In this coursebook, Ghanaian healthcare professionals will find a treasure trove of information on therapeutic communication from experts in linguistic communication and nursing. ***Therapeutic Communication Competencies for Nurses and Midwives*** is written in clear and accessible language with examples and activities relevant to the Ghanaian context. The content is comprehensive, yet detailed. This book is most certainly an important contribution to the work and mission of nurses and midwives throughout Ghana.

Ruth Gyang (FWACN, FGCNM)

Former Registrar, Nursing & Midwifery Council, Ghana

Effective nurse-patient communication enables the nurse/midwife to make the right clinical judgements to bring about therapeutic outcomes. This book is well-written and structured. The content keeps the reader interested to the end. It is informative, educative, very relevant, and contains unique insights for healthcare professionals. I strongly recommend ***Therapeutic Communication Competencies for Nurses and Midwives*** for nursing and midwifery trainees, and even those who have already completed their training.

Professor Ernestina S. Donkor (PhD, RN, RM)

Former Dean, School of Nursing, University of Ghana

Communication is central to all effective healthcare relationships. ***Therapeutic Communication Competencies for Nurses and Midwives*** is a practical book that addresses issues relevant to the changing trends of healthcare delivery including technological advances. This coursebook will enhance the ability for educators, students and healthcare staff to empathise as it focuses on cultural-sensitivity in communication. The competencies will help healthcare providers holistically address the multiplicity of conditions for which a patient may seek care. I consider this coursebook as very timely in teaching the type of communication that promotes health, allays fears of patients and relatives; and enhances the provision of collaborative care. I recommend this book to all nursing and midwifery educators and trainees.

Dr. Victoria B. Bam (PhD, RN, FWACN. FGGNM)

Head, Department of Nursing, KNUST

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THERAPEUTIC COMMUNICATION COMPETENCIES FOR NURSES AND MIDWIVES

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NANA ABA APPIAH AMFO, TOPE OMONIYI NII TEIKO TAGOE, ỌBÁDÉLÉ KAMBON AND KOFI KORANKYE SAAH

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DEDICATION

In fond memory of our co-author, colleague and friend, Professor Tope Omoniyi, with whom we had a shared vision of making linguistic knowledge relevant and applicable to professionals, and who, unfortunately, did not live to see the result of our joint labour.

Professor Tope Omoniyi (20 February 1956 – 27 May 2017)

ACKNOWLEDGEMENTS

The objective of the authors of this book is to provide a relevant, contextually appropriate, coursebook to guide the teaching and learning of therapeutic communication in nursing and midwifery training colleges. This has been made possible through substantial contributions by a number of organisations and individuals whose efforts we wish to acknowledge.

The basis and further inputs for some sections of this book was propelled by healthcare communication surveys conducted by participants of a Commonwealth Professional Fellowship Programme hosted by the University of Roehampton and funded by the Commonwealth Scholarship Commission of the United Kingdom (CSCUK) and the Department for International Development (DfID). We are grateful to the fellows who did the surveys. They include David Sampson, Anthony Edusei, Joana Danso, Emmanuel Acheampong, Dr. Ekua Essumanma Houphouet and Professor Nana Aba Appiah Amfo. We appreciate the platform that was provided by the Commonwealth Professional Fellowship Programme and the sponsors of the programme –the Commonwealth Scholarship Commission of the United Kingdom (CSCUK) and the Department for International Development (DfID). Also, the institutional host of this programme, University of Roehampton deserves special mention.

The Registrar of the Nursing and Midwifery Council of Ghana (N&MC), Mr. Felix Nyante, has been critical to the start and development of this coursebook. His vision, drive and innovation made it possible for us to facilitate a training programme for nursing and midwifery tutors throughout the country and to later develop this coursebook. The participants of those workshop sessions provided valuable inputs for the development of the coursebook, and we are grateful. The support provided by relevant staff of N&MC throughout this process has been remarkable. We are especially grateful to Mercy Avogo for facilitating various administrative processes, and to Nana Boateng Agyeman, and his team, especially Elorm Fianya, for arranging acceptable photographs for the purposes of illustration.

The office of the Dean of the School of Languages, University of Ghana, has been a keen partner in this project. The authors are grateful for the logistical support that the office constantly provided. We are grateful to the staff, particularly to Worlanyo N. Torvinyo, Sylvia A. Sarbah and Julius Owusu Afriyie for administrative services.

