signs observed have included non-verbal leakage of emotional expression, such as hand-wringing, and specific changes in facial expression and posture (see for example Kendall et al. 1979, Melamed & Siegel 1975, Shipley et al. 1979). Chevalier-Skolnikoff (1973) reviewed research into facial expression of emotion and found that many expressions are universally characteristic of the human species.

While observation has its place, most researchers have sought to use a battery of different measures of patient anxiety in their studies. Particular interest has been shown in the reliability and validity of physiological measures. Weinman (1981) has described the main physiological responses which have been found in individuals who have subjectively reported feeling anxious. These physiological responses are of two kinds, those mediated by the adrenal glands and those resulting from stimulation of the sympathetic nervous system. There are also thought to be two types of response to threat. One is the immediate response, in which increased sympathetic nervous system activity leads to raised heart beat, respiration and blood pressure, all of which are readily measurable. The second type of response occurs when the threat persists over a longer period of time and leads to the secretion of hormones such as 17-hydroxycorticosteroid hormone. However, Mason (1968) concluded that the presence of 17-hydroxycorticosteroids is not related to specific emotional states - they "*appear to reflect a relatively undifferentiated response state of emotional arousal or involvement*" (quoted in Weinman 1981: 65). In fact Schachter (1975) has shown that there is no clear link between any group of physiological changes and the nature of the emotion

experienced. In experiments, subjects showed similar physiological responses, while reporting induced emotions as diverse as anger and euphoria. Thus the experience of an emotion is cognitively mediated, and is not a simple and predictable response to a given situation.

Therefore observation or physiological measures have usually been supplemented by self-reporting of levels of anxiety. The most frequently used measuring instruments derive from four theories of personality and predisposition to experience anxiety:

1. Trait/State Anxiety
2. Neuroticism
3. Locus of Control
4. Vigilance/Avoidance Theories

In each case inventories have been developed which purport to measure the variable in question. Thus, Cattell & Scheier (1958 & 1961) differentiated two types of anxiety - trait and state. "*Trait*" anxiety is defined as a relatively stable individual predisposition to respond with anxiety to situational variables. *"State"* anxiety is the transitory experience of anxiety in a particular situation and at a particular time.

Spielberger et al. (1970) have developed two widely-used questionnaires to assess state and trait anxiety. These are particularly valuable for measuring changes in patients before and after a procedure. Fitzpatrick et al. (1984) have reported a number of health care studies which were consistent in finding little change in trait anxiety levels, but variations in before/after state levels of anxiety. Overall research evidence supports the validity of the state/trait distinction (Auerbach 1973, Spielberger et al. 1973).

However, studies of hospitalised patients have found that those with high trait anxiety scores are also highly susceptible to state anxiety (Spielberger et al. 1973).

Allied to the idea of trait anxiety is a measure of Neuroticism which is one of two personality dimensions on the Eysenck Personality Inventory (Eysenck & Eysenck 1964). The Eysencks described neuroticism as a measure of susceptibility to experience emotions and Hayward (1975) found that neuroticism correlated highly with trait anxiety in hospitalised patients. Wilson-Barnett & Carrigy (1978) found a close association between neuroticism scores and state anxiety measured by Lishman's (1975) Mood Adjective Check List, with a positive correlation between the mean anxiety scores and the neuroticism scores.

Another much used measure of trait anxiety derives from Locus of Control Theory, developed by Rotter (1966). Rotter suggested that individuals may be divided into two broad groups. One group has a predominantly internal locus of control, perceiving themselves to be the main source of rewards and punishments for their own behaviour; their behaviour is controlled "*internally*". The second group has a predominantly external locus of control, perceiving the approval or disapproval of others as the most powerful influence over their behaviour; their behaviour is controlled "*externally*". Rotter argued that locus of control acts as a mediator, influencing the relationship between environmental stressors and the emotional reactions of the individual. In general terms, externals are more directly affected by life events, while internals use a wider range of strategies to protect themselves against stressors (Clum et al. 1979, Husaini & Neff 1981, Johnson & Sarason 1978, Parkes 1984). Externals appear to experience higher levels of state anxiety before surgery (Friedlander et al. 1982). In an experimental study of reactions to dental surgery, Auerbach et al. (1976) found that internals responded better to the availability of specific procedural and sensation information about the surgery than did externals. They suggested therefore that intervention strategies need to be tailored to personality traits of individual patients.

In addition to their use as trait measures, attributions of locus of control may also be viewed as coping strategies which are potentially amenable to change. Thus Seligman (1975) argued that if an individual can move cognitively from interpreting aversive events from an internal locus ("*I have brought this upon myself*") towards an attribution from an external locus ("*It was just bad luck*"), then under certain circumstances the individual may experience less depression and apathy than before.

Another theory with applications both to personality traits and to coping styles concerns a suggested distinction between Vigilance and Avoidance. Cohen & Lazarus (1973) and Miller (1984) have suggested that individuals may have a relatively stable overall preference for particular coping styles in dealing with aversive events. One style is "*Vigilance*" or "*Monitoring*", the other is "*Avoidance*" or "*Blunting*". Vigilance/Monitoring means being alert for the aversive aspects of an event. A "*monitor*" will actively seek information to predict what will happen to him while in hospital. In contrast in many situations a "*blunter*" will prefer to distract himself from the aversive event (Miller 1984). As with locus of control, a number of experimental studies have found that provision of information reacts with coping style, with monitors responding better to maximal information and blunters preferring minimal information (Andrew 1970, DeLong 1970).

The four theories reviewed above are to a large extent mutually compatible. Each measure may well help to identify distinct features of complex cognitive and emotional states. Certainly all the theories of patient anxiety point to the existence of wide individual differences in susceptibility to anxiety. The best-designed research studies are those which have used a combination of observational, physiological and self-report measures to identify patients' levels of anxiety at specified times. However, while accepting the importance of

individual response, there is evidence from research that some health/illness events are strongly and consistently associated with the experience of anxiety in the majority of patients. The next section examines the nature of these events.

AVERSIVE EVENTS

Severity and chronicity of illness are major sources of patient anxiety (Thorne & Robinson 1988), as are uncertainty over diagnosis and prognosis, particularly when cancer is suspected (J McIntosh 1974, Molleman 1984). The experience of surgery has been shown consistently to give rise to high levels of anxiety measured by self-report (Hayward 1975) and by physiological changes (Boore 1978). In this situation, anxiety arises from worries about recovery from the anaesthetic, from concern over post-operative pain and its relief (Carnevali 1966), and from worries over the meaning of the pre-operative preparation routine (Hayward 1975). It is uncertain whether surgery is in itself an experience particularly likely to be stressful, or whether this impression results from the comparative neglect by researchers of medical, elderly, mental illness or learning difficulty settings. Janis (1958) argued from psychoanalytical theory that since surgery entails physical injury from the surgeon's knife, albeit accomplished with a curative intention, it will necessarily give rise to deep-seated survival fears. Kelly (1985) illustrated this by explaining from personal experience the way that disfiguring surgery led to feelings of loss and grief akin to those of a bereavement.

INVESTIGATIONS

Investigations carried out with the purpose of assisting diagnosis have also been found to be associated with the experience of anxiety. Patients alluded to blood tests and chest X-rays in Reynolds' (1978) questionnaire. Anxiety arose from lack

of explanation by doctors or nurses of the reasons for the tests, or of the results of the tests. Special investigations such as barium X-rays and lumbar punctures give rise to anxiety and discomfort as procedures in themselves, and also because of worries about the reasons why they were ordered or the nature of the results (Wilson-Barnett & Carrigy 1978).

HOSPITALISATION

It is also known that general events associated with hospitalisation are frequently experienced as anxiety-provoking. Even a person admitted for elective treatment will have to cope with the demands of institutional routines which will certainly impose some restrictions on freedom and autonomy. Admission procedures may be stressful (Wilson-Barnett & Carrigy 1978). Hospitalisation may also lead to anxiety through isolation from the ready support of family and friends (Bowlby 1971, Cartwright 1964, Volicer & Bohannon 1975). Kubler Ross (1969) found that terminally ill patients in USA feared, and experienced, loneliness while in hospital. Some illnesses, for example mental illnesses, carry a stigma. Hospitalisation, day care or attendance at out-patients' clinics may restrict stigma management strategies and of themselves lead to the experience of anxiety (Miles 1984, Teasdale 1987).

Given that the events surrounding surgery in particular are consistently associated with raised levels of anxiety, Marie Johnston (1980) conducted a series of studies trying to discover the normal course of the experience of anxiety in patients hospitalised for major orthopaedic and gynaecological surgery. Interestingly, she found high levels of anxiety before hospitalisation, and also high levels continuing for up to five to six days after the operation. Only a small proportion reached the highest level of anxiety on the day of the operation itself. Set in the context of the GAS (Selye 1956), this suggests a prolonged period of alarm and resistance.

All these studies confirm what common sense suggests, that the diagnosis of illness, its treatment, and hospitalisation itself, are consistently associated with the experience of anxiety. However, some researchers have tried to go beyond this to determine whether the experience of anxiety has any inhibitory effects on physical and psychological recovery from illness or treatment.

THE FUNCTIONS OF ANXIETY

Selye's (1956) General Adaptation Theory suggested that anxiety in the initial alarm stages may have a protective function, but that if excessive it may become dysfunctional. Research by Hayward (1975), Kleinknecht (1978) and Wells (1984) found that very anxious patients reported higher than average levels of post-operative pain. Johnston (1980) and Carey & Burish (1988) noted that anxious patients needed more anaesthesia than average. Dean & Surtees (1989) argued from research evidence that the course of breast cancer may be adversely affected by the presence of high levels of anxiety which affect hormone secretion.

However, a contrasting view of the function of anxiety in surgical situations was put forward by Janis (1958). He presented survey and case study evidence which suggested that moderate pre-operative anxiety was beneficial and acted as a predictor of good post-operative emotional recovery. He reasoned that moderate anxiety was a sign that the person had taken some steps to prepare himself realistically for the discomfort, or pain of the post-operative period. Therefore the patient was less shocked by its occurrence, or even encouraged by its absence. Those who showed little pre-operative anxiety were thought by Janis to have unrealistic beliefs about their own invulnerability. Consequently they were traumatised by the operation and the discomforts of the recovery period. Those with high levels of pre-operative state anxiety were probably those with high

levels of trait anxiety, whose potential for emotional recovery was already compromised.

However, this curvilinear theory of the relationship between pre-operative anxiety and post-operative emotional state has not been found in later studies, which have tended to show a small linear relationship - low pre-operative anxiety and low post-operative distress, high pre-operative anxiety and high post-operative distress (Johnston & Carpenter 1980, Ray & Fitzgibbon 1981, Sime 1976). Janis worked from a psychoanalytical background and part of his supporting evidence derived from clinical case studies rather than controlled experimental investigations. It may be that his theory about the importance of having realistic expectations of surgery remains valid, but that the connection between these expectations and the consequent experience of moderate levels of pre-operative anxiety is unfounded.

Other writers have also argued that there are times when the presence of anxiety is helpful and may be therapeutic (Faugier 1986, Kessel 1979, Malan 1979). The case is most strongly made in the fields of psychiatry and psychoanalysis, where practitioners have argued that the conscious experience of anxiety may be therapeutic, since it obliges the individual to address the underlying source of his problem, rather than to repress it. Thus Malan (1979: 77) stated that:

> "it is the task of therapy to bring out the patient's anxieties and to trace them to their origin, not to drive them underground by reassuring them."

Therefore the evidence suggests that anxiety in acute physical illness, particularly in situations where surgery is required, is potentially harmful both physically and psychologically. In the area of psychiatry and chronic illness generally, the research base is weaker and the limited evidence which exists suggests that the alarm function of anxiety may be important in these situations.

COPING STRATEGIES

Coping strategies may be divided into two main classes - described either as Direct Action and Palliation (Lazarus 1976), or as Primary Control and Secondary Control (Rothbaum et al. 1982). Essentially, Direct Action/Primary Control means bringing the environment into line with one's wishes. Palliation/Secondary Control means bringing oneself into line with environmental forces. Following this schema, coping strategies should interact with the external environment; there can be no single best strategy, since adaptation will depend upon the nature of the individual and of the external stressor. Suzanne Miller (1979a) argued from experimental studies in both laboratory and real-life situations that individuals respond differently when faced with events which they believe they can or cannot control. She defined "*control*" as the ability to avoid, escape from or mitigate an aversive stimulus. Direct Action strategies are attempts to exercise control over events and will lead to relief from anxiety to the extent that the patient believes he will be effective in exercising the desired control (Miller 1979a).

Miller's control theory therefore supports the view that anxiety is largely dysfunctional in situations where the patient can exercise little or no control over the course of events. On the other hand, in situations where patients must make important decisions for themselves, reduction of anxiety as a primary objective may not necessarily be helpful. This is consistent with the broad distinction made earlier between anxiety in acute physical illness and anxiety in chronic illness. These ideas are important since they suggest that professionals must be circumspect in choosing interventions which may reduce patients' levels of anxiety. They influence the study of reassurance, since they suggest that to reassure may not always be the most desirable helping intervention. However, before moving on to study evidence about these helping interventions, it is necessary first to review the extent to which nurses are capable of assessing whether patients are experiencing anxiety. If nurses are unable accurately to

identify anxious patients, any interventions will be haphazard and employed without a rational basis.

NURSES AS ASSESSORS OF PATIENTS' ANXIETY

The research evidence concerning nurses as assessors of patients' anxiety is contradictory. Some studies suggest that nurses underestimate patients' fears, while others suggest that they overestimate them. Thus Carnevali (1966) investigated surgical patients' fears about pain and anaesthesia, finding that nurses were largely unaware of these. In a series of studies in USA, Davitz & Davitz (1981) found that nurses' inferences of pain were related to socio-economic status of the patient, with lower status patients generally believed to suffer more pain than patients of middle and upper socio-economic status. The gender of patients was found to interact with socio-economic status in influencing nurses' reactions to suffering. Nurses viewed lower status females as suffering more than lower status males, but for upper status patients the opposite was true. The authors suggested that there is a professional sub culture in nursing with sets of beliefs concerning patients' suffering which nurses learn during training. They asserted that one of these beliefs is that the patients with whom one is working are really not suffering too badly:

> "This permits the nurse to remain emotionally and physically distant from the patient, reduces the potential threat to the nurse, and allows the maintenance of a reasonable degree of professional integrity as well as personal stability." (Davitz & Davitz 1981: 172)

In the United Kingdom, Lowe (1989) in a small-scale study of a coronary care unit found that nurses thought patients were more worried about the environment of care but less worried about their illnesses than the patients themselves reported. Biley (1989) reported that the mean patient-worry score obtained from nurses was approximately double the score given by patients. Wallace et al. (1985) again found a higher estimation by nurses of environmental worries, but a lower estimation of worries about illness. However, the researchers noted that qualified nurses were more skilled than students and unqualified staff in many aspects of communication with severely ill patients.

Johnston (1982) compared nurses' assessments of patients' worries with those of fellow patients. She found that nurses were more successful in identifying the number of worries reported by patients. Nurses tended to estimate higher numbers of worries about discharge, occupation and progress than either patients or colleagues. However they estimated fewer worries about cross-infection, about being confined and about being liked by staff. She observed that:

> "These results confirm . . . that nurses are not particularly good at identifying the worries of an individual patient. The high false positive rate is likely to result in nurses dealing with worries that patients do not have and, as a result, being inefficient at reassuring where relevant." (Johnston 1982)

However, methodological problems affect the reliability and validity of these studies. All the UK research is small-scale, studying a range of only 10-20 patients and 10-26 nurses. Johnston's claim (above) that the results apply generally to all nurses is unsound on these grounds alone. The topic itself is difficult to research, since nurses appear to be suspicious of the motives of outside

researchers in this field of study. Thus Johnston (1982) reported that: "The study was restricted to one ward and to a small number of patients because of its limited acceptability to nursing staff." Biley (1989) apparently tried to conceal the full purpose of his study for fear of similar resistance ("Subjects . . . were informed that the researcher was involved in research designed to find out what pre-operative patients were worried about. They were not informed that the results from the patients and staff were to be compared to each other.")

It is suggested that if nurses fear outside criticism of their assessment techniques they may well choose to err on the safe side and to tick as many items as possible. This will increase the likelihood of the discovery of false positives reported by both Johnston and Biley. Action research (Towell & Harries 1979) might be a more reliable method of investigating this topic, allowing the nurses themselves to be involved openly in the design, implementation and response to the results.

Finally, as Johnston (1982) noted, one cannot legitimately speak of nurses "*overestimating*" or "*underestimating*" patients' worries. The patients themselves may be inaccurate in their reporting, or may be using different criteria from the nurses. A patient who is very anxious about his situation may use denial as a coping strategy. On the other hand, a patient who has recovered from illness may minimise past anxieties which have proved groundless. In fact, it is argued that the only meaningful judgements are comparative. In the studies reported here, the nurses overall appeared to agree with the patients in identifying which patients reported high levels of anxiety. However, there was less agreement between nurses and patients over the sources of the patients' fears. The present study is designed to elicit some further evidence about nurses' assessments and patients' reports of their experiences, before going on to investigate the interventions which the nurses employed as a result of their assessments. These helping interventions are therefore the next area of the literature to be reviewed.

SECTION 2: THE RANGE OF HELPING INTERVENTIONS

There is a vast literature on interventions designed directly or incidentally to alter patients' levels of anxiety. This section begins with a summary of what has been said specifically about reassurance. Then research evidence about the range of helping interventions is critically surveyed.

REASSURANCE

Most published material dealing explicitly with reassurance has been written by clinicians and is based upon their experience rather than upon experimental research. Two questions are raised in the debate:

1. Can attempts to reassure ever be therapeutic?
2. Which are the most effective methods of reassuring patients?

THE CASE AGAINST REASSURANCE

Hays & Larson (1963) argued that attempts at reassurance are unhelpful because they are usually unsuccessful. They asserted that reassuring interventions tend to deny patients the opportunity to express their emotions. Because of this, the reassurer is usually seen as unsympathetic and the intervention fails. Balint (1964) and Nurse (1980) commented that staff frequently try to reassure patients in order to spare themselves from sharing their patients' distress. They argued that these attempts are likely to fail and then to damage relationships. In an observational study of clinical practice in Midwifery, Kirkham (1987) noted frequent uses of optimistic assurance, which she interpreted as attempts by the midwives to deflect their patients' search for information and to protect themselves against the risk of saying the wrong thing. However, for all these authors "*giving reassurance*"

meant simply giving an optimistic assurance, rather than the broad illocutionary usage described in Chapter Two and adopted in this study.

Another perceived problem with giving reassurance is that most writers believe it makes the patient dependent on the reassurer. Selye (1956) argued that anxiety has a protective and a motivating function. However, successful reassurance will induce the patient to become calmer, and the motivation for the patient to take independent action will diminish. He will become dependent on the accuracy of the predictions induced by the reassurer. Sherlock (1986) asserted that in clinical practice the sick should not be regarded as "*reasonable men*", but should be seen as highly dependent people and treated as such. This extreme form of beneficent philosophy has been strongly opposed by many clinicians in the psychiatric field (Faugier 1986, Malan 1979, Sullivan 1954), who argued that they need the active co-operation of their patients in therapy.

Balint (1964) asserted that giving reassurance has only a short-term effect on levels of anxiety. A similar point about the dangers of creating dependence was made by Brammer (1973), Eccleston (1987) and Smith (1972). Two case studies on the effects of giving reassurance to hypochondriacal patients were described by Salkovskis & Warwick (1986). Their definition of reassurance was consistent with a broad illocutionary usage, and their hypothesis was that reassurance-seeking and -receiving are important factors in the maintenance of hypochondriacal behaviour. In two controlled clinical case studies they found that when staff continually responded to patients' requests for reassurance, these requests increased in frequency. When staff consistently limited their responses to giving new information only when appropriate, the patients became calmer and less anxious about their state of health.

However, other writers have argued that in many clinical situations it is valuable to give reassurance. Sapira (1972) described "*reassurance therapy*", arguing that it is particularly valuable when used with symptomatic patients with essentially benign diseases. Starcevic (1990) argued that even with hypochondriacal patients, reassurance is of value when it successfully conveys empathy and acceptance. Kessel (1979) asserted that "there are few clinical situations in which reassurance is impossible." Buchsbaum (1986) argued that giving reassurance has a place in the rehabilitation of the chronically ill when it induces them to maintain hope and confidence in their own abilities:

> "The purpose of reassurance is to relieve anxiety and restore the patient's confidence in his or her ability to live as an autonomous and functioning individual." (Buchsbaum 1986)

Therefore the overall opinion of writers on reassurance is that it is valuable in the short term when patients' worries are genuinely misplaced. However, giving reassurance may be inappropriate when working with people with chronic problems, since it encourages dependence and may make them less likely to take control of their situation for themselves. In addition, giving optimistic assurance is generally thought to be unhelpful because it is believed to be ineffective in relieving anxiety.

Turning then to the question of how to be effective in giving reassurance, French (1979) has given the most detailed advice from a nursing perspective. He stated that a nurse must be able to identify the verbal and non-verbal signs of anxiety in an individual; she must also know the types of event which are likely to give rise to anxiety. Careful assessment is also emphasised by Balint (1964) and by Buchsbaum (1986) who argued that it is vital to elicit the precise meaning which each symptom has for an individual. French recognised that there is no such thing

as a unitary reassuring skill. His article is consistent with an inferential model of communication in advocating that:

> "The nurse should be able to describe and carry out a repertoire of behaviours which she may use to attempt to restore the person's confidence." (French 1979)

He then listed examples of some of the skills which should be part of this repertoire - explaining, familiarising an unfamiliar situation, using touch, using proximity, conveying emotional stability, counselling, clarifying facts, helping patients to verbalise and ventilate their fears, and using diversional techniques. However, each of these skills can be used in many different ways and in many different contexts. French is quite clear that it is the intention of calming a patient, rather than the interpersonal skill employed, which is the key distinguishing feature of a reassuring intervention.

Other authors place less emphasis on the use of interpersonal skills in reassurance than upon the development of a trusting relationship between nurse and patient. Gregg (1955) emphasised the need for the nurse to establish herself both as someone who can be trusted to act in the patient's best interests and as someone who is competent in performing her job. Spector & Sistrunk (1979) conducted an experiment which suggested that the presence of a sympathetic colleague is frequently experienced as reassuring in itself, regardless of any verbal interventions. Brammer (1973) argued that the effectiveness of reassuring interventions depends mainly on the positive quality of the relationship rather than on the words spoken. Sapira (1972) stated that reassurance can be achieved in conditions where: "It is probably not essential that the patient intellectually understands all or any of the details of the physician's explanation."

Although there is considerable agreement in the views of these writers about how best to reassure patients, they are nevertheless mainly asserting their individual beliefs. For systematic evidence rather than opinion one must turn to research studies where the word "*reassurance*" is not necessarily explicitly mentioned. If giving reassurance is distinguished by the intention of the communicator, rather than by the individual skills employed, one can find evidence about reassurance in studies of many different types of intervention. However, published research on interventions is at its strongest in studies of patients in acute wards of general hospitals, with an overwhelming bias towards studies of patients admitted for surgery. The reason is that a surgical operation is an anxiety-provoking situation which facilitates before/after comparisons, since it forms a watershed event in the patient's history.

A problem in reviewing research on interventions is that the studies rarely make explicit their theoretical perspective on the communication process. There are some published theoretical frameworks which categorise intervention-type, such as Heron's (1975 & 1986) Six Category Intervention Analysis. However, Heron's Six Categories in fact represent a mixed model. Thus, one category, "*catharsis*", is inferential, since it describes an attempt to induce another person to express emotions. However, the "*informative*" category relies on a coding model, since it is defined in terms of the new knowledge which a nurse might "*give*" to a patient, rather than in terms of the inferences which the patient might draw as a result of the information disclosed by the nurse.

Therefore, in order to make sense of the wide range of published studies, they have been grouped here into a scheme which derives from the inferential model of communication and which focuses on the communicative intentions of the helper and on the inferences drawn by the patient.

Theory and research evidence about four categories of intervention will be described:

1. Uncertainty Reduction
2. Patient Control
3. Cognitive Re-framing
4. Relationship-Building.

UNCERTAINTY REDUCTION

A great deal of attention has been paid in the last thirty years to investigating how patients respond to being given information which reduces their uncertainty about their condition and treatment. The impetus for these studies has arisen from surveys of patients' levels of dissatisfaction which have consistently shown lack of information to be the most frequent complaint (Cartwright 1964, Korsch & Negrete 1972, Ley 1982, Reynolds 1978). Correlations have been found between levels of compliance and satisfaction with the consultation and the communicator (Francis et al. 1969, Kincey et al. 1975, Ley 1979). Reviewing the range of studies in 1982, Ley concluded that:

> "Patients remain dissatisfied with communication, often do not understand and often forget what they are told. Written information for patients continues to be produced in language too difficult for its intended audience. Finally patients remain as non-compliant as ever." (Ley 1982)

Given this evidence of relatively high levels of patient dissatisfaction with communication, many experimental studies have been undertaken in which information has been manipulated as the independent variable, with levels of anxiety as one of the dependent variables. The research hypothesis has generally

been that giving more information will make events more predictable and as a consequence will reduce uncertainty and accompanying anxiety (Berlyne 1960, Sokolov 1963). Some theories propose that when an aversive event is predictable, an individual is better able to prepare himself to cope with the impact of the aversive event than if the event is unpredictable (Epstein 1972, Lazarus 1966, Perkins 1955, 1968). Another variation on this theme is the theory that a person who knows when an aversive event will occur can relax during the intervening safety periods, whereas if the event is unpredictable the person can never relax (Seligman 1968, Weiss 1970). These uncertainty-reduction theories all predict that an individual will prefer to have information about an aversive event than to remain uncertain about its nature or timing, and that overall levels of anxiety in the period before the event will be lower than under conditions of unpredictability (Miller 1981).

Experimental studies have provided only limited support for these uncertainty-reduction theories. Hayward (1975) and Boore (1978) obtained significant results when comparing high-information surgical patients with controls, where self-reported anxiety, measures of analgesic use (Hayward), and physiological measures of stress (Boore) were the dependent variables. Wilkinson et al. (1990) obtained significantly lower levels of anxiety in an experimental group of women who received a leaflet explaining the nature of their cervical smear result compared with controls who did not receive the leaflet. Wilson-Barnett (1978) found a significantly lower level of anxiety during barium enema for an experimental group given verbal and written preparatory information. However a number of other experimental studies have failed to obtain significant results for groups receiving preparatory information alone (Langer et al. 1975, Wilson-Barnett 1978 for barium meal patients, Ziemer 1983). Given the tendency for researchers and journals not to publish studies which give non-significant results, the efficacy of preparatory information in lessening anxiety and stress may be even lower than these inconsistent results suggest.

Some researchers have investigated the hypothesis that information about what the patient will feel during a procedure (sensory information) will be more effective in reducing anxiety and stress than information about what will happen (procedural information). Johnson & Leventhal (1974) obtained significant results from medication use and assisting behaviours among members of a sample (below 50 years) who received sensory information as opposed to procedural information. However, Mohros (1976) in another study of patients undergoing gastrointestinal endoscopy found no significant group differences on medication required, although sensory groups showed a significant decrease in heart rate during the procedure. In contrast, Miller & Mangan (1983), studying a group of 40 patients undergoing colposcopy found significantly higher levels of arousal and discomfort in patients receiving a combination of procedural, sensory and behavioural information than in a control group who received the usual levels of information for the hospital involved in the study. The researchers suggested that the additional information forced the patients into the psychological presence of danger which they could not control, hence leading to higher levels of arousal.

Kendall & Watson (1981) in a review of research from the United States concluded that:

> "The literature on the utility of providing information for the reduction of patient distress and the improvement of patient adjustment provides only equivocal evidence. However, the results . . . provide more support for the efficacy of sensory information over simple procedural information in achieving the desired goals."
> (Kendall & Watson, 1981: 204)

British studies lead to a similar qualified conclusion. Overall the studies are limited in range to surgical and major treatment procedures in acute settings in general hospitals. Some of the studies with significant results (Boore 1978, Hayward 1975, Wilson-Barnett 1978) combine information and behavioural instructions, so that it is impossible to know which intervention was associated

with the significant results. Virtually all the studies from both Britain and the United States appear to adopt a coding model of communication. As a consequence, they report the information which was given, but they do not attempt to check how much the patients understood nor the inferences which patients made from this. In one of the few studies where patients' understanding of information was rigorously checked, Ridgeway & Mathews (1982) found a signicant increase in knowledge for one group given pre-operative information, but no significant result for the same group on measures of reported pain, mood state or medication use. It may therefore be possible to reduce patients' uncertainty through information-giving interventions, but there is no simple link between this and lower levels of anxiety and stress.

A theory which appears to reconcile the conflicting evidence about uncertainty reduction has been proposed by Suzanne Miller (1979a, 1981, 1989). She suggested that the effects of uncertainty reduction interventions depend on whether the event in question is aversive or non-aversive, and whether it is controllable or merely predictable. Thus she asserted that when a patient is unnecessarily concerned that an event may be aversive, predictive information will be preferred because it will reduce the patient's uncertainty and induce him to predict safety. Where an event is controllable, the research evidence suggests that uncertainty reduction will again be preferred because it will enable the patient to minimise the maximum danger which he will face (this evidence is reviewed in the section on Patient Control below). However, where an event is uncontrollable and genuinely aversive, several studies suggest that patients will generally prefer to be distracted from the event and will experience less arousal when distracted than when they are given predictive information about the event (Averill & Rosenn 1972, Rothbart & Mellinger 1972, Miller 1979b). Miller & Grant proposed the following hypothesis:

> ". . . humans generally prefer predictable to unpredictable aversive events, because predictable aversive events provide more safety signals. However . . . there is one salient class of exceptions: When individuals are allowed to distract themselves, they prefer unpredictable aversive events, because distraction and other blunting techniques provide the most effective means of reducing stress." (Miller & Grant 1979: 148)

These ideas offer an explanation for the conflicting results obtained in research which has used "*information*" as an independent variable. Because most researchers have adopted a coding model of communication, they have neglected the context in which the "*information*" is given and received. Miller's ideas make it possible to distinguish four different contexts - aversive, non-aversive, predictable, and controllable. The inferential model of communication breaks up the "*information*" monolith and forces one to focus on the intentions of the information-giver. Is the nurse simply trying to reduce the patient's uncertainty? If so, the evidence suggests that accurate factually-based information will be experienced as reassuring in non-aversive situations, but as positively alarming in uncontrollable aversive situations. The effects of information-giving and other interventions on potentially controllable situations will be reviewed in the next section.

PATIENT CONTROL

Patient control is the second type of intervention to be reviewed. In uncertainty reduction, the communicator's intention is primarily to ensure that a patient is informed about his situation. In patient control the intention of the communicator is to empower the patient to take action for himself. Miller (1989) defined "*control*" as "the individual's perception that he or she can execute (or has the potential to execute) some action that changes an aversive stimulus". She contrasted this with uncertainty-reduction or predictability which "merely implies that the individual knows something about the event, whether or not he or she can

do anything to change it." (Miller, 1989: 107-108) According to Miller (1979a) there are three types of control: avoidance of an aversive event, escape from an aversive event which has already commenced, and mitigation of the objective aversiveness of an event. Miller has proposed the "*minimax*" hypothesis as a theoretical explanation of the relationship between controllability and human stress. Minimax states that:

> "Individuals are motivated by a desire to minimize the maximum danger to themselves. Therefore, they prefer and are less stressed by control, when having control allows them to put an upper limit on how bad the situation can become." (Miller, 1989: 108)

Therefore the minimax hypothesis predicts that patients will prefer instrumental control over mere predictability in aversive situations; it also predicts that patients will experience less anticipatory anxiety in situations where they know that they can potentially minimise the danger by exercising their control. One qualification to this hypothesis is that there may be conditions under which another person will be better able to control the aversive event than oneself. Under these conditions, it is predicted that control by the patient would be more anxiety-provoking than control by an external expert.

Miller (1979a) reviewed laboratory studies and found extensive corroboration for the minimax hypothesis. However there have been few studies in clinical practice where patient control is manipulated as an independent variable. Part of the problem is that in the highly specialised and technological world of the modern general hospital, opportunities for patient control are not obvious. Once a patient has made a choice and given consent to an operation or a procedure, the only type of control which is generally encouraged is limited control designed to mitigate the aversiveness of the procedure.

One aspect which has been explored in the clinical setting concerns interventions designed to induce patients to exercise control by using progressive muscle relaxation and/or deep breathing to mitigate tension and pain during or after a procedure. Kendall & Watson (1981) reported a study by MP Miller (1976) which found a significant lowering of anxiety in dental patients who were taught progressive relaxation, compared with a control group. Wilson (1977) compared information provision with behavioural training in muscle relaxation for patients undergoing cholecystectomy and abdominal hysterectomy. Both groups had shorter hospital stays than non-intervention controls, but the relaxation group reported less distress and needed pain injections on fewer days than the other groups. Aiken & Henrichs (1971) took great care to ensure that a group of patients due to undergo open heart surgery understood and actually practised relaxation exercises. The experimental group needed significantly less time in surgery, fewer units of blood and suffered less hypothermia than a control group.

Therefore, the limited clinical research evidence available suggests that where patients believe they can mitigate their experience of pain by systematic muscle relaxation, they show less anxiety than where they believe they have no such control. Another way of limiting post-operative pain and complications is by learning skills in deep breathing, coughing, turning in bed, and leg exercises. Unfortunately many of the studies which have obtained significant results for anxiety reduction using these techniques have confounded them with provision of predictive information, so that it is impossible to specify which intervention produced the result (Boore 1978, Hayward 1975, Schmitt & Wooldridge 1973).

It was noted earlier that theorists in the field of chronic illness have suggested that there is an antagonism between short-term relief of anxiety and long term increases in control and autonomy. Thus Auerbach & Kilman (1977) argued that in cases of disfiguring surgery, or when recovery will be incomplete, social adjustment is a more appropriate outcome measure than anxiety or physical

recovery measures in the immediate post-operative period. Similar ideas were proposed by JF Miller (1983), Molleman (1984) and Wilkes (1977). Thorne & Robinson (1988) argued from qualitative research that there is a pattern which chronically ill patients follow in their reactions to the providers of health care. They begin with naive trust in the doctors and nurses, based on media stereotypes and total faith in the power of modern medicine. When these expectations are not confirmed in reality, they go through a phase of doubt. For some this generalised doubt and lack of trust will always remain. Others will trust only individual professionals personally known to them. A third group will learn about their own condition and seek a relationship of guarded alliance with the professionals in which trust is mutual, and where control is shared. Malan's (1979) suggestion that reassurance is inappropriate in psychotherapy is an echo of this same theme, namely that reassurance and patient autonomy are not always compatible. In order for a person to exercise control over his life and return to independence, he may have to be persuaded to tolerate higher levels of anxiety than if he permitted himself to remain dependent upon others.

Therefore the minimax hypothesis is fairly well supported by research evidence although studies have been limited to mitigation (rather than escape or avoidance) as the main form of control investigated in patients in the clinical situation. It appears that control interventions of this type require patients to pay attention to the aversive situation which they are facing and this leads to an initial rise in arousal and anxiety (Melamed and Siegel 1975, Miller and Grant 1979, p144). However, the medium to long-term effects appear to be calming if the patient becomes convinced that he can effectively exercise control in the aversive situation. Patient-teaching in both acute and chronic illness will frequently be connected with the intention of promoting patient control. Patient control interventions are inconsistent with giving reassurance, at least in their short-term effects and are therefore best regarded as a distinct class of intervention.

COGNITIVE RE-FRAMING

Where Patient-Control interventions permit the patient to adapt an aversive situation to himself, Cognitive Re-framing approaches seek to induce the patient to adapt himself to the situation. The term "*cognitive re-framing*" here refers to interventions in which a health professional tries to induce a patient to view an aversive event as less threatening than he originally believed or feared. These interventions promote what Lazarus (1976) described as palliative coping. In other words, a patient who cognitively re-frames an event adjusts himself psychologically to what he perceives as the "*event*".

Cognitive interventions are most frequently used in the psychiatric field for treatment of affective disorders, especially depression. Aaron Beck (1976) described the theoretical basis for the interventions. He suggested that it is the particular meaning attached to an event which determines the emotional response which occurs. Different people may attach different meanings to the same stimulus. If an individual interprets an event as threatening, that person is likely to experience anxiety. If the event is seen as uncontrollable, the level of anxiety is likely to increase. Cognitive interventions are designed to induce individuals to re-frame events as less aversive than originally believed. Sainsbury (1980) described re-framing as a three-stage process. Firstly, the patient must become aware of the meaning which he attributes to the event in question. Secondly, the patient must recognise that his original attributions may have been exaggerated or incorrect, and then substitute less aversive attributions. Finally the patient must test out the validity of his re-framed view against actual events.

In experimental studies, this general theory has been tested using a variety of detailed interventions. Langer et al. (1975) taught surgical patients to exercise cognitive control by identifying favourable aspects of receiving treatment and then re-directing attention to these aspects whenever discomfort was anticipated or

experienced. It is noteworthy that a check for satisfactory understanding was embodied in the preparation given. The patients using the cognitive strategy fared significantly better than a group receiving information aimed to reduce uncertainty on three measures of stress - nurses' ratings of patient-anxiety, percentage of patients requesting sedatives at least once, and proportion of patients requesting both pain relief and sedation. Kendall et al. (1979) also compared a cognitive intervention with an uncertainty reduction intervention, this time for patients undergoing cardiac catheterisation. Again the study was well controlled with inbuilt checks for adequate levels of understanding in both groups. The results showed support for the efficacy of both interventions in reducing anxiety before and during the procedure. However, the cognitive intervention was significantly better than the uncertainty-reduction and placebo control groups on physician rating of anxiety during the procedure.

