Interpersonal competence and communication in the delivery of nursing care

Despite the importance generally attributed to communication in nursing, little systematic attention has been directed toward exploring the interface between communication and the delivery of nursing care. The primary factors that have tended to impede research have been the inability of emerging models of nursing to conceptualize communication from an adequate perspective and level and the lack of theoretic exemplars for guiding specific lines of investigation. This article suggests that one potential exemplar for guiding nursing communication research lies in the area of interpersonal competence. It is suggested that research can be profitably aimed at understanding how the social cognitive and communicative abilities of nurses interrelate with the sociocultural context in health care to influence interpersonal competence.

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THREE GENERAL conceptual frameworks have provided impetus for theory construction in nursing: developmental models, systems viewpoints, and interactional perspectives.[1] Thibodeau[2] argues that emerging theories and models of nursing must necessarily take into account the interaction between the individual and the environment, the nature of health and illness, and the nature of the nursing process. These general conceptual frameworks also make implicit assumptions about the nature of communication.

CONCEPTUAL MODELS AND APPROACHES TO THE STUDY OF NURSING COMMUNICATION

Developmental model

A number of researchers have viewed the maintenance and restoration of health as a developmental process. Development is understood to be a function of the processes of interaction between the organism

and the environment. The goal of nursing is to maximize adaptation, the process whereby an individual copes with environmental contingencies imposed by the demands of illness.

Developmental positions have often tacitly embraced the psychotherapeutic orientation to communication, which stresses the importance of interaction as a resocializing process aimed at helping patients cope with the crisis of illness and maximizing patient adaptation. Although developmental models are not inextricably linked with the therapeutic perspective, it has exerted significant influence on thinking about the nature and function of communication in nursing.[3] It is often assumed that the communicative demands of therapeutic contexts are similar and that concepts governing interactions between therapist and client may be applied to encounters between nurse and patient.

The therapeutic perspective has its origin in humanistic and counseling psychology and rests in part on the assumption that the patterns of human interaction are directly related to patterns of health and illness. The therapeutic process is generally characterized as a resocialization in which patients enter into a relationship with a professional helper to correct defective communication and restore "normal patterns" of social interaction.

Therapy at its most basic level is an interpersonal and communicative process. Although there is little consensus with regard to what constitutes therapeutic communication, most investigators agree that communication in the context of medical therapeutics is that which is "health promoting." As Barnlund suggests, to understand therapeutic communication, there is a need to "identify the principles which make it possible for one human being, through his presence and manner of communication, to create conditions conducive to the effective functioning and personal growth of another."[4(p615)]

In extending the counseling viewpoint to the nursing context, it is assumed that the caregiver-patient relationship plays a central role in facilitating the aims of the nursing process. Given that the nurse-patient relationship is the primary agent of therapeutic change and that communication is the means by which relationships are established, competence in communication is a function of the caregiver's ability to develop and maintain functional relationships. Through empathy, self-disclosure, authenticity, and the therapeutic use of self, caregivers are able to establish helping relationships that maximize patient adaptation and promote favorable health care outcomes.[5]

Interactionist perspective

Theories of nursing that build on the interactional perspective[6] view nursing as a process of symbolic interaction and suggest that the process of nursing can be most profitably understood in terms of the ongoing interaction between caregiver and patient. The interactional viewpoint is a meaning-centered perspective, which suggests that nurses construct a subjective understanding of events through a conscious process of interpretation and use these meanings to guide their behavior. Interaction is understood as a reciprocal process in which each person is confronted with the task of constructing personal

actions by interpreting and defining the actions of others. The nursing process essentially involves interpreting the meaning of patient actions and indicating or defining for the patient appropriate actions necessary to achieve an optimal level of wellness.

From the interactional viewpoint, competence in communication depends on mutual role taking, "mutual role-taking is the sine qua non of communication and effective symbolic interaction."[7(p10)] A common misconception about the interactional position is the assumption that interaction is an exclusive function of the cultural norms embedded within social roles. Mutual role taking is influenced by social role expectations but primarily involves caregivers and patients engaged in a process of jointly fitting together lines of action to accomplish the socially defined goals of the nursing process. Role-taking ability is primarily a function of the knowledge interactants built up in the history of a relationship and their ability to take the role of the generalized other (internalization of knowledge shared by those socialized within a common culture).

Systems viewpoint

The systems viewpoint and its application to nursing has been well articulated.[8] Systems perspectives develop theory by studying the formal patterns of system structure, function, and process. From the systems viewpoint, humans are behaving organisms whose actions are organized, patterned, and structured to maintain a functional relationship with the social environment. The systems perspective does not use the individual as a point of departure, and unlike the interactional perspective, it tends to discount the role of perception and meaning in social interaction. From a systems vantage point, it may neither be important nor apparent why people act as they do, only that their observed patterns of behavior have functional implications for system maintenance and change.

Individual communication behavior is understood only in terms of how it intersects and affects the functioning of the system. Communication and behavior are treated synonymously. To behave is to communicate and to communicate is to exist in relationship with the system. Because this approach uses the individual's relationship to the system as a starting point for analysis, the issue of interpersonal competence is not addressed in systems analysis. Communication research aims at identifying the recognizable and recurring patterns or sequences of behavior that characterize the nature of the system.[9]

LIMITATIONS OF CURRENT APPROACHES

Despite the significant attention to theory building in nursing, there has been little systematic attention directed toward exploring the interface between communication and the delivery of nursing care. The primary factors that have tended to impede research have been the inability of emerging theories and models of nursing to provide an adequate conceptualization of communication or to furnish a heuristic framework for generating systematic investigation.