Dr. Ekua Essumanma Houphouet provided a professional edit from a healthcare perspective, while providing suitable exercises for some of the chapters, and the authors are grateful. We are appreciative of Dr. Abobo Kumbalonah for doing a thorough linguistic edit of the coursebook.

Finally, the authors acknowledge their spouses for enduring many lonely nights and days as they prepared this coursebook within strict timelines.

FOREWORD

Nursing and midwifery training and education in Ghana and across the globe is responding to changing needs in healthcare delivery. Student nurses and midwives who acquire the knowledge, skills and behaviours that meet the standards of the Nursing and Midwifery Council (N&MC) will be equipped to address these present and future emerging trends, improve health and wellbeing, and lift the image of the profession high.

As a result of the changing needs in the provision of quality healthcare, six new courses were included in the revised curriculum (October 2015) for the training of nurses and midwives. One of the newly introduced courses is **Therapeutic Communication**. In response to the Council's interest in equipping tutors, in the various Nursing and Midwifery Training schools in Ghana, with instructional skills in therapeutic communication, this coursebook has been developed to serve as a teaching and learning guide.

In the light of this development, I welcome this excellent course book in which the seasoned authors - who have several years of distinguished professional experience in higher education - have covered a breadth of interesting, appropriate, and equally refreshing range of critically important topics in therapeutic communication, across all fields of nursing and midwifery practice. These authors were assisted by one of the Senior Staff of the Council. Prior to the development of this coursebook, the N&MC, in collaboration with the writers organised a nationwide workshop on therapeutic communication for tutors from the various Nursing and Midwifery Training Schools. The essence of these training programmes was to equip the tutors with current information and knowledge on how to address issues of therapeutic communication at our various healthcare facilities.

Therapeutic Communication Competencies for Nurses and Midwives is a coursebook that combines effective communication technologies and processes that are necessary in professional interpersonal interactions with patients, families, healthcare provision team members and the community.

This coursebook is no ordinary one; it challenges standard protocols of current nursing and midwifery practice by providing a comprehensive and practical approach to concepts in therapeutic communication that are necessary skillsets for the practitioner to competently manage the therapeutic function consequential to his/her care-relationship (with patients, family, the community, and colleagues).

It is worth noting that in the discharge of our professional duties as nurses and midwives, we sometimes experience situations where we consider that an interaction with a patient, family member or colleague did not go smoothly, and perhaps we were misconstrued. At a time like this, we may think that we could have said or done something differently that would have improved our own reactions and responses and that of those around us. It is for this reason also, that I find this coursebook important to guide us to understand the concepts of therapeutic communication and apply them in all circumstances of our encounters with patients, families and the community at large.

There is the need for practitioners and students to learn and improve when it comes to our relationship with patients and their families. This is mainly because there are so many factors that influence how we respond therapeutically in various situations. This coursebook is thus designed to provide you with the requisite skills to overcome communication barriers.

Students and professionals from all health disciplines will find this coursebook important in the development of skills that are foundational to the evolving complexities of the nursing and midwifery professions.

The Nursing and Midwifery Council is certain that this coursebook will help maintain high standards of nursing and midwifery education and practice in Ghana.

Signed

Felix Nyante (FWACN, FGCNM)

Registrar

AUTHORS

Professor Nana Aba Appiah Amfo is Associate Professor of Linguistics and Dean of the School of Languages at the University of Ghana. As a widely published academic, she is interested in language use in social contexts and in specific domains, such as health, religion, politics and migration. She holds a PhD from Norwegian University of Science and Technology. She has benefitted for various training programmes, and has been a facilitator of several capacity building workshops nationally, some of which have been for the benefit of health professionals.

Professor Tope Omoniyi, until his death in May 2017, occupied the Chair of Sociolinguistics at the University of Roehampton in London. He was the Director of the Centre for Research in English Language and Linguistics and Coordinator of the MPhil/PhD programmes in Linguistics. As a scholar of international repute, he served as facilitator and convenor of the English Plus Africa Project which sought to bring together healthcare practitioners and linguists in West Africa for mutual benefits. He published extensively, following his PhD degree from University of Reading.

Nii Teiko Tagoe is a Deputy Director of Nursing Services and a Regional Officer with the Nursing and Midwifery Council of Ghana. He has had over two decades of clinical practice as a mental health practitioner. In addition to his nursing qualifications, he has a degree in communication. He is an editorial board member of the Nursing and Midwifery Council, and Ghana Registered Nurses and Midwives Association. He is devoted to promoting mental health hygiene, therapeutic relationships and communication within professional settings and social contexts, and has facilitated several seminars and workshops for social, religious and professional organisations.

