THE EXPRESSED EMPATHY OF PSYCHIATRIC NURSING STAFF

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The acquisition of effective interpersonal skills is assumed to be inherent in the practice of professional nursing. All curricula provide courses in communication theory. Nursing theorists such as King (1981) stress the need for determining goals for care with the client. Benner (1984), describes one of the steps in the healing relationship as "finding an acceptable interpretation or understanding of the illness, pain, fear, anxiety, or other stressful emotion" (p.49). Pioneers in psychiatric nursing have all written of the necessity of paying attention to the spoken and unspoken messages of the patient (Orlando, 1961; Peplau, 1952; Tudor, 1952). In addition, nurses have emphasized the role of empathy, "the ability to know or understand the experience of another" (Bachrach, 1976) as a critical and necessary clinical tool (Brunt, 1985; Forsyth, 1979; Gagan, 1983; La Monica, Caren, Winder, Hasse & Blanchard, 1976). Thus, it follows that the empathic process is dependent upon the nurse paying attention to the meanings and interpretations patients place upon events in their lives. The subjective meaning or experience of an event may vary widely. The experience of empathy between a nurse and his or her patient is a dynamic process. This process is articulated by the authors in a previous paper (Gallop, Lancee & Garfinkel, 1990). That this process is hard to measure is evident from the enormous body of literature on the definitional, operational and measurement problems associated with the study of empathy. One way of measuring a part of the empathic process is to consider the verbally-expressed empathy of the nurse. Of course, this measures only one aspect of the empathic process and does not consider other aspects such as non-verbal expressions of empathy and the experience of empathy as perceived by the patient.

A review of the empirical literature on nurse-patient communication reveals that nurses tend to offer advice and provide information and pay little atten-

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tion to the subjective experience of the patient. One explanation for these behaviours, suggests that interpersonal skills are associated by nurses with working in psychiatric settings and not generalized to other nursing situations (Hills and Knowles, 1983). If this is the case then one would predict that studies of response behaviours of psychiatric nurses would demonstrate satisfactory interpersonal and empathic skills. In the study described in this paper, the responses of 113 psychiatric nurses to hypothetical patient statements are examined for attention to the subjective experience of the hypothetical patient and evidence of expressed empathy. In particular, we have investigated whether the nurses inquire into the meaning of the statement to further their understanding of the patient's experience?

Communication Research

Empirical studies of nurses' communication skills reveal generally low levels of inquiry with regard to the feelings and perceptions of patients. For example, in a study by Mathews (1962), nurses responded to nine patient stimuli. Data were analyzed using a binary decision tree grounded in person centred concepts (Rogers, 1957). Only eight out of 122 nurses gave one or more responses that encouraged the patient to disclose what he or she was experiencing. Graffam (1970) observed 75 nurses responding to 157 incidents of patient complaints of distress. Forty-two percent of the nurses performed no further inquiry in response to the complaints; one-third made a verbal inquiry; and, in only 10% of incidents nurses explored the patient's subjective experience. Another 23% either demonstrated blocking behaviours (e.g. the patient was ignored) or belittled the patient (e.g. scolded, contradicted). Clark (1981) analyzed audio and video tapes of nurse - patient interactions on general medical and surgical wards. The dominant technique used by the nurses "discouraged" or "blocked" communication. Other studies have found a similar paucity of inquiry about feelings or perceptions. In a content analysis of 30 nurses' verbal communications after a course in communication, Forrest (1982) found that only 3% either verbalized implied thoughts or acknowledged feelings. While the majority of the nurses' behaviours could be considered facilitative, 45% of these responses were general leads (e.g. "Go on" or "uh-huh"). Twenty two per cent of the responses were blocking responses.

Macilwaine (1978) examined nurses' interactions with female neurotic patients and found the majority of interactions were defined as administrative. The second highest set of interactions offered emotional support. Interestingly, a second categorization revealed that over 50% of the administrative or emotional support interactions were considered either banal and stereotypical conversation or the transmission of basic practical information.