Given the emergent nature of the nursing field, it is often true that too little effort

is devoted to critical evaluations of the presuppositions and knowledge claims that underlie particular conceptual systems. Although an assessment of comparative approaches to nursing communication is beyond the scope of this article, even a cursory appraisal reveals that limitations of the therapeutic and systems perspectives obscure the symbiotic relationship existing between communication and nursing.

The therapeutic perspective encourages a philosophy of care, which is incompatible with the instrumental and interpersonal demands of many clinical situations. Extending the counseling paradigm to the domain of nursing tends to ignore the constraints on communication in the health care context and the intense commitment to task activity that characterizes the delivery of nursing care. Bormann captures the essence of therapeutic interaction in his discussion of communication styles.[10(pp85-86)] The therapeutic point of view encourages a style of communication that is not easily actualized in many nurse-patient interactions.

The therapeutic point of view conceptualizes communication from an inadequate perspective and level. It tells nurses how they should behave: be trusting, be empathetic, and increase self-awareness. But it provides little understanding of communication processes or of what happens when people try to create the shared understanding necessary for effective communication. It is difficult to link concepts such as interpersonal trust[11] and therapeutic use of self[12] with the nursing process, and it is more difficult to translate these concepts into specific strategies for accomplishing nursing goals and objectives. Ulys[12] catalogs a list of theoretic behaviors associated with each facet of the therapeutic self.

Concepts such as these are unlikely to provide a very fruitful point of departure for systematic research or a solid foundation for training programs designed to enhance interpersonal effectiveness. Although the establishment of a "helping relationship" can be a critical factor in the nursing process, the therapeutic perspective focuses inordinate attention on the relational dimension of communication and fails to adequately consider other important communicative functions.[13] The therapeutic perspective has enhanced understanding of caregiver-patient interaction in certain areas, but on the whole it does not appear to be a very fruitful path to understanding the nature and function of communication in nursing.

Systems application in nursing comes in many flavors, and there are often diverse interpretations regarding the nature and uses of the systems viewpoint. Given that professional goals in nursing often conflict with organizational and system maintenance and that almost all theories of nursing claim to use the individual as the starting point for analysis, it seems peculiar to embrace a conceptual framework that tends to subordinate the individual to the demands of the system.

Systems theory is often used to organize content outside the general assumptions of the systems viewpoint, which can result in a loss of internal consistency. For example, Roy and Roberts[14] attempt to weave together insights from the developmental and interactional viewpoints within a systems framework. Although the fusion of diverse perspectives often provides a useful vehicle for theory development, there is a

need to be sensitive to the implicit values that are often embraced when insights from diverse disciplines are incorporated.[15] As Fisher suggests, "to adopt the systems explanation is to adopt its conceptual base and not to make inferences about systemic concepts from another implicit conceptual base."[16(p201)]

The dangers of theoretical eclecticism and the difficulties of fusing the systems viewpoint with the therapeutic perspective are indirectly suggested by Carper when the question is raised of how nurses should reconcile the demands for authenticity in relationships with the "responsibility to control and manipulate environmental variables to restore a steady state."[17(p19)] Although the systems viewpoint may prove useful in building a theory of nursing, "a theory based on defective assumptions or a theory made inconsistent by inattention to its assumptions is obviously a less than ideal theory."[18(p140)]

The lack of communication research in nursing may result in part from reliance on the systems viewpoint, which has often provided a useful metatheory for organizing knowledge but has proven less useful for generating empirical research. Systems concepts do not lend themselves easily to empirical investigation. Concepts such as "helicy," "resonancy," and "complementarity"[19] are difficult to translate into concrete research activity.

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The systems perspective does not provide a foundation for understanding individual differences in communicative functioning and thus fails to provide a foundation for training programs designed to enhance interpersonal effectiveness. For example, Daubermire, Searles, and Ashton argue "that if a nurse can accurately observe in interaction and predict behavior patterns which tend to be problematic she can more readily identify intervention strategies to facilitate positive change in the behavior pattern."[9(p310)]

Locating and specifying all systemic factors that influence an event or process to facilitate the aims of prediction may prove an unrealistic goal, given the complexity of nursing care. Because systems theory had little to say about the underlying process of communication, it is never clear how communication might be used strategically in the intervention phase of the nursing process. The systems framework has proven useful in encouraging researchers to consider all the potential factors that influence the nursing process. However, systems thinking has not contributed much to understanding caregiver-patient interaction in the delivery of nursing care.

INTERPERSONAL COMPETENCE: AN ALTERNATIVE PERSPECTIVE

Despite the lack of concrete research exemplars, a number of theorists have recognized the centrality of communication in the delivery of nursing care. As Auld argues, "for too long we have followed the traditional medical model of

teaching disease patterns, instead of placing emphasis on the need for social interaction between nurse and patient. . . ."[20(p234)] Henderson agrees that the adoption of primary nursing and patient assignment is likely to enhance the need for effective caregiver-patient interaction.[21] Thibodeau defines the nursing process as a problem-solving activity that promotes health by restoring or maintaining the dynamic equilibrium between the person and the environment.[22(p82)] Because communication is the means by which both caregivers and patients interact with and adapt to the demands of the environment, a comprehensive theory of nursing will need to provide an account of the nature and function of communication in the delivery of nursing care.

