

# NURSES' VERBAL EMPATHY IN FOUR TYPES OF CLIENT SITUATIONS

Joanne K. Olson and Carroll L. Iwasiw

Nurses are constantly confronted with the emotions that clients experience in health care situations: their responses can affect client outcomes. Although nurses' communication skills have been studied, their empathy responses to specific types of client situations have not been investigated.

The purpose of this study was to investigate whether differences exist in staff nurses' verbal empathy in response to clients who experience pain, depression, anxiety or anger – four situations common in health care. This investigation was part of a larger study of nurses' communication skills.

## Literature Review

### *Therapeutic relationships in nursing*

Therapeutic nurse-client relationships have been addressed in the nursing literature since the time of Florence Nightingale (1859). Several early nursing theorists described nursing as a relationship between a nurse and a client (King, 1981; Orlando, 1961; Peplau, 1952; Travelbee, 1971). More recent nursing theorists have not specifically described the nature of a therapeutic nurse-client relationship, but such a relationship is implicit within their theories (Neuman, 1982; Newman, 1986; Orem, 1985; Rogers, 1970; Roy, 1976).

### *Empathy*

Empathy is one of the most essential and complex variables in communication (Forsyth, 1980; Gagan, 1983; Kalisch, 1973; La Monica, 1981; Rogers, 1957; Stetler, 1977). The concept has been described in the literature for over 100 years (Gladstein, 1984).

Some authors have described empathy as interpersonal perception or intuition, the ability of one individual to know or predict the emotions of another

Joanne K. Olson, B.Sc.N., M.S. is Assistant Professor and Carroll L. Iwasiw, B.N., M.Sc.N. is Associate Professor in the Faculty of Nursing at the University of Western Ontario in London, Ontario.
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(Cline & Richards, 1960; Cronbach, 1955; Hobart & Fahlberg, 1965). Empathy has also been described as a vicarious emotional response to the perceived emotional experiences of others (Mehrabian & Epstein, 1972). Northouse and Northouse (1985) referred to understanding the feelings and thoughts of another. Kalisch (1977) has expanded these definitions to include a verbal component: empathy is the accurate perception of the feelings of another person and the ability to communicate this understanding back to him.

Others have defined empathy as the helper's understanding of both the client's feelings and the circumstances to which the client attributes those feelings, and the communication of this understanding back to the client (Brammer, 1985; Carkhuff, 1977; Egan, 1986; Gerrard, Boniface & Love, 1980). Rogers (1957, 1958, 1961) has described empathy as having three components: affective (sensitivity), cognitive (observation and mental processing) and communicative (helper's response). These definitions have led to behavioural training models and behavioural evaluations of empathy skills.

Attempting to be supportive, helpers may make statements such as, "don't worry" or "you shouldn't feel that way". These statements are antithetical to empathy because they discount or negate the feelings and deny the client's right to experience those feelings (Gerrard & Buzzell, 1980). Such statements are hurtful to the client and may prevent further productive conversation (Gazda, Walters & Childers, 1975).

### ***Empathy levels of nursing staff***

The affective and cognitive components of communicative empathy have been assessed in nurses. Truax and Millis (1971) reported that registered nurses (RN's) were generally low in empathy in comparison to 12 other occupational groups. In contrast, Forsyth (1978) found that the majority of nurses' scores on the *Hogan Empathy Scales* were in the middle and upper range. Medical-surgical nurses had the lowest mean scores and psychiatric nurses the highest mean scores (compared to hospital administrators and psychiatrists) on the empathy scales of the *California Psychological Inventory* (Brown & Hunter, 1987). Bagshaw and Adams (1986) reported that RN's employed in nursing homes had a mean score of 183 on the La Monica's (1981) *Empathy Construct Rating Scale*. Scores can range from -252 (low empathy) to +252 (high empathy).

These studies have assessed the prerequisites of the communicative component of empathy. However, this predisposition cannot be interpreted as a measure of actual practice. Furthermore, the potential for a bias of social desirability is present in the self-rating instruments used.