The studies examining the empathic skills of nurses have contradictory findings. Some studies, have found that nurses fail to score above the mini-

mally facilitative level (Hills and Knowles, 1983; La Monica et al., 1976). Such low scores may reflect characteristics of the nurse or may be a reflection of the inadequacy of scales such as the Carkhuff (1969) empathy scales in measuring the empathic responses of nurses. These scales define very broad categories which are poorly operationalized and may be inappropriate for the everyday spontaneous interactions of nursing (Gagan, 1983). In addition, serious questions concerning the reliability and validity of these scales have been raised (Lambert, DeJulio & Stein, 1978). On the other hand, Forsyth (1979) reported consistently high levels of empathy when patients rated their nurses. Similarly, La Monica, Wolf, Madea and Oberst (1987) reported high empathy scores for both client report and nurse self report pre and post empathy training programs. The lack of range in the results may be explained by a "ceiling" affect as La Monica et al. (1987) suggest, or it may suggest a serious limitation in method in the self-reporting of empathy. In addition, it may call into question the technique of asking clients to provide concurrent ratings of their caregivers, despite assurances of confidentiality.

Olson and Iwasiw (1989) examined the verbal empathy of nurses in response to videotapes of simulated patient situations. Subjects were most likely to identify feelings in situations combining pain and anger, while they were most likely to suppress feelings in situations combining anxiety and anger.

The study described below reports on the communication styles of 113 nurses employed in psychiatric nursing. The primary function of the study, reported elsewhere, was to examine the influence of diagnostic labelling on the expressed or verbalized empathy of the nurses (Gallop, Lancee & Garfinkel, 1989). Briefly, subjects were found to differ significantly on the use of belittling response and levels of expressed empathy, according to diagnostic label. In this paper we examine general styles of communication, regardless of diagnostic label of the hypothetical patient.

Methods

Subjects for this study were registered nurses working in five short-stay, acute psychiatric settings. Settings included teaching and non-teaching units within general hospital and psychiatric hospital facilities. One hundred and thirty six nurses were approached to participate in the study. Informed consent was obtained and the study was conducted in an anonymous fashion. One hundred and twenty four nurses participated. Mean age of the subjects fell in the 31-35 category. Years of experience ranged from 0 to 30, with a mean of 8.4 years and a median of 5.5 years. The majority of nurses were diploma graduates (n=112); 12 held university degrees (n=12). Five subjects were eliminated because of missing data, six were eliminated because they indicated that their primary location of employment was the outpatient department leaving 113 subjects for data analysis.

Instrument

Each subject completed the *Staff Patient Interaction Scale* (SPIR) for this study (Gallop et al., 1989). This four page scale facilitates the manoeuvring of experimental variables by allowing the systematic manipulation of contexts.

The SPIR scale was developed from a theoretical view of therapeutic empathy as a multiphasic time sequenced process (Gallop et al. 1990). Each of the three phases in this process: engagement, matching of experiences and participatory - helping have particular outcomes. For example, when presented with a patient stimulus, the nurse may become *engaged*. Engagement requires the maintenance of the communication either by inquiry into surface content, inquiry into non-surface content (i.e. affective content) or an expression of care and concern that indicates to the patient that the nurse is interested in hearing more. However, the nurse, under the influence of numerous mediating such variables as stereotypic views of patients with a particular diagnosis, fatigue, ward pressures or anxiety about the stimulus content, may avoid engagement by defensive behaviours such as belittlement or solution behaviours such as explaining rules. These latter behaviours are likely to close down the empathic process. The categories in the SPIR scale represent the operationalization of these outcomes. A detailed explanation of the theoretical model may be found in Gallop et al. 1990.

The SPIR scale is an analogue scale that uses the written responses to hypothetical patient stimuli to assess the expressed empathy of staff. The stimuli are referred to within contexts that incorporate the independent variables under consideration. An example of a context and stimulus set are shown in Figure 1. Each of the four pages of the scale reveals a context and five statements. The four pages are equivalent forms but the phrasing of the statements is not identical. The five patient statements on each page are presented in a random order. Subjects are given 30 minutes to complete the scale.