Many investigators have recognized the insights that can be gained and the contribution that other disciplines can make to the development of nursing theory. To be of maximum utility in organizing communication research in nursing, a theory of communication should:

- be consistent with some of the evolving theoretical perspectives in nursing and illumine the role of communication in the nursing process;
- provide a means of tapping individual differences in the communicative behavior of caregivers;
- furnish a foundation for theory-based training programs designed to enhance interpersonal effectiveness; and
- provide a heuristic framework for guiding concrete research activity.

Given the limitations of the therapeutic and systems perspectives, it is suggested here that a potentially fruitful explanatory framework for linking communication and nursing lies in the area of interpersonal competence. Although there are many communication perspectives that could be adopted, this perspective on interpersonal competence is particularly well suited to meet the demands of the nursing profession.

As the health sciences have begun to escape the confines of "physiological reductionism," nursing has been at the forefront of the movement toward a more holistic view of health, which focuses increasing attention on the active nature of persons and the way in which health and illness are experienced by each individual. The perspective on competence presented here is generally consistent with the interactional model of nursing and is grounded in a theory of interpersonal interaction[22] that recognizes the active way in which caregivers and patients organize and structure their interactions in adapting to the demands of the environment.

The nursing process aims at the attainment, maintenance, and restoration of health and is intricately linked with the diagnosis and treatment of the human response to illness. Given the changing patterns of disease and illness and the emergence of chronic and degenerative diseases as pervasive health care problems, caring is becoming a critical dimension of medical care. The task of caring will increasingly center on the impact of illness on the individual's psychological and social performance systems[23] and will likely be an area of professional responsibility that falls beyond the curative power of the physician. It is in the promotion of psychosocial adaptation that the link between

communication and the nursing process can be most clearly seen.

Although helping patients adapt to the demands of illness is recognized as an important goal in nursing, many models of nursing lack a specific discussion of the skills and competencies that can be energized to maximize adaptation. Katriel and Philipsen[24] have argued that as a cultural category, communication is the "work" we do to accomplish interpersonal tasks. A theory of interpersonal competence helps to elaborate how communication works to accomplish the goals of the nursing process. The dominant metaphor that underlies this approach to competence is "communication as resource." Communication provides a resource that caregivers can use to accomplish the interpersonal and instrumental goals of the nursing process.

Schaefer[25] suggests that an approach to medical science that recognizes the importance of the individual requires a comprehensive knowledge of individual differences in physiological function and the interrelationship with the organism and the environment. Just as the health sciences are increasingly recognizing individual variability in response to illness, a theory of interpersonal competence suggests how systematic differences in the control over the resources of communication influence interpersonal effectiveness. Hardy[26] argues that many models of nursing prevent overly restrictive views by focusing inordinate attention on the patient. The integration of communication and nursing provides a foundation geared for maximizing the interpersonal resources of the individual caregiver by elaborating specific skills and competencies that are applicable to a wide range of clinical situations and that are likely to improve the effectiveness of nurses in caring for patients.

Because of the complex communicative demands of the nursing profession, it is unlikely that an adequate explanation will emerge from a narrow theoretical viewpoint. This discussion presents a theoretical viewpoint that weaves together diverse perspectives in attempting to articulate a problematic set of issues and questions for guiding competence research in the delivery of nursing care.

In attempting to account for individual differences in control over the resources of communication, a competence-based approach draws attention to the full range of communicative skills and competencies involved in social interaction. Interpersonal competence depends on the social cognitive, behavioral, and cultural resources of communication that underlie the individual's capacity to anticipate, control, and flexibly adapt to the demands of the social environment.

SOCIAL COGNITIVE COMPETENCE

Social cognitive competence is a function of the individual's progressive capacity to control the interpretive and attributional inference processes involved in social perception. Social cognition refers to the way in which people acquire, organize, and give meaning to the information they use to formulate beliefs, goals, and plans that permit successful transactions with the environment and with others.[27] Communication at its most basic level is a process of social perception and of con-

structing an impression of the actions and attitudes of others by interpreting aspects of their appearance and behavior. This is one of the central processes underlying social interaction.

Viewing interaction as a process of social perception assumes that no one person perceives or interprets other people in exactly the same way, and thus, there are genuine individual differences that must be bridged to create the shared understanding necessary for effective communication. These individual differences can be bridged to a certain extent through perspective taking: the ability to interpret, understand, or make judgments about the viewpoint of other persons.