In a third major study, Ridgeway & Mathews (1982) compared a cognitive intervention with an uncertainty reduction intervention, an attention intervention and no-treatment controls. The subjects were seventy hysterectomy patients. The interventions were administered through written booklets and all patients were subsequently visited to check that they had read and understood the material. The cognitive intervention group needed significantly less post-operative pain control medication, reported significantly fewer days of pain post-discharge, and showed a non-significant trend to return to household tasks earlier than all the other groups.

These are three particularly stringently conducted studies, all showing significant results on a battery of measures in favour of cognitive interventions. The cognitive re-framing strategies which they taught were all skills which patients could adapt to their own particular worries. In this sense, the strategies were automatically adapted to the coping preferences of individuals, in contrast to

uncertainty reduction and patient control which are blanket strategies and do not necessarily take the coping styles of individuals into account.

However, some experimental studies have used blanket cognitive re-framing strategies based on filmed modelling. Melamed & Siegel (1975) showed children admitted for surgery a short film of a child who underwent surgery. The child in the film was initially anxious but eventually overcame this anxiety and recovered well from the operation. The intervention was designed to induce the viewers to identify with the child in the film and then to model their cognitive response to the impending uncontrollable event upon the view of the event shown in the film. It should be noted that although there are elements of uncertainty reduction in this intervention, the intention was to induce the viewers to re-frame the event in an exclusively positive light. The immediate effect was an increase in the anxiety levels of the treatment group. However, this rapidly lessened and the treatment group showed a significant pre- and post-operative decline compared with a rising curve of anxiety for the control group. The effects of filmed modelling do not appear to be limited to use with children. Thus Shipley et al. (1978) obtained significant results for a cognitive intervention group using a videotape model with adult patients undergoing gastrointestinal endoscopy.

Therefore cognitive interventions, which have a long pedigree in psychology, have been shown to be highly effective in reducing anxiety in experimental studies in general hospitals. This is important because most cognitive interventions are forms of reassurance, since the intention of the person using the intervention is generally to induce the patient to predict that the event will be less aversive than he initially feared. One of the issues for the present study is to identify the types and effectiveness of the cognitive re-framing strategies used by nurses to reassure patients in everyday clinical practice.

RELATIONSHIP-BUILDING

This fourth type of helping intervention has already been recognised in many of the studies reviewed, where the researchers used attention-control groups in case the mere presence of an attention-giving outsider produced a calming effect. The term "*relationship-building*" is here defined broadly as any intervention in which one person presents herself as caring, supportive or interested in another person. The most fully elaborated theoretical basis for regarding relationship-building as an anxiety-reducing intervention is John Bowlby's Attachment Theory. It was developed over a period of more than forty years, but its most detailed expression is to be found in Bowlby's trilogy on Attachment and Loss, the first volume of which was published in 1969. The theory derived originally from an ethological perspective. Bowlby argued that humans and other animals have developed control systems which help them to adapt themselves to their environment. Attachment behaviour is a response to a perceived threat which moves one close to a figure of attachment believed to be ready and willing to come to one's aid. The biological function of attachment behaviour is protection from predators, and to this extent the theory is compatible with Selye's (1956) view that anxiety has a protective function in triggering alarm. Attachment behaviour may be regarded as a natural human response to alarm. It occurs in two basic forms. One form is signalling behaviour, such as crying, smiling, calling, or making gestures. The aim is to induce the object of attachment to move closer to oneself. The other form is approach behaviour, moving oneself close to the object of attachment and maintaining that proximity while the danger persists. In childhood, one's parents are the main objects of attachment and Bowlby (1988) referred to them as providing a "*secure base*" from which to explore the world. However, Bowlby insisted that attachment behaviour can be reawakened in adult life, when the object of attachment may be any person who is believed to be able to protect one from the perceived threat:

> "That attachment behaviour in adult life is a straightforward continuation of attachment behaviour in childhood is shown by the circumstances that lead an adult's attachment behaviour to become more readily elicited. In sickness and calamity, adults often become demanding of others; in conditions of sudden danger or disaster a person will almost certainly seek proximity to another known and trusted person. In such circumstances an increase of attachment behaviour is recognised by all as natural." (Bowlby 1971: 255-6)

If an anxious patient regards a nurse as a powerful figure who is able and willing to protect him from the aversiveness of a threat to his health, attachment theory predicts that the presence of this object of attachment will induce the patient to feel calmer or more secure. In other words, the theory predicts that under certain circumstances a nurse may be able to reassure a patient by her very presence. Anything which a health professional does which promotes this relationship of trust will increase the likelihood that the patient will see the professional as an object of attachment.

In a laboratory setting, Spector & Sistrunk (1979) conducted an experiment to test the hypothesis that the presence of sympathetic others can be reassuring and reduce anxiety levels. Subjects were recruited and told they were to be part of an experiment in which electric shocks would be administered. They were then shown into a waiting room in which two other people were sitting. In the experimental group, the two people engaged each subject in supportive conversation, including optimistic assurances that: "*The shock couldn't be that bad*" etc. In the control condition, the two people kept conversation to a minimum and expressed no optimistic assurances. Anxiety levels in the experimental group decreased significantly, while no change was found in the control group. This experiment suggested that the mere presence of others is not reassuring in itself. Two explanations are possible - one is that the optimistic assurances induced the subjects to re-frame their view of their situation; the other is that the subjects felt safer because their companions were sympathetic and

friendly towards them. Spector & Sistrunk conducted a second experiment using the same method as the first, but administering an additional questionnaire designed to assess the subjects' appraisal of their situation. No cognitive appraisal changes were identified in either group. The tentative conclusion is that re-framing did not occur; it was because the colleagues were sympathetic that they established themselves as objects of attachment and their presence led to a reduction in subjects' anxiety levels.

In the clinical area, there have been relatively few systematic attempts to investigate the effects of relationship-building with adults. Gruen (1975) found significant results for supportive interventions with patients who had suffered a myocardial infarction. However, Kendall & Watson (1981) criticised this study and noted that it is unclear which aspects of the intervention produced the significant outcomes. Although the intervention relied heavily on relationship-building, it also contained elements of uncertainty reduction and of patient control.

Lucas (1975) divided cardiac surgery patients into four groups. A therapist helped one group actively to focus on plans for recovery and future life. A second group was merely asked to think about recovery and future plans, while a third group were given general conversation and attention for the same period of time. Finally the fourth group were given no intervention. The first three groups did not differ among themselves on measures of recovery, but fared significantly better than the non-intervention group, suggesting that it was contact with a sympathetic helper which produced the change.

In a survey of psychiatric crisis intervention, Kirk et al. (1988) found significantly less stress and arousal following interviews where there was a close match between patients' and therapists' perceptions of patients' needs and wants, suggesting a helpful function for preliminary relationship-building. Working with

hospitalised children aged three to five years, Lehman (1975) found that where mothers were allowed to room-in with their children, fewer post-operative complications occurred, although analgesic use was higher than in children whose mothers did not room-in. The latter effect may simply have been due to the mothers' ability to monitor their child's level of pain constantly and with more accuracy than the nurses.

Another aspect of relationship-building which has aroused research interest is the use of touch. Krieger (1976 & 1979) claimed positive effects for therapeutic touch on haemoglobin levels and on physiological measures of relaxation. However, as Clark & Clark (1984) noted, the studies are open to severe methodological criticism. The choice of haemoglobin levels as the dependent variable in the earlier study is hard to justify, while the actual measures taken in the second study are not reported. Heidt (1981) hypothesised that therapeutic touch would lower anxiety levels in patients. Heidt found a significant self-reported lowering of anxiety in the therapeutic touch group compared with a casual touch and a no-touch control group. However, Randolph (1980) in a double-blind study was unable to replicate this effect.

Considered overall, relationship-building is a promising area for further study in the clinical area. Although the use of touch as a therapeutic agent is not supported by research, it may have a wider role in communicating support or caring non-verbally. The limited research evidence available from clinical settings supports Bowlby's contention that:

> ". . . human beings of all ages are found to be at their happiest and able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise." (Bowlby 1975: 407)

The implications of this statement for the present study are that patients who are separated by hospitalisation from their loved ones will search for new figures of attachment; and that if nurses can build trusting relationships with them, this will have a reassuring effect independent of any other interventions employed.

SUMMARY OF SECTION 2

The studies reviewed suggest that differerent categories of intervention vary in their effects on patients depending on the aversiveness and controllability of the patients' situation. Thus, uncertainty reduction in broadly non-aversive situations appears to be effective in reducing patients' levels of anxiety. In genuinely aversive situations where patients can exercise control, interventions which promote patient control appear to be more effective than uncertainty reduction alone. Although these patient control interventions may lead to an initial rise in anxiety, they are usually followed by a marked decline in anxiety. In aversive situations where there is little or no scope for patient control, a variety of cognitive re-framing techniques appear to be effective in promoting calmness by inducing patients to control their own emotions and to reinterpret their situation as less aversive than it initially appeared. This approach is also compatible with relationship-building strategies which appear to have the potential to reduce patient anxiety by providing patients with an object of secure attachment.

SECTION 3: NURSES AND THE ORGANISATION OF HEALTH CARE

In order to analyse the use of reassurance in nursing, it is essential to understand the traditions and constraints which affect the way nurses act. This involves studying the professional socialisation and administrative regulation of nursing practice, setting reassurance into its organisational context.

NURSING AND MEDICINE

Nursing stands in a close historical relationship with Medicine, which is the dominant profession in health care in the western world. Nursing itself is regulated in line with some of the key attributes of a profession which were initially proposed by Carr-Saunders & Wilson in 1933. Thus it organises its own education and training and has formal standards and ethics enshrined in a Code of Professional Conduct (UKCC 1984). However, nurses are organised as a complex hierarchy, bound by rules and regulations. The individual nurse is not a free agent, she does not work as a truly independent practitioner. There are many different constraints on her freedom of action, and most apply whether she is working in a hospital or in a community setting.

Historically, Nursing developed in a helping role which was subordinate to that of the medical profession. The relationship between the two groups in the early part of the twentieth century was explored by Keddy et al. (1986), who interviewed nurses who had worked in Canada in the 1920s and 1930s. These nurses described a situation where doctors dictated much of the education of nurses and where they also frequently controlled their selection and dismissal. The researchers found plentiful evidence of sex role stereotyping. Gamarnikow (1978) characterised this as similar to that which existed in Victorian families, with male doctors seen as authoritarian father figures and female nurses either as handmaidens, or as surrogate mother figures. Christopher Maggs (1983), studying

the history of General Nursing in the United Kingdom, described a broadly similar pattern of subordination.

Stein (1967) proposed that in hospitals many interactions take the form of a "*Doctor-Nurse Game*". He suggested that doctors are trained to see themselves as the only true decision-makers in patient care. However, they cannot know individual patients as well as the nurses, nor do they all have as much experience in particular clinical areas as many nurses. Therefore the doctors in fact rely considerably on nursing advice, but must not be seen to do so. Stein suggested that the nurses are constrained to play a game in which they may make suggestions about the clinical care of patients, but may not do so in such a way as to challenge the authority of the doctors.

However, recent studies in the United Kingdom have called into question the extent of nurses' continuing subordination to doctors. Hughes (1988) studied interactions in a British casualty department. He found that the power of the nurses was enhanced by the large number of admissions, the high turnover of medical staff, and the cultural and linguistic distance between medical staff from the Indian subcontinent and indigenous patients. Nurses were openly involved in assessment and decision-making in this casualty unit. A similar trend was reported by Porter (1991) in a participant observation study of a general hospital in Northern Ireland. Porter found that overtly recorded decision-making by nurses was comparatively rare: the written care plans were not used greatly for this purpose. However, informal overt decision-making was frequently observed. It was only with the consultants that the nurses consistently played the doctor-nurse game as described by Stein (1967). Porter (1991) concluded that:

> ". . . It appears that there has been a definite historical progression in nursing involvement in decision-making. From their initial subservience, nurses have progressed through an era where informal covert decision-making appeared to be dominant to the present time

when informal overt decision-making is accepted as a valid nursing strategy." (Porter 1991)

ELECTIVE CONSTRAINTS

However, even when doctors do not constrain nurses in the helping interventions they use, the nurses sometimes voluntarily constrain themselves. J McIntosh (1977) found that nurses working in the Oncology Wards of a large Scottish hospital positively advocated the restriction of information about diagnosis and prognosis to all patients. They stated that they believed this was essential to maintaining the morale of patients. In Midwifery, Kirkham (1987) found that midwives in one consultant-led unit consistently used optimistic assurances as a way of deflecting patients' requests for information which might have allowed them to exercise control over their labour. These midwives even had one of their number moved from the unit, when she did not conform with their approach.

Menzies (1959) in a qualitative study of the way nurses were managed in a large London teaching hospital stated that: "By the nature of her profession, the nurse is at considerable risk of being flooded by intense and unmanageable anxiety." Menzies argued that nursing care was managed in such a way that this anxiety was constantly denied and avoided. Thus she noted that nursing work was organised into tasks to be performed on different patients, rather than entrusting the total care of a patient to one or a small group of nurses. Task allocation encouraged the nurses to see their job in terms of performing tasks rather than caring for people. She commented on the tendency to depersonalise patients by referring to "the hip in bed ten", rather than using the patient's name. She found that decision making was unnecessarily restricted, and nursing procedures were ritualised to allow little scope for creativity.

NEW SYSTEMS

Menzies has reviewed her 1959 conclusions about the nursing profession, asserting that they remain valid (Menzies Lyth 1988). However, the profession itself can point to certain theoretical, organisational and educational developments which have attempted to address the issues which Menzies raised. Soon after Menzies published her study, Virginia Henderson gave an influential re-definition of the role of the professional nurse:

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible." (Henderson 1966: 15)

Building on this, the governing bodies in Nursing in the United Kingdom pressed for the universal adoption of the "*nursing process*" as the basis for the delivery of nursing care by professional nurses. In the nursing process, the role of the nurse is that of a problem-solver. With every patient, her approach must follow a cycle of assessment, planning, care-giving and evaluation (MacFarlane & Castledine 1982). This approach was integrated with theories or "models" of nursing which emphasised a very broad role for the nurse in meeting the physical, psychological and social needs of patients. Menzies' criticisms were influential in highlighting the inadequacies of task allocation, leading to experiments in primary nursing - where a named nurse is totally responsible for the nursing care of each patient (see Salvage 1990 for a detailed review).

STUDENT NURSES

An attempt has also been made to change the system which Menzies found, where most of the nursing care was given to patients by student nurses. The British

Government accepted the Project 2000 Proposals (UKCC 1986), which greatly increased the theoretical content of nursing education and which made students supernumerary to staffing requirements during most of their training.

Nevertheless, the experience which student nurses will receive in the clinical area from the qualified nurses who act as their role models is unlikely to change radically overnight. Melia (1987) found that one important constraint on communication between student nurses and their patients was the students' uncertainty over the patients' diagnosis, prognosis and treatment. She labelled this "*Nursing in the Dark*". Melia noted that both doctors and trained nurses frequently restricted the amount of clinical information which was available to the student nurses. J McIntosh (1977) described the way in which doctors (at consultant level at least) were free agents in giving information to patients, or in withholding it. They were able to use information and uncertainty to influence patients to comply with the forms of treatment which they recommended. Several studies corroborate the suggestion that nurses generally accept a subordinate position with regard to disclosure of information, particularly if it is bad news (Faulkner 1985, Glaser & Strauss 1965, McIntosh 1977).

Melia (1987) regarded the socialisation of student nurses as a reflection of the accepted norms for trained nurses. On the basis of what the students said, she argued that Nursing may never claim the same degree of clinical autonomy as Medicine:

> "The trappings of profession are present, but the autonomy, it seems, is unattainable so long as the profession of medicine dominates. One of the striking features of the students' accounts was this lack of concern to rid themselves of medical dominance: in fact, they seemed rather to cling to it and take the medical position as their point of reference, or indeed their sanction." (Melia 1987: 181)

If what Melia says is valid, then nurses will be constrained in their use of helping strategies. One can predict that uncertainty reduction strategies will be permissible when the news is good, but that in situations where the news is bad, nurses may not have the authority freely to disclose what they know. Patient control interventions will also suffer from this constraint, particularly in those hospital settings where a medical model is dominant. One is led to predict that on many occasions nurses may fall back on cognitive re-framing techniques as a way of managing the anxieties of patients, rather than resolving them. In some cases these techniques will involve the nurses in trying to induce patients to infer that their situation is safer than the nurses believe it to be. Bok (1978) reviewed the ethical arguments about deceiving patients in what is believed to be their best interests. She summarised the difference between the patients' viewpoint and that of the health care staff:

> "The perspective of needing care is very different from that of providing it. The first sees the most fundamental question for patients to be whether they can trust their care-takers. It requires a stringent adherence to honesty in all but a few carefully delineated cases. The second sees the need to be free to deceive, sometimes for genuinely humane reasons. It is only by bringing these perspectives into the open and by considering the exceptional cases explicitly that the discrepancy can be reduced and trust restored." (Bok 1978: 241)

This tension between a respect for autonomy and a desire to act always in the best interests of the patient is a recurrent theme in debates over the ethics of health care (Beauchamp & McCullough 1984).

SPENDING TIME WITH PATIENTS

Melia (1987) found that student nurses followed certain unwritten rules. One of these was that '*Talking isn't Working*'. In other words, the students felt guilty if they spent time talking to a patient while not engaged in some physical nursing

care activity. This unwritten rule certainly tallies with other published research studies of nurses' behaviour. Major literature reviews by Wilson-Barnett (1981) and Macleod Clark (1985) revealed that general nurses appear to spend very little time communicating with patients and tend to avoid emotionally charged topics. Macleod Clark's summary of research into communication between nurses and patients on surgical wards is typical of the findings of other researchers:

> ". . . the nurses in the study demonstrated little evidence of interpersonal skills. Their questions to patients were nearly always closed or leading, with few examples of open questioning. Reinforcing or encouraging strategies were rarely used appropriately and there was evidence of a lack of listening and attending. Nurses' reponses to patients' questions and cues were often negative in that over half the responses or answers were evasive, cliched or even absent. The overall picture was one of tactics that discouraged communication rather than skills that encouraged it." (Macleod Clark 1985: 16)

Although most of the studies have concentrated on nurses working in general hospitals, Altschul (1972) and JB McIntosh (1975) found similar evidence of inadequate communication between nurses and patients in psychiatric and district nursing settings respectively. Altschul (1972) noted that the amount of time psychiatric nurses spent with patients, and the number of questions which they asked, decreased the longer the patients spent in hospital. She concluded that nurses were collecting information as part of an assessment of patients on admission, but that they were not using this information as a basis for planning care. There is some evidence that nurses are particularly inadequate in meeting patients' emotional needs. Maguire (1980) found that only five per cent of interactions between nurses and mastectomy patients concerned emotional needs. The same researcher in a 1978 study found that nurses ignored signs of distress in patients and gave platitudes or sedatives. Coser (1965) observed that staff in hospitals in USA discouraged complaints or open signs of distress.

ORGANISATIONAL CONSTRAINTS

If nurses are constrained in their communications with patients by a lack of professional autonomy, they are also likely to be affected by the rules and norms of the organisations in which they work. Morgan et al. (1985) gave an overview of organisation theory as it applies to health care settings. Early analyses drew on Weber's (1949) description of a bureaucracy as a hierarchical system of authority with clear and rational rules. However, this model must be modified in health care to allow for the autonomy of the medical profession, and the more limited clinical freedoms of other staff groups, including nurses. Etzioni (1975) looked at the nature of compliance. He suggested that members of an organisation may comply either because they are coerced, or because of the remuneration they receive, or because they willingly accept the norms. These forms of compliance give rise to differing levels of emotional involvement with the organisation - alienation, calculation and moral commitment respectively. Etzioni argued that hospitals are most effective when staff have a moral commitment to the service.

However, at a time of rapid change in the organisation of the service such a moral commitment becomes problematic. The Griffiths Report (DHSS 1983) and the NHS and Community Care Act (DoH 1990) point towards a Health Service which is more actively managed than ever before. Carpenter (1977), in a discussion of the history of nursing management, argued that the new managerial elite in nursing will have to choose between a responsibility to the organisation to remain within budgetary limits, and the nurse's moral commitment to provision of a high quality service to patients. Carpenter stated that many will come to see themselves as managers who are "*ex-nurses*". In contrast, the matrons of old were always clearly identifiable as nurses. If there is a conflict between the goals of managers and the goals of clinicians, nurses will be placed in a dilemma which will affect the whole of their clinical practice, including their ability to reassure their patients about the quality of the service which they provide.

SUMMARY OF SECTION THREE

Reviewing the organisational context of care, it is apparent that although the influence of doctors over nurses is less than it was, nurses are still far from free to choose whichever intervention which they believe will be best for each individual patient. Consultants still control much of the clinical decision-making in general hospitals. Qualified nurses also appear frequently to withhold information about patients from student nurses. In situations where the news is good, nurses appear to be relatively free to use uncertainty reduction strategies. However, in genuinely aversive situations, the use of uncertainty reduction and patient control interventions will both be affected by any constraints placed on disclosure of information. Relationship-building approaches may also be constrained by the legacy of a nursing culture which has used emotional distance to shelter nurses from more profound anxieties about the effects of the whole range of health care interventions and the systems which support them. These constraints form the organisational context in which the critical incidents in the present study are reported.

CHAPTER 4: RESEARCH METHODS

CHAPTER 4: RESEARCH METHODS

The data collected in this study are qualitative rather than quantitative, and the method of analysis employs induction rather than deduction. These approaches were not chosen from any ideological aversion to positivism; they were selected on practical grounds as the methods best suited to the exploration of this particular topic, at this particular time and with the resources available. The qualitative data comprise accounts in which informants were asked to describe incidents from their personal experience when nurses gave care to patients who were anxious, worried or distressed. Because reassurance is a relatively new field of study, there was no broad range of existing research from which to operationalise hypotheses for verification. What was needed first and foremost was a wide-ranging survey of the field which could yield a structured and detailed classification of relevant interventions. From this set of categories, explanatory theory could be generated to suggest links between the actions of the nurses and the outcomes of those actions on the patients. The term "*theory*" as used in this thesis is defined as:

> ". . . a strategy for handling data in research, providing modes of conceptualization for describing and explaining." (Glaser & Strauss 1967: 27)

The study combines two research methods: Grounded Theory (Glaser & Strauss 1967) and Critical Incident Technique (Flanagan 1954). Grounded Theory influenced the construction of the sample and determined the method of data analysis, while Critical Incident Technique influenced the choice of units of data. Ethical and practical constraints also affected both the construction of the sample and the choice of data collection methods.

This chapter is designed to provide a sufficiently detailed account of the research methods to permit replication, and to explain the limits of reliability and validity imposed by the research design. Accordingly the chapter is organised into

sections which explain the construction of the sample, data choice and collection, and the method of analysis. The chapter ends with an example of category development, to illustrate the application of the processes described.

SECTION 1: CONSTRUCTION OF THE SAMPLE

The sampling method employed was Theoretical Sampling (Glaser & Strauss 1967). This is a process of data collection for the purpose of theory generation in which the analyst jointly collects, codes and analyses the data, allowing the developing theory to dictate where next to collect data. Thus the logic of the developing theory determines the choice of sample sub-groups. One begins with a relatively homogeneous sub-group selected on the basis of what is already known about the problem area. From this sub-group the basic descriptive categories are established. When relatively little new theoretical material is being generated from this sub-group, one moves to a contrasting sub-group, aiming to maximise differences and promote theory generation by comparing the new data with the old. Any similarities which recur under these conditions extend the scope of the established categories. Any major differences may require the addition of new categories, or the modification of existing ones. The process of maximising or minimising diversity according to the dictates of the developing theory must continue until the categories are clearly delineated and further sampling adds little or no detail to the picture already established. Glaser & Strauss (1967) describe this as "*saturation*", at which point data collection may cease.

This process contrasts with probability sampling, as used in verification designs. In such designs, sampling decisions must be determined at the commencement of the study and an attempt must be made to eradicate the influence of researcher bias through random selection within each stratum of the sample. Because the present study explores a relatively new field in Nursing, probability sampling would not have been appropriate. Thus Sjoberg & Nett (1968) argue that

non-probability samples with built-in controls to ensure selection of a diversity in a working universe can provide more information than carefully drawn probability samples from a limited universe. In trying to establish ways of categorising different types of communicative intervention, the researcher was interested in collecting a wide range of data, including examples of comparatively rarely-used strategies. Theoretical sampling maximises the potential for variety, whereas both the practical and theoretical constraints of probability sampling militate against it.

The major limitation arising from the use of theoretical sampling in this study is that no claims may be made about the relative frequency with which different communicative interventions are used by the nursing population as a whole. However, the stated aim of the study is to identify the range of ways in which nurses can be effective in helping anxious patients to feel calmer or more secure. The emphasis is on the nature of the helping interventions, rather than on the frequency at which they occur. Knowledge of the relative frequency of such interventions would not necessarily reveal anything about their value in the care of patients.

Data were collected in the form of written critical incidents elicited by questionnaire from 202 nurses, and in the form of tape-recorded interviews from a further fifty-one patients and fifty-one nurses. Opportunity sampling largely dictated the selection of individual informants, while theoretical sampling was used to determine the selection of sub-groups. Thus sampling began with collection of written incidents from nurses working in hospital and community settings in two large rural districts. The first eighty-three incidents were collected from student nurses, on the basis that they were a relatively homogeneous group whose limited experience in nursing would minimise the complexity of the incidents and make it easier to establish basic descriptive categories.

When little new material was emerging from this source, sampling switched to qualified nurses. Initially these comprised opportunity samples of nurses who

were attending training courses run by the School of Nursing in which the researcher worked. In the later stages of collection of written incidents, groups of psychiatric nurses and district nurses were sought in order to widen the diversity of comparisons. No incidents were collected from midwives or health visitors; the reason is that, although most members of these professions are also qualified nurses, the nature of their clinical practice is distinct from that of nurses. Helping interventions in their professions will need to be investigated in quite separate research studies.

Once a comprehensive range of descriptive categories was established for the written incidents, it was decided again to widen the diversity of the sample by interviewing patients. Fifty-one patients from a single large district general hospital were interviewed. Interviewing commenced with thirty-two patients in two general surgical wards, since the literature suggested that these were areas where most patients were likely to be affected by anxiety. The diversity was then increased by collecting incidents from a sub-group of twelve patients from one medical ward and from seven clients of a psychiatric day unit in the same hospital.

Ethical and practical considerations affected access to patients. The researcher's previous experience in using interview methods with psychiatric patients (Teasdale 1987) suggested that some individuals might find the interview process stressful, and that appropriate levels of autonomy for giving meaningful consent may be difficult to gauge. On these grounds it was decided not to attempt to seek interviews in Psychiatric In-Patient Wards, and Children's Wards were excluded on the same grounds. Initially it was intended to include interviews with residents in a Mental Handicap Unit as part of the sample. However, the interviews with surgical patients indicated that a relatively high level of verbal ability and acuity of memory was needed if incidents of sufficient detail were to be elicited. It was decided therefore on practical grounds to omit people with learning disabilities from the study. Because of these sampling contraints, no claims can be made

from this data that the findings reflect the range of interventions made by Sick Children's Nurses (RSCNs), or Mental Handicap Nurses (RNMHs). The findings may also not reflect fully the interventions required in acute psychiatric areas with more disturbed patients.

In twelve cases the patients described incidents where it was possible to interview the actual nurses whom the patients referred to in their accounts of incidents. These **paired incidents** were considered particularly valuable, because they gave a view of the same incident from different perspectives. Ideally the researcher would have liked to have collected more paired incidents. However, ethical and practical constraints again intervened. It was considered particularly important that all patients voluntarily agreed to participate in the study. More paired incidents might have been generated by interviewing a nurse first, asking her to name the patient whom she had tried to help, and then seeking out that patient for interview. However, there might have been a temptation to put undue pressure on the patient to comply with the interview request. Also, by naming the patients, the nurses would have breached the patients' right to clinical confidentiality. Therefore all paired incidents commenced with the patient, and the nurse was only approached when a patient was able to name the nurse and agreed to allow the researcher to approach her for more details.

In addition to the twelve nurses in the paired incidents, thirty-nine other nurses were interviewed. They were selected to ensure that incidents were collected from a reasonable variety of clinical areas in hospital and community settings. Interviewing ceased when numbers of nurses and patients corresponded, and when new incidents were adding little to the detail of established categories. Table 4.1 shows the final composition of the total sample of nurses and patients.

TABLE 4.1: THE SAMPLE SHOWING CLINICAL AREAS

AREAS	NURSES' QUEST'S.	NURSES' INTERVIEWS	PATIENTS' INTERVIEWS	TOTALS
MEDICAL	78	18	12	108
SURGICAL	71	10	32	113
COMMUNITY	20	8	0	28
PSYCHIATRIC	33	13	7	53
M HANDICAP	0	2	0	2
TOTALS	**202**	**51**	**51**	**304**

The nurses were drawn from two large rural district health authorities, while the patients were all drawn from a single hospital. It should be noted that because of the nature of the district, both patients and nurses were ethnically and culturally relatively homogeneous.

The clinical areas listed are those to which the nurses referred in their incidents, or those in which the patients were receiving care at the time the incident was recounted. The term "*Medical*" includes Intensive Care, Accident and Emergency, Care of the Elderly Wards, as well as General Medical Wards. "*Surgical*" refers to incidents occurring in the Theatre suite, in ENT, Ophthalmic and Orthopaedic Wards, and to Surgical Wards ranging from major emergencies to elective day cases. "*Community*" refers to incidents supplied by District Nurses and Practice Nurses. "*Psychiatry*" includes incidents supplied by nurses working in Acute, Elderly Mentally Ill and Adolescent Psychiatry Wards, as well as Day Units and incidents recounted by Community Psychiatric Nurses. The patients in this category who were interviewed were all attending one hospital-based Day Unit.

The two mental handicap nurses interviewed both worked in residential care settings. Additional details of sample composition are given in Appendix One.

SECTION 2: DATA CHOICE AND COLLECTION

The basic data unit in this study is a critical incident, which comprises a retrospective description of a time when a patient was reported to be anxious, worried or distressed and a nurse said or did something to try to help the patient to become calmer or more secure. Observation methods are superficially attractive as a way of collecting data in the clinical area. However, there are profound ethical objections to a research design which involves intruding upon patients and nurses at moments which, by definition, are emotionally-charged. As an alternative, modern technology makes possible non-participant observation, but it also severely restricts the scope of what can be observed. Video cameras tend to be unduly intrusive, whereas microphones record only what was said: all the non-verbal communication is lost. Faulkner (1980) taped conversations between student nurses and patients in a general hospital ward, but found that the average length of her recorded interactions was only 2-3 minutes. Macleod Clark (1980) used tape and video to record similar conversations and also that found them to be short, superficial and task-related. Altschul (1972) noted a similar interaction pattern in an observation study in psychiatric wards. Therefore the evidence suggests that to use such observation methods to collect a reasonable body of data about helping interventions in different clinical settings would probably have proved excessively time-consuming and might not have supplied an adequate set of data.

CRITICAL INCIDENTS

In view of these considerations, a different method was selected: the retrospective collection of critical incidents from written questionnaires completed by nurses, and from tape-recorded interviews with both nurses and patients. Critical Incident Technique dates back to psychological studies designed to select aircrew for World War II bombing missions (Flanagan 1954). The technique was chosen then precisely because of the practical problems (and risks) involved in using direct observation methods. In Nursing, the ethical and practical difficulties of observation methods have led a number of British and American researchers to use critical incidents as their units of data (for example, Sims 1976 and Long 1976, on student nurse performance; Cormack 1983 and Rosen & Abraham 1963, on the role of qualified nurses; Jacobs et al. 1973 on psychiatric nurses; and Paley & Forrest 1984 on identifying nurses' training needs). In Critical Incident Technique, informants are asked to recall incidents from their own experience, elicited through presentation of prompt items which fulfil the criteria pre-determined as "*critical*" to the study in question. The value of the technique is that it gives access to data which are based on actual events rather than on hypothetical ones. So by employing critical incidents in questionnaires and interviews, it was possible to overcome the ethical and practical problems of trying to observe nurses in the process of reassuring patients.

RECALL BIAS

All research involves compromises, and there are certainly losses with this method. The main loss is that of first-hand observation data, which means that everything in this study has been filtered through the memories of patients or nurses. This filtering process must lead to some distortions. The aim of the research design was to identify the potential for distortion and to minimise it. Because efforts were made to ensure that participation was voluntary, it was

assumed that all informants would make an honest attempt to present accurate incidents. Therefore the most likely distortions were of two kinds: faulty recall of incidents, and biased or "*rose-tinted*" recall.

There are two classical theories of faulty recall: one which argues that memory traces decay spontaneously over time and another which suggests that forgetting occurs because new material interferes with retention. Modern researchers such as Baddeley (1979) have tended to regard both theories as having validity. Therefore in order to minimise both interference and memory decay, it is important to collect critical incidents as soon as possible after their occurrence. In this study eighty-three per cent of incidents were recounted within twenty-eight days of their occurrence, with fifty per cent of the incidents given by patients occurring in the preceding seven days (full details are shown in Appendix One). The risk of memory erosion by new events was minimised by allowing informants to offer any incidents they chose. Therefore they had freedom to relate those high-interest incidents which research evidence suggests are likely to be recalled better than low-interest topics (Menneer 1979). Many of the nurses spontaneously commented that the incidents which they recalled from beyond twenty-eight days were ones which they remembered because they have affected their clinical practice ever since. Benner (1984) and Schon (1983) have both argued that professionals typically build up their clinical expertise through reflecting on just such paradigm experiences.

Considering the second major source of distortion (rose-tinted recall), it was predicted that nurses would be more prepared to recount incidents where they felt their clinical practice was sound, than incidents where they felt they had made mistakes. It has already been noted in the literature review that Biley (1989) and Johnston (1982) were both concerned about resistance from nurses in supplying data about aspects of their clinical practice where they might be open to criticism. The literature on surveys of patients also suggests that they are reluctant openly to criticise nurses (see Locker & Dunt 1978 for a review of studies). Therefore

it was predicted that both patients and nurses would be more prepared to describe incidents where nurses were successful in calming patients, than incidents where they were not. However, the aims of research could accommodate this likelihood of selective recall, provided the incidents themselves were honestly described; examples of effective practice were precisely the type of data required for a study which focused on the nature of intervention strategies, without making any claims about their frequency.

Nevertheless, with no unsuccessful incidents, the comparisons in the study would have been limited in scope and it would not have been possible to indicate the situations where certain strategies were demonstrably ineffective. However, in fact seventeen per cent of all incidents offered were coded as interventions which were not fully effective in calming the patient. Nurses and patients supplied a similar proportion of these unsuccessful incidents, which proved to be an important source of data for theory development.

It has already been noted that twelve paired incidents were supplied by patients, in which it was possible also to interview the nurses involved. These paired incidents provided a limited opportunity to check recall reliability, although the form and small number of the paired interviews did not permit statistical comparisons. However, it was clear that discrepancies in dates, times and precise words spoken were occurring in most of the paired incidents. On the other hand, discrepancies appeared to be very rare on substantive issues, such as the fact that the patient was anxious, the nature of the nurse's actions, the general content of the nurse's speech, and the outcomes of the incidents. In other words, details were affected by faulty or rose-tinted recall, but patients and nurses gave substantially the same overall description of interactions in the paired incidents.

There can be no absolute guarantees about levels of accuracy of recall. The evidence suggests that distortions of detail did occur, so the precise timing or specific wording of the nursing interventions described cannot be relied upon.

However, patients and nurses were broadly in agreement on the main elements of the paired incidents. Safeguards were built-in to minimise recall distortions. The fact that many of the incidents collected were described by patients and nurses as highly significant events reduces the likelihood of interference by subsequent memories. The literature suggests that the longer the period of recall, the less confidence can be placed in the accuracy of recall. Because retrospective collection of incidents permitted the accumulation of a substantial database, it was possible in data analysis to develop all categories from incidents recounted within twenty-eight days of occurrence. The incidents recounted after a longer period were retained in the database because they included some vivid material which clearly illustrated key points originally established from the more recent incidents. However, whenever incidents recalled from beyond twenty-eight days are quoted in the results sections, the recall period is stated in parentheses.

DATA COLLECTION: THE QUESTIONNAIRES

All data collection was completed by the researcher. The first stage was to ask nurses to complete written descriptions of times when patients were anxious, worried or distressed and the nurse tried to help the patient to become calmer or more secure. The collection of written incidents was piloted with student nurses in timetabled one-hour sessions in the School of Nursing. Nurses were asked wherever possible to select an incident which occurred in the previous four weeks. The request for information was presented on a double-sided A4 questionnaire form (blank and completed examples are shown in Appendix Two). The form asked the nurse to state how she first became aware that the patient was anxious; what she thought the patient was concerned about; what she said or did; and what she thought was the outcome of her interventions.

Piloting established that critical incidents could be described by nurses using a single questionnaire form in about 30-40 minutes. Originally it had been hoped

that several incidents could be collected from each nurse, but in view of the time it took to write them, requests were limited to one written incident per nurse. The researcher introduced himself to each group of nurses, explaining that he was studying the ways nurses tried to calm anxious patients. At no time did he use the word "*reassurance*" or any of its grammatical parts, nor was this used in the printed questionnaire. The reason was that the researcher was interested in the full range of incidents, not just those which involved reassurance. It has also been shown that the word "*reassurance*" is used with several different meanings in everyday speech and for this reason was best avoided in the collection of data.