Two raters were trained by the investigators, according to a prepared manual. Raters were trained until an interrater reliability of 0.80 was obtained. Random interrater checks of 20% of the responses were conducted during the study to ensure maintenance of the reliability level. Responses were scored on the ten category response scale shown in Table 1. These ten categories, represent an ascending hierarchy of expressed empathy. Each response can be scored in multiple categories thus eliminating the rater subjectivity required in forced choice responses. Context was not revealed to the raters.

"A" is a patient in her mid-twenties.
She has history of *multiple* psychiatric admissions.
She was admitted to hospital 8 days ago.
"A" has a diagnosis of *borderline personality disorder*

1.I just want to stay in bed - please.
You respond:

2.Having to sit in a circle with a group of people again is stupid. I don't want to go.
You respond:

3.Life's not worth living. There is nothing anyone can do.
You respond:

4.Its really nice having a nurse who understands me, not like the others.
You respond:

5.Go away - get off my case - don't you ever give up?
You respond:

Figure 1
Example of Context and Stimulus Set From SPIR Scale

Data analysis

The ten scoring categories represent three levels of empathic care as conceptualized by the investigators. These three levels are:

1. No care - categories 1 and 2
2. Solution - categories 3, 4, 5 and 6
3. Affective involvement - categories 7, 8, 9, and 10.

Data were analyzed according to overall usage of each of the ten categories and these three levels of empathy. In addition, a total empathy score was calculated for each subject. In order to do this, only the highest category response was used for calculation of the total empathy score when raters indicated multiple categories for a response. There was one exception: when category 1. "belittles, contradicts or requires defense" was indicated within a response, this category overrode all other categories because it was assumed that the negative content of this response cancelled any concomitant positive content. A total empathy score was then calculated using weights of -1, 0, 1 and 2. A subject received a score of -1 for each category 1 response (i.e. belittles, contradicts) and 0 for a category 2 response. Responses in level 2 were given a score of 1, and responses in level 3 a score of 2 points. A maxi-

mum empathy score of 40 was therefore possible (20 statements x 2 for each). Total empathy scores of the subjects ranged from -1 to 34 with a median and mean of 22. Table 1 illustrates the frequencies of the highest level response according to the ten categories and the three levels of empathy.

Chi-square analysis for independent proportions was used to examine the association of age, experience and education with total empathy scores. Non-parametric analysis of variance was used to examined setting effects.

Table 1

Frequency of Category Endorsement According to Highest Response Level

	Number of Responses	
	N	%
Level 1 categories: "No care"	456	20
1. belittles, contradicts	146	6.4
2. platitudes, cliches	310	13.7
Level 2 categories: "Solution"	1158	51
3. explains rules or process	559	24.7
4. tells patient to do something	59	2.6
5. offers a solution	147	6.5
6. invites explanation	393	17.3
Level 3 categories:"Affect, involve"	646	29
7. expresses care or concern	229	10
8. addresses any feeling	286	13
9. addresses precipitant of feelings	121	5
10. addresses self-esteem	10	<1

Results

Response patterns of the subjects according to category endorsement

The 113 subjects provided a total of 2260 responses. Fifty-one per cent of all responses are in level 2 (solution). Level 3 (affective involvement) contains 29% of the total responses. Of these level 3 responses, 35% are in the category "expresses care and concern". Of the remaining 65% of the level 3 responses: 417 (or 18% of the total responses), address the feelings expressed in the stimuli.

The use of category 1 - "belittles, contradicts, requires defence" was largely determined by diagnostic label. One hundred and seventeen out of 146 category 1 endorsements (80%) were attached to borderline personality disorder labelled stimuli. The results and meaning of this distribution are discussed in an earlier paper (Gallop et al., 1989).

Chi-square analysis revealed no significant differences with regard to total empathy scores according to any of the demographic variables. Analysis of variance revealed no effects that were specific to setting.

Discussion

Before considering the meaning of these results certain caveats must be presented. Caution must be taken when drawing conclusions about the responses of the subjects when an analogue scale is used. Self-report scales indicate only what subjects state they would say in a situation and do not inform about actual behaviour. However, it is important to note that the distributions found in this study are similar to the findings of studies that have examined interactions in actual clinical situations (Clark, 1981; Forrest, 1982). The scale does not address all facets of the empathic process. To do this multiple measures and perspectives are required.