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Professor Kofi Korankye Saah is Associate Professor on post-retirement contract at the Department of Linguistics, School of Languages, University of Ghana He has published many articles in reputed academic journals, contributed book chapters and presented numerous papers at both local and international conferences. His teaching and research have been focused on syntax, child language development, language use and attitudes, and language teaching. He has been a facilitator for workshops on communication for healthcare professionals. His PhD degree is from the University of Ottawa in Canada.

GENERAL INTRODUCTION

In undertaking the preparation of a professional coursebook of this kind, it is prudent to undertake some groundwork to determine or at least estimate the level of interest in the subject that is to be covered. Thus, it is worth noting that the production of this book is in response to the strategic overhaul of the nursing and midwifery education in Ghana in 2015. The Nursing and Midwifery Council (N&MC) of Ghana as part of its periodic review process, revised the nursing and midwifery training curriculum. One of the substantial resulting changes is the substitution of the old Communication Skills module with a new and more relevant Therapeutic Communication course requirement. This is in alignment with good professional practice in nursing and midwifery in Ghana as well as in other parts of the world. Korsah (2011, p. 8) submits that there is the need for the training of nurses (and midwives) to be adapted in a way that permits them to "put themselves in the client's situation", allowing them to "explain their professional point of view in a therapeutic manner…". This coursebook is therefore a timely response to such calls to equip nurses and midwives with relevant, contemporary, culturally sensitive communication skills. It is intended to provide students of nursing and midwifery with the needed therapeutic communication competencies, which will enable them to function effectively in their professional roles as caregivers of vulnerable persons.

Writing this Coursebook

The decision to produce a definitive coursebook is always a good one towards streamlining the provision of curriculum content in the education sector. This is especially the case when the curriculum has been devised to attain and maintain a standard of expertise at an identified level of education. In this case, students enrolled at Nursing and Midwifery Training Colleges are the target readership of this coursebook. After a successful study period, these students are awarded a diploma in nursing/midwifery (as the case may be) from the respective universities to which their training colleges are affiliated. Concurrently, the Nursing and Midwifery Council of Ghana provides them with a license to practise as professional nurses and midwives. Thus, in

preparing the materials in the Units contained in this coursebook, the authors have been guided by this major objective.

The Nursing and Midwifery Council of Ghana, as the national authority and regulatory body on nursing and midwifery education, had the responsibility for commissioning the writing of this coursebook and it took the decision to seek and explore relevant expertise from resource persons drawn from three institutions: Nursing and Midwifery Council of Ghana, University of Ghana and the University of Roehampton, London. This collaboration originated from the participation of personnel from the three institutions in a Commonwealth Professional Fellowship Programme hosted by the University of Roehampton and funded by the Commonwealth Scholarship Commission of the United Kingdom (CSCUK) and the Department for International Development (DfID). But for administrative exigencies which got in the way, the Registrar of the Council was initially nominated for the scheme as a strategy of bringing in policy makers to a programme that was envisaged to change healthcare practice in the region.

The theme of the University of Roehampton fellowship programme was 'Effective communication in public health care delivery in sub-Saharan Africa (Ghana and Nigeria)'. The University of Roehampton resource person, Professor Tope Omoniyi, was invited to deliver a keynote lecture at the annual conference of the Council of Heads of Health Education &Training Institutions (COHHETI) in Cape Coast on October 4, 2015. It was only natural then that the addition of Therapeutic Communication to the curriculum and the writing of this coursebook should harness the benefits resulting from these historic interactions and collaborations.

The coordination of the writing process naturally fell on the Dean of the School of Languages at the University of Ghana, Professor Nana Aba Appiah Amfo, who herself is a Commonwealth Professional Fellow (2015). She generously deployed her resources to launch the project with a residential writing retreat in September 2016 that brought all the writers together for the first time (except for the Nursing & Midwifery Council representative). It was a unique and fruitful experience. The immediate follow-up to this was the involvement of the resource persons in a training programme for nursing and midwifery educators organised by the Nursing and Midwifery Council across three regional

centres-Tamale (Northern Region), Asante Mampong (Ashanti Region) and Accra (Greater Accra). This involved prospective nurse educators on the therapeutic communication programme in the over one hundred Nursing and Midwifery Training Colleges in Ghana.

Why Therapeutic Communication?