The questionnaire forms were distributed and their content explained. It was emphasised that participation was entirely voluntary. The researcher stated that he realised there would be some incidents which nurses preferred to keep confidential, and also that some individuals might be unable to think of any clear examples. Anyone who was unable or unwilling to complete an incident was allowed to use the time for library work. Eight students and seven qualified nurses from the 217 nurses approached elected not to supply an incident. The incidents were collected by the researcher at the end of the timetabled session. The same procedures were followed when collecting incidents from qualified nurses. The incidents from the pilot study were included in the main body of data, as no major changes in the questionnaire or the form of data collection were required as a result of the piloting process.

DATA COLLECTION: THE INTERVIEWS WITH PATIENTS AND NURSES

After the first 120 questionnaires had been completed and analysed, the diversity of the incidents was widened by seeking examples from patients, while continuing to collect written accounts from nurses. Data collection from patients was a form of triangulation: they could supply personal insights into aspects of interactions

which nurses could only infer from observation. Thus patients could describe how the nurses' interventions actually made them feel, whereas nurses could only state what they believed to be the effect on the patient of their interventions. Also Johnston's studies (1980 & 1982) showed that patients and nurses frequently differ in their explanations of the sources of patients' concerns and therefore it was essential to record the views of patients as well as those of nurses. However, at the pilot stage, the patients had difficulty in recalling how the nurses had first become alerted to the fact that they were worried and therefore information on this particular question was not pursued with the patients.

THE PATIENTS' INTERVIEWS

It was particularly important not to put any pressure on patients to comply with interview requests. Aside from Ethical Committee permission to conduct the research, permission was sought from all consultants admitting to the wards where patients were to be nursed, and from all ward sisters and senior nurses. The times when contact with patients could be made were limited. Doctors' rounds and other treatments ruled out large sections of the morning, while relatives or friends tended to visit in the afternoon and evening, making interviewing difficult at these times. The researcher generally used the morning period 11:30-12:30 to interview one or two patients. The nurse in charge of the ward was asked to name any patients whom she considered physically and psychologically capable of being interviewed without harm. The researcher then approached these individuals, giving a verbal and written account of the project (see Appendix Two for the written account) and asking if the patient was willing to be interviewed. The researcher deliberately did not wear a white coat, to avoid being mistaken for a doctor, but wore a badge showing his photograph, name and designation.

A total of sixty-four patients were approached, of whom fifty-one agreed to be interviewed and supplied a total of seventy-seven incidents. It was regarded as

a good sign that thirteen patients felt able to say they would prefer not to be interviewed, since this suggested that the tone and manner of the researcher's approach were appropriately neutral. All interviews were tape-recorded, except for two where the patients said they were willing to talk but would prefer not to be taped. In these cases, the researcher wrote notes as the patients spoke, and then wrote a fuller version on return to his office immediately afterwards.

The nature of the critical incidents sought at interview was exactly the same as that sought from the written questionnaires. However, it is argued that face-to-face interviews were a vital supplement to the collection of written accounts. Essentially the written accounts supplied an outline of the areas under study, but the interviews functioned as a magnifying glass which made it possible to zoom-in on points of detail. Since speech can be uttered more quickly than words can be written, the patients and nurses could supply far more detailed verbal accounts of incidents than was possible in the written questionnaires. Also, the researcher could use supplementary questions to follow up particular points of interest or to try to clarify obscurities.

A tightly-structured interview format was rejected as likely to inhibit patients and to constrain them into producing spuriously comparable information (Hindley 1989). However, a totally unstructured form would not have yielded incidents which could be compared with those of the nurses. Therefore the researcher asked each patient if he could think of any time in the past four weeks when he had felt anxious, worried or distressed and a nurse had tried to help him to feel calmer or more secure. If the patient was able to think of an incident, the researcher invited him to describe it in his own words. The researcher then asked supplementary questions to fill in details about the source of the patient's concerns, what the nurse had said or done, and what outcome had resulted.

THE NURSES' INTERVIEWS

Substantially the same interview procedure was followed in the interviews with the nurses. Fifty-five nurses were approached, of whom fifty-one agreed to be interviewed and supplied a total of seventy-two incidents. These interviews were largely conducted in the later stages of data collection when the major descriptive categories were established, but when particular points of detail needed to be probed and clarified. The researcher was previously known to the majority of the nurses in his roles as a teacher and career counsellor. The fact that the nurses appeared to be honest in revealing some incidents in which they failed to calm patients suggests that the researcher's existing work roles did not unduly constrain the process of data collection. Indeed Wilde (1992) has noted that existing work roles may actually facilitate data collection in some circumstances.

TRANSCRIPTION

All interviews were transcribed by the researcher. Any names or other identifying features were omitted, and most dialect or short-forms of words were transcribed as standard English. Preliminary discussions and aspects of conversation which did not include critical incidents were omitted, but in all other respects the transcriptions were **verbatim**.

Nevertheless there are losses in transcription. The inflections and particular points of emphasis cannot be conveyed fully, nor can hesitations. All gestures accompanying speech are again lost. On the other hand, there are also gains in the amount of detail which can be collected. On several occasions the researcher was surprised when transcribing to hear the interviewee saying something which he could not remember the person saying at the time of the original interview! Overall, the interviews complemented the questionnaires. The form of the critical incidents was similar; the limited detail in the questionnaires made initial analysis

easier and it was possible to establish the broad outlines of what was occurring. Then in the interviews the detailed picture emerged, with the views of patients and nurses again complementing each other by adding details particular to each group.

SECTION 3: THE CONSTANT COMPARATIVE METHOD OF ANALYSIS

Data analysis followed the Constant Comparative method described by Glaser & Strauss (1967). They recommend that the researcher begins by coding each incident into as many descriptive categories as possible. At the same time each data item in one category is compared with all other items in the same category. From this constant comparison it is possible to begin to generate theoretical properties of each category. Glaser & Strauss also recommend that thoughts which arise during the coding process are recorded separately as theoretical memos. These form a continuing record of the process of theory development, recording the blind alleys as well as the ideas which eventually prove to have explanatory power. As coding continues, the constant comparisons change from comparing one data item with another to comparing new data items with the properties of the categories which emerged from the initial comparisons. There will come a time when it will be possible to integrate categories and their properties into an overall schema, unified by a smaller set of higher-level concepts. Theoretical saturation will also gradually limit the number of new categories and properties. The process of analysis is deemed to be complete when the theory advanced describes the existing data, when it is grounded on data of sufficient breadth to answer the aims of the enquiry, and when new data adds little or nothing to the properties of established categories. Glaser & Strauss argue that theory generation using this method is well worth the time and effort:

> "Theory based on data can usually not be completely refuted by more data or replaced by another theory. Since it is too intimately linked to data, it is destined to last despite its inevitable modification . . ." (Glaser & Strauss 1967: 4)

The key words here are "*based on data*". One problem with Grounded Theory methods is that coding and theory development take place in the mind of the researcher, while the sheer bulk of data in a qualitative study makes it impossible to present more than illustrative examples of original data to the critical reader. What guarantee can be offered to the reader that the researcher has in fact grounded the theory upon the body of data? This potential criticism applies particularly to a study using Critical Incident Technique. Schneider & Locke (1971) published a critique of the reliability of the categories developed from critical incidents by Herzberg et al. (1959) in an influential book, "*The Motivation to Work*". In that study, critical incidents were used to collect information about factors which motivated or de-motivated employees. Schneider & Locke demonstrated that the original classification system devised by Herzberg et al. was logically flawed. It was an artificial system externally imposed upon the data and it did not fit the data soundly. As a safeguard, Schneider & Locke recommended that the researcher should always try to enlist the help of the informant when coding material.

In a study using Grounded Theory methods this is not fully possible, since the coding scheme develops over the whole period of data collection and is not finalised until quite a late stage. However, it is possible to conduct inter-rater reliability studies to test the extent to which the final coding scheme will give the same results when external raters code the same data. Desmond Cormack (1983) in a study using critical incidents offered a measure of inter-rater reliability based on a formula developed by Cohen (1960). Cohen's formula has been adopted for the present study, since it allows one to produce a coefficient of agreement for nominal scales from which the amount of agreement expected by chance has been removed. Chance agreement is a function of the length of the coding scheme. Cohen's formula is more appropriate than a Chi-square test in this context because Chi-square only measures association. Thus with Chi-square, significant disagreement between raters would affect the reliability score as much as significant agreement. With Cohen's formula, this problem is eliminated.

The formula is quite straightforward to apply. It involves counting ratings and placing them on a grid, calculating chance agreement by finding the joint probabilities of the marginals, then applying the formula. This gives a measure of K, which is the measure of agreement after chance agreement has been removed. Further calculations can be performed to estimate the degree of significance. In the present study, a significance level of at least 0.05 was specified as a requirement at the outset.

THE CODING SCHEME

The coding scheme applied equally to the three groups of incidents: those from written questionnaires, from interviews with patients and from interviews with nurses. The scheme makes use of two levels - **AREA** and **CATEGORY**. There are five Areas describing the five main elements of the study:

A. How the nurse first became aware of the patient's anxiety, worry or distress.
B. The source of the patient's concerns.
C. The nurse's actions.
D. The nurse's intentions.
E. The outcome of the nurse's intervention.

Detailed descriptive categories were developed within each of the five Areas. For example, Area B dealing with the source of the patient's concerns comprised categories for worries about health, treatment, the environment of care, relatives and friends, being discharged, and a catch-all other concerns section (full details of all categories are shown in Appendix Three). The category headings were developed from the constant comparison of incidents, which facilitated the identification of similarities and differences. Where the number of categories in any one Area was large, these were subsequently grouped under aggregate

category headings, which were used to summarise the main themes of each group as they appear in the Results Chapters.

INTER-RATER RELIABILITY

In order to test the reliability of the coding scheme, each incident was sub-divided into numbered sentences. It is accepted that this was an artificial division, particularly for the taped interviews: but it offered a reasonably convenient and consistent way of handling the data. Very long or complex sentences were further sub-divided by the use of a slash mark (/) as required. A random sample of twenty per cent of incidents from the questionnaires was first submitted for coding by independent raters. These independent raters were unpaid volunteers with a background in nurse teaching or other related health care fields.

The total number of categories required to code the questionnaires was forty-nine. Initially the raters found it difficult to master a coding scheme of this size in the limited amount of time which they could give to the task. Therefore the Area codings for the questionnaires were tested first. Adequate levels of agreement above ninety per cent were recorded for the Area codings. Then data from each of the five Areas was presented separately to the raters, so that they only had to master a limited number of category definitions at any one time. Two independent raters were used for each set of codings. The codings of each rater were separately checked against the codings of the researcher, and Cohen's (1960) formula applied to the results. This method again yielded agreement levels above ninety per cent for the Category codings.

It became apparent when conducting the initial interviews that many patients were unable to recall how the nurses first became aware of their concerns (Area A). Because the patients were unable to add much detail to this Area, questioning on this aspect was omitted from their interviews. This was the longest section in the scheme and its omission had the effect of reducing the total number of categories

required to code the patients' interview data to a more manageable level. It meant that the interviews with the patients could be rated as a whole, rather than being divided into separate Area sections for rating as had been necessary with the questionnaires.

Learning from this, Area A data collected from the interviews with the nurses was submitted first to the independent raters. It was then possible to submit all the remaining data (Areas B-E) for simultaneous rating in the same way as the data from the patients was handled. This procedure of rating most Areas simultaneously also had the effect of making the rating results for all the interview data more robust.

The researcher presented only such interview data as he himself had rated, omitting conversation extracts which in his opinion had not supplied relevant data. Two raters independently coded the marked sections of thirty incidents supplied by the patients and a further thirty incidents supplied by the nurses. Results are shown in the tables in Appendix Four. Overall agreement in the categories in the majority of Areas reached ninety per cent or higher. Three ratings below ninety per cent occurred in the categories in Area B (the nature of the patients' reported concerns) - these were eighty-three per cent and eighty-seven per cent for the interviews with nurses, and agreement of only eighty per cent for one of the raters of the interviews with patients (although agreement with the second rater reached ninety-seven per cent). Closer analysis showed that disagreement centred almost exclusively on separating concerns about Health from concerns about Treatment. Although the definition of the categories was mutually exclusive, in practice the expression of these concerns was so closely linked that it became difficult reliably to distinguish the precise source of the patient's concern in these two categories from the data recorded. In retrospect, this would have been an area where initial coding in collaboration with the informant would have improved reliability.

There were two other cases in rating the nurses' interviews where agreement with

individual raters dipped below ninety per cent - on Nurses' Actions (eighty-eight per cent) and Nurses' Intentions (eighty-nine per cent). However, in each case agreement with the second rater remained above the ninety per cent mark.

The probability of these levels of agreement occurring by chance was generally less than 0.001, and in all cases it was less than 0.01. It must be noted that one should expect to get high levels of agreement with any structured and clear coding scheme derived directly from a database. Nevertheless, the levels do demonstrate that the classification scheme as a whole was related closely and in a logically consistent way to the data collected.

It should be noted that is not claimed that the resulting categories are the only way of describing the data, merely that they are one way of doing so. In each case, the raters' judgements were tested only against those of the researcher, using the coding scheme which he had developed. The raters were not involved in the development of that scheme. The general levels obtained suggest that the coding scheme has a high degree of fit with the data, although it is slightly weaker in coding the difference between concerns about Health and concerns about Treatment.

SECTION 4: AN EXAMPLE OF CATEGORY DEVELOPMENT

Because of limitations of space it is not possible in the Results chapters to demonstrate how the categories and their properties developed over the period of data collection and analysis. Nor is it possible to give any more than illustrative quotations from the data itself as corroborative evidence for the results presented. However in this part of the chapter on Research Methods it is proposed to offer a rather more detailed explanation of the emergence from analysis of a single category. This is an example of the process which was

followed with all the other categories described in the Results chapters. The category described is one of the Area 4 categories, (Category D2 - Support) referring to the nurses' intentions when they intervened to try to calm the patients.

Category Title: SUPPORT

Definition: To induce a patient to interpret that a nurse supports and cares about him.

The process of analysing the data began with the written accounts of the nurses. The questionnaires were analysed sentence by sentence. Initially almost every line required a new descriptive category, but soon it became possible to use existing categories to code many subsequent data items. The process of initial category development can be seen from extracts from Questionnaire Two. The student nurse who described the incident was dealing with a pregnant woman accompanied to hospital by her husband. The couple had just been told that their baby had died in utero and were understandably very distressed. The nurse's sentence by sentence account is shown below in italics, followed by the codings in capital letters (the full list of codes is given in Appendix 3)

"When the patient arrived on the ward, I tried to appear friendly and calm."
CODE C1.4: ADOPTS A CALM AND FRIENDLY MANNER

"I held her arm as I was taking them to their room."
CODE C1.1: USES TOUCH

"I sat alongside her on the bed, / asking questions about their family, letting them get round to mentioning this pregnancy."
CODE C1.2: SITS OR MOVES CLOSE TO THE PATIENT
CODE C2.1: ASKS QUESTIONS

"I offered the services of the hospital chaplain which they accepted."

CODE C2.3: SUGGESTS, ADVISES OR TELLS THE PATIENT WHAT TO DO

"I went back in and talked about what the doctor had planned,/ encouraged them to ask questions / and made sure they knew that if they wanted a nurse, how to get one with the call bell or come to the nurses' station."

CODE C3.2: GIVES INFORMATION ABOUT TREATMENT

CODE C2.3: SUGGESTS, ADVISES OR TELLS THE PATIENT WHAT TO DO

CODE C3.4: GIVES INFORMATION ABOUT THE WARD ENVIRONMENT

"Physical contact - I held her arm and hand but felt that as her husband was there, he was very supportive and she didn't need me as much as I thought."

CODE C1.1: USES TOUCH

"I gave them a box of tissues."

CODE C4.1: GIVES PRACTICAL HELP

"After the patient had the termination she said that my silent care and concern on her arrival had helped far more than the busy-ness of staff in the clinic."

CODE E.1: PATIENT BECAME CALMER THAN BEFORE

The initial categories, as shown here, were attempts to describe as directly as possible the actions mentioned in the incidents. However, as more data built up, it became apparent that these categories were inadequate to describe fully what was occurring. For example, many uses of touch appeared in Category 1.1. In

Questionnaire Two the nurse appeared to be using physical contact to try to support and calm the patient. However, in other questionnaires the nurses stated that they touched patients in order to distract their attention from their fears. In another case a nurse held a patient by his shoulder in order to restrain him from leaving the ward. All were reliably coded as C1.1 USES TOUCH, but the category appeared to be concealing important differences in the way touch was being used.

It was while searching for a way of bringing out these differences that the researcher first came upon Sperber & Wilson's (1986) Inferential Model of Communication. The inferential model highlighted the fact that communicative actions cannot be fully understood outside the context of the communicator's intentions. Therefore a higher-level set of explanatory categories was developed from analysis of the different types of intention revealed in the data.

Four **Intentions Categories** were developed as follows:

PREDICTION
DISTRACTION
PATIENT CONTROL
DIRECT ACTION

Prediction is defined as inducing the patient to predict that he will be safer than he fears. Distraction occurs when a nurse induces a patient to move his attention away from a topic of concern. Patient control is an attempt by a nurse to induce a patient to control an aversive situation for himself, while Direct Action occurs when a nurse tries to control an aversive situation for a patient.

At the same time as these new explanatory categories were being developed, the interviews with patients were proceeding. Problems occurred when trying to code some of the material from these interviews: one of the passages which did not

seem to fit into any of the four Intentions categories was a **patient's** description of how a nurse helped to calm her before an operation:

> *"And this very junior nurse came and she just sat on the edge of the bed, and took my hand, and she said, 'I know it's difficult but is there anything I can do to help you, to make you feel better?' And it really was tremendously comforting. Calming. The fact of the touch, the fact of the concern in her voice, the fact that she made eye to eye contact, and the fact that she didn't appear too rushed were all very reassuring." (P50, 2)*

The existing intentions categories did not seem to fit this incident. The closest category seemed to be Patient Control, because the nurse invited the patient to name any way in which she could help. However, the patient's account concentrates on the fact that the nurse took time to show concern, using touch, voice and eye contact to demonstrate how concerned she was about the patient. In other words, the nurse's intervention appeared to achieve its calming effect in a different way from that described by any of the four intentions categories.

In the theory memos written at this time the term "*Relationship-Building*" was coined as a working title for a new category developing out of this material. The literature suggested that relationship-building was important in reassurance and a reading of Bowlby's (1971) work on Attachment appeared to offer an independently-developed theoretical framework for the concept. The questionnaire and interview data were reviewed and tentative codings were made. Many non-verbal actions, such as "*using touch*" frequently appeared to be associated with the Relationship-Building category, as did most of the expressions of optimism or understanding.

When trying to develop the properties of this category, theory memos were written which questioned the extent to which the relationship between the nurse and patient must inevitably be two-way. Incidents were noted where two-way emotional ties certainly existed and played a powerful part in interactions. However, in other incidents the contact between nurse and patient was relatively

brief and the relationship was one-way, in the sense that the patient was almost wholly dependent on the nurse. Therefore one of the properties of this category established by this method was that successful incidents could be one-way interventions. This led the researcher to question whether the word "*relationship*" was adequate to describe one-way interventions.

By this time it was also apparent that the title "*Relationship-Building*" was unsatisfactory because it was not couched in inferential terms. It summarises nurses' actions, but it does not state how the nurses intended the patients to respond. The cue to a more satisfactory title appeared on re-examination of some questionnaire data, tentatively coded under the relationship-building heading. A nurse reported that: "*Because she (the patient) was nervous, I held her hand*" (Q3). Here the nurse seemed to be trying physically to transmit support or caring through use of touch. In the theory memos a number of category headings were proposed to convey this idea:

- *Inducing the patient to experience a feeling of attachment.*
- *Supporting the patient emotionally.*
- *Getting close to the patient physically and emotionally.*

However, the title which seemed to fit the data most clearly was: **Inducing the patient to believe that the nurse supports and cares about him.** This was adopted as a tentative category heading to replace "*relationship-building*". The question then was whether "*Support*" as defined above could stand as an independent intervention, or whether it always needed to be associated with one of the other four intentions categories. Closer examination of the data made it apparent that the nurses themselves believed that interventions using Support could have an independent calming effect. Thus a nurse noted in one of the questionnaire incidents:

"I don't think what I SAID had any real effect on him. The assurance he gained, came from already having someone to talk to. It was being there that seemed to help him to see things in a better light. Another person who cared enough about him to ask about his well-being and show concern in his future health." (Q101)

Therefore the Support category could stand alone and, with its addition to the other four intentions categories, all the relevant data on intentions appeared to be reliably codable. Analysis then moved on to re-examining all the data thus coded, in order to establish the detailed properties of this new category.

This method of category development was employed in each Area of the classification scheme. Once the categories were established and data could be coded reliably, attention moved to establishing the detailed properties of each. The final stage in the process was the development of higher-level theory with explanatory and predictive power, which integrated the range of descriptive categories.

CHAPTER SUMMARY

The rationale for the choice of qualitative research methods has been explained in this chapter, arguing that a qualitative approach which results in systematic generation of grounded theory is of particular value at this stage in the study of reassurance in nursing. There is no perfect research method. There is a sense in which the strengths and weaknesses of any method are actually two sides of the same coin. Thus theoretical sampling as a form of intelligent enquiry yields a larger quantity and a broader span of data than is possible with the same resources in a probability sampling design. On the other hand, one may not generalise about frequencies from a theoretical sample, whereas a probability sample makes statistical predictions feasible. Again, the use of Critical Incident Technique gives access to data in situations where observation methods would be difficult to use. However, critical incident data is open to recall distortions which are not found

with observation methods. The potential recall distortions can be identified and countered, but they cannot be eliminated entirely. The Constant Comparative method of data analysis allows one to deal with large quantities of qualitative material in a systematic way, without inhibiting creative thought. However the nature of the data and the method of analysis make it hard to demonstrate that the results are genuinely grounded on the data. Inter-rater reliability tests give a limited measure of confidence, but there will always remain an element of subjective interpretation in the development of grounded theory.

The overall validity of the study can only be judged in the light of what is claimed for it. In the next three chapters the results of the analysis of the data from the sample are presented, and an attempt is made to demonstrate that the categories and their properties accurately describe and explain the data upon which they are grounded. Chapter Five begins with an account of the Experience of Anxiety, based on reports of how the nurses first became aware of their patients' feelings, and on the nature of the reported concerns of the patients.

PART 2: RESULTS

CHAPTER 5: UNDERSTANDING THE EXPERIENCE OF ANXIETY

CHAPTER 5: UNDERSTANDING THE EXPERIENCE OF ANXIETY

This chapter is divided into two sections. Section One describes how the nurses first became aware that their patients were anxious, and Section Two describes the nature of the reported concerns of the patients.

SECTION 1: HOW THE NURSES FIRST BECAME AWARE THAT THEIR PATIENTS WERE ANXIOUS

The description of this area is drawn exclusively from the written and verbal reports of the nurses. The patients who were interviewed were unable clearly to describe this aspect of the incidents and therefore the question was dropped from their interview schedule. Understandably the patients appeared to remember what happened only in terms of their direct experiences. A total of 624 codings were made from the 202 written and seventy-two interview incidents collected from the nurses. Fifteen categories were established which fully coded the data collected. For ease of understanding, the categories are aggregated under five headings: *non-verbal signs, behavioural signs, verbal behaviours, being alerted by others, and using empathy to infer patient anxiety.* It should be noted that all aggregate categories are included only to make the detail easier to understand - all the analysis and inter-rater reliability testing were performed on the full list of detailed categories. The nurses generally based their judgements upon more than one indicator of anxiety. Table 5.1 shows the number of codings for each aggregate heading, separating written questionnaire codings from interview codings, and then giving the overall totals for both.

NOTE: All quotations from critical incidents are followed by a reference letter (Q,P,N) showing whether their source was a Questionnaire, a Patient's interview or a Nurse's interview. Subsequent figures refer to the incident reference number and sentence number. Thus P3, 12 refers to an interview with a Patient, reference number three, sentence twelve.

TABLE 5.1: HOW NURSES FIRST BECAME AWARE OF PATIENTS' ANXIETIES

AGGREGATE CATEGORIES	QUESTIONNAIRE NO.	%	INTERVIEWS NO.	%	TOTALS NO.	%
NON-VERBAL*	240	47	29	27	269	43
BEHAVIOURAL	157	30	34	31	191	31
VERBAL	110	21	33	31	143	23
ALERTED BY OTHERS	6	1	8	7	14	7
EMPATHY	3	1	4	4	7	1
TOTALS	**516**	**100**	**108**	**100**	**624**	**100**

* Includes paralinguistics.

Although it is not possible to generalise from the sample to the population of nurses as a whole, Table 5.1 does serve to demonstrate the relative size of the categories upon which the subsequent analysis was based. By combining the small categories for "*alerted by others*" and "*empathy*" it is possible to apply a chi-square test to the table. This reveals a highly significant difference between the coding frequencies recorded from the questionnaires and those from the interviews ($chi = 34.1$; $df = 3$; $p<0.001$). The differences are particularly marked in the areas of non-verbal behaviours and the combined *alerted by others/empathy* frequencies. The results suggest that nurses tended to recall different aspects of incidents when they had to record them in writing from the aspects which they described in a face-to-face interview. This reinforces the value of using different methods of data collection to gain an overall view of what was happening in the clinical area.

In order to understand how the nurses went about making their initial assessments it is necessary now to examine the individual categories in more detail; their properties derive from both the questionnaires and the interviews. These properties will be discussed next, grouped under each of the five main headings listed in Table 5.1.

1. NON-VERBALS AND PARALINGUISTICS

NON-VERBALS & PARALINGUISTICS	**43%**
TEARS	15%
PARALINGUISTICS	7%
FACIAL EXPRESSION	6%
CONDITION OF SKIN	4%
TREMOR	4%
TECHNICAL OBSERVATIONS	4%
POSTURE	3%

If a patient was in tears, this was taken by the nurses as a sure indication that he was distressed. The same was true of some paralinguistic signs, such as screaming or shouting. Inferences from the other signs depended far more upon the context in which they occurred. For example, tremor might be due to a cold environment, a fever, or to nervousness. However, tremor in the anaesthetic room before an operation was regarded in this context as a strong indicator of anxiety. Technical observations such as measures of pulse or blood pressure were similarly

interpreted according to context, as were skin colour and facial expression. Many nurses observed the eyes of their patients, commenting on redness as a possible indicator of recent tears. Once nurses had noticed one possible non-verbal or paralinguistic sign of anxiety, they generally observed the patient carefully to try to confirm their inferences:

> "While working in Theatre I received a patient who was to undergo a mastectomy. The patient looked very pale and as though she had been crying. I started to do a list of information to ensure I had the correct patient. I took hold of her hand to look at her name bracelet and noticed (that) her hand was shaking. As I asked some questions, her voice quivered and her lips trembled." (Q4, 1-4)

2. BEHAVIOURAL SIGNS

BEHAVIOURAL SIGNS	**31%**
WITHDRAWAL	11%
RESTLESSNESS	10%
OTHER BEHAVIOURAL	10%

A combination of the main behavioural signs observed was reported in the following example from a questionnaire:

> "The patient appeared very quiet, which is unusual for him, and fidgeting (playing with his handkerchief constantly). He was pale and withdrawn, constantly looking out of the window. He was also rude on occasions to the nursing and medical staff, whereas normally he was very polite and charming." (Q178, 1-2)

The patient's overall quietness was coded as "*withdrawal*", his fidgeting and looking out of the window were forms of "*restlessness*", while the rudeness fell

into the "*other behavioural*" category. However the most notable feature of this incident was the fact that the signs were evaluated in relation to the patient's usual behaviour. The relatively close contact between nurses and patients permitted the frequent use of comparisons of this nature in the nurses' assessments of the emotional state of individuals. Another form of comparison which the nurses made was in relation to their own view of what should constitute "*normal*" behaviour for a patient in their clinical area. Thus, they commented on socially extreme behaviour such as violence towards self or property, and also on particularly restless or withdrawn behaviour :

> "He would come home from work and he'd go straight to his bedroom and next thing you'd hear all this shouting and crashing and things flying out of the door." (N16, 4)

> "He was very withdrawn and didn't seem to want to talk to us or with the other patients. He was very reluctant to eat - he just wanted to lay in bed all day. He didn't appear to be a typical 15-year-old who wanted to go home and back to his friends, and friends only visited him once during his stay." (Q30, 3-4)

3. VERBAL SIGNS

VERBAL SIGNS	**23%**
FEELINGS EXPRESSED	8%
QUESTIONS ASKED	8%
OTHER STATEMENTS	7%

In some incidents the nurses reported that patients expressed their feelings of anxiety directly. In other examples, they described bodily sensations such as pain or nausea which the nurses equated with the experience of anxiety or distress.

The nurses also described incidents in which they again compared what patients said against perceived norms for all patients, or against norms of verbal behaviour for individual patients.

> "The patient's anxiety was displayed firstly by his repeated questioning of how long the phone would be out of use and why. He approached each member of staff separately and became red in the face and unable to relax." (Q63, 3-4)

> "I knew she was worried about herself as the conversation was about the chemotherapy she had just finished and what it had done for her, and before that the treatment was hardly ever mentioned." (Q141, 7)

In both examples, the content of the patient's question or statement was less significant than the comparative context in which it was spoken.

4. ALERTED BY OTHERS (2%) **5. EMPATHIC INFERENCE (1%)**

These two headings occurred as individual categories in the coding scheme. Their presence indicates that the nurses did not always rely on direct observation. The sources of information which they recorded were other staff, both nursing and medical, and relatives or other patients. In empathic inference they inferred anxiety in the patient by virtue of the fact that the nurse would have felt anxious herself if she had been in the patient's situation. The category was used only when the nurse made the inference explicit, as in the following example when the patient being taken to theatre was a nurse herself:

> "She had her false teeth out. She would feel vulnerable. She was going to meet a nurse in theatre who she perhaps knew. And again I don't know whether she felt this, but I think if it had been me, I'd feel, 'Are they going to ask me the right questions?' Because I'm a member of staff and you don't feel like prying into their privacy." (N2, 8)

SUMMARY OF SECTION ONE

The nurses in the sample reported a wide variety of cues to patient anxiety, and at times the observation skills employed were complex and subtle. Certain cues, such as tears, were regarded as reliable indicators of anxiety whenever they occurred. However, many others only became important when interpreted in context. The nurses appeared to base these contextual judgements on two types of comparison: one was with the type of behaviour which they had come to expect from patients in their clinical area, and the other was a comparison with the behaviour which the nurses expected from their knowledge of each patient as an individual. Variations from either norm were seen as probable indicators of raised levels of anxiety.

SECTION 2: THE NATURE OF THE REPORTED CONCERNS OF PATIENTS

The findings described here relate to the nature of the patients' reported concerns - in other words, they are a description of the main topics reported to be troubling the patients. They are drawn from all three sources of data: the written incidents, the interviews with the nurses and the interviews with the patients. However, it is important to take into account the difference between the viewpoint of the patients and that of the nurses. The nurses reported their inferences about the patients' concerns, whereas the patients described direct personal experiences. The level of agreement between the patients' experiences and the nurses' inferences can only be assessed in the thirteen paired incidents, where there were two incidents in which nurses and patients differed in their view of the nature of the patients' concerns. It is not possible to draw any conclusions from such a small sub-group about the relative agreement levels in the rest of the incidents.

However, all the categories of concern occurred in the accounts of both the patients and the nurses. This suggests that, although some of the nurses' inferences about individual patients will have been incorrect, the overall pattern which emerged from the nurses' accounts has an acceptable level of validity as a description of the general types of concern which the patients also reported.

There was a difference between the limited amount of detail reported in the written incidents and the more complex picture which emerged from the interviews. At interview it was possible to ask questions to clarify what was happening, and patients and nurses tended to focus on one major source of concern which was then described in detail. Where the nurses gave their descriptions of incidents in written form, the incidents tended to be less detailed and several possible sources of concern were sometimes listed. Therefore, although the main categories emerged fairly early from the written incidents, the properties of those categories were only fully established through the question-and-answer process of the interviews.

Six categories were required to code all the data. The concerns most frequently reported related to patients' state of health, fears about medical or nursing treatments, and worries about the environment of care. The latter category was divided into four sub-categories: concerns about the physical environment, concerns about possessions, worries about staff, and worries about other patients. Additional categories were worries about relatives, friends or pets, concerns about being discharged, and a catch-all "*other*" category. Table 5.2 shows the coding distribution from the written questionnaires, the nurses' interviews, the patients' interviews, and overall totals.

TABLE 5.2: THE NATURE OF THE PATIENTS' REPORTED CONCERNS

CATEGORIES	NURSES' QUEST'AIRE		NURSES' INTERVIEW		PATIENTS' INTERVIEW		TOTALS	
HEALTH	69	27%	14	28%	22	31%	105	28%
TREATMENTS	61	24%	5	10%	28	40%	94	25%
ENVIRONMENT	48	19%	15	30%	9	13%	72	19%
RELATIVES ETC	41	16%	5	10%	8	11%	54	14%
DISCHARGE	7	3%	2	4%	1	1%	10	3%
OTHER	27	11%	9	18%	2	3%	38	10%
TOTALS	**253**	**100%**	**50**	**100%**	**70**	**99%**	**373**	**99%**

The incidents given by the patients included a higher percentage of worries about state of health and about treatments than the incidents given by the nurses. It is particularly noticeable that worries about treatments replaced state of health as the concerns most frequently reported by the patients. By combining the "*discharge*" and "*other*" categories, a chi-square test may be applied. This reveals a significant difference between the table of frequencies recorded in the interviews with patients compared with both the interviews with the nurses (chi = 22.9; df = 4; $p<0.001$) and the nurses' questionnaires (chi = 11.4; df = 4; $p<0.05$). There is no significant difference between the frequency table of the nurses' questionnaires compared with the interviews with the nurses (chi = 9.48; df = 4; $p>0.05$). The use of theoretical sampling means that it is not sound to employ these statistics to generalise from the sample to the population as a whole. However, within the sample itself, the fact that forty per cent of the patients' self-reported concerns related to Treatments while the same figures from nurses' incidents ranged only between 10-24% is something which needs to be considered in the appropriate section dealing with treatments. Therefore, the remainder of the chapter gives more detailed descriptions of the findings from each category in turn.

CONCERNS ABOUT STATE OF HEALTH

Number of codings 105: 28% of overall total

It is not surprising that concerns about state of health figured strongly in the incidents reported from both hospital and community settings. The nature of the concerns depended on the stage which patients had reached in their contact with professional help: they ranged from initial uncertainty about diagnosis, through to concerns about prognosis, and in some cases to the final certainty of death. Uncertainty appeared to be a major source of concern to the patients. Some medical diagnoses were picked out in the incidents as causing patients particular fear and distress. Prominent among these was heart disease:

> "There was some debate between consultant and doctors as to whether this patient had actually suffered a heart attack. Therefore all the tests were repeated. This in itself caused further anxiety for the patient. I thought the patient was distressed about the 'situation' - the limbo of not being told the correct answers." (Q61, 5-7)

Aside from concerns over life, death and disability, some patients found it hard to cope with the loss of control which was felt to be a frequent consequence of their contact with the Health Service. One patient, who had a mastectomy following discovery of a breast lump at a routine check-up, graphically described her feelings:

> INTERVIEWER: "You're someone who is in charge of your own life?"
>
> PATIENT: "Oh yes, in control. And here of course I'm not in control. I mean, I went for an insurance medical five weeks ago, and the doctor found the lump . . . And things just came to a stop. Again I wasn't in control. And as I said to my doctor, 'Fifteen days ago I didn't have a problem. You doctors created the problem.'" (P5, 28)

However, as the literature predicts, there were some patients who did not appear to find loss of control aversive. Some people seemed to be willing to trust themselves entirely to the skills of the professionals and chose not to seek out information about their state of health. For example, one 83-year-old patient described her attitude towards the nurses and hospitalisation:

> "I've worked in hospital long enough to have every confidence in the type of girl, the type of nursing I saw, everything about it. It was simply another experience . . . I wasn't the slightest bit alarmed, the slightest bit worried, and I haven't been since I came in. My only anxiety now is to finish and to get home." (P2, 6-7)

The researcher asked if the doctors or nurses had given her any information about her illness:

> "They give you no information except as you ask for, and if you don't ask, you don't get it. I'm one of these people who isn't the slightest bit interested in any of these medical subjects. I wouldn't even know what to ask if I wanted to ask. All the asking has been done by my husband. He wanted to know everything. A malignant growth, he wanted to know things of that kind. I simply took it for granted . . . I've always been like that with my doctor. When I'm ill I go to a doctor if I need one. I do everything he tells me. Have absolute confidence, put myself in his hands, and that's that." (P2, 12,14)

The contrast with the earlier patient who was angry at her loss of control is striking. Whereas the first patient appeared to be using a monitoring style to cope with her illness, the second patient preferred to distract herself, using a blunting style of coping (Miller 1987). The use of such an extreme blunting style was unusual among the incidents recorded. Most patients appeared to monitor their own condition quite closely, relying not only on subjective feelings, but also on information from doctors and nurses, on inferences from treatments given or omitted, and on cues from the environment.

CONCERNS ABOUT TREATMENTS

Number of codings 94: 25% of overall total

The mismatch between patients' self-reports of concerns about treatments (forty per cent) and the lower frequencies reported by the nurses (10-24%) is an interesting finding. It may be a chance effect of sampling, or it may be a distortion introduced by the recall process. However, an intuitive explanation is that the nurses were less alert to fears about treatments than the patients themselves, perhaps because the nurses were so much more familiar with those treatments. Thus for patients all surgery is major surgery, while for nurses routine surgery is indeed routine. The constraints of the research design mean that this finding must remain unexplained. The tentative hypothesis that nurses are less sensitive to fears about treatments than the patients themselves is however one which would be worth exploring further in another study.