The concept of perspective taking has been studied from a number of theoretical orientations.[28,29] It can be defined as a social perception process in which inferences are made about situations, other persons, and the inferences of other persons. All persons in varying degrees approach interaction with an egocentric orientation, and social competence is in part a function of an individual's capacity to escape the confines of personal perspective and to assume or construct the viewpoint of the other person.[30]

The concept of perspective taking calls attention to the full range of interpretive processes involved in constructing the psychological characteristics and capabilities of others. Constructing the perspective of the other person embraces making an effort to understand how another thinks and parallels the type of analysis involved in looking at oneself from another's point of view. It involves decentering, a conscious process of differentiating between the personal view of the situation and the view of another person. As Looft suggests, the process of perspective taking involves cognitive decentering, in which a person recognizes the existence of personal needs and affective states and comes to differentiate cognitively among several aspects of an event and personal point of view, as opposed to the view of another.[31(p74)]

Perspective taking involves more than taking the role of the other or asking, "What would I do if I were in this patient's shoes?" It implies a sensitivity to the individuality of a patient's point of view and an ability to view a person not only in the role of patient but also in terms of the unique motivational and dispositional characteristics brought to the illness role.

Constructing the perspective of the other person embraces making an effort to understand how another thinks and parallels the type of analysis involved in looking at oneself from another's point of view.

Flavell[32] identifies four components of listener analytic ability: existence, need, inference, and application. To be able to engage in perspective taking, nurses need to recognize the existence of subjective viewpoints and the significant variation in the way in which individuals adapt to the demands of illness. Nurses also must recognize when a consideration of the patient's point of view is called for in a particular communication transaction. Even though caregivers are sensitive to the existence of subjective viewpoints and recognize that certain encounters in health care demand this type of social understanding, nurses must still develop the

necessary inferential skills to make appropriate attributions about the patient's perspective. One important dimension of perspective taking is to overcome the natural tendency to evaluate the beliefs and actions of others from a personal point of view.[33]

Finally, caregivers must be able to translate inferences about the patient into an effective or appropriate message. The ability to understand the other's characteristics and perspective provides the basis for the construction of strategic messages.

Ability in perspective taking allows caregivers greater access to the affective, behavioral, and clinical data necessary for health care problem solving. A nurse's ability to use communication as a resource is limited by the alternatives perceived in a given situation. The ability to assess the patient's perspective and the basis of that perspective (attitudes, beliefs, and values) expands the range of alternatives or options available for constructing strategic messages and adapting communication to the specific needs of a particular patient. Sensitivity to the diversity of perspectives encountered in the delivery of nursing care is likely to enhance the ability of caregivers to anticipate and predict individual response to illness.

A person must be able to negotiate and manage the differences in perspectives in order to flexibly adapt communication to the demands of different patients and situations. The ability to communicate effectively depends in part on ability in perspective taking. Because of the close relationship between social perception and behavior, perspective taking provides a foundation for strategic message competence.

STRATEGIC MESSAGE COMPETENCE

Interpersonal competence also depends on caregiver capacity to use language strategically in the intervention phase of the nursing process. Reflective control over the resources of language better enables a person to influence another's beliefs and perceptions, adapt messages to different persons and situations, and control the outcomes of interaction to facilitate the accomplishment of interactional objectives.

In attempting to understand the way in which communication can be used as a strategic resource, a functional perspective can be adopted that points to the purposes toward which communication can be controlled to accomplish personally defined ends and goals.[34] To study communication in nursing from a functional perspective should lead to the development of "situation producing theory" by consideration of directly important communication-relevant goals central to the process of nursing.[35]

To maximize nursing effectiveness, caregivers need to develop a repertoire of verbal strategies that can be used in the pursuit of interpersonal and instrumental goals and objectives. Strategy is a term used to describe the choices and plans made or the lines of action taken in attempting to translate personal goals in a particular transaction into actual behavior. Strategies can be inference patterns, schemes for framing ideas, or general lines of argument for presenting ideas and altering beliefs. Competence in communication depends in part on the development of strategies, tactics, and routines to accom-

plish four basic communicative functions: regulative, relational, identity, and instructional. In the context of nursing, each of these functions represents ways in which nurses can use communication to maximize patient adaptation.

Instructional function

The instructional function refers to the ways in which nurses use language to convey information. Informational messages express ideational content and identify, classify, and analyze the facts relevant to a particular situation. Communication is the primary vehicle by which caregivers transmit the information and knowledge necessary for helping patients adapt to the demands of the health care system. Communication is used primarily by nurses as a resource to secure information for diagnosis, explain mode of treatment, offer nursing recommendations, facilitate the aims of health promotion, and meet the educational needs of patients and their families.

Relational function

The relational function refers to the way in which communication is used to establish, manage, and alter the relational contract existing between caregiver and patient. Relational talk functions as metacommunication by implicitly describing each person's view of the nature of a relationship.[36] In nursing, the establishment of a functional caregiver-patient relationship provides a resource for dealing with the psychosocial and emotional dimensions of illness, for securing cooperation and compliance (referent power), and for maximizing self-care by encouraging mutual participation in health care decision making.

Identity function

The identity function refers to the way in which communication is used in the presentation of self and in the control and management of identities in interaction.[37] Nursing, by its very nature, is a process of self-repair and self-renewal,[38] and communication provides caregivers with a vehicle for helping patients sustain a valid identity in the process of coping with the demands of illness. Although identity management in interaction generally operates at an implicit level, the ability to use language strategically to create an identity for another (altercasting) that is congruent with personal objectives appears to be an important skill in patient care. Positive altercasting (face support), in which nurses are able to provide patients with a more positive set of beliefs about self, is one way in which nurses can use communication to enhance patient ability to adapt to the demands of illness.