Development in nursing and midwifery practice around the world shows rather clearly that healthcare is a collaborative phenomenon between the carers and those to whom they have a duty of care. Previously, it was perceived as a one-directional operation in which the sick sought solutions to health problems from professionals who purportedly have all the answers. But a new holistic approach to the practice of nursing and midwifery reveals that patients and healthcare professionals are in fact engaged in a very significant social relationship. One that has a positive bearing on the outcome of any interventions that may be undertaken in addressing the health issues of patients. If the relationship works, there is the likelihood that the quality of care will be higher and society will record improved health standards.

Survey Report

Data from a number of surveys conducted between 2013 and 2015 in Accra, Kumasi and Dunkwa in Ghana as part of the 'Effective Communication in Public Healthcare Delivery Project' conducted by Commonwealth Professional Fellows identified the significance of *affect* in health care delivery. And affect is at the very heart of therapeutic communication. So, what is affect? Affect concerns our feelings, moods and emotions; 'affairs' of the heart. *Segen's Medical Dictionary* describes it as "subjectively experienced feelings encompassing emotion and mood". These feelings and moods are externalised in various ways which are then interpreted or assigned meanings. For example, tone, laughter, wince, crinkled forehead, smile, smirk, raised eyebrows, squint, wink, lip-suck, scrunched nose, a tear, frown, etc, convey varying emotions and we deploy them as part of the socio-psychology of communication.

Nurses and midwives, in engaging with patients, must be conscious of their display of affect and also must carefully read and interpret these to ensure success in their transactions. In one of the surveys referred to

above, 80% of the respondents agreed that it is easier to trust a nurse who understands and speaks one's language. Such trust is highly likely to be transmitted through a smile, an excited gaze at discovering that the nurse understands and speaks the patient's language. In a nutshell then, the therapeutic communication module must seek to equip nurses and midwives with communicative tools and strategies that evoke positive affect most, if not all, of the time.

The Units of this Coursebook

In order to provide prospective nurses and midwives with adequate therapeutic communication competences, this coursebook addresses the principles and processes involved in the therapeutic relationship expected between nurse/midwife and patient or relatives through their communicative encounters in thirteen Units.

Unit 1 discusses the principles of communication. This is done against the backdrop that the therapeutic relationship between the nurse/midwife and the patient relies heavily on an effective communication process. We demonstrate that communication is a complex multi-faceted process, which takes place within a socio-cultural context. Unit 2 is concerned with Ghana's language policy and practices. We look at the languages spoken in Ghana and how they have been utilised for national development. We note that in the health sector, there is no known official language policy. Therefore, nurses and midwives are expected to use whatever language that allows them to effectively communicate with their patients.

Unit 3 introduces the reader to the concept of therapeutic communication. We suggest that the communication process between the nurse/midwife and patient is expected to be therapeutic so as to yield healthy outcomes. Therapeutic communication strategies are presented as well as other communicative methods that hinder an effective therapeutic encounter. In Unit 4, we discuss verbal and non-verbal communication. We relate the importance of verbal and non-verbal communication to the therapeutic communication process. Non-verbal communication cues such as paralanguage, appearance and body movement are discussed within the context of how they add meaning to verbal communication. Ways for improving non-verbal communication skills for effective therapeutic communication are identified.

Unit 5 is concerned with the recognition of different communication styles. As a result, different communication styles and the behaviour patterns associated with them are examined. How these communication styles affect therapeutic communication are presented. Within the context of different communication styles, the nurse/midwife is expected to maintain therapeutic speech and behaviour at all times. Unit 6 focuses on how the nurse/midwife could therapeutically talk about face-threatening and emotionally challenging health concerns with patients and caregivers. The different communicative contexts present in the healthcare context require different approaches, and the nurse/midwife is encouraged to be assertive without being combative.

Unit 7 explores nursing and midwifery practice in other cultures within the context of universal professional practices. The impact of cultural and social issues on professional nursing and midwifery practice is discussed. Unit 8 describes the skills involved in effective conversation between nurses/midwives and their patients. Each patient ought to be considered as a unique individual bearing in mind his/her socio-cultural values. Unit 9 explores how the nurse/midwife can utilise nursing informatics to enhance communication within the healthcare setting. It describes what nursing informatics is and how it can be employed for aspects of therapeutic communication. Unit 10 is concerned with how the nurse/midwife is able to give and receive constructive criticism or feedback. Constructive criticism is expected to be offered in a kind and considerate manner with the aim of getting the individual to change a particular behaviour or attitude.