The distributions reported raise interesting questions: why are the use of communications in level 2 (solution) so high? and, how can the distribution of responses in level 3 (affective involvement) be understood?

The high endorsement of level 2 or solution responses does not contradict the wish of subjects to be therapeutic. These subjects appear to want to help the patient; they are not ignoring the surface content of the patient stimuli and 33% of the level 2 responses maintain the communication by "inviting explanation" (category 6). Most responses in this category ask the question "why" (e.g. "Why don't you want to get up....go to group....do you want to kill yourself?"). These responses, used in categories 6, refer to the surface content of the stimuli but do not encourage the conversation to proceed to the affective domain or the subjective experience. For one of the stimuli, it may be argued that the response "Why do you want to kill yourself?" will eventually lead to understanding; however, the response reflects none of the affect of a stimulus such as "Life's not worth living. There's nothing anyone can do?" The response fails to convey the basic requirement of therapeutic empathy "the wish to know and understand the experience of the other" (e.g. " What is happening to you now that is making you feel so hopeless?").

The responses used in category 3 "explain rules and process" pay attention to the surface content and try to supply information useful to the patient (e.g. "group is an important part of your treatment..."going on a walk will help

you meet others"...." There are lots of reasons for living" ....."I am your assigned nurse"). Responses in the "explain rules and process" provide an answer and terminate the conversation. Similarly, responses in categories 4 and 5 (offer solution and give advice) such as "talk to your doctor", or "get some rest" terminate conversation.

Of the level 3 responses, the use of "care and concern" responses, (e.g. *stimulus*: "Don't waste your time with me, I'm better off dead"; response: "I don't feel I'm wasting my time when I'm with you)," create an ambience of engagement for further disclosure. However, it cannot be determined whether the nurse will then proceed beyond surface content. Thirteen per cent of the total responses or 44% of level 3 responses, are in the category "addresses any feelings". Two categories specifically require curiosity about the subjective state of the patient. These are "precipitant of feelings" and "directly addresses the self-esteem of the subject". Endorsement of the former category was low (5% of total and 19% of level 3) and endorsement of the latter category was virtually nonexistent. This latter result may be an artifact of the instrument and further testing on nursing and other professional groups is necessary. However, because proceeding in the empathic process is dependent upon understanding by matching the subjective experience of the patient or demonstrating a wish to know or understand the subjective experience of the patient; as such, many of the subjects in this study are, de facto, unempathic. It may be postulated that nurses are not inherently unempathic but rather they do not understand or value the internal meaning or the subjective experience of the patient as useful explanatory models for their therapeutic work. As suggested earlier, the majority of the nurses in this study want to help the hypothetical patient. The nurses offer advice, solutions, explore surface content and explain - although often the advice and explanations serve to end communication.

Explanations for this posture and hence the extensive use of level 2 solution responses may range from beliefs about the therapeutic usefulness of empathy to the educational experience of nurses and the philosophy of the work environment.

Within the clinical setting, there will be times when a nurse may decide that the pursuit of subjective experience or further exploration may not be in the best interest of the patient. For example, a nurse may decide that a patient showing evidence of thought disorder would not be therapeutically served by further inquiry into statements about internal states. The decision is based on the belief that the patient will benefit from structure and clearly defined boundaries. Interestingly, in this study, patients identified as schizophrenic were recipients of more affective exploration than the borderline personality disorder group (Gallop et al., 1989). Other authors have suggested that empathic inquiry can be non-therapeutic or inappropriate with the hospitalized borderline patient (Sederer & Thorbeck, 1986).