Regulative function

The regulative function refers to the way in which communication is used as a tool of social influence to control the environment and regulate individual behavior. Nurses can use communication to influence the health-relevant beliefs and behaviors of patients in order to secure compliance and adherence with medical regimen. Compliance is a particularly important problem for health care providers and remains somewhat of a paradox in the delivery of medical care. Despite dramatic advances in treatment and diagnosis,

a significant percentage of patients do not comply with medical directions.[39] Because providing patients with information is often a necessary but insufficient basis for securing adherence, caregivers need to recognize the ways in which communication can be used as a tool for interpersonal influence.

Strategic message competence is a function of the ability to construct verbal strategies that consider multiple communicative aims and are adapted to the demands of different persons and situations. An evolving line of research represented by the work of Clark[40] may prove useful in discovering effective ways for nurses to present ideas to patients for the purpose of accomplishing the goals of the nursing process. A functional approach to the study of language presupposes that embedded within any interactional episode are simultaneously multiple communicative goals. Although the dominant objective in a situation may be regulative in nature, issues relevant to patient identity and interpersonal relationships must often be considered in formulating strategic messages.

A difficult challenge in the delivery of nursing care is to regulate patient behavior while maintaining the positive face of the patient as well as a functional caregiver-patient relationship. For example, a blind diabetic patient maintained on dialysis who is experiencing a general sense of helplessness and displaying significant anger and hostility toward staff members may exhibit a high degree of noncompliance. In using communication to secure patient compliance, caregivers would have to provide general lines of argument for persuading the patient to follow the medical regimen, as well as create strategies that deal with the potential obstacles to compliance (helplessness and relational conflict). The competent communicator may be better able to recognize dominant and subsidiary objectives within a particular encounter, construct messages that address multiple communicative aims, and adapt communication to the demands of different persons and situations.

The ability to adapt messages to the unique demands of persons and situations is also an important component of strategic message competence. The concept of communication adaptation can be understood by briefly looking at the social world of the child. In a number of studies, researchers have asked children to role play persuading their mothers to have an overnight birthday party.[41] The communication of younger children is often characterized by saying "please" or begging: "I want a party. Can I have one? Can I have one? Huh? Huh? Can I?"

With increasing age, children develop the ability to adapt communication by articulating advantages that would occur to another as a result of accepting the persuasive request: "You've been saying you wanted to get to know my friends better; if you let me have a party you can get to know them." In the nursing context, the movement away from routine and ritualized communication behavior toward interaction more explicitly adapted to the subjective motives and feelings of patients is likely to be a particularly important dimension of communicative competence.

Although there is not a set of component skills that can be learned to ensure competence in all situations, individuals do have the capacity to develop communica-

tive resources that permit greater autonomy, flexibility, and control. Competence is not primarily a function of learning what constitutes appropriate communicative conduct; it involves developing an interpersonal orientation characterized by flexibility. The overt conscious control over the modes of representing others and the ability to construct complex messages adapted to the demands of difficult persons and situations provide a basis for flexible communicative functioning.

DIRECTIONS FOR RESEARCH

The application of theory and research in interpersonal competence to the context of nursing suggests a number of fruitful avenues for future research. Research can be profitably aimed at understanding how the social cognitive and communicative abilities of nurses interrelate with the sociocultural context in health care to influence interpersonal competence.

Social cognitive competence

Nursing effectiveness depends in part on understanding the needs of the patient and being able to translate that knowledge into effective communicative action. Everyday social interaction does not usually demand a highly reflective mode of social inference making. However, accomplishing communication-relevant goals in nursing often depends on the capacity to understand the subjective viewpoint of the patient and to use this knowledge to guide health care problem solving. Although the role of perception in nurse-patient interaction has been investigated in a number of studies, no investigators have looked directly at the role of perspective taking in the delivery of nursing care. Future research might be profitably aimed at understanding the role of perspective taking in clinical decision making and nursing diagnosis.[42]

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Because people evolve different ways of viewing and orienting themselves toward others, the capacity to interpret and understand the viewpoint of another is not an ability possessed equally by all. Research needs to center on the nature and extent of these individual differences and their functional implications for interpersonal behavior in the delivery of nursing care.

Functional-behavioral competence

In the behavioral domain, research should focus on the way in which nurses use ordinary language strategically to accomplish interpersonal tasks. Although social support has been investigated in a number of studies,[43] little systematic attention has been directed toward looking at the specific verbal strategies used in caregiver-patient interactions. Because nursing remains a female-dominated profession and because women historically manifest higher levels of communicative competence,[44] the systematic observation of the communication behavior of nurses is likely to provide unique insights into the nature of strategic message competence.

Research should try to provide answers to the following types of questions. What specific verbal strategies do nurses use with patients in attempting to accomplish regulative, relational, identity, and instructional goals and objectives? What do nurses report they were trying to accomplish in specific interactions with patients? What are the consequences of particular strategies on the health-relevant beliefs and behaviors of patients? Identifying how communication functions in the delivery of nursing care, clarifying the potential obstacles that constrain the accomplishment of communication objectives, and establishing taxonomies of strategies that work to fulfill these functions should provide a utilitarian point of departure for studying strategic message competence in the delivery of nursing care.