Returning to the detail of the reported incidents, fears about surgical procedures were the concerns most frequently mentioned in this category. Patients were reported to be anxious about dying while under anaesthetic, about the surgeon making a mistake such as operating on the wrong limb, about pain during or after the procedure, and about the disfiguring consequences of some treatments. However, patients were also reported to be concerned about treatments other than surgery, including many aspects of nursing care. Incidents included fears about pain during investigative procedures, concerns over catching AIDS from blood transfusions, worries about different types of rehabilitation procedure, anxiety about the desensitisation treatments used by psychiatric nurses, and concerns about medication. In most cases there was a tension between hope and fear which was recognised by some patients as an inevitable feature of the need for treatment. Thus one patient tried to explain his feelings about the prospect of surgery:

> "I don't really know why you're scared. It's just something that you know you're going to have a cut in you, and you know darn well you're going to be out [i.e. anaesthetised] when you have it. You're not going to feel it. But you're just . . . I don't know, it's just something that gets your nerves going." (P3, 12)

Although there was considerable evidence of generalised fears about surgery, the nurses who were interviewed described the careful way in which they tried to assess the precise nature of the concerns of individual patients. An example of the lengths to which they might persist comes from an interview with a Registered Sick Children's Nurse. The nurse was faced with a child in tears who was refusing to go to theatre:

> "And I asked him had anything been explained about the operation. And he said the doctor had come and talked to him about it and marked him for his operation. Because he was having an undescended testicle brought down. It was explained to him. I asked him if a nurse had talked to him. And he said yes, everything was talked about. And I asked him if he'd asked any questions, and he said, 'No, but my mum did ask some questions.' And I said was he alright then, and he said yes, but when they came with some medicine, things like that upset him, and he really didn't think he'd have to take anything. 'I don't really want to get undressed, or get on that bed. I'm just scared, I don't want them to cut me.'" (N9,1)

The nurse elicited the fact that the child had been given some information about the operation, but had not felt able to ask questions himself. The child was afraid of the loss of control which the surgical procedure would bring. Finally the child announced a fear of the surgery itself. However, the nurse still did not take this at face value, and went on to check out the fear about being "*cut*":

> "And then I said, 'Has anyone else talked to you about it?', and he said, 'Yes, my brother had the same operation.' And I said, 'Did you see his scar?', and he said, 'No'. And I said, 'What did he tell you to expect?' And he said, 'Well he did tell me there'd be a big cut right across me.'" (N9,2)

Therefore, in this case the patient's concern about treatment was associated with an unrealistic expectation about the size of the surgical incision. The nurse only went on to make a helping intervention after the precise nature of the child's fears had been established.

Many adult patients were equally worried about having no real choice or control over treatment. The problem was not so much a lack of choice over treatment type as the fact that, for more serious diseases, the patients either had to accept an aversive treatment or to suffer the consequences of the disease. Many of the more seriously ill patients regarded this as no choice at all.

> "Approximately 15 months ago she had an enucleation of her right eye . . . as a result of an eye infection which she recalled started off in very much the same way as the infection had this time . . . I feel it was fairly obvious to see and work out that this lady was terrified of having to have her only remaining eye removed as well." (Q17, 3,5)

The key to the above example is that the nurse wrote about the patient "*having to have*" her eye removed, indicating that this was regarded as a forced choice should the infection fail to respond to medication. In addition, decisions about treatment sometimes caused distress when they were taken without the full agreement of the patient. It was notable that this was reported more frequently in incidents involving elderly, handicapped or confused patients in hospital situations, rather than in the community or with younger adults. Thus a nurse reported that an elderly patient was very anxious about a change of medication:

> "When I asked her why she was upset she said it was because the doctor had taken her off her steroids because he said they would 'poison her system'. She had been taking them for five years though for her rheumatoid arthritis and knew what it was like without them, so she didn't mind 'poisoning herself', as they helped." (Q47, 3-5)

Here the patient knew how her body responded to treatment and was prepared to accept the risk of side-effects from the medication rather than suffer the pain of the disease. However, on admission her medication was determined by a doctor who clearly acted without fully consulting the patient. In fact the nurse later persuaded the doctor to restore the medication, thus relieving the patient's anxiety.

It is interesting to note that in this example the patient actually welcomed the treatment despite its aversive side-effects. The same was true of many patients who were experiencing great pain. Thus, in contrast to the more usual fears about having an operation, the patient in the following example had openly welcomed surgery when in pain:

> INTERVIEWER: "How did you feel about that? [ie the prospect of surgery]."
>
> PATIENT: "Lovely. I mean this is it. You come in for the operation and you go for it, don't you?"
>
> INTERVIEWER: "I was just thinking, I've never had an operation myself, and I think I would feel a bit anxious, a bit worried."
>
> PATIENT: "No. If you were in the pain I was, you'd do anything to get shut of it." (P4, 6-7)

The same pattern was consistently reported throughout the incidents: the greater the pain, the less important the issue of control became, and the more willing the patient was to trust himself without hesitation to any treatments which promised relief.

CONCERNS ABOUT THE ENVIRONMENT OF CARE

CONCERNS ABOUT ENVIRONMENT OF CARE	72	19%
PHYSICAL ENVIRONMENT CONCERNS	48	12%
CONCERNS ABOUT POSSESSIONS	10	3%
CONCERNS ABOUT STAFF	7	2%
CONCERNS ABOUT PATIENTS	7	2%

Concerns about the environment of care occurred mainly in incidents involving hospitalised patients. The four sub-categories reveal separate patterns of concern, linked by a common theme, namely that of being in an alien environment. This concern was quite distinct from worries about illness or about treatment procedures.

Thus forty-eight codings were recorded in incidents where the patients' fears appeared to arise from concerns about the physical environment, and about their safety within it. Newly-hospitalised patients were troubled by their dependence on others in aspects of everyday living hitherto taken for granted; they were unable to find their way to the toilet or the bathroom without help; they did not know how to summon help when required; they were unsure of the hospital routine and rules. Many individuals seemed to regard any new environment as potentially threatening, as the following questionnaire examples illustrate:

> "I felt that it was 'fear of the unknown'. This lady had no idea what occupational therapy was and as she had only been in hospital a short time found it distressing to leave the ward as she did not know her way around." (Q70, 5-6)

> "The patient then beckoned me to her and said she 'felt poorly' and could I stay with her for a while . . . Because a nurse had not been into the room for at least half an hour she became restless, worried and afraid that she was in danger." (Q81, 3, 7)

Although most problems occurred close to the time of admission to hospital, living in the community could also be unsettling:

> "She's a 92-year-old lady . . . and she's been partially sighted for a long time, and living in warden-controlled accommodation. She came in one morning [to the day unit] and she'd been startled by people knocking on her window at three o'clock in the morning. And she bottled it all up until she got here. And then once she got inside and felt safe . . . she just dissolved [into tears]." (N31, 2-3)

Patients who were vulnerable by reason of age or disability, and who were particularly dependent on others for their safety, inevitably tended to regard any change in their environment with trepidation:

> "The patient was slightly mentally handicapped and I don't think she really understood what was happening to her. She was frightened of the new surroundings and probably of the people she did not know." (Q11, 4-5)

> "He [a 4-year-old boy] was worried about being placed in an unfamiliar environment with lots of strange faces. He was being removed from his mother and brothers and sisters. During the first few hours he was consistently tearful and cried out for his mother. He also refused to accept that he had to stay in hospital and said that he would be going home as soon as he'd had his dinner." (Q23, 4-7)

A similar pattern emerged in the sub-category relating to concerns about possessions. The total of ten such codings occurred in incidents where the patients described were either children or elderly people who were frail or confused. Within the sub-category, two areas of concern arose: some patients appeared to be worried about what was happening to their possessions at home during the time they were hospitalised; other patients were concerned about the

safety of the possessions which they had brought with them into hospital. In the former case, elderly people had particular problems when their disabilities obliged them to move from their own homes into nursing homes, and when the move was organised while they were still hospitalised and had little control over what was happening. Elderly people with short-term memory loss were also particularly vulnerable to worries about possessions they had brought with them into hospital:

> "The patient was wandering up and down the ward talking to other patients and searching in cupboards and on shelves . . . I approached him and talked with him and he sounded very anxious. At the time I presumed that the patient had lost something. He had poor short-term memory and had often mislaid things in the past. He was also searching through the ward cupboards. I did not know at the time what he was looking for." (Q75, 3-7)

The nurse noted the tendency of this patient to misplace his possessions and then even to forget what he was searching for. This type of situation presented particular problems to nurses who were trying to assess the nature of their patients' concerns. It has already been shown that a knowledge of how individual patients react was an important factor in enabling the nurses to identify the emotional state of their patients. The above example shows that prior knowledge of individuals also enabled the nurse to identify the nature of the patient's concerns, when the patient himself was unable to give a full explanation of them.

The remaining two small sub-categories - concerns about staff and about patients - are a reminder that the hospital environment comprises people as well as equipment or possessions. Although there were only seven codings in each sub-category, no conclusions can be drawn from this about the actual frequency at which such worries occur in the hospital population. This is because patients may be reluctant to discuss concerns about sensitive aspects of personal relationships directly with members of staff; also the patients who were

interviewed all knew that the researcher was a nurse himself, and may therefore have been reluctant to reveal concerns in this area, for fear that they would be related back to the ward staff.

Concerns about relationships with staff were expressed in diffident terms. Some patients confided that they were afraid that they were being a nuisance when asking the nurses to do practical things, such as bringing them a commode. Other patients expressed fears about how doctors or nurses would treat them if they made requests or complaints. Thus one patient contrasted her present experience of hospitalisation with what had happened on an earlier admission:

> "It's much more relaxed, the atmosphere. When I was in hospital before it was in a hospital where my brother worked. He had an argument with the ward sister on the ward where I was, and she took it out on me. Also there were more rules and regulations, like you weren't allowed to lie on your bed at certain times." (P24, 2)

The worries which were reported about other patients all referred to noisy or distressed patients in nearby beds in the general hospitals, or to quarrels with other residents in long-stay psychiatric areas:

> "Well you do get worried here at night, because just lately it's been a bit hectic. Last night they brought a young lad in, and it was drugs or something. He was kicking the bed and shouting . . . it did frighten me, yes. I think myself it was an overdose he took." (P45, 14, 19)

> "The resident became very verbally abusive with a fellow resident who requested in an undiplomatic manner for her to remove washing from the machine. The resident was left alone shouting and screaming until staff arrived on the scene. [She] became even more distressed and anxious when two residents joined in to shout at her." (Q40, 2-4)

CONCERNS ABOUT RELATIVES, FRIENDS OR PETS

Total codings 54: Overall percentage 14%

Incidents were recounted in which patients were worried about spouses, siblings, children, grandchildren, close friends and pets. In some cases, illness had come as a sudden interruption to everyday life, leaving the patient powerless to give support to family or friends as before. Thus one nurse reported that an elderly patient admitted for total hip replacement was very irritable with staff, and was consequently rather unpopular with most of them:

> "He seemed very agitated and distracted. No-one seemed to have much time or sympathy and he was often aggressive and abusive. I thought he was anxious about his wife as they both lived at home with each other, had no children, and he looked after her. So whilst he was in hospital she had been taken to [a nursing home]. He continually asked about her and wanted to know how long it would be before he could go home, as he wanted to see his wife, as he said they didn't have many years left and they wanted to spend what little time they have together." (Q100, 1-7)

In the above case, the patient's physical state had interfered with his ability to continue everyday life as usual. However for some of the psychiatric patients, the position was reversed; their everyday worries about family or friends formed the very subject of the psychiatric problems which brought them into contact with the Health Service. An example from an interview with a day patient brings out the contrast:

> "Well I lost my daughter-in-law when she was twenty-six in a very bad accident. Now the two children, they're ten and eight, and they've been with my daughter, they've been with her two years. But it's suddenly come into my mind, 'What if she didn't want them any more?' She's promised faithfully that she will keep them. And I know, but it's making my brain accept it . . . And I was getting myself down, getting everybody down, but they were very kind and listened. It was only a small thing but to me it was a mountain." (P30, 12)

Pets appeared to be important as companions for many of the elderly patients who lived alone in the community. Consequently the distress which they suffered from separation from their pets arising from hospitalisation was the same as if their companions had been human. One nurse described an incident where an elderly woman became very anxious on admission:

> "Her background was that she had been living alone and her home situation was getting worse. And she had a little dog, and a lot of the time she was actually running round the ward trying to find her dog. And she was getting more and more anxious, and of course the dog wasn't there. I think initially for the first week or so it was quite good if you just stayed with her and said the dog was with her next-door neighbour, which it was. And that the dog was being looked after. The problem was that she was wanting to go home, but her home was being sold and she was waiting for a placement in a [nursing] home . . ." (N8, 2-3)

In the above case, the prospective nursing home was able to take the woman with her dog. However, the same nurse described another case in which a patient's dog was destroyed while he was in hospital because the neighbours were unable to look after it. A linking theme between both situations was the way decisions appeared to have been made without consulting the patients, leaving the patients uncertain about the fate of their pets and distressed at their own inability to exercise any control over what happened to them.

BEING DISCHARGED

Number of codings 10: Percentage of total 3%

Some patients appeared to find the prospect of discharge as anxiety-provoking as others found admission. Four of the codings referred to patients being discharged home or into hostel accommodation from psychiatric hospitals; the remaining six

referred to elderly people who were being discharged from hospital into private nursing homes:

> "[I] accompanied a long-stay psychiatric resident to a long-term hostel. This particular person is extremely anxious when put in a new situation and stated as soon as we entered the place that he didn't like it." (Q39, 1-2)

> "She stopped being her usual happy, cheeky self and became more reclusive. The reason for this is that she had been with us for a long time and someone had told her that she was being moved to a home without consulting anyone." (Q19, 3-4)

The concerns of both patients centred on how they would react to a new environment, echoing the fears already described with reference to unfamiliar hospital environments. As with many of the other worries described, the feeling of **not being in control** of what was about to happen appeared to exacerbate the patients' fears.

OTHER CONCERNS

Number of codings 38: Percentage of total 10%

This category was developed as a catch-all for the relatively small percentage of idiosyncratic worries which were too unusual to merit separate categories. Incidents included a retired railwayman who was confused and wanted to leave the ward in order to open the level-crossing gates; a woman who was hallucinating and believed insects were crawling all over her; fears about facing a Mental Health Review Tribunal; and five incidents in which the nurses were unable to ascertain the nature of the patients' concerns.

SUMMARY OF SECTION TWO

Two threads link the detail of the patients' reported concerns - fears about uncertainty and distress at a perceived lack of control over events. Illness and hospitalisation clouded patients' views of the future. The patients dearly wanted to return to their former state of health, while at the same time their present state of uncertainty alerted them to a host of real and imagined dangers and threats. Although the treatments available brought with them a prospect of safety, those treatments were frequently aversive in themselves - highlighting the tension between their hopes and fears.

Where the patients believed that they lacked control over events, their fears were generally heightened; illness deprived them of control over their bodies; frequently they had little real choice over treatments. Hospitalisation separated them from supportive loved ones and placed them in new and potentially threatening environments. Those patients who were not regarded as fully autonomous by their carers were as a consequence particularly vulnerable to concerns arising from perceived lack of control. Having said that, there was also clear evidence of individual differences in coping style. Some patients were able calmly to vest all control in the health care staff and appeared to be quite confident in the efficacy of this coping strategy.

In addition to these differences in coping style, the worries reported by individual patients were quite varied, even when coded under a single category heading. Many of the nurses, and particularly the sample of experienced nurses who were interviewed, appeared to take considerable time and trouble to assess the precise nature of each patient's concerns. It was only after this that the nurses intervened to try to help, and it is the interventions which they used that will therefore form the subject of the Chapter Six.

CHAPTER 6: THE NURSES' INTERVENTIONS

CHAPTER 6: THE NURSES' INTERVENTIONS

The nurses in the reported incidents used five types of intervention to help their patients to feel calmer or more secure:

Prediction
Support
Patient control
Distraction
Direct Action

These five categories describe the intentions of the nurses when they intervened to try to help anxious patients to feel calmer or more secure. The categories provide a classification based on the inferential model of communication described in Chapter Two. When using "*prediction*" the intention of the nurses was to find ways of inducing patients to predict a safe outcome to their situation; "*support*" was an attempt to induce patients to feel supported or cared for; "*patient control*" was an attempt to get patients to make decisions or to take action to control their own situation; when using "*distraction*", the nurses tried to induce patients to move their attention away from the source of his concerns. The fifth category, "*direct action*" was not a form of communication at all - it was an attempt by the nurses to resolve patients' concerns by taking direct action on their behalf. The relative frequencies of the codings for the five Intentions categories are shown in Table 6.1 overleaf:

TABLE 6.1: THE NURSES' INTERVENTIONS

FREQUENCIES	NURSES' QUESTS.	NURSES' INTERVIEW	PATIENTS' INTERVIEW	TOTALS
PREDICTION	389	61	33	483
SUPPORT	317	41	24	382
PATIENT CONTROL	118	78	31	227
DISTRACTION	35	9	5	49
DIRECT ACTION	70	14	6	90
TOTALS	**929**	**203**	**99**	**1231**
PERCENTAGES				
PREDICTION	41.9	30.1	33.3	39.24
SUPPORT	34.1	20.2	24.2	31.03
PATIENT CONTROL	12.7	38.4	31.3	18.44
DISTRACTION	3.8	4.4	5.1	3.98
DIRECT ACTION	7.5	6.9	6.1	7.31
TOTALS	**100**	**100**	**100**	**100**

A chi-square test shows a non-significant difference between the coding frequencies of the nurses' interviews and those of the patients' interviews. However there was a significant difference on chi-square between the questionnaires and both the patients' interviews (chi = 26.08; df = 4; $p<0.001$) and the nurses' interviews (chi = 80.81; df = 4; $p<0.001$). The main difference was that more patient control examples occurred in the interviews than in the questionnaires. The questioning process used in the interviews seemed to promote the reporting of more complex types of incident involving patient control interventions, whereas the nurses selected more straightforward prediction or support interventions when asked for written accounts.

As well as coding the nurses' intentions, a complementary set of sixteen categories was established to describe their reported words and deeds. These sixteen categories may be aggregated under four headings: non-verbal actions, information-giving interventions, other verbal interventions, and practical help. Table 6.2 shows the relative frequencies of these codings compared with the intentions codings for the whole database. This reveals the overall pattern of actions used by the nurses to try to induce patients to respond in accordance with their intentions.

TABLE 6.2: OVERALL COMPARISONS BETWEEN INTENTION CODINGS AND ACTION CODINGS

FREQUENCY	PREDICT	SUPPORT	CONTROL	DISTRACT	ACTION	TOTAL
NON-VERBAL	13	225	12	5	8	263
INFORMATION	354	26	55	2	10	447
OTHER VERBAL	93	107	144	36	7	386
PRACTICAL HELP	14	24	16	6	65	125
TOTALS	**474**	**382**	**227**	**49**	**90**	**1222**
PERCENTAGE						
NON-VERBAL	5	86	5	2	3	100
INFORMATION	79	6	12	1	2	100
OTHER VERBAL	24	28	37	9	2	100
PRACTICAL HELP	11	19	13	5	52	100

Clear patterns link actions with intentions. When trying to induce patients to predict safety, the nurses relied heavily on information-giving and optimistic

verbal assurances. Support interventions were based primarily on non-verbal actions, supplemented again by optimistic verbal support. Patient control was effected verbally, particularly by the use of challenging questions. Distraction was again primarily based on verbal conversational interventions. Direct action was mainly described in terms of practical helping actions.

Nevertheless, it is notable that every main type of action appears under each of the intentions categories, demonstrating the variety of methods which the nurses employed in their attempts to induce the patients to respond as they intended. However a quantitative summary yields only a partial description of the properties of the categories. To develop the picture, each of the five intentions categories will now be examined in more detail, using examples from the different data sources to bring out the key properties of each category.

PREDICTION

"*Prediction*" refers to an attempt to induce a patient to develop a different and more optimistic view of his situation from the one which he held before the nurse intervened. Thus, it is used here as a shorthand term for: an attempt by a nurse to induce a patient to predict or interpret a safe or safer outcome to the situation that concerns him than he presently believes or expects.

This definition brings out the fact that the patient might be concerned about something which happened in the past but which had aversive effects continuing into the present, or he might be concerned about something aversive which he expected to happen in the future. The nurse might try to induce the patient to believe that he was completely safe; alternatively, she might simply try to lessen his anxiety somewhat, by inducing him to believe that he would be safer than he expected.

Prediction was the most frequently occurring intervention in the full database of incidents, with 474 codings or thirty-nine per cent of all recorded interventions. The majority of these codings occurred in incidents recorded in writing by the nurses (eighty-two per cent). Interviews with patients accounted for a further thirteen per cent of codings, while the remaining five per cent occurred in the interviews with the nurses. The nurses used the following overall pattern of actions:

PREDICTION CODINGS	NUMBER	PERCENT
NON-VERBAL ACTION	13	2.7
INFORMATION-GIVING	354	74.7
OTHER VERBAL	93	19.6
PRACTICAL HELP	14	3.0
TOTALS	**474**	**100.0**

Information-giving and other verbal interventions based on optimistic assurance were the actions most frequently used. An example of these was reported by an orthopaedic nurse. The patient was a young man who had caused a road traffic accident. The driver of the other car involved in the accident had been admitted to a different ward in the same hospital. The young man was desperately worried about the health of the driver, so the nurse visited the other ward on his behalf to find out about the patient's condition. On her return, she went to see the young man again:

NURSE: "So I went in to him and told him, 'I'm sure you will be pleased to know that I have seen the gentleman who was involved in the same accident as yourself'. I decided it was best to tell the truth. I said, 'He looks in a bit of a mess, because he was involved in the accident like you are, and you are a bit bloody and he is a bit bloody. He has injuries, he will be in hospital for a period of time. But in my opinion, he will have no injuries that will at this stage of diagnosis impair the rest of his life' . . .

"And the young man, it was quite obvious that he was relieved at this. Because until that time he didn't know if that man was conscious, dying, or anything. So I thought, if I tell him that he spoke to me, that will give him the impression that he was conscious. If I was saying that he was aware, that means that he could hear me. I told him that he was aware that I was there, which meant he could see me. So in actual fact I was trying to get from this conversation that there was nothing wrong with his eyes, as far as we knew. Nothing wrong with his hearing. I then again decided that it was time to get out and let this young man absorb this." (N1, 23-25).

The nurse's avowed intention was to persuade the young man to change his pessimistic view of the driver's condition into one which was more optimistic. The nurse consciously used an inferential model. She presented selected items of factual information about the other patient, from which she intended her patient to infer additional information. She combined this use of factual information with a cautiously optimistic assurance, in which she gave her overall opinion of the driver's prognosis. The nurse believed that this approach was successful in relieving the patient's anxiety by inducing him to predict that the other patient would not die as a result of the accident.

This incident is typical of the majority recorded, in that the patient believed the situation to be highly aversive, while the nurse genuinely believed it to be safer than the patient thought. When the nurse had made a comparative assessment of this difference in perception, she attempted to induce the patient to change his view of his situation towards one which was similar to that held by the nurse herself.

Thus when using prediction, the nurses' preferred methods were either to marshal factual information which supported their views, or to use personal assurances to convince patients of the truth of their assertions. These two important approaches will be examined in more detail.

USING INFORMATION

When the nurses used information to try to calm patients, the information they presented was usually selected to address the patients' specific concerns and in many cases a conscious attempt was made to pitch the information at a level of detail appropriate for each individual patient. Incidents were recorded in which the nurses took into account patients' educational background and patients' preferred coping styles. The following two extracts from separate questionnaires point up the variations in the amounts of information which might be given:

> "The lady in question obviously thought that she had been put in a single room to die . . . I sat down on her bed with her, held her hand and explained in simple terms that she had a bacterial chest infection which could be contagious but once it cleared up she could be moved back into a four-bedded room." (Q25, 8,15)

> "I discussed the tracheostomy and explained how we communicated - by phrasing our questions so that they require a yes/no answer. I also explained that at most times there will be a nurse with her, but that if there was not, she would be always in view of at least the nurse at the nurses' station. Included in this discussion was tracheal suction, the changing of tracheostomy dressings, and the expected oozing from this area which is normal and would feel quite damp . . . We discussed the routine nursing care - position in bed, two-hourly eye, mouth and pressure area care, and also the equipment that would be around her. It was at this time I explained that she would be attached to an ECG monitor, but again this was all routine and not to think something was wrong. As for going to the toilet, we discussed the fact that she would have a urinary catheter for 48 hours and why." (Q113, 14-16, 18-20)

Despite the difference in the amount of detailed information given to the patients in these two incidents, the overall intention of the nurses was the same. They were not simply trying to reduce the patients' levels of uncertainty by giving information for its own sake. They were presenting carefully selected items of information, calculated to induce each individual patient to predict safety. Both situations were ones in which the patients could exercise no real control over what would happen to them. The patients had to rely on the nurses and the medical staff to control events for them. What the nurses appeared to be trying to do was to convince the patients that everything that was happening was part of a rational plan designed in their best interests. To the extent that they succeeded in communicating this, the patients appeared to become not only calmer but also more compliant with the nurses' wishes.

This emphasis on the ability of staff to control situations which the patients could not control also occurred in incidents where patients were worried about pain. In these incidents, the nurses generally tried to minimise the threat and to emphasise the power of anaesthesia or of subsequent pain control medication. They gave information about sensations which appeared to be designed to induce the patients to distance themselves from the emotional features of the experience. The following examples are typical of many reported by nurses in theatre when preparing patients for the anaesthetic:

> "I helped reduce some of her worries by giving her simple explanations of the anaesthetic procedure, such as the anaesthetist would put a little needle into the back of her hand, then she would feel something cold running into the vein and would finally feel very sleepy." (Q5, 7)

> "Explaining in detail about the procedure that was going to happen to her, that she would have a needle put into the back of her hand, it would feel like a scratch. Reassure her that after the spinal [anaesthetic] she would feel no pain during the operation and for a while after . . ." (Q167, 7-9)

When using prediction, the primary aim of the nurses was to calm their patients, and they therefore selected items of information which they believed would alert the patients to the safety features built into most treatments:

> "Her main fear was about waking up during the operation and the surgeon carrying out the procedure on the wrong leg. I explained to the lady, after asking her what she thought would happen, everything that would take place. I explained why she would need to be put into a gown, a premedication may be given and that the leg in question would be marked by the doctor, therefore the correct leg would be operated on . . . I explained to her about the safety aspect within theatre, the checking of the patient at the door and in the theatre. She had no idea that all of these procedures were carried out for the safety of herself." (Q15, 8-10, 13)

Thus, not only did the nurse help the patient to predict the sequence of events, she also tried to induce the patient to interpret each new step of the procedure as a cue to safety. A patient reported a variant of this approach when recovering from a femoral artery bypass. This operation had been performed on his other leg twelve months previously:

> "The knee cap. It did seem to swell up yesterday . . . I went to the toilet, then back, and I mentioned to one of the nurses, 'My knee cap's come up.' And she had a look and she said, 'You can expect that. If you remember rightly, when they did your other leg last year, you wore a stocking on that leg for about two or three weeks.'"

The interviewer asked the patient if it made a difference that this particular nurse had cared for him on his previous admission:

> "Well, I should be lying if I was to say no. Because you know them slightly and they've done the job before . . . I believe in what she said. She's doing the job, she knows what she's doing." (P25, 1, 4-5)

Here the nurse's success in calming the patient depended on two factors. She

used the patient's memory of the aftermath of the previous operation as a cue to safety about the present one. Also, the patient remembered that this particular nurse had been competent in caring for him before, hence this continuity in care meant that she herself became a cue to safety in the present circumstances.

USING ASSURANCES

Sometimes the nurses simply assured the patients about their concerns without presenting detailed factual information. Assurance in this context means an expression of optimism or a promise of help or support. When using information, the nurses presented the patients with selected facts and allowed them to infer safety from them. When using assurances the nurses spelled out the inference of safety directly to the patient, as illustrated in this extract from an interview with a patient who was worried about the prospect of pain when her wound drain was removed:

> "I've been asking a nurse this morning not about the op, but about having this [drain] taken out. And I said to her, 'Does it hurt?' And she says, 'Well we've never had a problem with anybody yet.' I says, because I'm worried sick about it going to hurt. And she says, because I mean you're very tender anyway, she says, 'We've never had a problem yet.' She says, 'You'll find out there was nothing to worry about. If you carry on thinking it's going to hurt you'll be surprised when you get it out because it won't hurt. It'll probably feel a bit uncomfortable, but it won't hurt.' So she's made me feel better really, saying that. Because she says you always think the worst, and things are never as bad as you think they're going to be. Which is true." (P3, 18)

Some items of factual information were presented in this conversation, but the essence of the nurse's approach was "*Trust me, you are safe with me.*" Thus assurances relied for their success upon the extent to which the patients perceived individual nurses as worthy of their trust. One factor which was clearly

important in this context was whether the nurse could convince the patient that she was competent, in the sense that she had sufficient knowledge about the problem to assess it accurately. In many cases the nurses combined information and assurances, appearing to use the former to try to establish their credibility and the latter to ensure that the patient made the inference of safety which the nurse desired. One highly effective way of establishing credibility used by some nurses was to allude to personal knowledge of particular situations or procedures. For example, a patient who was recovering from a colostomy said that initially he felt devastated by the mutilating effect of the surgery:

> "And as it happened, this nurse . . . is going to eventually have the same operation herself. And really and truthfully, after she'd explained to me, she said, 'It's not going to affect my life, everything's going to be as it was before. I'm going to go out and enjoy myself. I'm going to swim. All those sorts of things. It'll not change my life one little bit.' And do you know, from that moment on, this has been nothing. I've grasped doing it [changing the stoma bag]. It's been nothing. Because she put my mind so much at rest." (P26, 2)

Promises were also forms of assurance. In some cases the nurses promised that the patient would be safe, effectively putting their own reputation for competence at risk if events did not happen as they predicted. In other cases they promised to take action, to do something for the patient. Examples included promises to intervene with medical staff, promises to look after relatives, promises to accompany a patient to theatre or to be present in recovery after the operation. In all the incidents where promises of action were made, the patients experienced at least temporary relief. Where the nurses were able to keep their promise, they gained credibility in the eyes of the patients, and this could be developed further in subsequent interventions. However, if they were unable to deliver as promised, the effect on the patient was invariably adverse, as if the nurse had been discovered in a lie.

LYING

Lying is defined here in the broad sense noted by Bok (1978: 13-14) as any attempt intentionally to deceive others. In all the incidents described thus far, the nurses appeared to believe that the patients were genuinely safer than the patients themselves thought, and therefore when predicting safety the nurses were not lying, even if their predictions proved inaccurate. However, some incidents were recorded in which a nurse believed that a patient's situation was genuinely aversive, but instead consciously chose to lie to the patient about this. These incidents were therefore ones in which a nurse attempted to induce a patient to predict that his situation was safe, even though she knew that this was untrue; in these circumstances the nurse was lying.

The nurses stated that they were reluctant to lie to patients, but in some cases elected to do so in order to manage difficult patients. It is noteworthy that all the incidents where lies were reported involved patients whose autonomy was judged by the nurses to be impaired. Thus one nurse explained how the ward team dealt with an elderly patient who was suffering from mental confusion. The patient's pet dog had been destroyed without the patient's knowledge or permission, after the patient had been admitted to hospital and the neighbours who were looking after the dog found that they were unable to control it:

> NURSE: "And he was asking about the dog, but we couldn't really tell him the dog was no longer with us. We were perhaps reinforcing negatives in that situation - the fact that he would get to see the dog at some time. But it wasn't nice to actually reinforce that. But then again, for our management of the patient at that time . . ."
>
> INTERVIEWER: "And what would you say when he was asking for his dog?"
>
> NURSE: "We were saying that, 'You will get to see him sometime'."

INTERVIEWER: "And what would have happened if you had told him the truth, do you think?"

NURSE: "I don't know. Really it didn't seem appropriate to tell him. He had had a couple of episodes where he got quite agitated, and a little bit aggressive. So actually telling him the truth might have made him aggressive." (N8, 11, 14)

The nurse was explicitly using a lie in order to induce the patient to predict that his dog was safe. The nurse's intention was to induce the patient to feel calmer, and her justification for using a lie was that the patient became aggressive and difficult to manage when he was agitated.

The practical problem when using a lie was the risk of being discovered. One nurse (N10) referred to this as the risk of "*losing a friend*", alluding to the fact that the relationship between the nurse and patient was liable to be permanently damaged. The nurses may therefore have judged that confused elderly patients, particularly those suffering from memory loss, would be less likely to discover a lie than fully autonomous patients. A similar view appeared in an incident where the nurses decided not to alert a resident with learning difficulties of the likelihood of his being moved to new bungalow accommodation. The nurses knew that when the patient became anxious, he tended to starve himself. They therefore lied to him, denying the move, as a form of stress management, in order to introduce him gradually and in a controlled way to the prospect of a move.

With all patients, the nurses were very concerned to maintain their credibility. Therefore there were many highly aversive situations where the nurses could not predict safety because they were certain to be discovered in a lie. They sometimes used optimistic assurances in these circumstances, but their force was more as a demonstration of caring than as an accurate prediction. In most of the reported incidents, the patients accurately recognised this. Thus, one woman awaiting the results of breast biopsy explained her hopes and expectations:

INTERVIEWER: "In that sort of a situation when you're waiting for the results of a test or whatever, is there anything that a nurse can say or do that's going to help in that situation?"

PATIENT: "Well I think they do try. They say, 'Oh don't worry, I'm sure it will be alright.' But you don't really believe them. You can't can you? No matter what they say. They don't know, nobody knows."

INTERVIEWER: "I suppose they're showing sympathy?"

PATIENT: "Yes. I think that's all they can do. Just to have somebody to talk to. But all the time, you're wanting somebody to say, 'You're going to be alright.' But it's not in their power to do so, or anybody's power to do so at that particular time. So I think that they do very well just to give people sympathy, and support at that particular time. But I don't think anybody can stop it from being a traumatic time. They can only help really." (P12, 19-20)

In some incidents the nurses were under instruction from medical staff not to disclose information about prognosis to particular patients. The problem here was how to calm the patients in order to maintain their compliance with treatments, while not revealing the true reason for those treatments. The likelihood of discovery made lying a risky approach, so a technique which will be described as "*targeted assurance*" was frequently employed:

"The patient had been diagnosed as having myeloma, but the doctors were putting off telling her due to her anxiety problems and history of 'cancer phobia'. She was frightened about dying and leaving her husband alone. She was very anxious about the blood transfusion. Also having to have diuretics, since she was worried about frequently having to bother the nursing staff for the commode.

I listened to what she had to say. We talked about her husband and her home. I then tried to reassure her that the blood transfusion would not necessarily be so painful. We wanted her to use the commode frequently, so that the drugs would be shown to work. I would talk to the doctor about the fears she had about the transfusion and the fact that the last one was a bad experience. The fears of the cancer were fortunately put to the back of her mind once I had reassured her about

> the blood transfusion. She did not ask so many questions about it. She settled, she agreed to the transfusion and was more calm about it. This was really only short-term success and she was still obviously anxious about the diagnosis and she still found other problems later to worry about." (Q38, 2-18)

This patient had multiple concerns. The nurse "*targeted*" the ones where she could give honest information or optimistic assurances, such as worries about the blood transfusion and the use of the commode. These interventions calmed the patient, and this general calming effect appeared to lessen her fears about her diagnosis, though only for a short time. Prediction and compliance were again linked in this situation. It appeared that a calm patient was usually a compliant patient. Thus prediction was used to induce calmness, with the secondary effect of also inducing passive compliance with the treatment regime.

PREDICTION SUMMARY

Prediction was an important method used by the nurses to try to calm their patients. They used both factual information and optimistic assurances, frequently combining the two. They employed prediction primarily in cases where they genuinely believed the patients' fears were not justified. Success depended on the extent to which the nurse could present herself as a competent assessor of the patient's true situation. A secondary effect of successfully calming a patient through prediction was the promotion of passive compliance. Therefore in some cases where the patient's situation was genuinely aversive, the nurses nevertheless resorted to lies in order to promote compliance and to facilitate patient management. All the recorded incidents involving lying related to patients whose autonomy the nurses judged to be impaired. An alternative technique in these circumstances was "*targeted assurance*", in which the nurses honestly and authoritatively predicted safety in one area of the patients' concerns, hoping that

the feeling of calmness thus induced would generalise to the deeper fears which the nurses chose not to explore. When working with autonomous patients in genuinely aversive situations, the use of prediction was self-limiting. The nurses could not use a lie if it was likely to be discovered, since this would damage their credibility in the eyes of the patient and make future interventions very difficult. Also, the patients themselves realised that there was a limit to the power of the nurses and medical staff to control all aversive situations for them. It was in these circumstances that an alternative approach based on Support interventions became particularly important.

SUPPORT

"*Support*" refers to an attempt to: induce a patient to predict or interpret that a nurse supports and cares about him.