The communicative component of empathy (verbal empathy) has only been assessed in a few studies. In response to the *Behavioural Test of Interpersonal Skills* (BTIS), RN's obtained verbal empathy scores of less than 60% (Iwasiw & Olson, 1985; Olson & Iwasiw, 1987). Pennington and Pierce (1985) studied the correlations between verbal empathy and demographic variables, and found that younger staff with moderate lengths of experience were the most empathic.

The lack of opportunity for on-going dialogue with simulated clients on the BTIS and the presence of observers in Pennington and Pierce's study may have affected the nature of subjects' responses. No conclusions can be drawn about quantitative levels of empathy and client outcomes.

### ***Outcomes of the health professional-client relationship***

Favourable psychological client outcomes (Ben-Sira, 1976; Bent, Putnam, Kiesler & Nowicki, 1976; Korsch & Negrete, 1972), such as client satisfaction and behavioural client outcomes (Becker, Drachman & Kirscht, 1972; Kincey, Bradshaw & Ley, 1975; Ludy, Gagnon & Caiola, 1977), particularly compliance, have been related to positive client-health professional relationships. More specifically, some link has been established between the use of therapist empathy during psychotherapy and positive client outcomes such as increased self-concept and client satisfaction (Mullen & Abeles, 1972; Sweet, 1984; Truax and Mitchell, 1971; Truax et al., 1966; Truax, Witmer & Wargo, 1971; Williams, 1979). McKay, Hughes and Carver (1986) reported that nurses' use of empathy was related to increased patient self-disclosure. However, the outcomes cannot be attributed solely to the health professional's empathy. Health professional-client relationships are complex and occur within changing contexts. Studies employing techniques of multivariate analyses are required to determine the relative importance of the variables affecting client outcome.

Therapeutic relationships have been identified as an important aspect of nursing practice. Empathy has been recognized as essential to a therapeutic relationship, although precise links between levels of helper empathy and client outcomes have not been described. No literature was found which addressed nurses' communication skills and empathy specifically, in response to different types of client situations.

## **Conceptual Framework**

### ***Concepts***

*Nurse.* The nurse is a knowledgeable, thoughtful professional who has the desire and the skills to be of assistance to clients. While focussing on the

client's concerns and perspectives, the nurse suspends personal needs. The nurse employs a wide range of knowledge to assess and interpret the client's behaviour, and responds in a manner that is intentionally helpful. The interaction with the client is continually evaluated by the nurse and the relationship is terminated when mutually established goals have been achieved.

*Clients.* Clients are individuals who possess the capabilities of all people, but who require and seek the assistance of others expected to be of help in alleviating or preventing a health problem. Clients strive to maintain their uniqueness in the potentially depersonalizing health care system. Acceptance of help may be dependent upon how well the nurse supports their view of themselves as unique and valued individuals.

*Therapeutic nurse-client relationship.* A therapeutic nurse-client relationship is one in which the nurse assists the client to express thoughts, feelings and concerns. The relationship is focused on the client's perspective of the situation causing concern and the reactions resulting from that perspective. The goals of the relationship are for the client to feel less isolated, to feel accepted as a unique individual and to learn new ways of coping with or managing the situation. A therapeutic relationship is purposeful in nature.

### *Verbal empathy*

Empathy has been identified as one of the major elements in establishing the trust that is essential to a therapeutic relationship (Rogers, 1958, 1961). Verbal empathy is the statement of the accurate understanding of another's feelings and the reason the other believes he is experiencing those feelings. It is based upon a desire to understand, the ability to listen accurately, the ability to interpret another's statements and behaviour and the ability to state this interpretation back to the client. This definition emphasizes the communicative component of empathy. Verbal communication is essential because a helper's knowledge of the feelings and experiences of the other is of little value unless successfully communicated (Stetler, 1977). A predisposition to help and a silent, internal understanding are inadequate bases for a therapeutic relationship. Verbal empathy by the nurse must be both an initial and an on-going response in a therapeutic nurse-client relationship.