A critical part of the nurse's/midwife's function involves making presentations. Unit 11 focuses on how information can be presented skilfully in the overall context of therapeutic communication. General and specific information on presentation skills are provided, based on which the nurse/midwife can enhance his/her presentation skills. As part of the therapeutic communication process, the nurse/midwife may be required to provide some basic counselling before the patient is referred to a professional counsellor. Unit 12 therefore discusses the basics of counselling with the aim of equipping the nurse/midwife for the basic counselling role that may be associated with his/her work. This coursebook ends by emphasizing the high professional standards required of the nurse/midwife. This is presented through an exposition of the Nurse's Pledge and the Midwife's Prayer in Unit 13.

UNIT 1:

PRINCIPLES OF COMMUNICATION

1.1 Introduction

This Unit focuses on principles of communication with the understanding that communication is critical to the development of effective nurse/midwife-patient relationship, which is a vital ingredient for effective therapeutic communication processes in the healthcare delivery context. This is occasioned by the understanding that interpersonal relationships are fostered or maintained through one form of communicative activity or another. If communication fails, relationships break down. To understand and explain this we must think of communicative encounters as transactions and negotiations, and look closely at the intricacies of the context. This Unit will therefore examine the principles of communication; examine the process of communication as well as the social dimensions that need to be considered in nurse/midwife-patient interactions.

1.1.1 Why Nurses and Midwives Need this Knowledge

In healthcare provision, a breakdown can be extremely costly; including the loss of lives. Breakdowns are often a 'joint venture' between the healthcare professional and the patient because they disregard the sanctity of the partnership and interdependence that exist between communicators. In healthcare facilities and other public service facilities in many societies around the world, cautionary notices are placed in strategic pressure areas advising clients that abuse of staff will not be tolerated. But such notices are actually incapable of guarding against breakdowns, so we must turn to the training of the professional healthcare provider, and inculcate in them the required communicative principles and practices. It is therefore important that nurses or midwives are provided with the fundamentals of communication which is expected to

guide the nurse/midwife in establishing and ensuring a good interaction with the patient, as a means of enhancing the healthcare delivery process.

1.2 Learning Objectives

After completing this Unit, you should be able to master the following skills and ideas:

- Understand that communication is a complex multi-faceted process.
- Appreciate the basic principles that apply in the communicative encounter.
- Understand the elements involved in the communication process including the value of feedback.
- Appreciate the social dimension of communication and the related factors that affect the interactional encounter.

1.3 Principles of Communication

Communication involves two parties, where one gives information and the other receives that information through a specified channel. According to Mondal (nd.), it involves an intention to elicit a response from the addressee, after meaning has been derived by the addressee. Communication could be verbal and non-verbal. It may involve just two participants; a speaker and an addressee. Or it could involve several participants; as in a communicative encounter with a speaker and several addressees. Communication can take place in a formal setting, such as a public lecture on a public health issue, or it could be in an informal setting, as in a conversation between spouses on what they should have for dinner. Furthermore, communication could take place in a semi-formal context. A conversation between a nurse and a patient on how the patient needs to adjust his lifestyle to suit his recently diagnosed diabetic status could be an example of communication in a semi-formal context. Irrespective of the context of communication or the number of participants, certain general principles need to be observed in order to ensure that the communication process is unhampered and successful.

For effective communication to take place, the authors of *Principles*

of Communication (Beimborn, nd), suggest that the communicator has to bear in mind a number of factors, some of which we have adapted and elaborated upon below:

- Know your audience: In the healthcare setting, communication is facilitated when the nurse/midwife is familiar with the patient in terms of his/her ethnic, language, socio-religious background. This allows for the appropriate choice of language if that is available in the linguistic repertoire of the interacting nurse/midwife. Also, knowledge of the socio-cultural and religious background of the patient, allows the nurse/midwife to tailor the conversation in such a way that religious and cultural sensitivities are not offended, while providing relevant and useful healthcare information.
- Know your topic: Familiarisation of the topic under discussion allows for the nurse/midwife to be in control of the conversation, such that the patient walks away with the relevant and updated healthcare information about the particular health situation under discussion. This evokes confidence on the part of the patient and he/she is likely to return to this informative nurse/midwife in the future.
- Anticipate objections: This is most effective when the nurse/midwife is familiar with the socio-cultural, religious (and sometimes) educational background of the patient. When objections are anticipated, the nurse/midwife prepares to counter them, in a professional manner, so long as they have the tendency to hamper the process of healthcare delivery.
- Achieve credibility with your audience: This can be done when the nurse/midwife makes the effort to familiarise themselves with the norms and practices of the community in which they serve, such that they are able to situate the patient-nurse/midwife conversation in the appropriate socio-linguistic context. For example, a nurse who is attending to a young mother who has just been delivered of a baby in a rural Ghanaian community will evoke a lot of confidence in what she has to say if she demonstrates local knowledge of child rearing narratives from the community that the new mother knows. In such circumstances, local idioms and other humorous asides become spice for the interaction that is taking place. Additionally, displaying adequate knowledge in

the specific topic being discussed increases the credibility of the nurse/midwife.