382 support interventions were coded, forming thirty-one per cent of the total number of recorded interventions. Support formed thirty-four per cent of interventions from the questionnaires, twenty per cent from the nurses' interviews and twenty-four per cent from the patients' interviews. The overall pattern of accompanying actions which the nurses used to induce patients to feel supported showed a clear emphasis on the use of non-verbal and encouraging verbal approaches:

SUPPORT CODINGS	NUMBERS	%
NON-VERBAL ACTION	225	59
INFORMATION-GIVING	26	7
OTHER VERBAL	107	28
PRACTICAL HELP	24	6
TOTALS	**382**	**100**

The support category first emerged clearly during the interviews with the patients when they reported that nurses who spent time with them, showing concern verbally and non-verbally, helped them to feel calm and safe. The same theme, coupled with a firm belief in its effectiveness in promoting calmness and security, was then discerned in the interviews and questionnaires supplied by the nurses. An example was recalled by a nurse who was caring for a young woman dying of cancer:

> "I just sat and let her talk. I wanted to assess that it wasn't pain, that she wasn't in pain. I gave her reassurance, holding her hand and by my presence . . . Just to know that I cared and I wanted her to know that I would hold her. Being there and listening, spending time. And not being frightened to let her express herself . . . I felt because I was there and she knew she wasn't alone, she would lie down and go into her sort of sleep. She knew you were there as someone who cared . . . It was very distressing for us all. But at least I felt I could calm her a bit by being there." (N50, 2-3)

The nurse believed that she could calm the patient by conveying to her that she was going to stay and support her to the end. The nurse appeared to view this supportive approach as an intervention complete in itself since, in the context described, any form of prediction or optimistic assurance would have been untruthful and hardly credible. The nurse accepted the aversiveness of the patient's situation and made no attempt to alter the patient's perception of it. Although there was nothing the nurse could do to alter the patient's prognosis, she still believed that she was able to help to calm the patient by being there, by holding her hand, and by allowing her to express her feelings. Many of the patients explicitly confirmed the independent calming effect of support interventions:

> PATIENT: "Well one of the nurses, she comes and sort of 'loves' you, you know. That makes you a bit better you see. To think you've got nurses who come and do that."

INTERVIEWER: "What do you mean by that, what do they actually do or say?"

PATIENT: "Well they come and put their arms around you and say, 'How are you Mr [patient's name]? How are you feeling? They feel sorry for you."

INTERVIEWER: "And how does that make you feel?"

PATIENT: "Well it makes you feel a lot better, because you've got somebody by your side, that's there to help you. Until they show that appreciation, you've got nobody. But when they show that appreciation, you've got it." (P15, 2-4, 6)

Support interventions were therefore of particular value in aversive situations where the nurse could exercise little or no control over the source of the patient's concerns, and in situations such as the one above where the patient felt lonely and isolated. The nurses used a wide range of non-verbal and paralinguistic actions to achieve their intentions: creating privacy, spending time with patients, getting close, using touch, and adopting a calm and friendly manner. Touch was the most frequently occurring action, particularly hand-to-hand, or hand-round-shoulder. One nurse commented that she adapted her use of touch according to the initial response of each patient. Another nurse described holding the hand of a patient who was having an eye operation under local anaesthetic. Touch here had two functions, one instrumental and the other expressive. The patient was told to squeeze the nurse's hand to signal if she was experiencing any pain. However, the nurse said she believed that the physical contact in itself had a calming effect on the patient.

One way of reducing patients' feelings of isolation was for the nurses to spend time with them. Frequently the nurses referred to spending "*spare time*" with patients. The sense seemed to be that technical nursing and medical procedures

usually took priority, but that when these were completed "*spare time*" became available for helping patients to overcome their anxiety:

> "I sat with the gentleman concerned, spending as much spare time with him as possible." (Q14, 11)
>
> "I spend spare time just sitting and talking about non-specific things and listening to Bill." (Q82, 10)

In contrast, some nurses reported "*giving time*", as if in these situations they made a deliberate decision to "*give time*" to patients as a higher priority than other duties:

> "I gave him time to ask questions and express his feelings . . ." (Q29, 8)
>
> "Time given to be with her was important, especially at meal times when she would refuse to eat." (Q69, 11)

Only seven per cent of the actions coded in this category included factual information. Instead the nurses tended to combine non-verbal interventions with verbal assurances. In one incident a nurse described how three months earlier she had used this combined approach to calm a patient who was having a long wait in theatre reception before surgery. The nurse described assuring the patient that she had never known any patients wake up during the operation, which was one of the patient's main fears. She also held the patient's hand at the start and end of their conversation. This was one of the paired interviews, and the patient was able to confirm the effectiveness of the nurse's support intervention. She commented on the fact that the nurse told her she was going to stay with her, and on the nurse's manner:

". . . very, very calm. Smiling. Sparkling eyes. Kind, caring eyes, bright eyes. A kind, pleasant expression. And touch. She held my hand for a little bit." (P50, 22)

A slightly different nursing action used in supporting patients was to allow or encourage them to express their thoughts and feelings. Many nurses appeared to believe that "*ventilation*" (as they termed the expression of feelings) was particularly helpful to patients when it was done in the presence of a nurse whom they found supportive. One nurse (N39) described a family she visited as "*waiting for someone to perform in front of*". She said that once they had expressed their emotions, they calmed and were able to think about their situation more constructively. In this sense, ventilation appeared to have both a calming and an empowering effect through the release of the tension which had been interfering with rational thinking.

Support approaches were also frequently used with patients suffering from loss of short-term memory or other disabilities which meant they could not rationally appreciate the value of predictive information or optimistic assurances. One nurse described calming a patient with multiple physical and mental handicaps. This patient had very limited verbal communication, and would sometimes begin screaming, kicking and head-banging if she could not make herself understood. Because of her inability to express her feelings, the nurses were often limited in the range of interventions which they could use and tended to resort to support:

"We are inclined to hold her hands. We sit at the side of her, cuddle her in. Speak very, very calmly to her. Usually the hand-holding and the speaking in a quiet tone of voice works." (N46, 7)

Support was also used in combination with other interventions. Most frequently the nurses appeared to use support as a preliminary, in order to establish their credibility with patients as caring nurses. The nurses then went on to use prediction, distraction or patient control approaches, drawing on their established

credibility to promote their intentions. One nurse described using a preliminary support intervention to win a patient's trust, before going on to help the patient to review his decision over consent to surgery:

> "And I held his hand, let him have a cry. I think the physical contact was very important because he'd set up a big barrier around himself and wasn't prepared for any contact. Once we'd broken that barrier he was alright with everybody, though there were times after surgery that we had problems with him. We spent a lot of time talking about his past, and things that he was interested in." (N10, 8)

This preliminary use of support was illustrated in a different context by a psychiatric nurse working with a patient who was anxious about her grandchildren:

> "She's a motherly lady and likes physical contact. And she will put her arm in yours. And I always put my arm round her and say, "As far as I can possibly tell you, your husband and daughter assure me that they are going to keep the children. And there is no likelihood of them going into care. And she accepts that. And she says, 'Are you sure?', and I say, 'That is the truth as I know it, I can reassure you on that' . . . And she will just squeeze me and say, 'Thank you, that's alright, thank you.' That's all the reassurance. Then after that she needs diverting into some diversional activity." (N11, 6-7)

The nurse used primarily non-verbal means to induce the patient to feel supported and cared for, then gave her information predictive of a safe outcome, finally switching to distraction. This was one of the paired interviews and the patient confirmed the calming effect of the nurses' interventions:

> PATIENT: "Yes, the nurses are very kind."
>
> INTERVIEWER: "When you say they're 'kind', what is it they do that makes you say that?"
>
> PATIENT: "Well they talk to you, don't shout at you. Don't say, 'Why did you do that, you stupid woman.' Nothing like that."

INTERVIEWER: "They don't judge you then?"

PATIENT: "No. They just talk to you. Reassure me . . . And every time I've been upset over it, they've never pressured me, they've spoken to me, they've rung my husband up, and generally helped me on every occasion. And I was getting myself down, getting everybody down, but they were very kind and listened . . ."

INTERVIEWER: "And you say they phoned your husband, what did they phone him to say?"

PATIENT: "Well, to reassure me. Because I didn't believe him at first about my daughter. Very kind." (P30, 5-7, 12, 14)

The patient commented several times on the kindness of the nurses, which appeared to be a reference to the feeling of being supported, as described in this category. The nurse used a predictive intervention after this initial feeling of support had been achieved. Once a trusting relationship was established, each successful intervention further reinforced the credibility of the nurses in the eyes of the patients, and hence appeared to enhance their ability to intervene effectively on subsequent occasions.

In some cases the support interventions described by the nurses were part of a continuing close relationship with individual patients. The nurses described their role in these relationships in a variety of terms ranging from "*friend*", "*facilitator*", "*advocate*" and "*provider*". Shared interests helped to move some relationships beyond the professional into close personal attachments. Length of stay appeared to influence the growth of these closer relationships. Some nurses chose to limit all their involvements to a purely professional level, but others reached the stage where the mutual attachment between patient and nurse was described in the same terms as that between relatives. One of the most striking of these relationships emerged from the paired interviews where a student nurse had helped to resuscitate a patient who had collapsed. Five years later the patient was re-admitted and the nurse, now qualified, happened to be on the same ward:

"I've a very special, personal relationship with him. I look on him as a sort of grandfather figure and I'm a sort of granddaughter figure to him . . . He is a very special person, there's no doubt about that. It's 'professional' because he's a patient and I'm a nurse, but the professional barriers aren't there." (N20, 2, 6)

The patient independently confirmed this relationship in similar terms:

". . . [She] talks to me like she's talking to her own grandad. I think she's always had a bit of a soft spot for me ever since that five year ago . . . As I say, with her, you knew you were safe. I don't know why. She put her arms round me. Fighting for breath I was. 'Come on', she says, 'You've always been a fighter. This ain't like you.' She said, 'Just breathe in, take it easy.' She calmed me down, right down. By the time I'd bloody finished, you felt safe with that girl." (P48, 11, 12)

In this example, the supportive relationship had persisted over five years, and it meant that the nurse was able to intervene in more directive ways than the other staff, with no fear of her intentions being misunderstood. Where a patient had such total trust in a nurse, the technical detail of the nurse's interventions appeared to be less important than the fact that it was this particular nurse who was there to support and care for the patient. In Bowlby's (1971) terms, the nurse had become an object of secure attachment for the patient.

SUPPORT SUMMARY

Support functioned both as an independent intervention and as a supplement to other interventions. Its independent function was most frequently used in situations which both nurse and patient recognised as aversive and uncontrollable. In these circumstances the nurses nevertheless appeared to be able to calm and comfort some patients by skilled support interventions. Another independent

function of support occurred when the source of the patient's fears was isolation and when the presence of a nurse induced the patient to feel that someone cared about him. Support could also be used to supplement other interventions by establishing the credibility of the nurse as a caring person. This enhanced the efficacy of predictive approaches; it could also induce such a feeling of calmness and security that distraction became possible; alternatively it could give the patient confidence to follow the nurse's subsequent advice and to take control of the situation for himself.

PATIENT CONTROL

"*Patient control*" refers to an attempt by a nurse to: induce a patient to exercise control over himself or his situation.

"*Control*" is defined following Miller (1979a) as the ability to avoid, escape from or mitigate the effects of an aversive event. 227 patient control interventions were coded, forming eighteen per cent of the total recorded interventions. Patient control formed thirty-eight per cent of the interventions from the interviews with patients and thirty-one per cent of those from the nurses. In contrast it formed only thirteen per cent of the interventions from the written questionnaires. Patient control interventions were generally complex and involved more two-way interaction than the other types, and therefore it may have been easier for nurses and patients to report these verbally than to write them down in answer to the questionnaires.

The pattern of accompanying actions was clear and consistent throughout the database. The following figures are the totals from all three sources of information:

PATIENT CONTROL CODINGS	NUMBER	PERCENT
NON-VERBAL ACTION CODINGS	12	5.3
INFORMATION-GIVING CODINGS	55	24.2
OTHER VERBAL CODINGS	144	63.4
PRACTICAL HELP CODINGS	16	7.1
TOTALS	**227**	**100.0**

The "*other verbal*" codings comprised mainly suggestions and advice given to patients, or encouragement to express thoughts and feelings. The "*information-giving*" codings were in marked contrast to those found in prediction. When using a predictive approach, the nurses selected information which would lead patients to see their situation as safe. However, much of the information used under patient control tended to be selected for the opposite effect: to induce patients to predict that their situation was aversive!

The reason is that patient control was used when the nurses wanted the patients to be active, to do something to control their situation. The nurses used patient control when they viewed the patients' circumstances as aversive but potentially controllable by the patients themselves. However, in many cases the patients were not fully aware of the aversive nature of their situation. Therefore aversive information had to be given first, so that the decisions or actions open to the patient could then be explored on a rational basis. The calming effect of patient

control interventions was therefore not inevitable. It occurred only when the patient came to accept that he could indeed exercise control over his situation for himself.

An example comes from an interview with a nurse who worked in Out-Patients. A woman had been diagnosed as having breast cancer and the consultant initially suggested a mastectomy. The woman raised objections to having surgery and the consultant then agreed to give her radiotherapy. After her appointment the woman began to have second thoughts, wondering whether she should not have accepted the consultant's initial recommendation. The nurse set out to try to help the woman to review her decision:

> "So I explained that we had no way of knowing whether there had already been spread beyond the axilla. So whichever decision, treatment she had, it wouldn't be her fault if suddenly we had to give her some treatment for a secondary elsewhere. That rather pleased her, surprisingly . . . So I said really the only thing was that she'd got to face up to the very strong possibility that sometime or other she would have to have a mastectomy if a local recurrence occurred. But we would check regularly if this was happening. So she's gone off quite happily about it now . . . But she certainly wasn't in a position to accept a mastectomy. She said she felt that if it was life-saving she would have it, but she didn't want to do it unless she had to."
> (N41, 11,12)

The nurse set out to make the patient aware of the true nature of her situation, and did not hide or tone down the aversive information. However, the nurse realised that only the patient could make a decision about these treatment possibilities, and therefore deliberately avoided predicting that one approach would be better than another. Paradoxically the information that even the consultant was unsure about the spread of the cancer was welcomed by the patient, since it confirmed that she had nothing to lose by following her original decision.

In order to make sense of the considerable variety of situations in which patient

control was employed, four sub-headings will be used: controlling self, controlling staff, making a choice, and implementing a choice.

CONTROLLING SELF

This type of intervention was used in situations where a patient was becoming very distressed, and the patient's emotional state was endangering his physical or mental health, or was making treatment impossible. In these situations, the nurses had a definite view of how they wanted the patients to behave. Their problem was how to induce them to do what they wanted. The control which the nurses wanted the patients to exercise was directed at mitigating the effects of an aversive event in the present, and sometimes also at avoiding a potentially aversive event in the future.

Thus in one incident a patient was being prepared to come off a ventilator and resume independent breathing. The patient began to panic about his breathing as his sedative wore off, and verbal communication was impossible for him because he was still intubated. The patient was experiencing distress at the presence of the intubation tube, and his emotional reaction potentially endangered his health:

> "He started to thrash around the bed a bit . . . I went over to him and spoke to him in a very soft, very calm voice. Which he listened to. First of all I had to get his attention, and say fairly firmly . . . "If you just breathe slowly, listen to me and I'll help you." Told him when to breathe in, when to breathe out. Because virtually he was panicking because this tube was there. And he seemed to settle down. And then I held his hand. He was sitting at maybe a 45-degree angle at this stage. And I remember having my hand on his head, stroking his hair a little, just to let him know I was there." (N42, 3)

The nurse used a conditional promise of safety - "*if you do this, I will be able to help you*" - to induce the patient to attend to what she told him to do. The nurse

was quite directive in her instructions. It may seem odd that such a directive approach should form part of a patient control intervention, but this was a frequent occurrence. In circumstances where active control by the patient was the best route to safety in the nurses' opinion, they made their persuasive messages very directive. The most directive approach encountered came from a paired incident mentioned earlier in which nurse and patient identified each other as granddaughter and grandfather figures (N20, P48). The patient became breathless and the nurse used her established relationship in order to induce the patient to "*Shut up*" and then told him to put up a fight and breathe steadily. In the patient's words: "*She just calmed me down*". To the patient it felt as if the nurse had done the calming, whereas in fact he himself was the only person who could exercise direct control over his own emotional state. It is in this sense that directive approaches are categorised as forms of patient control.

CONTROLLING STAFF

This refers to situations in which the nurses allowed patients explicitly to exercise control over what staff were permitted to do to them. In Miller's (1979a) terms, the patient was allowed a way of escaping from the aversive event by exercising control over the actions of the staff. Although theoretically patients always had a right to withdraw their consent to any treatment, in practice this appeared to be difficult to exercise in many hospital situations where passive compliance was expected and assumed. Some examples of allowing patients to control staff concerned bargains over the confidentiality of information. In one incident, a nurse (N34) was trying to persuade a patient to allow her to explain to his wife that the patient was being tested in case he was HIV Positive. The patient allowed the nurse to talk to his wife, on condition that she did not mention his past sexual history.

Another form of patient control was related by a theatre nurse, who told patients who were to have surgery under local anaesthetic that they had only to squeeze her hand if they experienced pain and she would stop the surgeon and ensure they were given more anaesthetic. This nurse also stated that she could vividly recall another incident involving patient control which had happened more than a year earlier:

> INTERVIEWER: "Does it ever happen that they just have to abandon the operation?"
>
> NURSE: "I can't think of one that has been abandoned. I can think of one that should have been. But the surgeon carried on. The surgeon was annoyed with the patient, and it wasn't the patient's fault. It was a dental operation, and the patient was in pain, she was frightened. And I don't think he should have carried on. It was only a short procedure, a removal of a tooth or a couple of teeth. But she was frightened. And we had stopped once and given her some more analgesia, but she still complained of pain. The surgeon carried on regardless. He went quite quickly, but it was obviously a bad experience for her."
>
> INTERVIEWER: "And what was your job there?"
>
> NURSE: "Well I was assisting at the time, but I was still trying to go between the patient and the surgeon. Trying to reassure the patient, saying, 'It's only a little bit more', or something like that. It puts you in a difficult position, because you can't say 'Stop, you should stop this.' You can suggest, but you can't insist."
>
> INTERVIEWER: "Because the surgeon could still do whatever he wanted?"
>
> NURSE: "That's right. And I don't think the patient felt able to say to him, 'Stop'. Which would be quite within her rights." (N13, 19-21)

This unsuccessful outcome illustrates what could happen when a nurse offered the patient more control than she was competent to deliver. Competence in this sense refers to the power or authority of the nurse, rather than to her knowledge. The offer of indirect control was sufficient to calm the patient before the operation, but

the nurse then failed to deliver on her promise to stop the operation. She said that she would have given support had the patient attempted to get the surgeon to stop, but her position within the organisation did not appear to permit her to suggest this course of action to the patient. Instead the nurse changed her approach and fell back on predicting that the operation would soon end. However, she had been revealed in the patient's eyes as lacking the necessary authority to help her in this aversive situation. Therefore her subsequent assurances had no persuasive force to calm the patient. The fact that the nurse could still remember this incident after more than one year is a testimony to the strong feelings of frustration that her powerlessness in the situation had aroused in her.

MAKING A CHOICE

This was the most frequently reported situation in which patient control was used. The choices primarily concerned illness and treatment-related issues, or family problems. In several incidents, the basic technique used by the nurses was again to present aversive information to patients. An example was given by a nurse who disclosed to a patient that she was close to death. In this case the nurse was responding to a request for information from the patient. The nurse explained that her intention in answering honestly was to allow the patient to exercise control over what happened in the time which remained to her:

> INTERVIEWER: "So what's your evaluation of the effect of what you did on the patient?"
>
> NURSE: "Quite positive I hope, I think. That it enabled, it's answered her questions honestly, which I think is a very strong point. It's put the ball back in her court. Because she now has to quickly decide in a sense if there's anything she needs to do. Explaining things or whatever. So it's giving her more control of the situation, because she

now knows it. The sedation - although the pain relief is going to get to her whether she likes it or not, she's had that all the time - but I've left the sedation question up to her. It's still as she requires. So again I'm trying to keep her in control of the situation, which is one of the aims."

INTERVIEWER: "Is that a basic philosophy?"

NURSE: "It's a basic philosophy that unless the patient opts . . . I try not to let the patient opt out. I think the more control they have the better. Obviously it doesn't always work. The effect was hopefully to help the family through a distressing time." (N25, 9-10)

Elsewhere in the interview the nurse explained that there was an explicit organisational policy supporting staff in answering patients' questions honestly. She made it clear that she gave only the information which the patient asked for. This is an additional example of allowing the patient to exercise control over staff. Its value was to ensure congruence with the patient's wishes concerning the timing and amount of disclosure.

The nurse had to weigh several considerations in her own mind. One was the risk of discovery and damage to her credibility if she lied to the patient. Another was the extent to which the patient would be able to exercise control if she was given the aversive information about her imminent death. If the information was given, would it allow the patient to exercise sufficient meaningful control to counterbalance the initial anxiety which such information would inevitably provoke? This nurse reported that she tended to rate patient control as highly desirable, although she also took into account each patient's coping preferences.

Other examples of the use of aversive information concerned decisions about whether or not to consent to facial surgery or radiotherapy, whether to take discharge from hospital, and whether to move house to care for elderly parents. In each case the nurses appeared to have clear views on the best course for the patient to take, but firmly defended the patient's right to make any choice for

himself. This belief in the importance of patient decision-making appeared to strengthen the nurses' resolve in presenting honest but aversive information to the patients. In this type of situation, the nurse was not being directive. She respected the patient's right to choose and tried to fashion her intervention around it.

Another important technique employed for patient control was non-directive counselling. Here the nurses established themselves in the patients' eyes as caring individuals, then used supportive verbal questioning, listening, and summarising to help patients to clarify their thoughts and feelings for themselves. Thus in one of the paired incidents, a psychiatric nurse (N17) helped a patient (P39) to choose what to do when she received a wedding invitation from a relative. The patient's dilemma was that she did not want to go to the wedding, but also she did not want to offend the person who had invited her:

> "She came in and she was weepy and distressed. I spent quite a lot of time and talked it through with her and said, 'Let's look at what you want to do and what your reactions are.'" (N17, 5)

The patient reported that the nurse emphasised her right to choose for herself whichever option she wanted:

> "'Well you're a person in yourself'. This is what I'm always being told. 'You're your own person, and you must do what you feel you want to do, not what people want you to do.'" (P39, 6)

The nurse appeared to interpret her role as that of helping the patient to become more independent. The nurse's action here appeared to be part of a longer-term plan to induce the patient to regain control over all aspects of her life.

IMPLEMENTING A CHOICE

In some situations the nurses attempted to induce patients to decide how to implement a choice. The control offered to the patient was that of escaping from an aversive situation by acquiring new skills or by following a particular course of action. In a paired incident, the patient was frustrated at being unable to find voluntary work. The patient described how the nurse helped him to overcome his problem:

> ". . . So [nurse 12] has sorted these telephone numbers out for me, nursing homes and places to see if I can go in and spend a couple of hours with them, helping them voluntary. Old people and that. She just gave me some telephone numbers to ring around in the town . . . I came lousy, but she's been talking to me and it wanders by. Because you're like in a different world when you come here. I was feeling lousy, but then [nurse 12] was talking to me, then she came down with the telephone book and gave me these numbers, and started talking to me, and it just floats away." (P34, 3, 5)

The nurse's technique in this situation was to listen, to convey caring and to make a comparative assessment of the patient's own view of his problem and her own "objective" view of his situation. She then gave information about a course of action which he could take. She explained that she wanted to ensure that the patient took control of the situation, and therefore consciously decided to limit her intervention to supplying the telephone numbers:

> "I want him to be independent. I don't want to take away his independence. And I think in the end he's got to meet these people anyway, and so I would only be making it harder for him than if he did it in the first place. Even a simple phone call to other people, if he can do that, it boosts his ego tremendously. And the next one isn't quite as hard . . ." (N12, 7)

The nurses also gave several examples of teaching patients new skills. All the forms of patient teaching described appeared to be ways of inducing patients to

exercise control over how they implemented a particular solution to a problem. One nurse reported teaching a patient with mental and physical handicaps how to use Makaton (a sign language) to help her to communicate; a stoma nurse described teaching patients how to change their stoma bags; a diabetic nurse explained how she tried to teach a patient to administer his own insulin injection and to check his blood sugar levels.

Again the issue of how directive or persuasive an approach the nurse chose to take was an important theme. Problems occurred where the nurse was trying to teach the patient something which the patient was reluctant to learn. This came to the fore in the cases of the stoma nurses and the diabetic nurses. The surgical intervention or the progress of the disease made patients dependent on others for help. The nurses were employed specifically to help the patients to regain their independence and control over their own bodies. Problems occurred where patients became attached to the sick role and were reluctant to exercise control. In a paired incident, a stoma nurse explained what she said to a patient to induce her to try to change her stoma bag for the first time:

> "I changed the bag with her, and went through the routine again . . . and then said to her, 'Now, it'll be alright till tomorrow morning. But tomorrow morning I'd like you to change it please. And I'll ask one of the nurses to come with you, so that you're not having to do it on your own." (N3, 23)

The patient described her view of this nurse's approach:

> "Well, she was abrupt, and she wasn't sympathetic. Which I thought in one way was very good. It tells you you've got to stand on your own feet and get on with things and not be sorry for yourself . . . You see on the first day I saw her, I felt faint. And I turned my head away. She said, 'Fine, that's fine with me. You do that.' Then she said, 'Next day, you have a nurse in, you've got to do it on your own [pointing at the colostomy bag]. Well I felt a lot better. Because I told myself I'd got to do it, you see." (N3, 14-15)

This nurse was seen by the patient as competent in terms of knowledge and authority. She was someone who had the patient's best interests at heart. Having presented herself in this way, the nurse was able to use a directive approach to bolster the patient's confidence to undertake the procedure for herself. Effectively the nurse induced the patient to change her view of the stoma to one which was congruent with the nurse's own view. Directive approaches failed when the nurse was unable to effect this move to congruence and when the patient continued to believe that he could gain more comfort and support by remaining dependent.

PATIENT CONTROL SUMMARY

Patient control interventions were used in situations which the nurses viewed as aversive but potentially controllable. These were situations in which the active co-operation of the patient was required, rather than the passive compliance induced by prediction. Patient control approaches tended to be based upon a longer-term view of the patient's interests, since the patient's initial reaction was frequently to demonstrate a rise in anxiety. It was only when the patients were confident that they could reliably exercise control that they became calmer.

Some nurses appeared to use non-directive forms of patient control because of personal beliefs concerning their role in helping patients to become independent. Directive approaches tended to be used in situations where patients' physical health was liable to be endangered by inaction and where patient control offered tangible benefits. The nurses adopted a non-directive counselling approach in situations in which all the choices were aversive, or in family situations where the nurse was unsure of the underlying dynamics. Patient control interventions were virtually the only situations recorded in which nurses initiated interactions where they confronted patients with aversive information. The function of the aversive

information was either to make the patient aware that the time for a decision had arrived, or to motivate the patient through fear to follow the nurse's directions about a course of action which promised a route to safety.

DISTRACTION

"*Distraction*" refers to an attempt by a nurse to: induce a patient to move his attention away from a situation which he finds aversive.

Distraction is therefore similar to prediction in having an essentially passive function. However, unlike prediction, it does not induce the patient to change his perception of the situation but instead masks that perception by drawing his attention away from it. Forty-nine instances of distraction were coded, forming only four per cent of the total database. These formed four per cent of the intervention codings in the questionnaires and nurses' interviews, and five per cent of those in the patients' interviews. The nurses mainly used verbal, conversational approaches when trying to achieve distraction:

DISTRACTION CODINGS	NUMBERS	PERCENT.
NON-VERBAL ACTION	5	10.2
INFORMATION-GIVING	2	4.1
OTHER VERBAL	36	73.5
PRACTICAL HELP	6	12.2
TOTALS	**49**	**100**

The nurses tended to use distraction in situations where passive compliance was sought, but predictive approaches were likely to fail, either because the patient

was so upset that it was difficult to gain his attention, or because he was intellectually incapable of understanding or remembering the nurse's predictions. In all the incidents in which distraction was used, the nurses appeared to believe that the situation was less aversive than the patients believed it to be.

Several distraction techniques were described. The most frequent was the encouragement of conversation. Thus one nurse (N28) who was taking an agoraphobic patient to the shops deliberately kept a conversation going to keep the patient from dwelling on his fears. In a different incident, a surgical patient described how a nurse distracted her up to the moment when the anaesthetist was about to give the anaesthetic:

> "And a young nurse was very, very nice. We were talking about all sorts of things under the sun. Then the anaesthetist came and said could I clench my fist a few times as he couldn't get the thing, you know. And then I saw him shaking his head as if to tell the nurse to stop talking now, and I could feel it going up my arm . . . We were talking about holidays, and where she was going on her holiday. It was just general chit chat. Nothing vital. She did it right I do know that. [It made me feel] distracted from what was going to happen. If I'd been laid there with nobody talking to me, I would have been rather frightened." (P5, 12, 15-16)

Another nurse working in theatres described how she would deliberately use her presence and gaze to distract patients under local anaesthetic from the actions of the surgeon during ophthalmic operations:

> "I would think a lot of it is just distraction. Trying to take their mind off it. That's sitting next to them in the eye operation. With the eye contact. You're bringing them away from looking down to looking sideways." (N13, 16)

Objects were used as distractors, particularly with children. A nurse described using a cuddly toy to distract a child who was distressed at the prospect of an

X-Ray, and who would not allow anyone to touch him. The child accepted the toy and the nurse made conversation with him through the toy, saying:

> "Oh dear, what's all this noise about? This little toy is getting a bit frightened. Would you like to play with him?" (N2, 17)

Physical activity was also frequently used as a distractor, particularly in combination with a predictive technique and as a way of prolonging the calming emotional effects of the prediction by keeping the patient's attention away from his fears.

One other distinct technique was the use of humour. One nurse joked that a patient due for dental surgery might look like Mike Tyson, the boxer, afterwards. Essentially the nurse was exaggerating the patient's fears about post-operative swelling to such an extent that the image became ridiculous and amusing. The same technique was used without success by a nurse caring for a patient who feared she was dying:

> "I tried to make her laugh by asking her to stop crying otherwise I would have to change her pillowcase, but she was too distressed to even hear me." (Q90, 12)

In the above case the nurse was trying to help, but was inaccurate in her initial assessment of the patient's state of health, since the woman did indeed die soon after. Nevertheless, several patients commented on the value of well-judged humour as a way of calming them. It gave direct access to the person's emotions, and also provided an immediate release of tension.

Although distraction was used in many different situations, it was another technique much used with children and elderly people whose autonomy was impaired in the eyes of the nurses. With people who suffered short-term memory loss, distraction appears from the interview and questionnaire data to be the intervention of choice. Its value here was that it could be achieved either verbally or non-verbally, and it actually used the individual's memory deficits to promote the desired outcome of a switch of attention.

DISTRACTION SUMMARY

Distraction was used in situations which the nurse assessed as less aversive than the patient feared, and where passive compliance was sought. It was achieved principally by changing the topic of conversation, supplementing this with use of touch or of objects as plausible distractors. Humour was also used as a variant.

DIRECT ACTION

"*Direct action*" refers to times when a nurse intervened by: taking action on behalf of the patient to try to alleviate or resolve a situation which the patient found aversive.

A total of ninety direct action codings were made, forming seven per cent of the database of interventions. Direct action formed eight per cent of the questionnaire codings, seven per cent of the nurses' interviews and six percent of the patients' interviews. The majority of the actions were in the form of practical help:

DIRECT ACTION CODINGS	NUMBERS	PERCENT.
NON-VERBAL ACTION	8	9
INFORMATION-GIVING	10	11
OTHER VERBAL	7	8
PRACTICAL HELP	65	72
TOTALS	**90**	**100**

This category differs from all the other interventions in that it does not necessarily refer to an attempt by the nurse to communicate with the patient. The category involved nurses in direct actions to try to control aversive situations on behalf of patients. All the other Intentions categories involved nurses in communicating to try to induce patients to control situations for themselves, or to alter the patients' perception of the situation. Direct action was only immediately calming when it took place in the presence of the patients. In some incidents it took place outside the patients' range of perception and any calming effect was the result of a predictive intervention when the nurse informed the patient of what she had done.

Thus direct action was frequently preceded by verbal assurances of success or promises of action. For example one nurse promised a patient that she would accompany her to theatre, and then fulfilled the promise as a direct action. This was a paired incident and so the experience of the patient was recorded:

> INTERVIEWER: "So did [Nurse 2] actually come down?"
>
> PATIENT: "She came down when I was going to theatre, and took me across, and stayed with me until I was going into the anaesthetic room."
>
> INTERVIEWER: "And how did that make you feel?"
>
> PATIENT: "Much better."

INTERVIEWER: "What was it, do you know what it was?"

PATIENT: "The fact that she cared about me. Because when I got down to theatre, she actually introduced me to the receiving nurse, which I found comforting." (P8, 17-19)

In this instance the helpful effect of the action was partly the elimination of the patient's loneliness, and partly through the provision of direct evidence to the patient that someone cared about her. Many of the nurses' actions were ones which were accomplished in the presence of patients. In these cases the actions spoke for themselves and had direct calming effects. Examples were a nurse tailoring a stoma bag so that it precisely fitted the patient's stoma; a nurse who moved a mother recovering from a road traffic accident into the Children's Ward so that she could sleep in the same bed as one of her children; and a nurse who drafted out a difficult letter for a patient to copy in her own handwriting.

A variant on the above was the case of a nurse who firmly but gently restrained a suicidal patient from leaving the ward. In this case direct action "*on the patient's behalf*" must be interpreted as acting beneficently on behalf of a patient whose autonomy was impaired. The nurse followed up this intervention with determined attempts to build a supportive relationship with the patient.

In some cases a nurse took action when the patient was not present. For example, one nurse went to see a consultant on a patient's behalf to try to persuade him to admit the patient for day surgery rather than for an overnight stay in hospital. The calming effect of the nurse's action came when she informed the patient that her advocacy had been successful. In all these incidents, the nurses appeared to believe that they could potentially control the aversive situation for the patient and therefore it was better to do this than to attempt to reconcile the patient to its aversiveness. Frequently there was also an urgent short-term need for the patient both to remain calm and to be passive or compliant. A nurse working in an

intensive care unit illustrated this in describing an incident where she took action to make sure that the wife of a seriously ill patient returned home safely:

> NURSE: "In fact I had to organise a taxi. It was a specific problem, and you just have to deal with that."
>
> INTERVIEWER: "What do you think would have happened if you hadn't done that?"
>
> NURSE: ". . . Well, obviously, it could go, it could certainly affect the condition of the patient. Because anxiety it can bring on pain, and the chap wouldn't rest probably. It may affect his decision to stay in hospital." (N27, 6-7)

DIRECT ACTION SUMMARY

Direct action interventions occurred when the nurses wanted to control an aversive situation while inducing the patient to be passively compliant. From their comparative assessments, the nurses accepted the patients' view of their situation as aversive, but regarded it as potentially controllable. Their concerns were with immediate changes in contrast to the longer-term outlook found in the patient control interventions.

SUMMARY: THE NURSES' INTERVENTIONS

Taking a step back from the detailed properties of each of the five main interventions, it is important to keep track of what emerged about how these interventions were used in clinical practice. Many of the nurses certainly appeared to adapt the detail of their approaches to the coping styles and special worries of individual patients. However, it was the nurses' comparative assessments of the nature of the patients' situation which appeared to be the major influence on their initial choice of helping intervention.

Where a nurse regarded a patient's situation as genuinely safer than the patient believed it to be, prediction was the intervention of first choice. This tended to be supplemented with support, emphasising the caring qualities of the nurse. Support therefore added to the persuasive power of the nurses' predictions. The only consistent exception to this pattern occurred where the patient had intellectual difficulty in understanding or retaining the meaning of predictions. Here distraction and support tended to be combined instead.

More complex were the incidents where a nurse's assessment of a patient's situation was that it was genuinely aversive. The interventions differed, according to whether the nurse believed the patient's situation to be controllable or not. In aversive but potentially controllable situations, the nurses either chose to take direct action to control the situation on the patient's behalf, or they tried to induce the patient to control it himself. Some nurses appeared to have philosophies of nursing which inclined them towards using patient control interventions whenever possible, in order to empower patients and to promote their independence. More directive forms of patient control tended to be used in emergency situations where this was the only option which offered immediate results. Otherwise direct action was favoured, frequently combined with prediction when dealing with anxieties about investigations, invasive procedures or surgery.

Situations which the nurses viewed as aversive and largely uncontrollable appeared to be the most difficult of all for the nurses to manage; these included incidents in which the nurses were giving care to dying patients. Support interventions figured strongly. Sometimes they were used in isolation, but on other occasions they were combined with patient control. This involved confirming the patient's view of his situation as highly aversive and uncontrollable, but then supporting him and encouraging him to exercise control over related areas: for example, choices over pain control and over where and in whose presence he would like to die. However, in some incidents the nurses chose to use prediction in uncontrollably aversive situations: in other words they lied to patients by presenting their situation in a more optimistic light than the facts justified. The nurses tended to use this approach with patients whom they regarded as not fully autonomous, where the risk of discovery was low and where patient management was felt to be especially difficult.

Thus far, this account of the five main types of intervention has concentrated on establishing the main properties and uses of each of the interventions. However, in order to complete the analysis it is essential to know how the patients reacted to the use of the different types of intervention. Therefore the next chapter will deal with the effects on the patients of the nurses' interventions.

CHAPTER 7: THE PATIENTS' RESPONSES TO THE NURSES' INTERVENTIONS

CHAPTER 7: THE PATIENTS' RESPONSES TO THE NURSES' INTERVENTIONS

The previous chapters have described how the nurses became aware that the patients were anxious, what they thought the patients were anxious about, and the five types of intervention which they used in their attempts to help the patients. This chapter will therefore deal with the final element in the equation, the way the patients responded to the nurses' attempts to help them. Data from the questionnaires, the interviews with nurses and the interviews with patients was analysed and four categories of response emerged:

1. CALMNESS
2. TRANSIENT RELIEF
3. NO CHANGE
4. RAISED ANXIETY

The chapter begins with an analysis of the relative frequencies of the four types of response coded from the database. Definitions of "*successful*" and "*unsuccessful*" outcomes are then given, followed by a qualitative analysis of each.