POTENTIAL INFLUENCE OF THE HEALTH CARE CONTEXT ON INTERPERSONAL BEHAVIOR

Competence in communication also depends in part on the acquisition of the cultural knowledge shared by those socialized within a common culture or social group. In the process of socialization, nurses acquire generative systems of meaning and interpretation that organize and influence interpersonal behavior. Cultural knowledge refers to the beliefs, values, and rules that implicitly govern communication in the health care context. Individual differences can be bridged to a certain extent because there are rules, norms, and routines that set standards for appropriate communicative conduct in the various situations encountered in the health care arena. The relationship between the cultural context in health care and communication can be described in terms of three interrelated levels of context: cultural, socioinstitutional, and situational.

Cultural influences on communication

The cultural level of context embraces the assumed knowledge that organizes and influences the general patterns of group life within the social world of nursing. At the cultural level, research can be directed toward understanding how sociocultural and demographic antecedents influence interpersonal behavior. How do variables such as age, sex, educational level, and social class influence social cognitive and communicative competence? For example, given the diverse educational levels that characterize the nursing profession, the nature and duration of professional training may account in part for differences in interpersonal competence.

Although sociocultural antecedents can provide a baseline for comparative analysis, they furnish only a surface level understanding of the specific factors that may account for the regularity and variability in communication behavior. This suggests the utility of incorporating more refined analysis of possible cultural influences on the study of the communication behavior of nurses. This might be accomplished by observing the functional communication behavior of nurses in other social contexts and comparing it to behavior in the health care context. It may also be useful to construct a descriptive culturally based theory of speaking that is characteristic of the nursing profession.

Implicit communication theories provide the assumptive ground on which personal beliefs about the nature of communication are based. Different social groups within medicine may emphasize different functions of communication, and through socialization, individuals within these groups acquire value orientations that tell them the purpose of communication and what constitutes competent communication. Participation, observation, and ethnographic analysis seem most appropriate for uncovering how implicit communication theories orient nurses toward certain modes of interpersonal behavior.

Roles, rules, and relationships

The socioinstitutional level accounts for the way in which the value structure within institutionalized role and relational systems organizes, facilitates, and constrains interpersonal behavior. Although significant attention has been devoted to the physician-patient relationship, there is no similar literature and there are no similar models of the nurse-patient relationship or the nurse-physician relationship. As chronic and degenerative diseases have become pervasive health care problems, the dynamics of the traditional nurse-patient relationship have changed. Within nursing there are many categories of relationships that differ in duration and intensity and are likely to develop different sets of relational rules and different interactional histories.[45] Research might profitably proceed by studying relationships developmentally to identify the stages of different types of relationships and the interactional dynamics that characterize each behavioral stage.[46]

Role systems within health care are likely to exert a significant influence on interpersonal behavior. Research needs to provide a more precise description of the relationship between role systems in health care and social cognitive and communicative competence. The work of Bernstein[47] provides a conceptual framework for explaining how role systems within nursing influence communication behavior. Bernstein argues that cultural symbol systems orient individuals toward certain modes of interpersonal behavior (position-centered and person-centered speech). The difference between these two styles is reflected in the degree to which communication is oriented toward individual differences or grounded in the generalized rule and role structure operating in a particular social group. The distinction between position-centered and person-centered behavior has proven useful in preliminary work aimed at understanding how role systems within nursing influence interpersonal competence.[48]

Impact of the situation on interpersonal behavior

The situational level points to the way in which ecologic and situational constraints influence interpersonal behavior. The physical properties, task requirements, and types of caregivers and patients involved in a situation are likely to vary widely in the hospital context. Research might profitably proceed by describing the social ecology and interactional demands of various clinical settings and the rules, norms, and routines that characterize communication within particular health care contexts.

There is also a need for research

exploring the relationship between nurses' personal definition of the situation and their interpersonal behavior. The definition of the situation is a concept derived from the interactionist perspective and refers to personal beliefs about the rules and norms governing conduct in a particular situation.[49] Different situations in health care are likely to impose different communication demands on the participants. For example, Emerson, in her study of gynecologic examinations suggests that "many situations where the dominant definition is occupational or technical, also have a secondary theme of sociality which must be explicitly acknowledged."[50]

Are there individual differences in the way in which caregivers view the norms and rules governing communication within a particular situation? To what extent is a nurse's definition of the situation shaped by interaction with other caregivers? How do nurses and patients differ in their perceptions of the interpersonal climate that characterizes a particular situation? Do these perceptions differ in situations in which there is considerable person-centered talk?

There has been little research to determine how various situational factors constrain the interpersonal capital a nurse is willing or able to invest in meeting the communicative demands of psychologically demanding clinical settings. How does the nature of the situation facilitate and constrain communicative competence? Is there a gap between the communicative potential of nurses and actual performance because of the demands of the situation? In this regard, research should focus on factors that impinge on the emotional state of the nurse, to determine if the psychological demands of various clinical settings foster cognitive and communicative regression.

RESEARCH STRATEGY

Research that investigates the interface between nursing and communication should employ diverse methodological approaches and address the difficult challenge of linking communicative competencies with health care outcomes. The interactional demands of the nursing context are complex, and researchers adopting triangulated methodological approaches using both quantitative and qualitative approaches stand the best chance of understanding communication behavior in the delivery of nursing care. For example, there are three primary methods for assessing the strategic message behavior of caregivers:

1. to provide nurses with a list of strategies and ask them which they would use in a particular situation[51];
2. to have nurses actually produce messages in response to role play situations[52]; and
3. to use an ethnographic participant-observational approach, and record the actual strategies employed in caregiver-patient interactions.