- Follow through on what you say: To build up confidence in the communicative encounter, it is essential that the nurse/midwife follows through on what he/she says.

Imagine this scenario: A very distraught and ill young man arrives at a healthcare facility in pain and totally unaware of what is wrong with him. The nurse on duty meets him with a warm, caring but concerned smile and says "Please sit on that bench over there and I'll come to you immediately." If he/she almost immediately suspends what she was doing, goes over to the man and bends so that she is at eye-level with him and as she takes his temperature and pulse rate she says "Young man, how long have you been feeling this way?" How do you think the young man would feel? He would obviously feel a sense of relief and his level of anxiety would have lowered considerably. This is because the nurse actually followed up on what he/she said when the young man walked in and demonstrated empathy. What if it took her/him another 20 minutes to get back to this young man in pain. He would certainly feel disappointed, may think of the nurse as an unwilling helper, and that could even affect how much of his condition he would be willing to share with the nurse. A situation which ultimately results in adverse healthcare provision outcomes.

- Communicate a little at a time: Nurses/Midwives should constantly remind themselves that the majority of their patients are lay people who have not had the benefit of medical education. As a result, bombarding them with a lot of medical information at the same time does not often achieve the desired intentions, especially when the patient is going through the emotional struggle of dealing with a newly diagnosed illness. It is therefore advisable that the necessary health information is communicated a little at a time. More information can be added when the feedback indicates that the earlier information has been well understood.

- Present information in several ways: Since nurses/midwives interact with a wide spectrum of patients from varying socio-economic, linguistic, cultural and educational backgrounds, which may correspond to varying levels of understanding of health conditions and appreciation of different treatment regimes, it is vital that they adopt several strategies in communicating essential healthcare information. Presenting information in several ways may involve one or more of the following strategies.

    - The use of multiple languages. For example, given the linguistic diversity of a set of pre-natal women, the midwife may decide to use English, Akan and Ga in her pre-natal lesson. Such that each vital piece of information, first provided in one of these languages, is repeated in the two other languages. This is to ensure that every pre-natal woman present goes away with vital information pertaining to their upkeep and that of their unborn babies.

    - A piece of information could be presented orally (by word of mouth) and well as pictorially (for example by the use of posters, dummies, etc). The use of multiple means of communication usually helps in reinforcing the message that is being transmitted. Pictorial evidence often helps in imprinting vivid images in the minds of the audience, and often helps them to remember the information being communicated.

- Develop a practical, useful way to get feedback: It is important for the nurse/midwife to bear in mind that communication involves two parties. Even though in the healthcare context the health practitioner is the more powerful member of the communicative

duo, his/her success as a communicator depends to some extent on the cooperation of the other party, the patient. It is therefore critical that the nurse/midwife is sensitive to feedback, and is able to identify both verbal and non-verbal feedback, which is then used to improve the communicative encounter. For example, if a nurse starts to explain a particular treatment regime to a patient in English and he/she observes a lack of interest on the person's face, it is appropriate to pause and ask the patient his/her preferred language (assuming that was not done earlier). If the nurse/midwife is able to speak the preferred language, he/she ought to then switch to that. If he/she is unable to speak the language, he/she can then seek help from other nurses/midwives on duty, or resort to the language support services provided within the healthcare facility, if such services exist. If this is not done, there is the risk of talking without actual communication taking place.

1.4 The process of communication

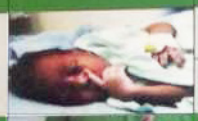
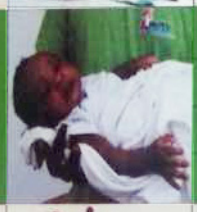
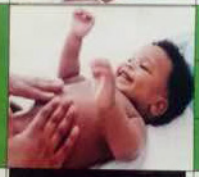
The process of communication involves a speaker and an addressee, and a chosen channel of communication. The speaker encodes her message into a code (language) that the addressee is expected to understand, and transmits that message through a chosen channel. The addressee, having received the message, then decodes it, in order to get the meaning of the communicated message. The actual interpretation, eventually derived, takes into cognisance the linguistic and extra-linguistic context available to the speaker and addressee.