THE PATIENTS' RESPONSES: CODING FREQUENCIES

Table 7.1 overleaf shows the relative coding frequencies of each of the four categories, taken from the three different sources of data.

TABLE 7.1: THE PATIENTS' RESPONSES

FREQUENCIES	NURSES' QUEST'AIRES	NURSES' INTERVIEWS.	PATIENTS' INTERVIEWS	TOTALS
1. CALMNESS	173	51	64	288
2. TRANSIENT RELIEF	12	5	1	18
3. NO CHANGE	12	9	4	25
4. RAISED ANXIETY	5	2	8	15
TOTALS	202	*67	77	346
PERCENTAGES				
1. CALMNESS	85.6	76.1	83.1	83.24
2. TRANSIENT RELIEF	6.0	7.5	1.3	5.20
3. NO CHANGE	6.0	13.4	5.2	7.23
4. RAISED ANXIETY	2.4	3.0	10.4	4.33
TOTALS	100	100	100	100

*Total of 72 incidents, but 5 were ongoing casework with no clear outcome at time of interview.

DEFINITION OF "SUCCESSFUL" AND "UNSUCCESSFUL" INCIDENTS

Following the inferential model, the only meaningful way of coding the success or failure of the nurses' interventions is in terms of the responses which the nurses intended to induce in the patients. In each case informants were asked to describe incidents in which a nurse attempted to calm an anxious patient. Therefore the achievement of calmness was by definition a successful outcome. If a patient did not respond by becoming calmer, or if the patient briefly calmed but then became

more anxious again, this is defined as an unsuccessful outcome. Thus the 288 incidents in the first category may be regarded as having successful outcomes, and the fifty-eight incidents which fell into the remaining three categories are here defined as having unsuccessful outcomes. A chi-square test comparing successful with unsuccessful outcomes from the three data sources showed no significant differences, demonstrating consistent data reporting.

SUCCESSFUL OUTCOMES: THE NURSES' VIEWS

Because the nurses generally employed several different types of intervention in each incident, it is difficult to separate the contribution of individual interventions to the outcome of each incident. However, in many cases the nurses gave their own commentary on how they thought each of the five types of intervention affected the patients.

PREDICTION

The most frequently-occurring intervention in the database was prediction. The nurses appeared to consider that if the information or assurances which they gave were predictive of a safe outcome, and if the patient believed them, then the patient would inevitably become calmer. What the nurses were trying to do was to convince patients that they needed cognitively to re-frame their situation and view it as less aversive than they originally feared. However, in some cases the nurses even reported success in calming patients when giving them information predictive of an aversive outcome. In these cases they appeared to believe that their honesty helped the patients to come to terms with the reality of the situation and at least relieved the aversiveness of uncertainty:

"She was a very demanding lady both physically and emotionally, but gradually she accepted the situation [terminal illness] and became from my point of view very easy to nurse. Asking questions and accepting answers as they were given, and dying fairly calmly." (Q120, 10-11)

"I felt she was happier and more content in herself and at ease with the decisions. She understood reluctantly that we had no date for her operation but as soon as we knew we would tell her. All of her previous worries seemed minimal to her and [she] returned to her usual cheerful self." (Q195, 8-10)

SUPPORT

In the majority of incidents, support interventions formed a vital backdrop to successful outcomes. Throughout their accounts, the nurses reported that patients thanked them for being *"kind", "honest", "caring"* and *"friendly"*. They said that some patients appeared to see them as providing the support and comfort which they usually obtained from their family. The nurses seemed to believe that the patients' warm feelings towards them made it possible for them to calm patients by their very presence:

"By the time the anaesthetist arrived my patient was much more relaxed. I still had hold of his hand and as he was going off to sleep he just said, 'Thank you, but don't let go of my hand.' I felt a sigh of relief of achieving to make this man feel better. Although he could not say exactly what he was afraid of, in my own way I had helped him, just by chatting to him like one would outside to a friend." (Q12, 15-18)

PATIENT CONTROL

In the cases in which patient control was employed, the nurses seldom made explicit their beliefs about the process through which the interventions achieved their effects. Explanations appeared to centre on beliefs in the confidence-building value to patients of being in control of events:

> "She felt that by being able to discuss her operation and whether it would be carried out under local or general anaesthetic she had more control over her stay in hospital." (Q16, 16)

This idea of feeling more in control of events is one emphasised by Suzanne Miller (1979a) in her Minimax Theory, which suggests that control permits one to minimise the maximum threat which one may experience in a given situation.

DISTRACTION

When the nurses commented on the effects of successful uses of distraction, they generally believed that their interventions made waiting time more bearable or actually reduced the impact of the pain arising from a procedure. Thus one patient was distracted by a student nurse while a district nurse took a blood sample:

> "I think the old lady derived some comfort from leaning and touching me, rather than me touching or holding the lady. Her birthday party had been an obvious source of pleasure to her and telling a new face all about it distracted her. She commented on how quick it had all been and she had hardly felt anything. She said she wouldn't worry about having another blood test at any time in the future." (Q106, 15-18)

DIRECT ACTION

Where the nurses were able to take direct action to deal with patients' problems, they reported that the evidence of practical help which they presented to the patient had powerful calming effects:

> "Once the patient saw that his jacket was safe and not lost, he became less anxious and more relaxed. The patient in question was very possessive about his own belongings and always liked to wear his own clothes and know where his possessions were . . . Thus to him 'seeing was believing' and once he had seen his cap and jacket he became less distressed and was reassured." (Q75, 14-15,17)

In many cases direct action and prediction were successfully combined. The nurse promised the patient that she would take action, went away and did what she had promised, then returned to inform the patient. In these situations, it was the predictions of a safe outcome which induced the patients to feel calmer because they trusted the nurses to carry out the promised actions and to report truthfully about them on their return.

SUCCESSFUL OUTCOMES: THE PATIENTS' VIEWS

The patients evaluated the reasons for successful outcomes in more personal terms than the nurses. They credited the nurses with inducing them to feel calmer by virtue of their personal qualities, rather than relating success to technical aspects of the nurses' interpersonal skills or intervention choices. The patients appeared to expect all nurses to be caring people, and felt safe and confident when this expectation was confirmed. The words which the patients used to describe this differed, but their meaning was consistent. Thus for one patient it was important that the nurses showed "*friendliness*", and for another it was the fact that the

nurses were "*interested in you*". A patient who received a pre-operative visit from a theatre nurse described the value of her visit to him:

> "I had a very nice nurse lady come down and gave me quite a bit of comfort. She said she'd be in the recovery room when I came round, and she'd be with me all the while in the operation. And she was. She was there when I came round, and she was the first person I saw. So she was very nice." (P9, 6)

For this patient, caring was embodied in the nurse making promises and keeping them. The effect was to increase his trust in this particular nurse. He went on to explain what happened in the theatre recovery suite:

> "She held my hand, and said I was alright and everything had gone well, the operation had gone very well. And I think that here again she told me that all had gone very well, and there weren't any complications." (P9, 29)

The patient appeared to believe the nurse's optimistic assurances because she had earlier established herself in the patient's eyes as someone who cared about him. However, a caring attitude was not sufficient in all circumstances to induce patients to trust particular nurses. Where nurses were undertaking technical nursing procedures, the patients also needed to believe that they were competent to complete them. In addition to technical or interpersonal skills, the notion of competence included an assessment of the nurse's power or authority in the organisation. The patients quoted practical examples which allowed them to assess the nurses' overall competence. Thus several patients commented with pleasure on being offered immediate post-operative pain relief. One patient said that this made him feel "Even more confident" (P20, 4). Another patient appreciated the way that a student nurse would not give him any details about the condition of another patient. This demonstrated to him that she was aware of the importance of confidentiality and made her more trustworthy in his eyes. The same nurse also gave a technical explanation about his operation, which further

demonstrated her competence to him. Then when the nurse told him that he could cease to keep a record of his fluid intake, he commented:

> "She would only do that because she knows its the right thing to do. I have confidence in her now." (P23, 18-19)

Successful interventions could therefore be built upon by the nurses to induce the patients to believe that they were competent in their jobs, and this predisposed the patients to feel calm and secure. Although the patients appeared to expect all nurses to be caring people, their expectations of technical competence varied. Thus one patient compared a stoma nurse with the other nurses on the ward:

> PATIENT: "She's so gentle. She really makes you feel safe. Really safe . . . Well she's so competent, and she knows what she's doing. She just knows and you feel at ease . . ."
>
> INTERVIEWER: "It sounds as though sometimes the person who's doing the dressing isn't as competent as that? . . . There obviously are differences."
>
> PATIENT: "Well yes. When she's here it's just OK. I wish she was here all the time." (P19, 5,8,10)

Some patients appeared to see the nurses as having only a limited range of knowledge and expertise, and looked to them principally for support rather than for technical help.

> "I think I could see quite clearly the difference between the doctors and the nurses. The nurses were actually only really concerned that your vital bodily functions were going. The doctors were concerned about the actual operation that you'd had, and how you were progressing." (P51, 17)

In contrast, another patient commented favourably on a change in the level of responsibility devolved to nurses since an earlier admission:

PATIENT: "They have much more responsibility than they did before, which I think is good. For example, after my operation there was something that I wanted to know. So I asked a nurse and she said she didn't know, but she would look it up in my notes. And she did, and she came back and told me . . ."

INTERVIEWER: "Can you think of any other examples of that change?"

PATIENT: "When the nurse was checking my stitches, I said that the dressing was uncomfortable and she said, 'Right, we'll take it off then'. And she did that, and she didn't need to refer to anyone else. That was different from twenty years ago." (P24, 5,7)

Therefore, the patients' assessments of the competence of individual nurses were influenced by their personal expectations of the role and responsibilities of the Nursing profession. In addition, several patients distinguished between student nurses and trained nurses in their expectations and assessments. In part this was linked to role, but the nurse's length of experience in the profession also appeared to be an important influencing factor. One expressed confidence in a particular ward sister:

"Because she is in control you might say, being the Sister. You feel that she is more experienced, and she is also a good listener, very understanding." (P33, 13)

UNSUCCESSFUL OUTCOMES: THE NURSES' VIEWS

This section focuses on the nurses' accounts of forty-five unsuccessful incidents reported in the written questionnaires and interviews. The nurses were of course only able to infer patient outcomes, but in all cases supplied observational details which supported their overall conclusions. From the nurses' viewpoint, it must have been uncomfortable to disclose unsuccessful incidents, since they may have felt that they were admitting their own failures. However, this probably means

that those incidents which they chose to reveal were particularly significant for them, as no pressure was placed on them to reveal unsuccessful incidents as opposed to successful ones.

PROBLEMS WITH COMPARATIVE ASSESSMENT

Many of the incidents supplied by the nurses which were coded as unsuccessful were ones where the nurses' assessment of the aversiveness of the patients' situation did not correspond either with the patients' views of their situation or with the eventual outcome. In some cases the nurses alerted patients to dangers which were not present, and in other cases they predicted safety when the patient's situation was genuinely aversive. One such incident was reported by a student nurse:

> "I was determined to calm her [the patient] down and cheer her up before I left work. I held her hand and stroked her hair away from her face. I also wiped away her tears. I reassured her that she wasn't dying and that getting all upset wouldn't help her to get better. I asked her what made her feel that she was dying, but she couldn't answer it . . . She held my hand tightly and begged me to let her go home. I told her that she wasn't well enough to go home and must try and rest. I informed the sister and she told me that there was no way that she could go home and that she was confused . . . She died that night. It was this that made me think that she had had an aura that she was going to die. I only wish that she had have been able to go home!" (Q90, 7-10,12-14,16-18)

The student nurse was inaccurate in her comparative assessment of the gravity of the patient's physical state. Therefore the chosen interventions (prediction, support and limited patient control) were relatively ineffective, because the powerful evidence of the patient's subjective experience contradicted the optimistic assessment of the nurse.

PROBLEMS WITH UNANTICIPATED INFERENCES

The second factor which emerged from the nurses' accounts of unsuccessful incidents was unanticipated inferences made by the patients as a result of the nurses' interventions. Some problems emerged from the nurses' familiarity with technical terms, which at times blinded them to their meaning for the patients. Thus an infection control nurse was critical of ward staff who accurately told a patient that her diagnosis was "*salmonella*". The patient inferred that the staff were criticising her for "*dirty habits*", and also that her life was in immediate danger because of the infection. A secondary fear was that the infection might have been acquired while in hospital. None of these inferences was correct, but the infection control nurse believed that the staff should have anticipated the possibility that use of the word "*salmonella*" would unnecessarily alarm the patient:

> "I think with all patients, you've got to judge how best to explain something. You've got to tell them something. And maybe they could have told her that she had a tummy bug which had probably been lurking there for some time, and because of her major surgery it had just come up a bit because she couldn't defend herself so well. But it would go down away. That's told her everything. But they assumed she was an intelligent lady, she could take the 'salmonella'. It didn't matter. Didn't matter to them. So I do think people should have information, but information they can cope with and understand." (N29, 34: Incident recalled from 12 months earlier)

The infection control nurse appeared to be using an inferential model when planning her communication with patients, whereas the ward staff seemed to have used a coding model which did not allow for the importance of inference in communication.

LACK OF COMPETENCE OR AUTHORITY

The third factor which emerged from the nurses' accounts of unsuccessful outcomes arose from occasions when the nurse was unable to deliver all that she promised a patient, either because she lacked the necessary authority within the organisation or because she was not competent technically to carry out a procedure. One example cited in Chapter 6 arose when a nurse (N13) was unable to stop a surgeon from continuing with an operation under local anaesthetic, despite the fact that the patient was finding it very distressing. Here the authority of the nurse did not extend to control over the actions of the surgeon. Several similar incidents were cited, where nurses offered to act as advocates for the patients, but then were unable to deliver what the patients expected.

Lack of competence arising from inadequate technical knowledge occurred when one patient became extremely anxious after a doctor changed his medication and a nurse did not recognise the name of the new medication. This destroyed the patient's confidence in the individual nurse, but had a knock-on effect over his confidence in the whole clinical team. Thus, prediction, patient control and direct action interventions all demanded that the patient trusted the nurse to be competent, evidenced either by her knowledge or by her authority and power to get things done. Anything which damaged the patient's perception of the nurse's competence, also appeared to reduce the likelihood of a successful intervention.

LACK OF CARING

Support interventions appeared to be especially important in establishing another aspect of the trust between a patient and a nurse, namely a belief that the nurse cared about the patient and about what happened to him. In many cases it was not enough for the patient to know that the nurse was technically competent. The

vulnerable patient also needed to believe that the nurse cared enough to act in his best interests. When firmly established, this feeling of trust added power to prediction and patient control interventions, and even helped in distraction by establishing an appropriately calm emotional atmosphere. However, trust could easily be lost, and the actions of one nurse could again affect the patients' perceptions of others. An example was reported by a nurse who had supported a long-term patient who had just been told by a doctor that he was suffering from a terminal illness. Unfortunately the nurse went on weekend leave, and her message that the patient now knew his prognosis was not passed on to the other staff as she requested. Therefore the nurses continued to distance themselves from the patient, mistakenly fearing difficult questions:

> "My senior staff nurse . . . said it was strange because all weekend she and one of the other girls got the impression that he wanted to talk, 'But we carried on being evasive', not evasive but sort of acting as if he didn't know . . . I think that shattered a lot of the trust. By the time I'd come back from the weekend, he'd already begun to deteriorate." (N45, 9-10)

The nurses failed to use support interventions at a time when the patient desperately needed them. The nurse believed that this destroyed the patient's trust in the nursing team as caring people. The source of the problem was a communication breakdown within the team, but it was because this breakdown affected the patient's trust in the nurses that his distress was increased.

INTRACTABLE SITUATIONS

The nurses in their explanations of unsuccessful incidents argued that in some cases it simply was not possible for anyone to calm certain patients. The nurses believed that problems arose from sources within the patients themselves.

Particular difficulties were caused when patients were unable to assimilate or to remember factual information for any length of time. Some of these were elderly patients suffering from organic brain diseases, others were patients whose physical condition produced temporary confusion as a side-effect. Prediction would usually have been the preferred intervention in non-aversive situations, but when a patient's memory was adversely affected this strategy appeared to have short-term value at best. The nurses were generally able to calm patients by using support interventions instead. However, the drawback was that support was only effective when the nurse was present. Once the nurse had left the patient, the anxiety and subsequent disturbed behaviour tended to return. Thus a 79-year-old patient repeatedly sought to leave the ward, believing he had to go to his job as a level-crossing keeper:

> "He was quite aware that he had retired. For a few minutes he seemed calmer and he appeared to be thinking over our conversation. Next he said, 'I know all that, but I've got to go to bloody work. I am the relief and you will get me the bloody sack.' " (Q62, 7-9)

The nurses tended to avoid giving information for control to disorientated patients. Prediction had limited value, so they had to rely on a restricted range of support, distraction or direct action interventions. The analysis of outcomes adds weight to the idea that the anxieties of such patients present distinctive management problems which are not amenable to the types of intervention which frequently succeed with fully orientated patients.

INDIVIDUAL COPING STRATEGIES

A group of five incidents comprised unsuccessful interventions with patients who were facing surgery. The imminence of the surgery appeared to induce excessive anxiety in a small number of individuals, although it was not always possible to

identify an explanation for the strength of their fears. However, in one case a patient revealed that his father had died under anaesthetic one month earlier:

> "I explained to him that the anaesthetic would only be very short. He seemed to accept this. He seemed more relaxed in himself, but when the anaesthetist arrived he tensed all up and started shaking. The needle was inserted and his induction was not a smooth affair. I felt as if I failed, but I feel I could do no more." (Q171, 8-12)

Suzanne Miller's (1979b) research on monitoring and blunting supports the idea that there are individuals who feel a need to retain control as a way of coping. The imminence of an operation under anaesthetic is perhaps the most serious threat to personal control which one can face, short of death. Little wonder then that distraction and predictive information-giving sometimes failed in these circumstances with particularly susceptible individuals.

The nurses gave examples of some unsuccessful incidents where the patients' diagnosis or prognosis was unfavourable. The problem for the nurses in these incidents was that their assessment of the situation differed from that of the patients, and also that it suggested that the aversiveness of the patients' situation was essentially uncontrollable. In a number of the latter incidents the nurses were successful in calming the patients by using prediction to lull them into a false sense of security that they were safer than was in fact the case. However, this misleading use of prediction was unsuccessful where the patients' subjective physical experience led them to infer that their condition was worse than they were being told. Thus one nurse reported that a seriously ill patient "suddenly decided that she was going to die". The nurse stayed with the patient during the invasive medical treatments, getting close to her and using distraction:

> "I believe my actions as part of the nursing team did not help the patient to relieve her anxieties because she became more tearful, withdrawn and quiet as the days went on. Her prognosis was not good

> at all but she did not know that. Her relatives were aware and they seemed to find it difficult to converse with her." (Q33, 14-16)

The nurses also experienced problems when their assessment of a patient's situation suggested that it was potentially controllable by the patient himself, but when the patient either regarded it as not even potentially under his control or believed that the "secondary gain" from illness behaviour (Kent & Dalgleish 1986: 145) outweighed the benefits of exercising control. A psychiatric nurse (N28) explained her view of the thinking of a patient suffering from agoraphobia, who resisted the nurse's attempts to induce him to use systematic desensitisation to regain control of himself and his life:

> "I think that the general feeling was that it was a way of life to him. That panicking was sort of, he was out of work and his marriage wasn't too good, and the panic was a way of validating his being out of work and his marriage problems. So the general view was that a lot of it was put on. Well, not 'put on', learned. It was his way of coping." (N28, 11)

Without talking to the patient himself, it is impossible to know how much weight to give to the nurse's view. However, it is certainly plausible that some patients may have had an interest in remaining dependent and would therefore find all patient control interventions anxiety-provoking.

UNSUCCESSFUL OUTCOMES: THE PATIENTS' VIEWS

When reporting unsuccessful incidents, the patients were acting as witnesses to their own experience. Whereas the nurses were active in assessing the patients and their situations, the patients once again tended to see events largely in terms of their responses to individual nurses as people. Thus they explained successful

or unsuccessful outcomes in terms of the attitudes of individual nurses, rather than as a function of the particular intervention techniques employed:

> "I never liked [this nurse] . . . I'd think, 'Oh no, God it's her shift again, here she comes.' But the poor girl was doing her job. And in fact I remember saying to somebody else, 'I don't think she should have been a nurse, she's not got the right kind of manner.' " (P51, 12)

However, although the patients themselves explained incidents in very personal terms, the constant comparative method made it possible to identify some of the technical features of the unsuccessful incidents which contributed to the patients' overall judgements. These were primarily the same problems as emerged from the nurses' accounts: inaccurate assessment by the nurse, unintended inferences made by the patient, and technical incompetence on the part of the nurse.

INACCURATE ASSESSMENT

The patients were able to report incidents where the nurses made no attempt to allay their anxieties because they appeared to be unaware of them. The problem seemed to arise from the fact that the nurses were more familiar with medical matters than the patients. In some incidents, they appeared unable fully to appreciate patients' feelings. Thus one patient was in the ward when a patient in a bed opposite suffered a fatal cardiac arrest. The patient commented that the nurses kept coming to his bed asking if he was alright, but none of them offered to move him:

> PATIENT: "I mean, I was in that ward ten days. And to see that empty bed where the chap was. A change of environment you see, that was what I needed." (P27, 13)

Another example was recounted by a patient who had developed a raised temperature when recovering from an operation:

> PATIENT: "And the nurse came and said, 'Look we'll take the bedclothes off,' and there was blood all over my wound. She wasn't worried at all about this. She didn't seem to bother. But to me it was a vast quantity. And obviously it wasn't. And she said, 'Oh it's alright, I'll just put a pressure dressing on it.' Terribly matter of fact. Which in retrospect was fine, but I at the time, I tensed, I mean all my muscles tensed. And I was sort of lying there really hardly daring to move. But now I think, well obviously it was just matter of fact. It happens all the time to them. That was just neither here nor there." (P51, 1)

The patient appeared to be making an attempt to see the incident from the nurse's perspective as "*just matter of fact*". The patients in general were very reluctant to criticise the nurses and almost always qualified their accounts of unsuccessful incidents with forgiving comments. Nevertheless, inadequacies of assessment certainly led some patients to feel vulnerable in the knowledge that the nurses were not always closely in touch with how they were feeling.

UNANTICIPATED INFERENCES

The second type of unsuccessful incident arose from unanticipated inferences from the nurses' communications. For example, one patient was told by a nurse that she would have to have an injection in the stomach and this was 'not very nice'. In the patient's context, the message was open to two interpretations: the patient said she was unsure whether the nurse meant that the injection itself would be unpleasant, or whether the nurse was telling her that some unpleasant complications had arisen which made the injection necessary. The latter interpretation was the more aversive for the patient. She questioned the nurse who said that there were no complications, she was simply trying to prepare her for the

injection. In the event, the patient found the injection virtually painless. Thus she had two reasons for feeling dissatisfied: the nurse had failed to communicate clearly, and the warning which she had tried to convey was inaccurate.

Unanticipated inferences also derived from information which was already in the possession of the patient, but of which the nurse was unaware. One patient who had a mastectomy was told by a nurse that she did not have to say anything about it to her friends and relatives. The nurse explained that people find the idea of a mastectomy difficult to deal with and sometimes try to avoid people who have had this type of surgery. The nurse appeared to be trying to help the patient to control events on her discharge from hospital. However, the patient's husband had already informed many of her friends and relatives of the reasons for her admission to hospital. The nurse believed that this aversive feature of the patient's situation was potentially controllable, and therefore chose a patient control intervention. However, the patient had additional information which indicated that the situation was in fact uncontrollable. Thus the nurse had unknowingly alerted the patient to an aversive situation which the patient now could not control.

In another unsuccessful incident, the conditions were reversed. In this case the nurse withheld information from the patient prior to operation, because she believed that the pain which would arise was uncontrollable. However, the nurse did not appear to be aware that the patient had already concluded from what the anaesthetist had said that the pain would be relatively mild. When the patient came round from the anaesthetic she was experiencing intense pain. She was distressed at the pain, but also inferred that a mistake must have been made during the operation because the doctor had not prepared her to expect so much pain. She informed a nurse who asked the doctor to prescribe a stronger analgesic, which the nurse administered at once. The nurse explained that she had had the same operation herself, and had found it very painful. The patient asked

her why she had not warned her, and the nurse said, "Well I didn't want to frighten you, because you thought it wasn't going to hurt very much." (P8, 22)

The nurse knew that the patient was not expecting very much pain, but had not considered the possibility that the patient might subsequently infer that the operation had gone wrong, and so experience additional distress. Again, in this example the nurse appeared to believe that the post-operative pain was uncontrollable, whereas in fact the prescription of a stronger analgesic relieved much of the pain. The patient found the incident deeply disturbing on several levels. She was led to call into question the competence of both doctor and nurse, and also to question the extent to which the nurse was willing to involve her in her own care by not disclosing information which could have been used by the patient to control events for herself.

LACK OF COMPETENCE

The third type of unsuccessful incident occurred when the nurses lacked competence in the execution of technical aspects of nursing care. Only two incidents were recorded, one in which a nurse failed to regulate an intravenous infusion correctly, and another when a nurse failed to respond effectively to a patient's request for pain relief.

What emerged from all the interviews with the patients was a strong feeling of vulnerability. The patients appeared to be very reluctant to challenge the nurses on any matters, and so were highly dependent for their care upon the existing knowledge, skill and personal attitudes of the nurses. In these circumstances, the patients tried to distinguish particular nurses who could reliably give them practical and emotional assistance. They appeared to place their trust in caring nurses who appeared competent in the technical aspects of their work.

OUTCOMES SUMMARY

From a patient's point of view, the calming outcome of any intervention depended largely upon the establishment and maintenance of trust. The key questions for the patient were: "Does this nurse care about me?" and: "Is she competent to help me in this situation?" Caring involved understanding the patient, his problems and his coping style. Competence had a knowledge component, which related to the nurse's ability accurately to assess the objective features of the patient's situation; it also had a power/authority component, which related to the nurse's ability to take effective action.

Whenever anything went wrong, it affected a patient's level of trust in the particular nurse involved and, frequently, in other members of the team. Problems occurred when comparative assessment was inaccurate. The nurses might not notice that an individual patient was anxious, they might inaccurately assess the objective features of his situation, or they might be unable to identify his preferred coping style. This led to inaction, or to the selection of interventions which were ill-adapted to the patient and his situation.

Unanticipated inferences were another major source of problems, as was technical incompetence in the execution of an intervention. In both cases, the nurses were unable to induce the patient to respond in the ways they intended. There appeared also to be a hard core of situations where the nurses' choice of intervention was restricted by factors which were beyond their control. Patients whose short-term memory was damaged presented particular problems, which in some cases were intractable.

A successful intervention therefore depended on accurate assessment of the patient, his situation and his coping style, followed by selection and skilled implementation of one or a range of interventions carefully adapted to each situation. It is apparent that there is no single *best* intervention for promoting calmness; the choice has to be adapted each time to the prevailing circumstances, although support interventions appeared to have a particularly wide range of applications. These themes are taken up in more detail in the final discussion chapter.

PART 3: CONCLUSIONS AND REFERENCES

CHAPTER 8: DISCUSSION

CHAPTER 8: DISCUSSION

This chapter begins with a summary of the main findings from preceding chapters and a discussion of their theoretical implications; issues concerning the validity of the study are then discussed, followed by a review of the practical implications of the findings for those working in the clinical area and in nursing education; the final section examines areas for further research.

THE MAIN FINDINGS AND THEIR THEORETICAL IMPLICATIONS

REASSURANCE DEFINED

The semantic analysis in Chapter 2 established a nursing definition of the verb "*to reassure*" which is compatible with the inferential model of communication: "*to reassure*" means that a nurse attempts to communicate with a patient who is anxious, worried or distressed, with the intention of inducing him to predict or interpret that he is safe or safer than he presently believes or fears. Five types of intervention with anxious patients emerged from the critical incidents in this study: Prediction, Support, Patient Control, Distraction and Direct Action. Only two of these, Prediction and Support, are always forms of reassurance.

In Prediction, a nurse sets out to induce a patient to predict or interpret a safe or safer outcome to a situation than he presently believes or expects. This is a form of cognitive re-framing. Support interventions are defined as attempts to induce a patient to infer that a nurse supports and cares about him. The key question here is whether a patient who feels supported will necessarily infer that he is safer than he originally believed. The evidence strongly suggests that where a nurse can successfully establish herself as a caring person in the eyes of a

patient, this perception has a reassuring effect on the patient regardless of the objective aversiveness of his situation. The research into relationship-building cited in the literature review indicates that this is not an isolated finding and Bowlby's (1971) Attachment Theory offers an explanation of how contact with another supportive and caring individual may re-awaken feelings of security first experienced in childhood contacts with parent figures.

The inferential model resolves the controversy over whether or not one should use phrases such as "*Don't worry*", "*You'll be alright*" or other forms of optimistic assurance when attempting to reassure patients. What matters is whether or not the patient infers that he is safe or safer than before the intervention. In the course of some interactions, optimistic assurance will be precisely what is needed to reassure anxious patients. In other interactions it will be interpreted by patients as evidence of a lack of caring by the nurse and may actually lead to an increase in anxiety levels: precisely the opposite of what was intended. Thus the inferential model shifts the emphasis from the use of a precise form of words in reassurance and instead emphasises the intentions of the nurses and the inferences drawn by the patients.

Reassuring interventions such as prediction and support will, if successful, induce a passive response in the patient. Successful reassurance encourages the patient to predict that he is safe and therefore need take no further action, since he has re-framed his situation as non-aversive. In contrast, Patient Control interventions, which are not forms of reassurance, are primarily designed to promote an active response. The patient is asked to face up to the aversive features of his situation and to attempt to overcome them. The evidence of this study suggests that this approach is likely to lead to a rise in anxiety levels, at least initially. The experimental studies reported by Suzanne Miller (1979a) lend support to this view that control, or potential control, may initially increase levels of anxiety as individuals are obliged to confront aversive situations. Medium- to longer-term

calming effects may arise from patient control interventions when the patients predict that they will be safer if they act as the nurses suggest. However the primary function of these interventions is not to calm the patients but to induce them to take action.

Distraction, the fourth category, is never a form of reassurance. Although distraction may have a calming effect, it achieves this simply by masking the aversive situation from the patient's attention and therefore does not induce the cognitive re-framing which is essential in reassurance. The remaining category, Direct Action, can be a form of reassurance when used with a calming intention in the presence of a patient. However, in many cases the intention of the nurse is simply to deal with the practical problem to which she has been alerted by the patient: the fact that the patient becomes calmer as a result is frequently incidental. Again, in direct action, the nurse's action may take place outside the patient's range of perception. In such a case, successful direct action will have no effect upon the patient until he becomes aware of what has been done, and the act of informing the patient will be a predictive intervention, not a direct action intervention.

THE IMPORTANCE OF COMPARATIVE ASSESSMENT

Having determined which interventions are forms of reassurance and which are not, it becomes important to try to glean some insights into those situations where reassurance is indicated and those where it is not. It was notable that no single intervention was used in all situations. The nurses frequently combined several strategies, making it difficult to disentangle the outcomes from each. However, the patterns of use of the different types of intervention can be explained by the principle of Comparative Assessment. In choosing a helping strategy, each nurse compared her view of the aversiveness of the patient's situation with her

assessment of the patient's own view of its aversiveness. In simplified terms this gave rise to the four possible cases shown in the matrix below, where they are labelled from the viewpoint of the nurse:

	PATIENT	NURSE
1. UNJUSTIFIED FEARS	**AVERSIVE**	**SAFE**
2. SHARED FEARS	**AVERSIVE**	**AVERSIVE**
3. FALSE SECURITY	**SAFE**	**AVERSIVE**
4. SHARED SECURITY	**SAFE**	**SAFE**

This matrix is an oversimplification, because in reality there are infinite gradations in one's perception of the aversiveness of a situation. Nevertheless, the four cases may be used to illustrate the indications for the use of particular types of intervention as they arise from a COMPARATIVE ASSESSMENT of the patient's situation. Case 4, Shared Security, will not be discussed in detail: since, if both patient and nurse believe the patient's situation to be safe, no calming intervention will be required. The remaining three cases are explored below.

UNJUSTIFIED FEARS

In cases of Unjustified Fears, the nurse views the patient's situation as less aversive than the patient himself views it. Reassurance was the strategy of choice in these situations with prediction and support interventions most frequently used, either alone or in combination. Because the nurse viewed the patient's fears as

unjustified, her intention was to calm the patient AND to promote passive compliance with the likely course of events.

In the recorded incidents, success in reassuring the patient depended in large measure on the extent to which the nurse could present herself as both competent and caring. Competence meant having the knowledge and skill accurately to assess the situation, and in some cases also having the power or authority to be able to deliver the substance of any promises of help which were made. From the patient's point of view, it was logical to place more reliance on the predictions of a person who was competent than on those of a person who was not. Most patients in this study did not regard themselves as competent in assessing the illness or treatment problems which were the sources of most anxiety. Therefore the patients were generally prepared to give credence to the optimistic predictions of the nurses. Support interventions were an important feature of these interactions because they embodied the notion of caring which the patients who were interviewed particularly sought from the nurses. Support interventions tended to induce the patients to trust the nurses who used them and hence made the patients more willing to believe the predictions of the nurses.

However, anything which suggested that a nurse was not competent or caring was deeply disturbing to patients. It affected their confidence not only in the individual nurse involved, but in some cases in all the other nurses in the clinical area. This finding is consistent with the work of Thorne & Robinson (1988) who reported that patients with chronic illnesses alter their perceptions of nurses over the course of their illnesses. They found that over time patients became more discerning in their judgements of the limits of competence and caring of the staff and were less willing than before to place absolute trust in their predictions.

The nurses also used distraction in some cases of Unjustified Fears. Distraction is congruent with the coping style of patients who have a strong preference for

blunting (Miller 1979b). It also appears from the present study to be of value when working with people suffering from loss of short-term memory; it actually takes advantage of the susceptibility to distraction which arises from the disability. It can be used to prolong the calming effects of reassuring interventions, by blocking out the return of aversive doubts. However, distraction is a paternalistic intervention used on the assumption that nurse knows best. The side-effect is that, if effective, it reduces the patient's awareness of his situation and therefore reduces his ability autonomously to respond should that situation change.

SHARED FEARS

In some incidents, both nurse and patient shared the fear that the patient's situation was genuinely aversive. The choice of intervention depended on the extent to which the nurse regarded the situation as controllable. If she acknowledged the genuine aversiveness of the patient's situation, but believed that it could be mitigated or resolved in some way, then active interventions were chosen. Thus if the nurse saw the patient's situation as potentially controllable, the physical and mental health of the patient was best served by an attempt duly to control it.

Two broad types of active intervention were identified: **direct action**, in which control was initiated by the nurse, and **patient control**, in which the nurse tried to induce the patient to initiate control for himself. Within the patient control category, two sub-categories of intervention emerged. In some cases patient control interventions promoted the independence of patients through recognition of their autonomy; however, in other incidents the nurses used powerful and directive persuasion techniques which in practice circumscribed the degree of independence permitted to patients.

Whereas active interventions were used in shared-fear situations which were potentially controllable, these were rarely used in uncontrollable aversive situations. Thus, a stage may be reached in an illness in which it becomes clear to both patient and nurse that the patient is not going to recover. Judging from the data in the present study, support interventions using a full range of verbal and non-verbal actions appeared to be the most effective way of inducing patients in this situation to feel calm without lying to them. There was a tendency for the nurses to play down the value of expressions of support for patients, saying that they felt inadequate at being unable to do anything more practical to help the patients. The evidence from this study suggests that the patients themselves placed a high value on support interventions in these circumstances.

In an aversive situation which is uncontrollable, there is always pressure on health care staff to induce a patient to maintain hope. The nurses' fears are that patients in these situations may become demoralised, emotionally distressed, and perhaps suicidal. The temptation therefore is to use prediction as well as support to reassure the patient. However, prediction in these circumstances means lying, since it involves inducing the patient to predict or interpret that he will be safe, when the nurse knows that this is highly unlikely. The present study uncovered several incidents in which lying was used by nurses. Leaving aside the powerful ethical objections to lying, in practical terms it is a high-risk strategy. If the patient discovers the lie, the risk is that his trust in the caring qualities of the nurse who lied will be severely compromised. Most lies demand a co-ordinated approach for their maintenance, so the loss of trust if they are discovered is likely to extend beyond individual nurses to the team as a whole.

Having said this, there can still be no hard and fast rules. It is notable that in all the critical incidents where lying occurred, the patients were people whose autonomy the nurses regarded as impaired; the nurses may have thought them incapable intellectually of discovering the lie. Incidents have been cited in which

lying appeared to be highly effective: calming the patient, facilitating his management, with concealment maintained indefinitely. Nevertheless, lying is a paternalistic strategy in which the nurse decides and acts upon what she regards as the best interests of the patient, without open consultation with the patient. It therefore promotes dependence and, if discovered, may limit the options for subsequent interventions.

FALSE SECURITY

These are situations in which the patient believes he is safe, but which the nurse regards as aversive. The question here is whether or not to alert the patient to the reality of his situation, as assessed by the nurse. In the recorded incidents where the situation was viewed as potentially controllable, the nurses considered it essential to alert the patients. This involved the nurses in disclosing information which the patients found anxiety-provoking, generally given as part of a patient control intervention. It usually involved the nurse in disclosing aversive information but following this with a route-to-safety argument. The nurses needed to weigh the medium- and long-term benefits arising from active interventions against the immediate distress thus caused.

