A CONTINUING EDUCATION 
WORKSHOP ON HUMAN 
RELATIONS SKILLS

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Nursing has long been considered a profession directed towards helping others. However, in the nursing world of today, with so many technological advances, and such rapidly changing scientific knowledge demanding time and attention, the interpersonal skills which are basic to a helping relationship are not, in the author's estimation, being adequately developed.

Increasing levels of technology have resulted in a dehumanization of health care. Consumer groups are voicing their dissatisfaction. If one listens closely, it is usually lack of human contact rather than physical care which is being condemned. Patients complain of being treated like numbers, of being made to wait long, anxious periods for tests and consultations, and of inadequate or non-existent explanations regarding their conditions or treatments.

The time has come for intensive human relations skills training for nurses and all other health professionals. The majority of nurses who enter the nursing profession do so because they genuinely care about, and want to help, others. Unfortunately, this is not enough. The ability to communicate effectively and truly help others is for most a skill that must be learned.

Research conducted by La Monica in one health care facility showed that many of the nurses possess extremely low level of empathy. A subsequent human relations skills program was effective in improving this situation. The need for a proliferation of such programs cannot be overemphasized.

In a doctor-patient relationship, the trust that a patient has in his doctor is directly related to his following the doctor's directions, paying his bills, and recommending the doctor to his friends. The same kinds of positive results could be expected from a trusting nurse-patient relationship.


Nurses in all areas must be able to relate effectively with patients, family members, and other health care workers. Unfortunately, many generations of nurses have not received adequate training in this vital and essential area.

Realizing that human relations skills development requires increased emphasis, and in response to an expressed desire of Nova Scotian nurses for continuing education in this area, a two day workshop was designed and presented by four faculty members of Dalhousie University School of Nursing.

Planning

There were many things to be considered in planning for a human relations skills program. Since the learning of any skill, including human relations skills, requires the active participation of the learner, it was decided to use a workshop approach.

The physical environment for the workshop needed important consideration. The atmosphere should be relaxed and comfortable. The room should have movable furniture conducive to the formation of small groups. Minimal outside distractions and a place away from the working environment of the participants were also desirable. Consequently, a local hotel was deemed to provide the best situation.

The modified Carkhuff model of Gazda, Walters, and Childers was selected in planning for the workshop because it encompassed the principles of communication skills that the workshop leaders believed in, and because it outlined a specific, structured approach which could be readily used in a workshop format.

Carkhuff's concept of a helping relationship includes three phases: the facilitation phase, the transition phase, and the action phase.

In the facilitation phase, empathy, warmth and respect on the part of the helper are considered essential in the development of a base for a helping relationship. The importance of effective non-verbal communication during this phase is emphasized.

The transition phase occurs when the helpee is able to define his problem and accept responsibility for change directed towards resolution of the problem. The helper during this phase "...gently presses the helpee toward recognizing his (helpee's) role". The dimensions used by the helper during this phase are concreteness (ability to be specific), genuineness, and self-disclosure (revealing to the helpee's own experience of similar problems or conditions).

The action phase is Carkhuff's final phase in a helping relationship. In this phase the helpee "...takes appropriate actions to solve problems".

5Ibid, p. 13
6Ibid, p. 13
7Ibid, p. 13
The helper's self-confidence and knowledge are crucial during this phase for he is expected to use confrontation (pointing out discrepancies), and immediacy (telling it like it is right now), to assist the helpee in solving his problem.

Carkhuff has also developed a means for evaluating the effectiveness of responses made by the helper. It consists of a four point scale for rating the overall effect of helper responses.\(^6\)

Responses at level one of the scales are considered not helpful: damaging. They may make the helpee feel sorry he ever talked with the helper. Level two responses are classified as not helpful: ineffective. They slow down the conversation to the extent that the helpee feels he has to be careful about what he says. Level three responses are helpful: facilitative. They encourage the helpee to say more about his problem. Level four responses are helpful: additive. The helpee learns more about himself and becomes more able to help himself in the future.\(^7\)

The length of the workshop was difficult to decide. Considering that both participants and workshop leaders had other work commitments, it was felt that two days would be the longest time feasible. This would provide approximately sixteen hours of working time and would only be sufficient to cover the facilitative phase of the model.

Gazda, Walters, and Childers, in their *Instructor's Guide to Accompany Human Relations Development*, state that twenty-five to thirty hours are required for mastery of the facilitative dimensions of warmth, empathy and respect. However, they do admit that significant increases in functioning have been achieved in less time. In this case, sixteen hours for the workshop would have to be considered a potential limitation.

The ratio of leaders to participants and the experience of workshop leaders also needed consideration. The workshop was to be based on Gazda, Walters, and Childer's modification of the Carkhuff model of human relations training as presented in their text *Human Relations Development: A Manual for Health Sciences*. The Carkhuff model has proven an effective training guide,\(^8\) but research has also shown that adequate supervision is essential in human relations training.\(^9\) Pfeiffer and Jones recommend that there be a pair of facilitators for every ten to twenty participants in a human relations skills workshop.\(^10\) Thus, a maximum registration of thirty applicants was decided on for the workshop.