### *Relationship of the concepts*

When the nurse and client meet in a health care situation, the client expresses thoughts, feelings and needs in many ways. Through the nurse's verbal responses of empathy, clients know that the nurse is able to view the situation from their perspectives. Verbal empathy will encourage the client to trust the nurse and to disclose further. The cycle of client disclosure and the nurse's verbal empathy form the basis for a therapeutic relationship.

## ***Definitions***

Verbal empathy is: the accurate restatement of the feeling and content of another's message. Terms used in the hypotheses are:

Content: The reason for the speaker's feeling.

Feeling: Any relevant general (e.g. upset) or specific (e.g. angry) reference to the speaker's feeling.

Don't Feel: Any attempts to suppress or discourage expression of the speaker's feeling (Gerrard & Buzzell, 1980, p.43).

## **Hypotheses**

No literature was found about nurses' empathy in different types of client situations; as such, it was expected that nurses would be equally empathic in all situations. The specific hypotheses were:

1. There will be no differences in scores for the category "content" in client situations of pain, depression, anxiety, and anger.

2. There will be no differences in scores for the category "feeling" in client situations of pain, depression, anxiety, and anger.

3. There will be no differences in scores for the category "don't feel" in client situations of pain, depression, anxiety and anger.

## **Method**

### ***Sample***

Settings comprised six acute care hospitals and two community health agencies in two Ontario cities. Full-time RN's who had been employed as staff nurses for at least one year, and who were graduates of Canadian nursing programs, were the target population. Staff nurses were defined as nurses who spent at least 75% of their time in direct patient care.

The population consisted of 840 staff nurses. Every second eligible diploma nurse by clinical area and all baccalaureate nurses in the acute care agencies were invited to participate. All nurses in the community agencies were asked to participate. It was hoped that this procedure would yield approximately similar numbers of hospital- and community-based baccalaureates to meet other study purposes. The data-producing convenience sample was composed of 66 volunteer nurses.

The age range of the sample was 23 to 59 years, with 71.3% between the ages of 25 and 34 years. Over one-third of subjects had 1-5 years of nursing practice and over one-third had 6-10 years of practice. All 28 community health nurses and 14 acute care nurses had a baccalaureate nursing degree. Twenty-four acute care nurses had a nursing diploma.



## *Instrument*

The *Behavioural Test of Interpersonal Skills* (BTIS) was used. It . . . "is a test that can be used to assess the interpersonal/ interviewing skills of any health professional. The half-hour test consists of 28 common patient and health professional situations which have been role-played by actors and actresses and recorded on color videotape" (Gerrard & Buzzell, 1980, p. 1). There is a 30-second silence on the videotape that allows subjects to respond after each situation. Specific clinical knowledge is not required for effective responses. In each situation, the actor's feelings are apparent, through either statements or behaviour. The reason for the feelings is stated.

Content validity of the BTIS was established through an extensive literature review and input from 68 health professionals. Fair concurrent validity of the "feeling" category was established through peer ( $r = .38$ ) and supervisor ( $r = .33$ ) ratings of psychiatric nurses and nurses enrolled in graduate study. In the same study, fair concurrent validity ( $r = .33$ ) was established for the category "content" through peer ratings. A fair negative correlation ( $r = -.33$ ) was established between the "don't feel" category and supervisor ratings on the rating scale dimension "knows how I feel". Construct validity of the "feeling" ( $p = .004$ ) and "don't feel" ( $p = .001$ ) categories was demonstrated by comparing scores of two "known to be different groups" (Gerrard & Buzzell, 1980).

The BTIS includes two of each type of the following client situations.

*Pain* - The client refers to physical pain and feelings of discouragement or fear: "It's a dull nagging pain. I don't know what else I can tell you. It just goes on and on night and day. I don't think it's ever going to go away."

*Depression* - The client has a sad facial expression and makes a statement referring to his unhappiness: "Even since my surgery life hasn't been the same. I don't know where to turn. I wonder if it's worth going on."

*Anxiety* - The client expresses a vague dread or apprehension and has a worried facial expression: "I feel so weak. What am I going to do? Will I ever get better? Just look at me, I can hardly sit up without getting dizzy. What am I going to do, what am I going to do?"