In the recorded incidents where the patients' situations was essentially uncontrollable (typically terminal illness), ethical rather than clinical considerations came to the fore. Beauchamp & McCullough (1984) highlighted the essential tension between promoting patient autonomy by disclosure of information for control or intervening in a beneficent way to induce the patient to remain calm by withholding information and by falsely reassuring the patient. Generally there will be some aspects of the patient's overall situation where patient control will be feasible and desirable, such as making a will, or being able

to communicate openly with close family and friends. However, patient control in these circumstances can only be exercised if the uncontrollably aversive nature of the patient's illness is openly acknowledged.

TO REASSURE OR NOT TO REASSURE?

The comparative assessment matrix reveals four different cases in which a nurse must exercise judgement over whether or not to reassure. In many situations, the issue of whether the patient's problem is potentially controllable or uncontrollable adds a further dimension to the question. It has been argued that successful reassurance promotes not only calmness but also passivity in the patient. In the medium- to longer-term, many patient control interventions will also induce the patient to feel calm, while making it possible for him to retain a sense of autonomy through an active response which is not present if reassurance is used. The penalty with patient control is the initial rise in anxiety which occurs when the patient has to confront the aversive situation.

It must be recognised that all interventions which promote a passive response in the patient (i.e. reassurance, distraction and direct action by the nurses) also promote compliance. When faced with a patient who is proving difficult to manage, there may be a temptation to resort to interventions which promote passivity, including lying, as a means by which the nurse can control the situation. It is in these difficult circumstances that attention to the inferential model can encourage the nurse openly to consider the extent to which she is trying to manipulate the patient's response to promote compliance, and to consider the balance of good or harm to the patient which she expects to result.

THE VALIDITY OF THE STUDY

The issue of what may or may not be claimed from the present study must now be addressed. Questions of validity are questions about whether a piece of research actually measures what it claims to measure (Bateson 1984). This means that one must first be clear about what is claimed for the study and then assess the accuracy of the results in representing those claims.

WHAT IS CLAIMED FOR THIS STUDY?

The research design employed theoretical sampling rather than probability sampling. This means that no claims may be made that the sample represents a survey of the population as a whole. Therefore it would not be valid to use the frequencies cited here to make any inferences about how frequently nurses in general use the different types of helping intervention identified, nor about how frequently those interventions are effective or ineffective. Further limitations arise from the fact that practical and ethical considerations limited the scope of the sample, with comparatively few incidents collected about children's wards, about people with learning difficulties or nurses who work with them, and about those in acute and long-stay psychiatric in-patient settings. In addition, the study was carried out in two large rural districts of England, where the population of patients and nurses was predominantly white and culturally homogeneous.

Therefore it is not possible to claim that the study has identified all the possible varieties of helping intervention employed by nurses when they set out to calm patients. Nor is it claimed that the descriptive categories established in the study are the only way of viewing the data: there may be many other possible analyses. However, what is claimed is that the categories described provide one way of making sense of the data and of identifying their relevance in relation to the aims

of the study; it is also argued that the categories of intervention identified were grounded on sound data: that they were interventions which were genuinely used by nurses. Finally it is claimed that the theory of comparative assessment provides a sound explanation of how the nurses in this study selected the interventions which they used in the critical incidents collected.

The methodology of Grounded Theory (Glaser & Strauss 1967) depends upon acceptance of inductive reasoning as a fundamental logical principle. In this study, data were collected in the form of critical incidents; data analysis involved studying similarities and differences between the critical incidents; this led to the emergence of five intentions categories and a theory of comparative assessment, which are claimed respectively to describe and to explain links between the intentions and the actions of the nurses. The reasoning process is inductive in that it starts with empirical data, which is then used to generate theory. Therefore, in terms of the philosophy of knowledge, the study may only be accepted as valid if one accepts Russell's view that:

> "Induction is an independent logical principle, incapable of being inferred either from experience or from other logical principles, and without this principle science is impossible." (Russell 1974: 647)

One aspect of the study, the semantic analysis of the verb "*to reassure*", does not rely on induction, but instead rests largely upon deductive reasoning. The claim here is that the Inferential Model of Communication (Sperber & Wilson 1986) offers a more accurate explanation of the process of communicating than the conventionally accepted coding model. It is claimed that the meaning of reassurance in nursing has been systematically deduced from a linguistic analysis employing the inferential model to explain the processes of communication occurring in the critical incidents collected.

THREE WAYS OF ASSESSING VALIDITY

In reviewing questions of validity in social surveys, Bateson (1984) argued that there are potentially three ways of assessing validity. One is to obtain a "*criterion value*". This means finding a "*true*" criterion, ideally one established through direct observation, against which the results can be measured. In practice, widely-accepted criteria are virtually impossible to find in the social sciences, particularly in a relatively new field of study such as reassurance.

Bateson's second test of validity is "*construct validation*". This means checking the measures obtained from empirical research against established theory with proven predictive power in the area under study. The difficulty here is that research frequently runs ahead of theory. Only in certain very specific areas can this method of validation be used with the present study. Miller's (1979a) Minimax Theory and Bowlby's (1971) Attachment Theory both make certain predictions about how individuals will react emotionally in the face of aversive situations. In terms of construct validity in these areas, the findings of the study are broadly consistent with the predictions of both theories.

The third and most practical test of validity is what Bateson terms "*process validation*" and which is also sometimes described as "*content validation*". This involves making a critical assessment of three areas: the design of the data matrix, the data-construction task required of the informants, and the classification task required of the researcher.

THE DESIGN OF THE DATA MATRIX

Grounded Theory methods are unusual in that the design of the data matrix emerges as the study progresses, rather than being fixed before data collection

commences as in verification studies. The core of the matrix in the present study is formed by an X axis of Intention categories claiming to describe the intentions of the nurses, and by the Y axis of Action categories which describe the reported behaviours of the nurses. The validity of the matrix rests principally upon the assumption that the inferential model is the most accurate representation of communication processes currently available to us, and upon the claim that it is possible reasonably reliably to identify nurses' intentions as well as their actual behaviours from the data collected.

It is claimed that the Intention categories are mutually exclusive, fully code all the data collected, and are directly relevant to the study aims. However, it is acknowledged that the patient control category is particularly complex and that further studies may yield sub-divisions of this category which will increase its descriptive and explanatory power. A particular strength of the matrix is that it was developed through a triangulation process from data collected by both interview methods and written questionnaires, and using both nurses and patients as informants.

Turning to the issue of whether it is possible accurately to identify the nurses' intentions from retrospectively collected critical incidents, it is certain that some distortions will have occurred. Whereas in some cases the nurses described their own intentions, in other cases these were inferred from their actions, either by patients or by the researcher. However, the study does not stand or fall on the requirement for total accuracy in coding the nurses' intentions; nor does it require the nurses always to recall their intentions accurately. The primary aim of this study is theory generation rather than verification. Provided the five Intentions categories which emerged from the data are mutually exclusive and provided that they potentially code all the data, then they stand in their own right as valid results within the limits of the study previously stated. Thus, it is claimed the five

categories describe five possible types of intention which inform the actions of nurses when they work with anxious patients.

Therefore it is argued that the present study offers a valid typology of the nurses' intentions in the critical incidents collected, since it is grounded on data from a variety of sources, which show logically consistent links between actions and coded intentions. Thus Glaser & Strauss (1967) asserted that valid theory may be generated even when (as is usually the case) the evidence from which it emerged is not totally accurate:

> "Naturally we wish to be as sure of our evidence as possible, and will therefore check on it as often as we can. However, even if some of our evidence is not entirely accurate this will not be too troublesome; for in generating theory it is not the fact upon which we stand, but the conceptual category . . . that was generated from it."
> (Glaser & Strauss 1967: 23)

THE INFORMANTS' DATA-CONSTRUCTION TASK

According to Bateson (1984), there are two types of task which one may ask informants to perform. A "*Type A*" task requires the informant to present an item of data in ready-classified form. Generally the researcher will ask a question and present a selection of classified answers, asking the informant to select the one which best describes his views. The second type of task, "*Type B*", asks the informant to present information in unclassified form, for the researcher later to work up into classified data. The informants in this study were asked to perform a Type B task, presenting critical incidents in their own words. The advantage of this approach is that it makes the informants' task more straightforward and less demanding. Given that many of the informants were patients who were already under strain from illness and related anxieties, it is argued that the presentation of

a Type B task made it easier for informants to supply accurate incidents than if a Type A task had been required.

The validity of the data-construction task was certainly limited by the decision to collect critical incidents which were retrospectively recalled, rather than to collect them through direct observation. (The rationale for this decision was explained in Chapter 4.) However, safeguards were built in by asking whenever possible for incidents which occurred within the previous twenty-eight days and by allowing informants freely to choose incidents, working on the assumption that they would select salient incidents which had made a vivid impression upon them.

By comparing the accounts of nurses and patients in the paired incidents, it was possible to identify at least some of the ways in which the task of remembering distorted the information given. Thus no claims may be made that the words actually uttered by nurses or patients are precisely as stated in the critical incidents. However, the nurses and patients were substantially in agreement in their overall interpretation of what occurred in the paired incidents. There is no reason to believe that the paired incidents were in any way different from the bulk of incidents where data was collected from only one informant. Therefore it is argued that the full body of critical incidents broadly represents an accurate picture of what occurred in the situations described, and that the recall distortions which occurred did not significantly affect the construction of the categories or the development of theory.

THE RESEARCHER'S CLASSIFICATION TASK

As was discussed in Chapter 4, studies using Grounded Theory can only claim to tell us something about the issues studied if the coding categories are genuinely "grounded" on the data collected, and if those categories are systematically applied

during the classification stage. The present study offers measures of coding reliability which indicate a ninety percent level of inter-rater agreement in most areas, with slightly weaker coding reliability for some of the interview data. The difficulty of coding was increased by the fact that informants were set a Type B task. In some cases they did not explain incidents in sufficient detail to permit reliable coding judgements to be made. For example, in many cases it was impossible to separate Worries about Health from Worries about Treatment. In retrospect, the reliability of the codings would have been increased if the informants had been asked to perform some elements of a Type A task, for example by asking them to classify retrospectively any doubtful aspects of the incidents which they first supplied in completing the Type B task.

There is a tendency when critically analysing research to judge studies as either valid or not valid. In fact, most studies lie somewhere on a continuum between these two extremes. In practice, one's assessment of the validity of any study will also depend upon how one plans to use the results. Research never establishes absolute truth; if well-designed and conducted it merely represents the world in a slightly more accurate way than was possible before. If high-risk decisions about patient care were being considered as a result of the ideas emerging from the present study, then further investigation using direct observation and quantitative methods for verification purposes would be vital before proceeding further. However, the strongest findings from this study surround the uses and value of adopting an inferential model of communication in describing and explaining five categories of nursing intervention. It is claimed that the study demonstrates sufficiently the explanatory power of the model to make it worthwhile for nurses immediately to use it for analytical purposes. Benner (1984) described the learning process by which nurses develop their skills as involving a progression "*from novice to expert*". It is claimed that the inferential model of communication can safely be used by individual nurses to analyse interactions in order to promote progress towards Benner's "*expert*" level.

THE PRACTICAL IMPLICATIONS OF THE STUDY

It has already been stated that one may not make any generalisations about the frequency of different types of nursing actions or patient outcomes from the results of this study. However, this does not mean that the study has no direct implications for nursing practice. The theory generated about the five types of helping intervention and about the importance of comparative assessment in selecting interventions merits attention in its own right. These have been found to exert a major influence on nursing actions and patient outcomes in 351 critical incidents. The implication is that individual nurses working in different specialties need not only to be aware of the ideas generated by this study but should also test them out for themselves in their clinical situations.

Donald Schon (1983) has described any professional who constantly tests new ideas as a "*reflective practitioner*". This description applies readily to many nurses who are, by and large, practical people with an eclectic approach to theory. This researcher in an earlier case study has described in detail the way an experienced nursing practitioner may test the application of a wide variety of theoretical findings in order to address the particular problems of individual patients (Teasdale 1992). Individual verification in clinical practice will always be necessary in the absence of formal verification studies. Given the current limited funding available for Nursing research, such large-scale verification studies are likely to remain sparse. However, grounded theory methods, if properly applied, offer the reflective practitioner a qualified assurance that the theory thus generated has genuinely emerged from data which was carefully collected and systematically analysed. In this case, verification does not need to be undertaken in expensive controlled trials. It can and should take place in the many thousands of one-to-one nurse-patient interactions which occur each day.

The notion of developing one's clinical practice through the collection and study of critical incidents of one's own is now gaining wider acceptance in Nursing in the United Kingdom. The UKCC's (1990) Post Registration Education and Practice Project (PREPP) has concentrated the attention of the profession on the need constantly to maintain one's own updating. Both the English and Welsh National Boards for Nursing and Midwifery advocate the collection of critical incidents in the professional portfolios which they have published (ENB 1991, WNB 1990). As the present study demonstrates, the collection and use of critical incidents offers one way of creating a genuine link between everyday clinical practice and the research base which underpins it.

The special value of the theories which have emerged from this study is that they are empowering. They do not require the nurse to undertake one action and then undertake another as if she were a technician simply following a routine procedure. Instead they encourage the nurse to take certain ideas into account when planning and carrying out her clinical practice; to evaluate for herself the situations in which the theories apply and the ones in which they do not; in fact to conduct a form of action research (Towell & Harries 1979) which is an essential part of modern nursing.

Turning now to the detailed implications of this study, three main aspects are highlighted: the assessment of patient anxiety, the selection of interventions, and the conscious use and study of support interventions.

ASSESSING PATIENT ANXIETY

The study has direct implications for the way nurses assess patient anxiety. Three elements of assessment emerge as particularly important. The first involves the nurse in establishing the patient's view of himself and his situation. It means

assessing the nature and weight of the patient's concerns. Here close and continuing observation of body language is particularly important as a way of checking for the presence of anxiety. The nature of the fears identified in the present study were quite predictable in the sense that they were similar to those described in the existing research literature. However, there is sufficient evidence from this study and from others quoted in the literature review to conclude that much patient anxiety continues to pass unnoticed by health care staff. Improved assessment of patient anxiety in clinical practice does not demand the administration of a host of anxiety-measurement questionnaires. The evidence of this study suggests that good observation and the use of follow-up questions will elicit many of the concerns of patients. However the assessment needs to be repeated at regular intervals throughout the whole period that the patient is in contact with the health care service.

The second element of assessment which emerges from the study is that nurses need to take into account the coping styles of different patients when planning their interventions. It was the more extreme monitoring or blunting styles of coping which appeared to cause the nurses particular problems in the critical incidents collected. Therefore it is suggested that the likelihood of effective intervention is increased when extreme coping styles are identified early and when helping strategies are adapted to them as far as possible. In the clinical area, nurses are notoriously reluctant to use formal assessment inventories, citing their complexity and the amount of time required for their completion as a problem. In fact, scales such as Miller's (1987) Monitoring/Blunting Scale are relatively quick and easy to administer. It would also be interesting to know the extent to which experienced nurses can accurately identify a patient's coping preference through general conversation, as opposed to the use of a systematised inventory.

The third important element of assessment to emerge from the data was the need for nurses to establish an accurate and objective view of the aversiveness of each

patient's situation. The key factor which influenced the type of intervention selected by the nurses was their assessment of the genuine aversiveness of each patient's situation. This required a sound knowledge of diagnosis, prognosis, treatment options and the risks associated with each, as well as a good grounding in psychology and sociology. It was no coincidence that some of the most difficult situations for the nurses to handle were ones where the patient's future was uncertain and the overall situation hard to judge. Also, many of the unsuccessful incidents arose from over-optimistic predictions by nurses, which were subsequently proved to be incorrect. This affected patients' perceptions of the competence of nurses and reduced their ability to reassure in the future. The findings of the current study suggest that the more accurate the nurse's assessment of the genuine aversiveness of the patient's situation, the more likely she is to choose an effective intervention.

This aspect of assessment has clear implications for nursing education. It provides support for the pattern of student nurse education which has resulted from Project 2000 (UKCC 1986). The increased emphasis on in-depth academic study of health and illness should provide a sound grounding for accurate assessment of the aversiveness of diagnoses, prognoses, treatments, etc. However, it will also be important to match this with learning in the clinical area. A text book can inform a student about the nature of a particular surgical operation, but the patients themselves are the best source of information about the reality of levels of post-operative pain, movement restrictions, persisting disability, or speed of recovery. The results of pre-treatment investigations are by definition uncertain at the time of the procedure, but the patients' experience of the procedures themselves can be assessed.

Individual nurses need to develop their knowledge by systematic observation and questioning of patients, aiming for the levels of expertise revealed by some of the specialist nurses in this study. This is also an area where expert nursing

practitioners need to share their knowledge by publishing articles which address the issue of the genuinely aversive features of different treatment options.

SELECTION OF INTERVENTIONS

The study has highlighted five types of helping intervention which may be used in situations where patients are anxious and which are consistent with the inferential model of communication. With its emphasis on intentions and inferences, this model highlights processes which previously went largely unnoticed. It can be used not only for large-scale research, but also by individual nurses who wish to analyse critical incidents from their own clinical experience. At first one may experience uncomfortable doubts when doing this. In trying to get to grips with one's intentions in communicating, one begins to realise the potentially **manipulative** nature of the communication process. This is particularly marked in information-giving actions. A coding model of communication encourages us to think of "information" as a blockbuster concept:- "*Objective information is out there in the world and I must collect it and then pass it on to my patients.*" The inferential model explains information-giving from a radically different perspective. It implies that all information is partial; it is partial in the sense that it is impossible to give "*full information*" because there is no end to what can be imparted; it is also partial in the sense that a communicator is never truly objective. The nurse always has intentions when communicating with a patient: she always wants to induce the patient to respond in a certain way as a result of her communication. Yet this process does not have to be manipulative. It is possible to make one's intentions explicit and to involve the patient as a partner in the communication process. This is another instance of the way in which an understanding of the inferential model has the potential to empower both nurse and patient.

In clinical practice, the five Intentions categories which emerged from this study can be used as a starting point for individuals who wish to conduct a critical review of their helping interventions. Individual nurses working in their own specialty will be able to tease out more detailed properties of the categories as they apply to the patients in their area. In Nursing education, there has long been a need for a unifying model of communication which can give overall direction to the growing range of experiential and theoretical study which is built into a modern curriculum for student nurses (Fielding & Llewelyn 1987). However, the inferential model will not supply this overall direction unless its implications for the full range of Nursing practice are developed through further published studies. Its acceptance entails the revision (as opposed to outright rejection) of some popular conceptual frameworks used in teaching and researching communication processes. One example is Heron's (1975 & 1986) Six Category Intervention Analysis, which would readily lend itself to such a revision.

SUPPORT INTERVENTIONS

Support interventions emerged very strongly from the critical incidents in this study as being almost universally valued by patients and as having a particularly wide range of applications. They could be used on their own, for example in uncontrollable aversive situations where no other meaningful interventions would serve; they could also be used in combination with any of the other interventions, enhancing the effects of each.

Experienced nurses have always understood the importance of inducing patients to feel cared for and supported. However, there is a danger that this activity is seen by students as an unglamorous, non-technical activity which does not merit detailed study. The evidence from the critical incidents suggests that nurses need to be particularly skilled in designing and using support interventions in a vast

array of clinical situations. The implication is that this is an area of nursing practice which must be openly acknowledged and promoted. The New Nursing movement (Salvage 1990) with its emphasis on primary nursing and the British Government's commitment in the Patient's Charter (DoH 1991) to each patient having a named nurse all lend themselves to the development of the types of supportive relationship which patients appear particularly to value from nurses.

FURTHER RESEARCH

Although intelligent investigation by individual practitioners is believed by this researcher to be the most important way in which the findings of the study should be pursued, there are some key areas of the study which would repay larger-scale research investigations.

ASSESSING AND MANAGING PATIENT ANXIETY

This study has again opened up the issue of how accurate nurses are in assessing the sources and degree of patient anxiety in different clinical settings. This area would benefit from further studies, but it is essential that any research undertaken actually involves clinical nurses. There is little value in outsiders publishing results which are highly critical of nursing practice, if the nurses themselves believe they are being unfairly criticised. Their way of protesting will simply be to ignore the results. A useful way forward in this area is Action Research (Towell & Harries 1979), where clinicians and researchers collaborate to address the issue of anxiety management in specific clinical areas, seeking to achieve measurable improvements which will last because they are practical and can be built into the reality of everyday clinical nursing.

MEASURING OUTCOMES

Grounded Theory has been used to open reassurance and related concepts to systematic study. The emergence of five Intentions categories and a classification of patient outcomes as a result of nursing interventions has paved the way for quantitative studies which could provide statistical evidence of the relative efficacy of the five types of intervention. Ideally an observation study, supplemented by interviews with nurses and patients, would be required. However, the cost of large-scale observation studies would be considerable. A more feasible approach might involve baseline measurement of patient anxiety in a specific clinical area. An action research project which involved clinical nurses in exploring the five types of intervention and deciding for themselves how they could reduce overall patient anxiety could then be designed. Further post-intervention measurements of patient anxiety could be used to identify any resulting changes. If the baseline and post-intervention measurements were sufficiently extensive, it should be possible to make meaningful before/after comparisons using this design.

INVESTIGATING PATIENT CONTROL

Interventions which promote patient control have emerged from this study as quite distinct from reassuring interventions. It was noted in the literature review that some promising studies of the use of patient control interventions in anxiety management have been conducted, but that their scope in hospital-based practice appeared to be limited. The evidence from this study suggests that individual nurses with strong personal beliefs in the importance of patient autonomy can always find ways of enhancing patient control, even in the least promising surroundings. This area is ripe for further work.

Research using grounded theory to investigate the full meaning of patient control in nursing practice would be a valuable complement to the present study. It would also be valuable to compare the frequency of use of patient control interventions in hospital and community settings, or in general nursing and psychiatric nursing. Mavis Kirkham (1987) in a study of midwifery found disturbing evidence that women's freedom to control their own labour was highly dependent on the setting in which labour took place. In a consultant-led unit, information was consistently withheld from patients and the progress of their labour was controlled by the medical staff, assisted by the midwives. In contrast, when deliveries took place in the patients' own homes, the patients themselves controlled the labour and the midwives and medical staff gave information and support to facilitate this. It is predicted that very similar results could be found in many areas of nursing practice.

ACHIEVING PATIENT COMPLIANCE

The use of lying by nurses as a means of reassuring patients and at the same time promoting patient compliance is worthy of further study. In the critical incidents collected, nurses only lied to patients whose autonomy they regarded as impaired. One large group of people in this category are those who suffer from short-term memory deficits. They emerged very strongly from the critical incidents as a group which required distinct reassuring and management techniques. This is one specialist area where observation studies may be feasible, since particular patients who repeatedly show signs of anxiety should be readily identifiable. A detailed description of the types and outcomes of different anxiety management techniques employed by nurses in dealing with people with short-term memory problems would be a valuable contribution to our knowledge in this area.

CONCLUSION

Probably the most important outcome of the study is not the detailed definition and description of reassurance, nor the identification of five types of helping intervention; instead it is the demonstration of the value of the inferential model in explaining what happens when nurses and patients try to communicate. With its emphasis on intentions and inferences, the model highlights processes which hitherto have evaded systematic study. It is the researcher's hope that this example of the application of the inferential model to *reassurance in nursing* will assist and encourage reflective practitioners consciously to use inferential approaches whenever they strive to deliver sensitive and effective patient care.

****

REFERENCES

Aiken LH & Henrichs TF, (1971), Systematic relaxation as a nursing intervention technique with open heart surgery patients. Nursing Research, 20, 212-217.

Altschul AT, (1972), Patient/Nurse Interaction: A Study of Interaction with Patients in Acute Psychiatric Wards. Churchill Livingstone, Edinburgh.

Andrew J, (1970), Recovery from surgery, with and without preparatory instruction, for three coping styles. Journal of Personality and Social Psychology, 15, 223-226.

Auerbach SM, (1973), Trait-state anxiety and adjustment to surgery. Journal of Consulting and Clinical Psychology, 40, 264-271.

Auerbach SM et al., (1976), Anxiety, locus of control, type of preparatory information, and adjustment to dental surgery. Journal of Consulting and Clinical Psychology, 44, 809-818.

Auerbach S & Kilman P, (1977), Crisis Intervention: A Review of Outcome Research. Psychological Bulletin, 84, 6, 1189-1217.

Austin JL, (1962), How to do things with words. Clarendon Press, Oxford.

Averill JR & Rosenn M, (1972), Vigilant and nonvigilant coping strategies and psychophysiological stress reactions during the anticipation of an electric shock. Journal of Personality and Social Psychology, 23, 128-141.

Baddeley A, (1979), The Limitations of Human Memory: Implications for the Design of Retrospective Surveys. In Moss L & Goldstein H eds., (1979), The Recall Method in Social Surveys. University of London Institute of Education, London.

Baker D, (1983), "Care" in the Geriatric Ward: An Account of Two Styles of Nursing. In Wilson-Barnett J ed., (1983), Nursing Research: Ten Studies in Patient Care. John Wiley & Sons, Chichester.

Balint M, (1964), The Doctor, His Patient and the Illness. Pitman Medical Limited, London.

Bateson N, (1984), Data Construction in Social Surveys. George Allen & Unwin, London.

Beauchamp TL & McCullough LB, (1984), Medical Ethics. Prentice Hall, New Jersey.

Beck AT, (1976), Cognitive Therapy and Emotional Disorders. New York International Universities Press, New York.

Benner P, (1984), From Novice to Expert. Addison-Wesley, Menlo Park, California.

Berlyne DE, (1960), Conflict, Arousal and Curiosity. McGraw-Hill, New York.

Biley FC, (1989), Nurses' perception of stress in preoperative surgical patients. Journal of Advanced Nursing, 14, 575-581.

Bok S, (1978), Lying. Harvester Press, Sussex.

Boore RP, (1978), Prescription for recovery. RCN, London.

Bowlby J, (1971), Attachment. Vol 1 of Attachment and Loss. Penguin Books, Harmondsworth.

Bowlby J, (1975), Separation: Anxiety and Anger. Vol 2 of Attachment and Loss. Penguin Books, Harmondsworth.

Bowlby J, (1988), A Secure Base. Routledge, London.

Brammer LM, (1973), The Helping Relationship. Prentice Hall, New Jersey.

Buchsbaum DG, (1986), Reassurance Reconsidered. Social Science and Medicine, l23, 4, 423-27.

Burnard P, (1985), Learning Human Skills. Heinemann, Oxford.

Carey MP & Burish TG, (1988), Etiology and treatment of the psychological side effects associated with cancer chemotherapy: A critical review and discussion. Psychological Bulletin, 104, 3, 307-325.

Carnevali D, (1966), Preoperative anxiety. American Journal of Nursing, 1536-1538.

Carpenter N, (1977), The New Managerialism and Professionalism in Nursing. In Stacey M et al., (1977) Health and the Division of Labour. Croom Helm, London.

Carr-Saunders A & Wilson P, (1933), The Professions. Clarendon Press, Oxford.

Cartwright A, (1964), Human Relations and Hospital Care. Routledge & Kegan Paul, London.

Cattell RB & Scheier IH, (1958), The Nature of Anxiety. Psychological Reports, 4, 351-358.

Cattell RB & Scheier IH, (1961), The Meaning and Measurement of Neuroticism and Anxiety. Ronald Press, New York.

Chevalier-Skolnikoff S, (1973), Facial Expression of Emotion in Nonhuman Primates. In Ekman P ed., (1973), Darwin and Facial Expression. Academic Press, New York.

Chomsky N, (1957), Syntactic Structures. Mouton, The Hague.

Chomsky N, (1965), Aspects of the Theory of Syntax. MIT Press, Cambridge Massachusetts.

Clark P & Clark M, (1984), Therapeutic Touch: Is There a Scientific Basis for the Practice? Nursing Research, 33, 1, 37-41.

Clum G et al., (1979), Information and Locus of Control as Factors in the Outcome of Surgery. Psychological Reports, 45(3), 867-873.

Cohen J, (1960), A coefficient of agreement for nominal scales. Educational and Psychological Measurement, 20, 1, 37-46.

Cohen F & Lazarus R, (1973), Active coping processes, coping dispositions, and recovery from surgery. Psychosomatic Medicine, 35, 375-389.

Cormack D, (1983), Psychiatric Nursing Described. Churchill Livingstone, Edinburgh.

Coser RL, (1965), Some functions of laughter. In Skipper JK & Leonard RC eds., Social Interaction and Patient Care. Lippincott, Philadelphia.

Cullberg J, (1970), Stencil. Psykiatriska Kliniken, Karolinska Sjukhuset, Stockholm. Cited in Gyllenskold K, (1982), Breast Cancer. Tavistock, London.

Davis B ed., (1987), Nursing Education: Research and Developments. Croom Helm, London.

Davitz JR & Davitz LL, (1981), Inferences of Patients' Pain and Psychological Distress. Springer, New York.

Dean C & Surtees PG, (1989), Do psychological factors predict survival in breast cancer? Journal of Psychosomatic Research, 133(5), 561-569.

DeLong R, (1970), Individual differences in patterns of anxiety arousal, stress-relevant information and recovery from surgery. Doctoral dissertation, Univ. of California, Los Angeles.

DHSS, (Department of Health and Social Security), (1983), NHS Management Inquiry (Griffiths Report), HMSO, London.

DHSS, (Department of Health and Social Security), (1989), Working for Patients. HMSO, London.

DoH, (Department of Health), (1990), The NHS and Community Care Act. HMSO, London.

DoH, (Department of Health), (1991), The Patients' Charter. HMSO, London.

Eccleston D, (1987), Management of Anxiety: how important is medication as opposed to reassurance? Medical Dialogue, 16 February 1987, No. 121.

ENB, (English National Board), (1991), Professional Portfolio. English National Board for Nursing, Midwifery and Health Visiting, London.

Epstein S, (1972), The nature of anxiety, with emphasis upon its relationship with expectancy. In Spielberger SD ed., (1972), Anxiety. Current trends in theory and research (Vol 2). Academic Press, New York.

Etzioni A, (1975), A Comparative Analysis of Complex Organisations (2nd edn.), Collier MacMillan, London.

Eysenck HJ & Eysenck SGB, (1964), Manual of the Eysenck Personality Inventory. University of London Press, London.

Faugier J and Reilly S, (1986), Towards a communication breakthrough. Nursing Times, 82, 4, 60.

Faulkner A, (1980), Communication and the Nurse. Nursing Times, 76, 93-95.

Faulkner A, (1985), The Organisational Context of Interpersonal Skills in Nursing. In Kagan CM ed., (1985), Interpersonal Skills in Nursing. Croom Helm, London.

Fielding RG & Llewelyn SP, (1987), Communication training in nursing may damage your health and enthusiasm: some warnings. Journal of Advanced Nursing, 12, 281-290.

Fitzpatrick R et al. eds., (1984), The Experience of Illness. Tavistock, London.

Flanagan JC, (1954), The Critical Incident Technique. Psychological Bulletin, 51, 4, 327-358.

Francis V et al., (1969), Gaps in doctor-patient communication: Patients' response to medical advice. New England Journal of Medicine. 280, 535-540.

French HP, (1979), Reassurance: a nursing skill? Journal of Advanced Nursing, 4, 627-634.

Friedlander M et al., (1982), Demographic, Cognitive and Experimental Predictors of Presurgical Anxiety. Journal of Psychosomatic Research, 26(6), 623-627.

Gamarnikow E, (1978), Sexual division of labour: the case of nursing. In Kuhn A & Wolfe A eds., (1978), Feminism and Materialism. Routledge & Kegan Paul, London.

Glaser B & Strauss A, (1965), Awareness of Dying. Aldine, New York.

Glaser B & Strauss A, (1967), The Discovery of Grounded Theory. Aldine, New York.

GNC, (General Nursing Council), (1982), Training Syllabus: Register of Nurses: Mental Nursing. General Nursing Council for England and Wales, Portland Place, London.

Gregg D, (1955), Reassurance. American Journal of Nursing, 55, 2, 171-174.

Grice HP, (1957), Meaning. Philosophical Review, 66, 377-388.

Grice HP, (1975), Logic and conversation. In Cole P & Morgan J eds., (1975), Syntax and semantics 3: Speech acts. Academic Press, New York.

Gruen W, (1975), Effects of brief psychotherapy during the hospitalization period on the recovery process in heart attacks. Journal of Consulting and Clinical Psychology, 43, 223-232.

Gyllenskold K, (1982), Breast Cancer. Tavistock, London.

Hays JS & Larson K, (1963), Interacting with Patients. MacMillan, New York.

Hayward J, (1975), Information - A Prescription Against Pain. Royal College of Nursing, London.

Heidt P, (1981), Effect of therapeutic touch on anxiety level of hospitalized patients. Nursing Research, 30, 32-37.

Henderson V, (1966), The Nature of Nursing. Collier MacMillan, London.

Heron J, (1975), Six Category Intervention Analysis. Human Potential Research Project, University of Surrey, Guildford.

Heron J, (1986), Six Category Intervention Analysis, 2nd Edition. Human Potential Research Project, University of Surrey, Guildford.

Herzberg F, Mausner B, Synderman B, (1959), The Motivation to Work. John Wiley & Sons, New York.

Hindley CB, (1979), Problems of Interviewing in Obtaining Retrospective Information. In Moss L & Goldstein H eds., (1979), The Recall Method in Social Surveys. University of London Institute of Education, London.

Hughes D, (1988), When nurse knows best: some aspects of nurse/doctor interaction in a casualty department. Sociology of Health and Illness, 10(1), 1-22.

Hunt M, (1987), The process of translating research findings into nursing practice. Journal of Advanced Nursing, 12, 101-110.

Husaini B & Neff J, (1981), Social class and depressive symptomatology: The role of life change events and locus of control. Journal of Nervous and Mental Disease, 169, 638-647.

Jacobs A et al., (1963), Critical behaviors in psychiatric-mental health nursing. 3 Volumes. American Institutes for Research, Washington DC.

Janis IL, (1958), Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients. John Wiley & Sons, New York.

Johnson JE & Leventhal H, (1974), Effects of Accurate Expectations and Behavioural Instructions on Reactions during a Noxious Medical Examination. Journal of Personality and Social Psychology, 29, 5, 710-718.

Johnson JH & Sarason I, (1978), Life stress, depression and anxiety: Internal-external control as a moderator variable. Journal of Psychosomatic Research, 22, 205-208.

Johnston M, (1980), Anxiety in Surgical Patients. Psychological Medicine, 10, 145-152.

Johnston M, (1982), Recognition of patients' worries by nurses and by other patients. British Journal of Clinical Psychology, 21, 255-261.

Johnston M & Carpenter L, (1980), Relationship between pre-operative anxiety and post-operative state. Psychological Medicine, 10(2), 361-367.

Kagan CM ed., (1985), Interpersonal Skills in Nursing: Research and Applications. Croom Helm, London.

Keddy B et al., (1986), The doctor-nurse relationship: an historical perspective. Journal of Advanced Nursing, 11, 745-753.

Kelly MP, (1985), Loss and grief reactions as responses to surgery. Journal of Advanced Nursing, 10, 517-25.

Kendall PC et al., (1979), Cognitive-behavioural and patient education interventions in cardiac catheterization procedures: The Palo Alto medical psychology project. Journal of Consulting & Clinical Psychology, 47, 49-58.

Kendall PC & Watson D, (1981), Psychological Preparation for Stressful Medical procedures. In Prokop CK & Bradley LA eds., (1981), Medical Psychology: Contributions to Behavioural Medicine, Academic Press, New York.

Kent G & Dalgleish M, (1986), Psychology in Medical Care. Baillere Tindall, London.

Kessel N, (1979), Reassurance. The Lancet, 26 May, 1128-1133.

Kincey JA et al., (1975), Patients' satisfaction and reported acceptance of advice in general practice. Journal of the Royal College of General Practitioners, 25, 558-566.

Kirk A et al., (1988), Changes in patients' stress and arousal levels associated with therapists' perception of their requests during crisis intervention. British Journal of Clinical Psychology, 27, 363-369.

Kirkham MJ, (1987), Basic Supportive Care in Labour: Interactions with and around women in labour. Unpublished PhD Thesis, University of Manchester.

Kleinknecht RA, (1978), Fear and avoidance of dentistry. In Advances in Behavioral Research in Dentistry. Washington University Seminar Series, Seattle.

Korsch BM & Negrete VF, (1972), Doctor-patient communication. Scientific American, 227, 66-72.

Krieger D, (1976), Healing by the "laying-on" of hands as a facilitator of bioenergetic change: the response of in-vivo human hemoglobin. Psychoenergetic Systems, 1, 121-129.

Krieger D et al., (1979), Therapeutic touch, searching for evidence of physiological change. American Nursing Association, 79, 66-662.

Kubler Ross E, (1969), On Death and Dying. MacMillan, New York.

Langer EJ et al., (1975), Reduction of Psychological Stress in Surgical Patients. Journal of Experimental Social Psychology, 11, 155-165.

Lazarus RS, (1966), Psychological Stress and the Coping Process. McGraw-Hill, New York.

Lazarus RS, (1976), Patterns of Adjustment. McGraw-Hill, New York.

Leech GN, (1983), Principles of Pragmatics. Longman, London.

Lehman EJ, (1975), The effects of rooming-in and anxiety on the behavior of pre-school children during hospitalization and follow-up. (Doctoral dissertation, Cornell University 1975). Dissertation Abstracts International, (1976), 36, 3052B.

Ley P, (1979), Improving communications: Effects of altering doctor behaviour. In Osborne DJ et al. eds., (1979), Research in Psychology and Medicine. Academic Press, London.

Ley P, (1982), Satisfaction, compliance and communication. British Journal of Clinical Psychology, 21, 241-254.