The channel used may be verbal or non-verbal. Verbal communication involves the use of words, which may be written or spoken, while non-verbal communication does not involve words. See Unit 4 for a detailed discussion of verbal and non-verbal communication. Nurses/midwives communicate with patients verbally through face-to-face interactions in conversations, interviews, presentations (for example a talk to a group of post-natal women on breastfeeding), telephone calls, SMS messages, WhatsApp messaging, etc. The aforementioned means of verbal communication are oral. Note that verbal communication could be in written form such as letters, memos, leaflets and signages.

Most public health leaflets and health facility signages are multi-modal, in the sense that they make use of both text and images in communicating the desired messages.

Such multi-modal means of communicating to patients is commonplace in healthcare facilities. Within multilingual communities, it is possible for signages and leaflets to be presented in more than one language, which is tacit acknowledgement that communication difficulties may result from discordant language (Binder, Borné, Johnsdotter, & Essén, 2012) between the healthcare provider and the patient, and so the health practitioner has the responsibility to go to various lengths to ensure that the communicated message is accessible to the target audience.

MINISTRY OF HEALTH/GHANA HEALTH SERVICE
EXPANDED PROGRAMME ON IMMUNISATION
NATIONAL IMMUNISATION AND VITAMIN A SCHEDULE FOR CHILDREN

AGE	PICTURE	VACCINES	DOSE	ROUTE AND SITE OF ADMINISTRATION
At Birth		BCG	0.05ml	Intra-dermal, right upper arm
		OPV 0	2 drops	Oral
6 weeks		OPV 1	2 drops	Oral
		DPT-HepB-Hib 1	0.5ml	Intra-muscular, left thigh
		Pneumococcal 1	0.5ml	Intra-muscular, right thigh
		Rotavirus 1	1.5ml	Oral
10 weeks		OPV 2	2 drops	Oral
		DPT-HepB-Hib 2	0.5ml	Intra-muscular, left thigh
		Pneumococcal 2	0.5ml	Intra-muscular, right thigh
		Rotavirus 2	1.5ml	Oral
14 weeks		OPV 3	2 drops	Oral
		DPT-HepB-Hib 3	0.5ml	Intra-muscular, left thigh
		Pneumococcal 3	0.5ml	Intra-muscular, right thigh
6 months		Vitamin A	100,000 I.U	Oral
9 months		Measles / Rubella	0.5ml	Sub-cutaneous, left upper arm
		Yellow Fever	0.5ml	Sub-cutaneous, right upper arm
12 months		Vitamin A	200,000 I.U	Oral
18 months		Measles	0.5ml	Sub-cutaneous, left upper arm
		Vitamin A	200,000 I.U	Oral

When the speaker has encoded his/her message and transmitted it to the addressee through an appropriate channel, the addressee receives it, decodes it, interprets it with the help of other contextual information, and then provides feedback to the speaker. The feedback

from the addressee may come in various ways. It could be by means of verbal communication, such as an oral or written response. It could also be by non-verbal means like a shrug of the shoulder or nod of the head, or simply silence. The nurse/midwife needs to bear in mind that communication is a two-way process, and so he/she needs to be alert to feedback from the addressee throughout the communicative encounter, as that informs whether and how to adjust the presentation of the message to ensure better communicative outcomes.

1.5 The social dimension of communication

As mentioned in section 1.4, the addressee in interpreting the message received from the speaker takes into consideration other features of the context. Context is not restricted to the utterances that precede or follow the utterance in question. Sperber and Wilson's (1995) psychological definition of context does not exclude the inclusion of physical, social and cultural factors as features that influence the interpretation process. The factors that they propose affect the context of interpretation include expectations about the future, scientific hypotheses or religious beliefs, anecdotal memories, general cultural assumptions and the interlocutor's beliefs about the mental state of the speaker (Sperber & Wilson, 1995, pp. 15-16). It is therefore imperative for the nurse/midwife to be well aware of these background assumptions that communicators bring to the interactional process.

Within our African and Ghanaian contexts, social relationships are key factors that mitigate communication. Social relationships are defined by culture and varying levels of power and authority. In most African communities, including ours, age is highly respected. In the communicative encounter, one is expected to give due cognisance to that. For example, it is considered highly impolite to interrupt an older person. Likewise, social status is valued. A young lecturer is expected to be given due regard by her older student. Even though patients are increasingly becoming aware of their rights, society still assigns a lot of power and authority to healthcare professionals rather than their patients. There is therefore a greater obligation on the healthcare professional to ensure that the communicative process between them and their patients is functional, such that healthcare outcomes are

improved. Nurses/midwives need to note that even though society assigns power and authority to them, they cannot operate successfully without the cooperation of their patients.