Chances for knowledge are enhanced through the use of diverse methods in diverse settings. Thus, it is preferable to compare checklists and free response measures with naturalistic observational accounts to enhance validity and better understand how interpersonal orientations are actualized in everyday interactions. In the rush to be "scientific," researchers

often adopt highly quantitative approaches and overlook the insights that can be gained from the systematic description and interpretation of naturally occurring communication behavior.[53]

Perhaps the most critical question for research that links communication and nursing is whether individual differences in interpersonal competence are important. Hinshaw and Atwood[54] argue that the relations among care activities and outcomes for the patient must be systematically traced to provide evidence of impact on client health. Grypdonck[55] agrees that the central question guiding research efforts should be: "What difference does it make to the patient?" The research landscape is particularly barren of studies of the relationship between what nurses actually say to patients and selected health care outcomes.

In the evolution toward a more health-oriented system of care, the role of the nurse will be increasingly expanded, and there will be an increase in patient-centered or primary nursing.

In the evolution toward a more health-oriented system of care, the role of the nurse will be increasingly expanded, and there will be an increase in patient-centered or primary nursing. Although many investigators argue that the primary focus of nursing should remain on "tasks of care," it is often obscured that caring requires a well-developed repertoire of interpersonal skills and competencies. A persistent problem in nursing communication research has been the inability of emerging theories and models of nursing to link the process of caring with the process of communication. The theory and research in interpersonal competence will probably be useful in linking the process of caring with the process of communication and in making an important contribution to nursing theory and research. It is likely that establishing interdisciplinary research partnerships can serve as a catalyst for intensified research efforts that will increase understanding of the symbiotic relationship between communication and the delivery of nursing care.

REFERENCES

1. Riehl JP, Roy C: *Conceptual Models for Nursing Practice*, ed 2. New York, Appleton-Century-Crofts, 1980.
2. Thibodeau JA: *Nursing Models: Analysis and Evaluation*. Monterey, Calif, Wadsworth, 1983.
3. Travelbee J: *Interpersonal Aspects of Nursing*, ed 2. Philadelphia, FA Davis Co, 1971.
4. Barnlund D: *Interpersonal Communication: Survey and Studies*. Boston, Houghton Mifflin, 1968.
5. Forsyth GL: Analysis of the concept of empathy: Illustration of one approach. *Adv Nurs Sci* 1979;1:53-62.
6. Riehl JP: The Riehl interaction model, in Riehl JP, Roy C (eds): *Conceptual Models For Nursing*, ed 2. New York, Appleton-Century-Crofts, 1980, pp 350-356.
7. Blumer H: *Symbolic Interactionism: Perspective and Method*. Englewood Cliffs, NJ, Prentice-Hall, 1968.
8. Altschul AT: A systems approach to the nursing process. *J Adv Nurs* 1978;3:333-340.
9. Daubermire JJ, Searles S, Ashton CA, et al: A methodologic framework to study nurse-patient communication. *Nurs Res* 1978;27:303-310.
10. Bormann E: *Communication Theory*. New York, Holt, Rinehart & Winston, 1980.
11. Northouse P: Interpersonal trust and empathy in