\(^6\)Ibid, p. 254

\(^7\)Ibid, pp. 116-117


It is also important for the facilitators to be well qualified for their roles. Egan says "...it is a demonstrated fact that in human relations training, trainees not only fail to grow but even regress in training programs run by ineffective people".

The four faculty members who would be conducting the workshop realized that although they had experience in utilizing the Carkhuff model with student nurses, this would be their first experience in a short term continuing education setting.

The workshop leaders were aware that the learners would probably feel "defensive" as well as "eager to learn" new ways of relating to others. It would be difficult in the span of a two day workshop for the participants to develop trust in the leaders and in each other, and trust is basic to the development of human relations skills. It was hoped that the skills approach to human relations would allay some of the anticipated defensiveness as skills may be perceived as a more tangible learning situation rather than a personality trait.

There was a possibility that some of the participants may be sent to the workshop by their employing agencies rather than requesting to go on a volunteer basis. Research has shown that volunteers showed gains in some areas of self acceptance while conscripts showed losses. "Given that a desired outcome of human relations training is greater self-acceptance, the results suggest the possibility of negative outcomes when participants are conscripted for a microlab experience."\(^{12}\)

Having considered these limitations, the following objectives for the workshop were formulated:

1. Participants will understand the key concepts of the Carkhuff model for human relations training.
   1.1 Participants will be able to identify helper responses which convey empathy, warmth, and respect.
   1.2 Participants will understand the meaning of the terms: genuineness, concreteness, self-disclosure, confrontation, and immediacy of relationship, as applied to helper responses.

2. Participants will make facilitative (level 3)* responses to helpee problems in the facilitation phase of a helping relationship.
   2.1 Participants will demonstrate awareness of listening (attending behaviour) and other forms of non-verbal behavior in making helper responses during practice sessions.
   2.2 Participants will write "level 3" responses to post-test items.

\(^{11}\)Ibid., p. 226.

The objectives were formulated with ease of evaluation in mind considering the available time for participant learning and the desire of workshop leaders not to use a "knowledge" examination in a continuing education program intended to be non-threatening to the learners.

*The Workshop*

The workshop was preceded by a pre-test consisting of four separate statements presumably made by someone seeking help. The participants were to write a response for each situation. The situations were either nurse-patient or nurse-nurse interactions. The pre-tests were rated and kept for comparison with post-tests to be written following the workshop.

The workshop then proceeded with an orientation to the Carkhuff model and skills training in the facilitation phase of a relationship. Terminology and key concepts were presented with particular emphasis being placed on listening skills, perceiving feelings, perceiving empathy, and communicating with empathy.

* Level 1: response is not helpful but hurtful. It is destructive to the relationship.*

* Level 2: response is not helpful to the helpee but does not in any way harm him. It may impede continuance of the relationship.*

* Level 3: response is helpful to the helpee. It communicates empathy, warmth, and respect to him and encourages continuance of the relationship.*

* Level 4: response is helpful to the helpee and additive to the relationship. It assists the helpee to clarify his problem and be more able to help himself in the future.*

*Figure 1: Levels of Helper Response according to Gazda, Walters and Childers.*

Videotapes made by the leaders prior to the workshop were shown to illustrate the use of empathy, respect and warmth; in short nurse-patient or nurse-nurse interactions. They were intended to demonstrate the facilitative or first phase of the model. Phase two, the transition phase, and phase three, the action phase, were only briefly introduced as they could not be covered during the time constraints of the workshop.

Small group work with extensive use of role playing and video taping was interspersed between content presentations. Participants were encouraged to give feedback to each other as they practiced their new skills. A workshop leader was available at all times for reinforcement and clarification of problem areas.
At first the participants responded to and discussed prepared materials, but by the second afternoon they were introducing situations they had personally encountered and had experienced difficulty with. Participants frequently stated that they now felt better prepared to deal with similar situations in future.

The workshop closed with a post-test requiring participants to write responses to four separate situations. The average score for these were then compared with individual's pre-test averages.

Participants completed a questionnaire which included age, area of employment, basic nurse education, past experience with human relations skills development, and reason for attending the workshop. The questionnaire also asked if participants had achieved their own objectives and if they felt the workshop was relevant and directly applicable to their present nursing situations.

**Results**

Two workshops of the type described were held, and each had twenty-one participants. They were all Registered Nurses whose work situations varied, from all areas of acute and chronic care situations and community health nursing. A number of the participants held administrative positions in Nursing Service or Inservice Education.