The findings may suggest deficits in nursing education that are indigenous to many nursing programs. That they are similar to those in studies over the last two decades suggests that educators may not be addressing the interpersonal process adequately. Nursing programs have relied heavily on models of communication that are variations of sender-receiver feedback loop models (Watzlawick, Beavin & Jackson, 1976) or skills training models (Carkhuff, 1969; Egan, 1975). These models, including the person-centred theory of Carl Rogers (1951), fail to provide a theoretical model for understanding the meaning of the interpersonal process. This understanding requires a theoretical base, grounded in a theory of the person. Theories deriving from the psychoanalytic tradition, such as object relations theory (Buckley, 1986), and theories of intersubjectivity help in understanding the consequences of early experience on later relationships and behaviours, and how individuals evolve in relationship to others. This knowledge enables the nurse not to "psychoanalyze" but to appreciate that behaviour does not exist in a vacuum but has particular meaning to all participants. These meanings should be explicit if the nurse is to help his or her patient. The therapeutic relationship is a critical intervention strategy in the psychiatric setting, and a key component of any structured intervention protocol. Knowledge about the patient's subjective experience of treatment and intervention regimes will enable the nurse to understand resistances and difficulties encountered in the implementation of treatment and intervention strategies.

Pothier (1988) recently expressed concern that the value of the interpersonal process was becoming lost in Nursing's pursuit of science. The nursing process, taught to all nurses, focuses on the collection of information from the patient as a base for care plans, and is pre-emptive, "in that it views the interaction or relationship from the point of view of the nurse" (Davis, 1984, p.78). The questionable efficacy and application of nursing care plans suggest that this viewpoint is inadequate (Manthey, 1980). Davis (1984) suggests more emphasis on interpersonal processes that reveal the dynamics of the interaction.

Within psychiatry, shifts to a closer affinity with medicine, emphasis on symptom control and crisis intervention may also lead to a devaluation of interpersonal skills in the therapeutic milieu (Gutheil, 1985). Hall has suggested that "when psychiatric practice became an inpatient medically ruled profession, nursing was forced to modify its psychosocial practice" (Pothier, 1988, p.193). A number of authors have suggested or demonstrated that attitude may be a more significant determinant of patient care than nursing process or expert knowledge (Gallop, 1988; Moss, 1988; Wood & Cullen, 1983). As beliefs and attitudes about inpatient psychiatry are modified, response behaviours may change to reflect these shifts. The findings of this study, and of previous research, indicate that nurses provide quick solutions to immediate problems such as providing advice or making a supportive

comment, but fail to plan care based on an understanding of the patient's subjective experience (Clark, 1981; Gelfand, Gelfand & Dobson, 1967). Given the current climate in psychiatric practice, these activities may be considered good nursing practice.

Conclusion

This study, like previous studies, continues to raise questions about the nature of nursing communication. Even in the psychiatric setting, little investigation of feelings occurs. Is the subjective experience of patients worthy of investigation, or has the investigation of feelings been abandoned with remedicalization and deinstitutionalization?

If nursing continues to espouse the value of empathy and therapeutic communication, then nurses must understand their roles in the interpersonal process so that they can understand how their behaviour contributes to outcome in the nurse-patient dyad. Unfortunately this cannot be done by the traditional approach of theory courses on communication. Process phenomena can only be learned when nurses are provided both theoretical understanding and opportunities to explore their behaviours and their responses to patients. The latter can be done by clinical supervision that values the meaning of behaviour and the interpersonal process and help nurses integrate this new understanding into their practices. Nursing has been clearly recognized as an art and a science. Being able to hear the pain of another requires both parts of the equation.

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RÉSUMÉ

Expression de l'empathie par le personnel infirmier de services psychiatriques

Cette étude rend compte de l'empathie exprimée par le personnel infirmier travaillant dans des unités de soins psychiatriques intensifs. Les sujets ont répondu au questionnaire intitulé *Staff Patient Interaction Response Scale* (SPIR). Ils ont ainsi indiqué comment ils réagiraient vis-à-vis des patients dans certaines situations hypothétiques. L'analyse des réponses par des évaluateurs chevronnés a permis de constater que dans la majorité des cas (soit 51%), la réaction du personnel infirmier consiste à expliquer les règles et les attentes du service, à prodiguer des conseils ou à s'enquérir du contenu superficiel. Vingt pour cent des réponses ont été jugées dépréciatives ou banales. A peine 29% des répondants ont manifesté de l'intérêt pour les sentiments des patients hypothétiques ou exprimé à leur égard de la sympathie ou de la compassion. Une telle répartition des réponses peut s'expliquer par les méthodes d'enseignement du processus interpersonnel ou par la modification des valeurs dans les unités de soins psychiatriques intensifs.