nurse-patient relationships. *Nurs Res* 1979;28:365-368.
12. Ulys LR: Towards the development of an operational definition of the concept "therapeutic use of self." *Int J Nurs Stud* 1980;17:175-189.
13. Vaughn R, Burgoon M: Interpersonal communication in the therapeutic setting. Mariah or messiah, in Miller GR (ed): *Explorations in Interpersonal Communication*. Beverly Hills, Calif, Sage Publications, 1976, vol 5.
14. Roy SC, Roberts SL: *Theory Construction in Nursing: An Adaptation Model*. Englewood Cliffs, NJ, Prentice-Hall, 1981.
15. Kritek PB: Commentary: The development of nursing diagnosis and theory. *Adv Nurs Sci* 1979;2:73-80.
16. Fisher BA: The pragmatic perspective of human communication: A view from system theory, in Dance FEX (ed): *Human Communication Theory: Comparative Essays*. New York, Harper & Row, 1982, pp 192-219.
17. Carper BA: The ethics of caring. *Adv Nurs Sci* 1979;3:11-20.
18. Delia JG, O'Keefe BJ, O'Keefe DJ, et al: The constructivist approach to communication, in Dance FEX (ed): *Human Communication Theory: Comparative Essays*. New York, Harper & Row, 1982, pp 147-191.
19. Rogers ME: Nursing: A science of unitary man, in Riehl JP, Roy SC (eds): *Conceptual Models for Nursing Practice*. New York, Appleton-Century-Crofts, 1980, pp 329-337.
20. Auld MG: Nursing in a changing society. *J Adv Nurs* 1979;4:287-298.
21. Henderson V: The concept of nursing. *J Adv Nurs* 1978;3:75-84.
22. O'Keefe BJ, Delia JG: Psychological and interactional dimensions of communicative development, in Giles H, St Clair R, Hewstone M (eds): *Language and the Paradigms of Social Psychology*. Hillsdale NJ, Erlbaum, to be published.
23. Kasch CR: Communication, adaptation, and the restoration of psycho-social competence: Understanding the impact of chronic illness. Read before the annual meeting of the American Association of Nephrology Nurses, Chicago, Ill, Oct 9-12, 1982.
24. Katriel T, Philipsen G: What we need is communication; Communication as a cultural category in some American speech. *Commun Monogr* 1981;48:302-316.
25. Schaefer K: Introduction, in Schaefer K, Hensel H, Brady R (eds): *Toward a Man-Centered Medical Science: A New Image of Man in Medicine*. New York, Future, 1977, vol 1.
26. Hardy LK: Nursing models and research—A restricting view? *J Adv Nurs* 1982;7:447-451.
27. Schlenker BR: *Impression Management: The Self-concept, Social Identity and Interpersonal Relations*, Monterey, Calif, Brooks/Cole, 1980.
28. Flavel JH, Botkin PT, Fry CL, et al: *The Development of Role Taking and Communication Skills In Children*. New York, Wiley, 1968.
29. Selman R: *The Growth of Interpersonal Understanding: Developmental and Clinical Analysis*. New York, Academic Press, 1980.
30. Roberts SL: Piaget's theory applied to the critically ill. *Adv Nurs Sci* 1980;2:61-78.
31. Looft MR: Egocentrism and social interaction across the life span. *Psychol Bull* 1972;78:75-92.
32. Flavell JH: The development of inferences about others, in Michel T (ed): *Understanding Other Persons*. Totowa, NJ, Rowman and Littlefield, 1974, pp 66-116.
33. Jones EE, Nisbett R: *The Actor and the Observer: Divergent Perceptions of the Causes of Behavior*. New York, General Learning Press, 1971.
34. Clark RA, Delia JG: Topoi and rhetorical competence. *Q J Speech* 1979;65:187-206.
35. Dickoff J, James P, Wiedenbach E, et al: Theory in a practice discipline: Part I. Practice-oriented theory. *Nurs Res* 1968;17:415-435.
36. Watzlawick P, Beavin J, Jackson D, et al: *Pragmatics of Communication: A Study of Interactional Patterns, Pathologies, and Paradoxes*. New York, Norton, 1967.
37. Goffman E: *The Presentation of Self in Everyday Life*. Garden City, NY, Doubleday, 1959.
38. Bergsma J, Thomasma D: *Health Care: Its Psychosocial Implications*. Pittsburgh, Pa, Duquesne University Press, 1982.
39. Haynes RB, Taylor DW, Sackett DL (eds): *Compliance in Health Care*. Baltimore, Johns Hopkins University Press, 1979.
40. Clark RA: The impact of self interest and desire for liking on selection of communicative strategies. *Commun Monogr* 1979;46:257-273.
41. Delia JG, Clark RA: Cognitive complexity, social perception, and the development of listener-adapted communication in six, eight, ten, and twelve-year-old boys. *Commun Monogr* 1977;44:326-345.
42. McLaughlin EA: Current priorities in nursing research. *Adv Nurs Sci* 1979;1:79-82.
43. Dimond M, Jones SL: Social support: A review and theoretical integration, in Chinn PL (ed): Advances in Nursing Theory Development. Rockville, MD, Aspen Systems Corporation, 1983, pp 235-249.
44. Gilligan C: Why should a woman be more like a man? *Psychol Today* 1982;16:69-77.

45. Delia JG: Some tentative thoughts concerning the study of interpersonal relationships and their development. *West J Speech Commun* 1980;44:97-103.
46. Duck SW, Gilmour R (eds): *Personal Relationships: II. Studying Personal Relationships.* London, Academic Press, 1981.
47. Bernstein B: *Class, Codes, and Control: Theoretical Studies Towards A Sociology of Language* (rev ed). New York, Schocken Books, 1974.
48. Kasch C: *Interpersonal Competence and Communication in the Delivery of Nursing Care; Selected Studies,* dissertation. University of Illinois at Urbana-Champaign, 1983.
49. Ball DW: The definition of the situation: Some theoretical and methodological consequences of taking W. I. Thomas seriously. *J Theory Soc Behav* 1972;2:61-82.
50. Emerson J: Behavior in private places: Sustaining definitions of reality in gynecological examinations, in Drietzel HP (ed): *Recent Sociology: II.* New York, Macmillan, 1970, pp 73-97.
51. Miller GP, Booster F, Roloff M, et al: Compliance-gaining message strategies: A typology and some findings concerning effects of situational differences. *Commun Monogr* 1977;44:37-51.
52. Clark RA: Suggestions for the design of empirical communication studies. *Cent States Speech J* 1979;30:51-66.
53. Denzin NK: *The Research Act.* Chicago, Aldine, 1970, pp 255-274.
54. Hinshaw A, Atwood J: Theoretical model testing in nursing care to patients: An operative trajectory study, in Philips T (ed): *From Accommodation to Self Determination: Nursing Roles in the Development of Health Care Policy.* New York, American Academy of Nursing, 1982, pp 16-27.
55. Grypdonck M, cited by Hardy LK: Nursing models and research: A restricting view? *J Adv Nurs* 1982;7:447-451.