*Anger* - The client is shouting and has tense facial muscles: "I'm sorry but I've got to sound off to someone and you're the first one in here. I can't understand why I'm not getting more care. This is the third day I haven't had any help with my walking. I'm trying to get better and nobody's helping me."

### ***Data collection***

Data were collected at the agencies employing the subjects over five months. One community health agency allowed nurses to use work hours for study participation. Individual appointments were made for data collection. Subjects were alone and audiotaped as they responded to the BTIS. There were no interruptions during audiotaping. Written consent and demographic data were obtained.

### ***Scoring procedures***

Each communication behaviour (feeling, content, don't feel) was scored as being present or absent in the subject's response to each of the eight client situations. A total of 528 situations were scored. Scoring was done by the principal investigators, who had established inter-rater and intra-rater scoring reliability prior to the study. Kappa statistics for reliability ranged from 0.85 to 0.98 on each scoring category. This same level of inter-rater and intra-rater scoring reliability was confirmed during the study, using ten randomly selected rated tapes.

## **Results**

Hypotheses were tested with pair-wise comparisons of the different situations. A two-tailed Wilcoxin matched-pairs, signed-ranks test was used. To maintain a Type 1 error level of .05, individual comparisons carried Type 1 errors of .0083 to allow for multiple comparisons.

Hypothesis 1 was supported. There were no significant differences in nurses' scores in the category "content" for the four types of situations. The mean "content" score was 7.87 (60.56%) on 13 situations.

Hypothesis 2 was not supported. For the category "feeling", nurses obtained higher scores in situations of pain ( $X = 8.65$ ) than depression ( $X = 4.53$ ) ( $Z = -3.881$ ;  $p = .0001$ ); higher scores in situations of pain than anxiety ( $X = 4.00$ ) ( $Z = -3.466$ ;  $p = .0005$ ); and higher scores in situations of anger ( $X = 5.33$ ) than depression ( $Z = -3.599$ ;  $p = .0003$ ).

Hypothesis 3 was not supported. For the category "don't feel" nurses obtained higher scores in situations of anxiety than pain ( $Z = -3.481$ ;  $p = .0005$ ) or depression ( $Z = -3.133$ ;  $p = .0017$ ). They also obtained higher "don't feel" scores in situations of anger than pain ( $Z = -2.912$ ;  $p = .0036$ ) or depression ( $Z = -2.856$ ;  $p = .0043$ ).

Mean scores for each communication behaviour in the four types of situations are reported in the Table.

**Table 1****Table Mean BTIS Scores in Four Client Situations**

BTIS Categories	Pain	Depression	Anxiety	Anger
Content	7.19(55.3%)	8.96(68.95%)	7.57(58.25%)	7.77(59.75%)
Feeling	8.65(66.5%)	4.53(34.85%)	4.00(30.75%)	5.33(41.00%)
Don't Feel	0.49(3.80%)	0.592(4.55%)	2.99(23.00%)	1.87(14.40%)

## Discussion

The major finding is that nurses do respond with differing levels of verbal empathy in four types of client situations. The discussion will address each communication behaviour in the four types of client situations.

### *Content*

The content portion of the clients' messages was restated with similar frequency in all types of situations. "Content" scores were higher than "feeling" scores in three situations. Clients explicitly stated the reasons for their feelings on the BTIS and nurses may have found it relatively easy to restate the content. Furthermore, because a verbal response was required, nurses may have responded to the content, even when they found the expressed feeling difficult to identify or accept. Restating the content conveys some understanding of the client's perspective of his situation. This aspect of verbal empathy contributes to the therapeutic nurse-client relationship.

### *Feeling*

Nurses were able to identify "feeling" more frequently in situations of pain than in situations of anxiety and depression and more frequently in situations of anger than depression. On the BTIS, feelings of pain and anger are blatantly expressed. However, in situations of anxiety and depression, the nurse had to interpret voice tone, facial expression and body posture, as well as content, to identify the more covert feelings. Recognizing what is not being said requires more skill than identifying overt emotion (Carkhuff, 1977).