All participants at both workshops expressed personal satisfaction with the results of the workshop, as did workshop leaders. Pre and post-test scores were the only concrete measures available to determine achievement of the objectives. Not all pre and post-test scores could be correlated. In three cases, individuals either arrived after the pre-test had been given or had to leave prior to the post-test so that only one of the tests were completed. Four of the pre-tests in the first workshop could not be scored because participants wrote how they would approach the situation rather than giving their actual verbal responses. This was probably due to inadequate instructions on the part of workshop leaders as it did not recur in the second workshop.

The average pre-test scores for the workshops were 1.5 and 1.6 with individual averages ranging from 1 to 2.75. Post-test averages were 2.6 and 2.5 with individual averages ranging from 1 to 3.

In the first workshop, sixteen participants completed and turned in both pre and post-tests. Of these, fourteen showed increases in their post-test averages. One participant obtained the same average on post-testing and one received a lower average on the post-test than on the pre-test.

In the second workshop, nineteen participants completed both tests. Sixteen showed increases in their post-test scores and three showed no change. No participants in the second groups received a lower post-test average.
Figure 2: Comparison of Pre- and Post-test Averages for Workshop I
Conclusion

Although the objective was that participants achieve at least a “level 3” on post-test items and only eight participants achieved a post-test average of 3, the positive increases in the majority of participant’s ability to make “helpful” responses adequately demonstrated that the workshop had been beneficial.

It might also be noted that Gazda, Walters and Childers state that when trainees enter training they are typically functioning around levels 1.5 and 2.5 with the average at level 2.0. In this case, pre-test scores averaged 1.5 and 1.6. Also, the time for the workshops was significantly less than the twenty-five of the thirty hours recommended by Gazda, Walters and Childers.

It must also be noted that although the workshop leaders had planned on having the pre and post-tests responses rated by four objective raters, this was not done. One workshop leader rated all pre and post-tests with two other leaders checking several of the tests to confirm the rating. This must be considered a limitation in evaluating the effectiveness of the pre and post-tests as a measure of workshop success.

As for evaluation of the objective stating that participants be aware of non-verbal behaviour in making responses, it can only be said that workshop leaders’ subjective appraisals were that participants made significant gains in this area during role-playing sessions. For example, as observers and role players, they recognized and commented on the empathy expressed by eye contact and the loss of respect indicated by fidgeting and lack of attention. They were also able to identify empathy, warmth and respect in the verbal and non-verbal helper responses of workshop peers.

The success of the workshops was even more gratifying when the levels of motivation of participants was considered. Three of the participants who showed improvement openly admitted that their prime reason for attending the workshop was to receive Continuing Education Unit (C.E.U.) credit and this was the only credited workshop that they had been available in their area.

There did not appear to be any conscripts. All participants had come to the workshop of their own volition although many had been financially supported by their employers. Consequently, the detrimental effects of conscription in human relations training were fortunately not apparent.

A repeated comment on evaluations of the workshops was that participants had enjoyed their practical nature. They enjoyed being able to practice immediately the theory which had been presented.

*See figure 1.

It is noteworthy that the modified Carkhuff model proved to be an effective teaching tool when the participants ranged from one 1978 graduate to a retired R.N., and job situations were also as varied. All participants stated that the workshop had been a valuable learning experience whether they worked in hospitals, nursing schools, senior citizen homes, or the community.

Other than what they had received in their basic nursing education, only six of the participants had previously participated in any human relations skills programs. This would appear to further substantiate the fact that human relations skills does indeed need increased emphasis.

In closing, it should be reiterated that the modified Carkhuff model was an effective teaching guide in improving the human relations skills of participants. The fact that the majority of participants did not achieve level 3 averages on post-tests only serves to attest that this is truly a “continuing” education need, and work in this area is required for both participants and their colleagues who have still to partake of a similar program.

**RÉSUMÉ**

**Atelier de formation permanente en relations humaines**

Dans cet article, l'auteur propose un exposé sur l'évaluation du besoin, la planification, la mise sur pied et le bilan de deux ateliers sur les compétences en relations humaines organisés pour les infirmiers diplômés des régions rurales de la Nouvelle-Ecosse.

Les ateliers ont été fondés sur le modèle de développement des relations humaines de Carkhuff tel que modifié par Gazda, Walters et Childer's; ils avaient pour but d'enseigner aux participants à être compétents au niveau de la phase 1 (phase de facilitation) d'une relation d'aide.

Le bilan de l'atelier a été fondé sur un questionnaire d'évaluation rempli par les participants et sur une comparaison des réactions des participants à quatre interactions infirmier-infirmier, infirmier-malade, avant et après le bilan.

On a noté chez les participants une amélioration de leur capacité à prêter une oreille plus sympathique au malade, à faire preuve de plus de chaleur et de respect, bien que la majorité des participants n'aient pas atteint le niveau souhaité par les animateurs de l'atelier.

L'étude présentait certaines limites, notamment, une durée trop courte pour réaliser des modifications du comportement; par ailleurs, l'objectivité entre les évaluateurs était suffisante pour permettre d'évaluer complètement les modifications du comportement qui ont découle de l'atelier.