Lishman WA, (1972), Selective factors in memory. Part 2: Affective disorders. Psychological Medicine 2, 248-253.

Locker D & Dunt D, (1978), Theoretical and Methodological Issues in Sociological Studies of Consumer Satisfaction with Medical Care. Social Science & Medicine, 12, 283-92.

Long P, (1976), Judging and reporting on student nurse clinical performance. International Journal of Nursing Studies, 13, 115-21.

Love RE & Greenwald AC, (1978), Cognitive responses to persuasion as mediators of opinion change. Journal of Social Psychology, 104, 231-241.

Lowe L, (1989), Anxiety in a Coronary Care Unit. Nursing Times, 85, 45, 61-63.

Lucas RH, (1975), The affective and medical effects of different preoperative interventions with heart surgery patients. (Doctoral dissertation, University of Houston 1975). Dissertation Abstracts International, (1976), 36, 5763B.

MacFarlane J & Castledine G, (1982), A Guide to the Practice of Nursing using the Nursing Process. CV Mosby, London.

Macleod Clark J, (1980), Nurse-Patient Interaction. Unpublished PhD Thesis, University of London.

Macleod Clark J, (1985), The Development of Research in Interpersonal Skills in Nursing. In Kagan C ed., (1985), Interpersonal Skills in Nursing. Croom Helm, London.

Maggs CJ, (1983), The Origins of General Nursing. Croom Helm, London.

Maguire PG, (1980), Emotional Aspects of Mastectomy - A conspiracy of pretence. Nursing Mirror, 150, 2, 17-19.

Malan DH, (1979), Individual Psychotherapy and the Science of Psychodynamics. The Butterworth Group, Sevenoaks, Kent.

Mason JW, (1968), Organisation of psychoendocrine mechanisms. Psychosomatic Medicine, 30, 5, Part 2.

McIntosh J, (1974), Processes of communication, information seeking and control associated with cancer. Social Science & Medicine, 8, 167-87.

McIntosh J, (1977), Communication and Awareness in a Cancer Ward. Croom Helm, London.

McIntosh JB, (1975), An Observation and Time Study of the Work of Domiciliary Nurses. Unpublished PhD Thesis, University of Aberdeen.

Melamed BG & Siegel LJ, (1975), Reduction of anxiety in children facing hospitalization and surgery by use of filmed modeling. Journal of Consulting & Clinical Psychology, 43, 511-521.

Melia K, (1987), Learning and Working. Tavistock, London.

Menneer P, (1979), Retrospective Data in Survey Research. In Moss H & Goldstein H eds., (1979), The Recall Method in Social Surveys. University of London Institute of Education, London.

Menzies IEP, (1959), The functioning of social systems as a defence against anxiety. Human Relations 13, 95-121. [Reprinted in Menzies Lyth I, (1988), Containing Anxiety in Institutions. Free Association Books, London.]

Menzies Lyth I, (1988), Containing Anxiety in Institutions. Free Association Books, London.

Miles A, (1984), The stigma of psychiatric disorder. In Reed J & Lomas G eds., (1984), Psychiatric Services in the Community. Croom Helm, London.

Miller JF, (1983), Coping with chronic illness. FA Davis Company, Philadelphia.

Miller MP, (1976), The effects of electromyographic feedback and progressive relaxation training on stress reactions in dental patients. (Doctoral dissertation, University of Oklahoma, 1976) Dissertation Abstracts International, (1977), 37, 6340B.

Miller SM, (1979a), Controllability and Human Stress: Method, Evidence and Theory. Behaviour Research & Therapy, 17(4), 287-304.

Miller SM, (1979b), Coping with impending stress: psychophysiological and cognitive correlates of choice. Psychophysiology, 1, 16(6), 572-581.

Miller SM, (1981), Predictability and human stress: Towards a clarification of evidence and theory. In Berkowitz L ed., (1981), Advances in experimental social psychology: Vol 14. Academic Press, New York.

Miller SM, (1984), Coping with stress by monitoring versus blunting: Implications for cancer and chronic diseases. Paper presented at American Psychological Association, Toronto, Canada.

Miller SM, (1987), Monitoring and Blunting: Validation of a Questionnaire to Assess Style of Information Seeking Under Threat. Journal of Personality & Social Psychology, 52(2), 345-353.

Miller SM, (1989), Coping Style in Hypertensive Patients: Nature and Consequences. Journal of Consulting & Clinical Psychology, 57, 3, 333-337.

Miller SM & Grant R, (1979), The Blunting Hypothesis: A View of Predictability and Human Stress. In Sjoden P et al. eds., (1979), Trends in Behavior Therapy. Academic Press, New York.

Miller SM & Mangan C, (1983), Interacting effects of information and coping style in adapting to gynaecologic stress: Should the doctor tell all? Journal of Personality & Social Psychology, 45, 1, 223-236.

Mohros KLL, (1976), Effects of reassuring information and sensory information on emotional response during a threatening medical examination. (Doctoral dissertation, University of Minnesota, 1976) Dissertation Abstracts International, (1977), 38, 1304-1305A.

Molleman E et al., (1984). The significance of the doctor-patient relationship in coping with cancer. Social Science & Medicine, 18(6), 475-80.

Morgan et al., (1985), Sociological Approaches to Health and Medicine. Croom Helm, London.

Nurse G, (1980), Counselling and the Nurse. HM&M, Aylesbury.

OED, (1991), The Concise Oxford English Dictionary. The Clarendon Press, Oxford.

Paley J & Forest I, (1984), In-Service Training Needs for Nurses. Cranfield Institute of Technology, Cranfield.

Parkes KR, (1984), Locus of Control, Cognitive Appraisal and Coping in Stressful Episodes. Journal of Personality & Social Psychology, 46, 3, 655-668.

Perkins CC Jr., (1955), The stimulus conditions which follow learned responses. Psychological Review, 62, 341-348.

Perkins CC Jr., (1968), An analysis of the concept of reinforcement. Psychological Review, 75, 155-172.

Petty RE et al. eds., (1981), Cognitive Responses in Persuasion. Erlbaum, New Jersey.

Porter S, (1991), A participant observation study of power relations between nurses and doctors in a general hospital. Journal of Advanced Nursing, 16, 728-735.

Randolph G, (1980), The differences in physiologic response of female college students exposed to stressful stimulus, when simultaneously treated by either therapeutic touch or casual touch. Unpublished Doctoral Thesis, New York University.

Ray C & Fitzgibbon G, (1981), Stress Arousal and Coping with Surgery. Psychological Medicine, 11(4), 741-746.

Reynolds M, (1978), No news is bad news: patients' views about communication in hospital. British Medical Journal, 1, 1673-1676.

Ridgeway V & Mathews A, (1982), Psychological preparation for surgery: A comparison of methods. British Journal of Clinical Psychology, 21, 271-280.

Robinson K & Vaughan B eds., (1992), Knowledge for Nursing Practice. Butterworth Heinemann, Oxford.

Rosen A & Abraham G, (1963), Evaluation of a Procedure for Assessing the Performance of Staff Nurses. Nursing Research, 12, 78-82.

Rothbart M & Mellinger M, (1972), Attention and responsivity to remote dangers: A laboratory simulation for assessing reactions to threatening events. Journal of Personality & Social Psychology, 24, 132-142.

Rothbaum F, Weisz JR, Snyder SS, (1982), Changing the World and Changing the Self: A Two-Process Model of Perceived Change. Journal of Personality & Social Psychology, 42, 1, 5-37.

Rotter JB, (1966), Generalized Expectancies for Internal Versus External Control of Reinforcement. Psychological Monographs, 80(1), Whole No. 609.

Russell B, (1974), History of Western Philosophy. George Allen & Unwin, London.

Sainsbury MJ, (1980), Key to Psychiatry. John Wiley & Sons, Chichester.

Salkovskis PM & Warwick HMC, (1986), Morbid preoccupations, health anxiety and reassurance: a cognitive-behavioural approach to hypochondriasis. Behaviour Research & Therapy, 24, 5, 597-602.

Salvage J, (1990), The Theory and Practice of the "New Nursing". Nursing Times, 86, 4, 42-45.

Sapira JD, (1972), Reassurance Therapy: What to Say to Symptomatic Patients with Benign Diseases. Annals of Internal Medicine, 77, 603-604.

Schachter S, (1975), Cognition and peripheralist-centralist controversies in motivation and emotion. In Gazzaniga MS & Blakemore C eds., (1975), Handbook of Psychobiology. Academic Press, London.

Schmitt FE & Wooldridge PJ, (1973), Psychological preparation of adult surgical patients. Nursing Research, 22(2), 108-116.

Schneider J & Locke EA, (1971), A Critique of Herzberg's Incident Classification System and a Suggested Revision. Organizational Behavior & Human Performance, 6, 441-457.

Schon D, (1983), The Reflective Practitioner. Temple Smith, London.

Searle JR, (1979), Expression and Meaning. Cambridge University Press, Cambridge.

Seligman MEP, (1968), Chronic fear produced by unpredictable shock. Journal of Comparative & Physiological Psychology, 66, 402-416.

Seligman MEP, (1975), Helplessness: On Depression Development and Death. WH Freeman, San Francisco.

Selye H, (1956), The Stress of Life. McGraw-Hill, New York.

Sherlock R, (1986), Reasonable Men and Sick Human Beings. The American Journal of Medicine, 80, 2-4.

Shipley RH et al., (1978), Preparation for a stressful medical procedure: Effect of amount of stimulus pre-exposure and coping style. Journal of Consulting & Clinical Psychology, 46, 499-507.

Sime M, (1976), Relationship of Pre-operative Fear, Type of Coping and Information Received about Surgery to Recovery from Surgery. Journal of Personality & Social Psychology, 34, 716-724.

Sims A, (1976), The critical incident technique in evaluating student nurse performance. International Journal of Nursing Studies, 13(2), 123-30.

Sjoberg G & Nett R, (1968), A Methodology for Social Research. Harper & Row, New York.

Smith E, (1972), Reassure the Patient. Nursing Times, 68, 1334-5.

Sokolov EN, (1963), Perception and the Conditioned Reflex. MacMillan, New York.

Spector P & Sistrunk F, (1979), Reassurance: A Mechanism by which the Presence of Others Reduces Anxiety. Journal of Social Psychology, 109(1), 119-126.

Sperber D & Wilson D, (1986), Relevance. Basil Blackwell, Oxford.

Spielberger CD et al., (1970), STAI: Manual for the State-Trait Anxiety Inventory. Consulting Psychologist's Press, Palo Alto.

Spielberger CD et al., (1973), Emotional Reactions to Surgery. Journal of Consulting & Clinical Psychology, 40(1), 33-38.

Starcevic V, (1990), The role of reassurance and psychopathology in hypochondriasis. Psychiatry, 153(4), 383-395.

Stein LI, (1967), The doctor-nurse game. Archives of General Psychiatry, 16, 699-703.

Sullivan HS, (1954), The Psychiatric Interview. Tavistock, London.

Teasdale K, (1987), Stigma and psychiatric day care. Journal of Advanced Nursing, 12, 339-346.

Teasdale K, (1992), Reflecting on care for the mentally ill. In Robinson K & Vaughan B eds., (1992), Knowledge for Nursing Practice. Butterworth Heinemann, Oxford.

Thorne SE & Robinson CA, (1988), Reciprocal trust in health care relationships. Journal of Advanced Nursing, 13, 782-789.

Towell D & Harries C eds., (1979), Innovation in Patient Care. Croom Helm, London.

UKCC, (United Kingdom Central Council), (1984), The Code of Professional conduct. 2nd Edition. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

UKCC, (United Kingdom Central Council), (1986), Project 2000. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

UKCC, (United Kingdom Central Council), (1990), Post Registration Education and Practice Project [PREPP] Report. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

Volicer BJ & Bohannon MW, (1975), A Hospital Stress Rating Scale. Nursing Research 24, 352-359.

Walker L & Avant K, (1983), Strategies for Theory Construction in Nursing. Appleton Century Crofts, Connecticut.

Wallace LM et al., (1985), Nurses' perceptions of patients' needs for information and their concerns in an English coronary care unit. Intensive Care Nursing, 1, 84-91.

Weber M, (1949), The Methodology of the Social Sciences. Free Press, New York.

Weinman J, (1981), An Outline of Psychology as applied to Medicine. John Wright & Sons Ltd, Bristol.

Weisman AD, (1979), Coping With Cancer. McGraw-Hill, New York.

Weiss JM, (1970), Somatic effects of predictable and unpredictable shock. Psychosomatic Medicine, 32, 397-409.

Wells N, (1984), Responses to acute pain and the nursing implications. Journal of Advanced Nursing, 9, 51-8.

Wilde V, (1992), Controversial hypotheses on the relationship between researcher and informant in qualitative research. Journal of Advanced Nursing, 17, 234-242.

Wilkes E, (1977), Effects of the knowledge of diagnosis in terminal illness. Nursing Times, 73, 39, 1506-7.

Wilkinson C, (1990), Anxiety caused by abnormal result of a cervical smear test: a controlled trial. British Medical Journal, 300, 440.

Wilson JF, (1977), Determinants of recovery from surgery: Preoperative instruction, relaxation training and defensive structure. (Doctoral dissertation, University of Michigan, 1977). Dissertation Abstracts International, (1977), 38, 1476-1476B.

Wilson-Barnett J, (1981), Communicating with Patients in General Wards. In Bridge W & Macleod Clark J, (1981), Communication in Patient Care. HM&M, London.

Wilson-Barnett J, (1978), Patients' Emotional Responses to Barium X-Rays. Journal of Advanced Nursing, 3, 37-46.

Wilson-Barnett J, (1981), Communicating with Patients in General Wards. In Bridge W & Macleod Clark J, (1981), Communication in Patient Care. HM&M, London.

Wilson-Barnett J & Carrigy A, (1978), Factors influencing patients' emotional responses to hospitalisation. Journal of Advanced Nursing, 3, 221-9.

WNB, (Welsh National Board), (1990), Professional Profile. Austen Cornish, London.

Ziemer M, (1983), Effects of Information on Postsurgical Coping. Nursing Research, 32, 5, 282-287.

THE APPENDICES

APPENDIX 1: THE COMPOSITION OF THE SAMPLE

SECTION A: THE NURSES

SECTION B: THE PATIENTS

APPENDIX 1: THE COMPOSITION OF THE SAMPLE

SECTION A: THE NURSES

1. THE NURSES WHO COMPLETED QUESTIONNAIRES

TABLE A1: QUALIFICATION DETAILS

	GENERAL NURSES	PSYCHIATRIC NURSES	**TOTALS**
STUDENTS	66	17	**83**
QUALIFIED	113	6	**119**
TOTALS	**179**	**23**	**202**

TABLE A2: CLINICAL AREAS MENTIONED IN THE INCIDENTS

MEDICAL	78 NURSES
SURGICAL	71 NURSES
PSYCHIATRIC	33 NURSES
COMMUNITY	20 NURSES

TABLE A3: THE TIME SPAN OF RECALL

0-4 WEEKS	167 INCIDENTS
4+ TO 20 WEEKS	32 INCIDENTS
20+ TO 52 WEEKS	3 INCIDENTS

2. THE NURSES WHO WERE INTERVIEWED

TABLE A4: QUALIFICATION DETAILS

	GENERAL NURSES	PSYCHIATRIC NURSES	MENTAL HANDICAP	**TOTALS**
STUDENTS	1	1	0	**2**
QUALIFIED	35	12	2	**49**
TOTALS	**36**	**13**	**2**	**51**

TABLE A5: CLINICAL AREAS MENTIONED IN THE INCIDENTS

MEDICAL	25 INCIDENTS
SURGICAL	18 INCIDENTS
PSYCHIATRIC	17 INCIDENTS
COMMUNITY	9 INCIDENTS
MENTAL HANDICAP	3 INCIDENTS

TABLE A6: THE TIME SPAN OF RECALL

0-4 WEEKS	54 INCIDENTS
4+ TO 20 WEEKS	17 INCIDENTS
20+ TO 52 WEEKS	1 INCIDENTS

TABLE A7: GENERAL DETAILS

NURSING EXPERIENCE	MEAN 16 YEARS
	RANGE 2-45 YEARS
GENDER	12 MALE
	39 FEMALE

SECTION B: THE PATIENTS INTERVIEWED

TABLE B1: CLINICAL AREAS OF PATIENTS

GENERAL SURGICAL	32 PATIENTS
GENERAL MEDICAL	12 PATIENTS
PSYCHIATRIC DAY UNIT	7 PATIENTS

TABLE B2: THE TIME SPAN OF RECALL

0-4 WEEKS	72 INCIDENTS
4+ TO 32 WEEKS	5 INCIDENTS

TABLE B3: GENERAL DETAILS

NUMBER OF PATIENTS	51 PATIENTS
MEAN AGE	58 YEARS
AGE RANGE	23-83 YEARS
GENDER	23 MALE 28 FEMALE
NUMBER OF INCIDENTS	77 INCIDENTS

APPENDIX 2: DATA COLLECTION

SECTION A:	**THE QUESTIONNAIRE FORM**
SECTION B:	**AN EXAMPLE OF A COMPLETED QUESTIONNAIRE**
SECTION C:	**WRITTEN INFORMATION FOR INTERVIEWS WITH PATIENTS**
SECTION D:	**THE SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH PATIENTS**
SECTION E:	**SAMPLE INTERVIEW WITH A PATIENT**
SECTION F:	**WRITTEN INFORMATION FOR INTERVIEWS WITH NURSES**
SECTION G:	**THE SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH NURSES**
SECTION H:	**SAMPLE INTERVIEW WITH A NURSE**

APPENDIX 2: DATA COLLECTION

SECTION A: THE QUESTIONNAIRE FORM

This is the content of the form which was distributed to nurses for recording critical incidents in writing. The form was double-sided and space was left between each question for the nurses to record their incidents.

RESEARCH INFORMATION

Please complete this information sheet without mentioning the name of any member of staff or of any patient.

Think of a time IN THE PAST 4 WEEKS when you:

a. Nursed a patient who was anxious, worried or distressed.
b. Tried to help the patient to become more calm, secure or assured.
c. Were able to observe or find out the effects on the patient of what you said or did.

1. Try to describe the situation which led up to the event, including how you recognised that the patient was anxious, worried or distressed.

2. At the time, what did you think the patient was anxious, worried or distressed about? What led you to think this? (If you do not know, please say so).

3. Try to describe what you said or did to try to help the patient to become more calm, secure or assured. Please be specific and include as much detail as you can remember.

4. Please describe the effect on the patient of what you said or did, and explain what led you to this conclusion.

SECTION B: AN EXAMPLE OF A COMPLETED QUESTIONNAIRE

NUMBER 19

Try to describe the situation which led up to the event, including how you recognised that the patient was anxious, worried or distressed.

1 The patient I nursed was a patient who needed constant reassuring all the time.

2 I noticed that she was becoming distressed and worried when she was constantly talking, always walking about looking for a nurse, and always asking you to do little things that she knew she was capable of doing, but just wanted someone to be there.

3 She stopped being her usual happy, cheeky self and became more reclusive.

At the time, what did you think the patient was anxious, worried or distressed about? What led you to think this? (If you do not know, please say so).

4 The reason for this is that she had been with us for a long time, and someone had told her that she was being moved to a home, without consulting anyone.

5 At the time I did not know why she was worried, as she never said in specific words.

Try to describe what you said or did to try to help the patient to become more calm, secure or assured. Please be specific and include as much detail as you can remember.

6 Because I was on a late shift, I had time to sit down and talk.

7 I asked her what was worrying her, and to tell me slowly.

8 I sat down holding her hand, and telling her that I wasn't going to rush off anywhere, I was just going to sit and listen.

9 When she told me, I assured her that although she might be leaving, we still all loved her and would miss her just as much as she missed us.

10 Also that we weren't just 'pushing her' out, but that the move was for her good.

11 I also humoured her in saying that she'll soon forget us and she'll be rid of hospital food at last, and the early morning call she always hated.

12 At the time, the tea lady came round so I sat and had tea with her, because she was upset, all the time talking and reassuring.

Please describe the effect on the patient of what you said or did, and explain what led you to this conclusion.

13 After talking to her she became more her usual self.

14 She liked to hold people's hand, so it helped her to hold mine.

15 But she also asked a lot of questions and still needed constant reassuring after our little chat until the day she left.

16 I think it was because she was so attached and had got into a routine that she didn't want to leave, and was frightened to go to another place.

17 I think that her security was threatened, and left her very anxious and distressed.

SECTION C: WRITTEN INFORMATION FOR INTERVIEWS WITH PATIENTS

The written information given to patients when seeking their agreement to an interview was as follows:

I am a nurse tutor working in the School of Nursing at (name) Hospital. I am doing some research into how nurses and patients communicate, and I would like to talk to a number of patients about their stay in hospital.

I am particularly interested in hearing examples of times when patients were anxious or worried, and a nurse tried to help.

- Can you think of any times when you felt at all worried or anxious during your hospital stay?
- Did a nurse say or do anything to help you at this time?

All examples, even if they do not seem very important now, are useful to me.

If you have any examples which you are willing to tell me, I would like to record them on a small tape recorder. I will not keep any record of the name of any patient or member of staff. Usually I talk with patients for about 10-15 minutes.

The interviews are entirely voluntary.

I will ask you whether or not you are willing to talk to me, and will accept whatever you decide.

Kevin Teasdale
(Work Address)

SECTION D: THE SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH PATIENTS

1. Can you think of any time while you have been in hospital when you felt anxious or worried and a nurse tried to help you?

If yes, Please tell me about it.
If no, probe - Can you tell me about your first day in hospital this time? How did you feel?

2. For all incidents, recap the following:

a. What precisely were you worried about?
b. Did the nurse say or do anything else at the time?
c. How did the nurse's intervention make you feel?

3. Can you remember any other examples of times when you were anxious or worried and a nurse tried to help you?

If yes, Please tell me about it.
If no, Can you think of any times when you were anxious and a nurse did NOT help you?

4. When all incidents have been collected check the following :

Patient's Age
Reason for Admission
Usual Occupation
Date of all Incidents Recounted

In addition to the above, particular lines of enquiry were followed up with patients at different stages in theoretical sampling.

SECTION E: SAMPLE INTERVIEW WITH A PATIENT

KT refers to the researcher and PT stands for the patient.

INTERVIEW WITH PATIENT NUMBER 17

Female : 37 : ward orderly for this ward : hemi-colectomy 7 days earlier

1 KT - You actually work on this ward, do you?
PT - Yes. I've only been on here two months.

2 KT - Can you think of any times while you have been here when you were worried or anxious, and a nurse did something to try to help you to feel calmer?
PT - They were always there when you needed them. But I always felt they were rushed off their feet really. I think with the ratio of patients there should be more staff, more hands. It's hard work I think, cos I see them rushing about when I'm working, doing my cleaning. I've had a good stay.

3 KT - But you would have liked more time if you could have had it.
PT - Yes. I think when you come in like that, you don't know what's happening to you, it's a real emergency.

4 KT - So when you actually came in, were you frightened?
PT - Well I was a bit, because they didn't know what was wrong with me. I was really frightened. And nobody recognised me because I was in that much pain. They didn't recognise me for two days.

5 KT - Really?
PT - Yes. They reckoned I was that bad, you know pain, they didn't know me.

6 KT - You recognised them obviously?
PT - Yes. But they didn't recognise me. But they are very good, and worth their money when they get it.

7 KT - So, you said they are very busy, they are rushing around. What sorts of things would you have liked them to say to you or to give you, when you first came in? What would you have wanted?
PT - Well, somebody to sit with you and hold your hand. When you're in pain, you know, clutch hold of something. But you obviously can't have it if there's only two or three on at night.

8 KT - So you would have liked somebody to spend time with you, holding your hand, but in fact what did happen for your pain? Did a nurse spend time with you, or not?
PT - I think they did. You see I can't remember a lot of it. It was all hazy after they'd examined me. They gave me an injection, and I think it knocked me out a bit. I can't remember that much at all. Can't really add a lot more to that.

9 KT - Does anything come to mind as an example of something that was good? Even a small thing?
PT - Well when you ask, they do explain things, you know.

10 KT - What sort of things have you asked?
PT - Well I've asked how long the [wound] drain and everything would be here, and when it would come out. And if it would hurt. And they reassured me it wouldn't hurt.

11 KT - How did the nurse actually go about that?
PT - Well it was the male nurse that came to do the drain. Cos I don't like pain you see. And I said, 'It's not going to hurt is it?' And he said, 'I'll promise you it won't hurt at all.' And it didn't.

12 KT - It didn't?
PT - No. I didn't feel a thing. He must have known what he was talking about.

13 KT - When he said, 'I'll promise you it won't hurt', did you believe him or not?
PT - No. I didn't believe him. Because I think when you have things stuck in you, and they come out, they do hurt. But they pull so much out, then they pin it. But I'm lucky, because mine fell out this morning, so I've not had to have it, my body's rejected it.

14 KT - But, he said it wouldn't hurt, and you didn't believe him, and it didn't hurt!
PT - It's a good job I didn't bet him! Because I'm one of these people that's cynical, and I bet if I know it's going to happen, I'll bet. But I'd have lost my bet I'm afraid.

15 KT - Did it make any difference to you, him saying, 'It's not going to hurt', then?
PT - I think it did, it reassured me, because all the pain I'd gone through before when I came in, I didn't fancy any more.

16 KT - So it reassured you a bit, but you weren't entirely convinced?
PT - No. That's right.

17 KT - Would it make any difference if he were to come back now, and you had to have an injection, and you asked him, 'Will it hurt?', and he said, 'No it won't hurt' - would you be more likely to believe him this time or not?
PT - No I wouldn't because I know injections do hurt! I was surprised when it didn't hurt. Because I had my sister here this morning, and she's had a major operation about five years ago, and she had all these drains. I was saying, 'he's going to take mine out today', and when they pulled hers out they gave her a flannel rolled up in her teeth [for the pain]. Because they had a suction thing, and pulled them out, and they were really painful.

18 KT - That must have made you feel an awful lot worse then?
PT - It did. And then when the nurse came before they did the ward round, and said, 'Oh it's fallen out'. So obviously with a different type of drain . . .

19 KT - Do you think the male nurse knew you were worried?
PT - Well probably. I look anxious when I'm worried.

20 KT - How do you look? How would I know when you're anxious?
PT - Well, in my face, frowning, like that.

21 KT - Did he give you any information about what he was going to do?
PT - Yes. He told me about what he was going to do - cut it off two inches near the side, and then he was gong to cut the stitch and pull it out so much. Cut another piece off, then put a safety pin in to stop it from falling back into the site. He explained it well, before he did it. And I think it helps the patient as well, when they're explaining what they're doing.

22 KT - How did it make you feel?
PT - Well, it reassured me.

23 KT - Do you have any other examples then, of times when you were worried or anxious, and a nurse tried to do something to help you, and maybe succeeded or maybe didn't? I'm interested in both really.
PT - Well, I did have a tube down my nose and throat, and it was hurting on the third day, so I told the nurse. Said it felt as if my neck was swelling. So she had a feel and said it wasn't too bad, but she'd have a word with the doctor and see if they'd take it out, even though it was early days. Because it being the sort of operation I had, and she told him, when the doctor came, and he said if it was hurting that much, to take it out.

24 KT - What would you have done if the nurse had forgotten, or hadn't mentioned it to the doctor?
PT - I would have got on to him myself I'm afraid. I don't like pain!

END OF INTERVIEW

SECTION F: WRITTEN INFORMATION FOR INTERVIEWS WITH NURSES

I am a nurse tutor working in the School of Nursing at (name) Hospital. I am doing some research into how nurses and patients communicate, and I would like to talk to a number of nurses about their interactions with patients.

I am particularly interested in hearing examples of times when patients were anxious or worried, and you tried to help them to feel calmer or more secure.

All examples, even if they do not seem very important now, are useful to me.

If you have any examples which you are willing to tell me, I would like to record them on a small tape recorder. I will not keep any record of the name of any patient or member of staff. Usually I talk with nurses for about 20-30 minutes.

The interviews are entirely voluntary.

I will ask you whether or not you are willing to talk to me, and will accept whatever you decide.

Kevin Teasdale
(Work Address)

SECTION G: THE SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH NURSES

1. Can you think of any time recently when a patient you were nursing felt anxious or worried and you tried to help the patient to feel calmer or more secure?

If yes, Please tell me about it.
If no, probe - can you tell me about the clinical area where you are working now? What does your work involve? (Hoping to cue an incident.)

2. For all incidents, check the following if not mentioned spontaneously:

a. How did you first become aware the patient was anxious?
b. What did you think the patient was worried about?
c. What exactly did you say or do?
d. What do you think was the outcome of your intervention on the patient?

3. Can you remember any other examples of times when a patient was anxious or worried and you tried to help the patient to feel calmer or more secure?

If yes, Please tell me about it.
If no, Can you think of any times when a patient was anxious but you were unable to calm the patient?

4. When all incidents have been collected check the following:

Nurse's Years of Clinical Experience
Clinical Area where working at the time of the Incidents
Date of all Incidents Recounted

In addition to the above, particular lines of enquiry were followed up with nurses at different stages in theoretical sampling.

SECTION H: SAMPLE INTERVIEW WITH A NURSE

This interview pairs with that given by Patient 17. KT is the researcher, NU is the Nurse.

INTERVIEW WITH NURSE NUMBER 5

Male Charge Nurse : Surgical ward : 10 years experience in nursing : Incident took place one day earlier.

1 KT - In this example, when you came to take out this woman's drain . . .
NU - It was to shorten it actually.

2 KT - Can you remember how long ago it was?
PT - It was last night.

3 KT - Can you describe what you did, how you went about it, from the first contact with the woman?
NU - Basically the woman had been told that she was going to have her drain shortened, so I went in and explained that I was going to do it. I went away and got all the equipment to do it. Then I went back, explained the procedure to her. Explained that it wouldn't hurt, hopefully, and everything else. And then proceeded to cut the tubing, shorten it, put the pin in, put a bag over the top.

4 KT - Fine.
NU - During this time, one of the first years [student nurse] came in, and obviously she not having a great deal of aseptic technique experience, asked if she could watch. And I explained one or two things that I was going to do while I was in the process of doing it. And that's basically it.

5 KT - How was the woman feeling, do you think, when you first went into the room to tell her that you were going to shorten the drain?
NU - Well, she was sitting in the chair, watching the television, bright and cheerful. She's not in pain, and she's post-operatively doing very well.

6 KT - How did she react to the information that you were going to shorten the drain?
Nu - Well she didn't quite understand what that was. So after a little bit of explanation I think she understood what I was going to do.

7 KT - How did you know that she didn't understand?
NU - From her attitude.

8 KT - And how did you know what her attitude was?
NU - Well, the lady has a certain amount of knowledge of the NHS because she works within the system, and for that reason, I kept the minimum time of doing the technique as short as I could. Because I feel people that sometimes have a little bit of knowledge are more frightened if you take longer. And I did at a later date explain to the student that I would have, on maybe a non NHS worker, have taken a longer time explaining various things. But I personally felt in her circumstance, the shorter the exercise the better.

9 KT - Did you think then that she was nervous?
NU - Very. Because she does see a lot of it going on here, and I'm sure that although she doesn't have any in depth experience of it, she hears patients talking. So I felt that the quicker the exercise could be completed, the better.

10 KT - Was there anything you observed at the time you were with her that suggested she was nervous, or not?
NU - To be honest, no. She was very relaxed, she seemed very relaxed. When I told her that it wouldn't hurt, or I didn't think it would hurt, she looked at me with a great deal of doubt.

11 KT - She looked at you with doubt.
NU - But after that, once it was over, and I said to her, 'Well did that hurt?' and she said, 'No', and I said, 'I told you so', she seemed a little relieved. But because I hadn't given her much time to think about it, or to do anything, I think the whole thing went very well. Because I think, again being a hospital worker, and listening to patients - and some patients it can hurt or whatever - if I'd given her a long time to think about it, and spent a lot of time explaining, I think she would have been a lot worse the longer I'd gone on. So I just went and did it as quickly as I could, and I think that was the best approach. And after it had all finished, she was again somewhat surprised that it had all gone well, without any pain, or any complications or whatever. And she was very thankful about it.

END OF INTERVIEW

APPENDIX 3: THE DATA CLASSIFICATION SYSTEM

APPENDIX 3: THE DATA CLASSIFICATION SYSTEM

The system was divided into AREAS and CATEGORIES.

AREAS

AREA A: How the nurse first became aware of the patient's anxiety, worry or distress.
AREA B: The nature of the patients' reported concerns.
AREA C: The nurses' actions.
AREA D: The nurses' intentions.
AREA E: The outcomes of the nurses' interventions.

CATEGORIES IN EACH AREA

AREA A: How the nurse first became aware of the patient's anxiety, worry or distress.

Non-Verbals and Paralinguistics

A1.1 Tears
A1.2 Paralinguistics
A1.3 Facial Expression
A1.4 Tremor
A1.5 Condition of Skin
A1.6 Technical Observations
A1.7 Posture

Behavioural Signs

A2.1 Withdrawal
A2.2 Restlessness
A2.3 Other Behavioural

Verbal Signs

A3.1 Feelings Expressed
A3.2 Questions Asked
A3.3 Other Statements
A4 Alerted by Others
A5 Empathic Inference

AREA B: The nature of the patients' reported concerns.

B1 Health
B2 Treatment
B3 Physical Environment
B4 Possessions
B5 Staff
B6 Patients
B7 Relatives
B8 Being Discharged
B9 Other Concerns

AREA C: The Nurses' Actions.

Non-Verbal Behaviours

C1.1 Uses Touch
C1.2 Sits or Moves Close to the Patient
C1.3 Creates Privacy
C1.4 Adopts a Calm or Friendly Manner
C1.5 Spends Time with the Patient

Verbal Communicative Behaviours

C2.1 Asks a Question
C2.2 Allows or Encourages Conversation
C2.3 Suggests, Advises or Tells the Patient what to do
C2.4 Expresses Support or Understanding or Optimism

Gives Information to the Patient about . . .

C3.1 The Patient's Medical Condition
C3.2 The Patient's Treatment
C3.3 The Nurse as a Person (Self-Disclosure)
C3.4 The Environment of Care
C3.5 Relatives of the Patient
C3.6 Any Other Matters

C4 Gives Practical Help to the Patient

AREA D: The nurses' intentions.

D1 Prediction
D2 Support
D3 Patient Control
D4 Distraction
D5 Direct Action

AREA E: The outcomes of the nurses' interventions.

E1 The patient became calmer than before
E2 The patient briefly calmed, then became anxious again
E3 The patient remained anxious
E4 The patient became more anxious than before

APPENDIX 4: INTER-RATER RELIABILITY MEASURES

SECTION A: THE QUESTIONNAIRES

SECTION B: THE INTERVIEWS WITH PATIENTS

SECTION C: THE INTERVIEWS WITH NURSES

APPENDIX 4: INTER-RATER RELIABILITY MEASURES

SECTION A: THE QUESTIONNAIRES

Because of the length of the classification system, the questionnaires were rated in two parts. First raters were asked to make Area codings, then different raters were presented with data pre-coded for Area and asked to make Category codings. Cohen's (1960) coefficient of agreement for nominal scales was used to analyse all ratings.

TABLE 4.1: OVERALL AREA CODINGS

	% AGREE	K SCORE	Z SCORE	PROBABILITY
RATER A	95	0.92	15.4	< 0.001
RATER B	91	0.87	14.2	< 0.001

4.2: THE QUESTIONNAIRE CATEGORY CODINGS

A CODES	% AGREE	K SCORE	Z SCORE	PROBABILITY
RATER C	94	0.94	33.1	< 0.001
RATER D	97	0.96	34.3	< 0.001
B CODES				
RATER E	92	1.1	5.4	< 0.001
RATER F	93	1.1	5.2	< 0.001
C CODES				
RATER C	90	0.89	37	< 0.001
RATER D	92	0.91	37.9	< 0.001
D CODES				
RATER G	91	0.88	16.7	< 0.001
RATER A	95	0.93	17.9	< 0.001
E CODES				
RATER C	92	0.82	5.38	< 0.001
RATER D	100	—	—	—

SECTION B: THE INTERVIEWS WITH PATIENTS

TABLE 4.3: CODINGS

Category A was not coded for the interviews with patients. Using the resulting shorter classifcation scheme, raters coded Area and Category simultaneously.

B CODES	% AGREE	K SCORE	Z SCORE	PROBABILITY
RATER H	97	0.94	5.88	< 0.001
RATER A	80	0.69	4.93	< 0.001
C CODES				
RATER H	88	0.85	14.17	< 0.001
RATER A	94	0.94	18.8	< 0.001
D CODES				
RATER H	89	0.83	6.92	< 0.001
RATER A	92	0.88	7.33	< 0.001
E CODES				
RATER H	97	0.89	3.18	< 0.001
RATER A	93	0.77	2.66	= 0.004

TABLE 4.4: CODINGS

Category A was rated separately in the interviews with nurses. This shortened the length of the coding scheme for the remaining sections and so made it possible for Areas B-E to be rated for Area and Category simultaneously.

A CODES	% AGREE	K SCORE	Z SCORE	PROBABILITY
RATER D	92	0.91	18.2	<0.001
RATER J	90	0.89	17.8	<0.001
B CODES				
RATER H	83	0.79	8.78	< 0.001
RATER I	87	0.84	10.50	< 0.001
C CODES				
RATER H	90	0.89	29.67	< 0.001
RATER I	94	0.94	31.33	< 0.001
D CODES				
RATER H	96	0.95	13.57	< 0.001
RATER I	96	0.94	10.44	< 0.001
E CODES				
RATER H	97	0.89	3.07	= 0.001
RATER I	100	—	—	—