Accurate reflection of the client's feelings is an aspect of verbal empathy. Because nurses were able to communicate the client's feelings of pain and anger back to him, they may be better able to establish a therapeutic relationship with these clients than with anxious or depressed clients.



## ***Don't feel***

Although "don't feel" responses were infrequent, nurses did respond with "don't feel" statements in situations of anxiety more than in situations of pain or depression, and in situations of anger more than those of pain and depression. It may be that angry and anxious clients cause anxiety in the nurse because there are no direct physical interventions that can be offered. As a means of gaining control, nurses may first attempt to deal with these clients by trying to suppress the clients' feelings.

Nurses are cognizant of the need to assess pain, and there are specific interventions to offer. As well, it would be illogical to tell someone not to feel pain. For these reasons the feelings of pain may have been more acceptable to the nurses.

Depressed clients made no implicit or explicit requests; they merely described their situations. These clients may not have evoked feelings of inadequacy in the nurse, so no attempt was made to change their outlook for the nurse's own benefit.

The "don't feel" responses are probably used to meet the nurse's needs. These responses are non-therapeutic because they do not validate the client as an unique individual who is entitled to his own feelings and perspectives. "Don't feel" responses are antithetical to verbal empathy.

## ***Verbal empathy and client situations***

Nurses seemed most likely to establish the basis of a therapeutic relationship with clients experiencing pain. They responded with verbal empathy to these clients. Although they may have had the desire to help, nurses were least empathic with anxious clients, possibly because they had difficulty in interpreting and accepting these clients' statements and behaviours. Clients' trust and self-disclosure may be limited (McKay, Hughes & Carver, 1986). As a consequence, feelings of isolation and heightened anxiety may result and the potential benefits of the nurse-client relationship will not occur.

## **Conclusions**

Differences do exist in staff nurses' verbal empathy in response to four types of client situations. Nurses most frequently identified the feelings expressed in situations of pain and anger. They most frequently attempted to suppress the feelings of anxiety and anger. However, nurses were consistent in their restatement of the content of the message in situations of pain, depression, anxiety and anger.

Continuing education should be directed at nurses' verbal empathy skills, particularly with angry and anxious clients. Nurses should see these clients as people seeking assistance with health problems and to whom they can offer help.

Study findings may be biased by the fact that community health nurses were over-represented in the sample. A self-selection bias may also have existed if only those nurses who felt confident about their communication skills and comfortable with audiovisual equipment volunteered to participate. The lack of opportunity for on-going dialogue may have influenced the subjects' responses.

This study has added to the literature about nurses' empathy by investigating the variable of type of client situation. The client situations were general in nature and not related to a specific clinical area. In addition, the study sample was composed of nurses from many clinical areas. Therefore, the study may have broader application than previous research into nurses' empathy.

Further studies should be undertaken to determine the range of client variables that influence nurses' use of verbal empathy. More research should be conducted to study nurses' verbal empathy in clinical situations. As well, the client outcomes of nurses' verbal empathy should be investigated further.

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## RÉSUMÉ

### **L'empathie chez les infirmières: quatre situations types**

Cette étude cherche à déterminer s'il existe des différences au niveau de l'empathie verbale dont les infirmières font preuve face à la douleur, à la dépression, à l'angoisse et à la colère de leurs patients. L'empathie est la faculté de s'identifier à quelqu'un et de ressentir ce qu'il ressent. Les réponses au *Behavioral Test of Interpersonal Skills* (BTIS) de soixante-six infirmières bénévoles ont été enregistrées. Les cassettes ont ensuite été évaluées en suivant les directives propres au BTIS. La douleur et la colère sont des situations face auxquelles les infirmières affichent la plus grande faculté d'empathie. Elles font preuve par ailleurs d'une grande cohérence dans la reformulation des raisons qui motivent les quatre différents types de situations. Elles essaient davantage d'apaiser l'angoisse et la colère. En conclusion, l'empathie dont les infirmières font preuve varie d'une situation à l'autre; ces résultats devraient avoir une certaine influence sur les programmes d'éducation permanente.





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