1.6 Summary

This Unit has been concerned with the fundamentals of communication. It has sought to explain that communication is a collaborative process between two parties involving a specified channel. It elaborated upon the principles which communicators need to keep in mind to ensure that effective communication is achieved. This includes knowledge of the ethnic, language, socio-cultural, religious and educational background of the participants. It involves adequate knowledge of the subject area. Within our multilingual setting, it is imperative for nurses/midwives to explore the linguistic options available within a particular communicative encounter, as a means to maximise the communicative outcomes. The process of communication was explained, and the social dimension of the communicative process was examined.

► Exercise

A 60-year-old woman who is a farmer from Mempɛasɛm Village has been referred from the village health centre with suspected advanced breast cancer to your facility (which is a regional hospital). She reported with her 62-year-old husband who completed basic school and is also a farmer. Her condition is confirmed to be advanced and she has been admitted to your ward. The husband has been asked to run several laboratory tests and buy medications and he is confused as to why his wife should still not feel better. Even though the doctors have communicated the woman's diagnosis and prognosis to both of them, he (the husband) has come to you to find out when his wife is expected to recover and whether it would be possible to be discharged the following week. You get the impression he did not understand what the doctors discussed with him. You have sought the doctors' permission to explain the situation to him (with a doctor sitting in with you and giving you support).

► Question

How would you communicate the woman's diagnosis and prognosis to her husband?

Further Reading

Bernhardt, J. M. (2004). Communication at the core of effective public health. *American Journal of Public Health*, 94(12), 2051–2053. PMCID: PMC1448586

Websites

Doak, L. G., & Doak, C. C. (2004). Pfizer Principles for Clear Health Communication. Retrieved from http://aspiruslibrary.org/literacy/PfizerPrinciples.pdf

Beimborn, E. A. (nd). Principles of Communication. Retrieved from https://www4.uwm.edu/cuts/bench/commun.htm

PHAST. (2017). Principles, theories and methods of effective communication (written and oral) in general, and in a management context. Retrieved from https://www.healthknowledge.org.uk/public-health-textbook/organisation-management/5a-understanding-itd/effective-communication

UNIT 2:

GHANA'S LANGUAGE POLICY AND PRACTICES

2.1 Introduction

Though we sometimes take language for granted, it "pervades almost every aspect of our lives. We talk, think, argue, question, theorise, command, insult, promise, and joke – all with language. An infinitely adaptable system, human language allows speakers to be as specific or general as they wish in communicating on an endless variety of topics" (Perlmutter & Soames, 1979, p. 3).

Munoz and Luckmann (2007, p. 13) also have the following to say about language:

> Language is the primary means used by humans to communicate with each other. Humans have developed written, sign, and oral language in order to share messages. Humans use language to express ideas, feelings, and emotions; to communicate information, reactions, and directions to each other; and negotiate with each other.

In the healthcare delivery system, both practitioners and their clients use language in communicating with one another. Nurses/midwives are one of the first professionals a patient may encounter and interact with in a health facility. The interaction between the patient and the nurse/midwife is done through language. "Language provides the tools (words) that allow" the patient and nurse/midwife "to express their thoughts and feelings" (Munoz & Luckmann, 2007, p. 86). Without language of one form or another, this expression of thoughts and feelings cannot take place.

The complex linguistic landscape in Ghana and other African countries, if not properly handled, can become a barrier to effective therapeutic communication. No matter how skilled a nurse/midwife

is in therapeutic communication, if he/she does not share a common language with the patient, he/she will find it difficult to communicate with the patient. As Munoz and Luckmann (2007, p. 86) state, "even when nurses and patients speak the same language, misunderstanding can arise." It is of the utmost importance, therefore, that nurses and midwives exercise great care in their choice and use of language in their interactions with patients.

In this Unit, we will look at the languages spoken in Ghana and the attempts made to utilise them for national development.

2.1.1 Why Nurses and Midwives Need this Knowledge

In Ghana, nurses and midwives communicate with people of diverse ethnic and linguistic backgrounds in their workplaces every day. Communication may be impeded if they do not share a common language. Even when they use the 'official' language (English), communication may break down if the patient has a low proficiency in the language. Even in situations where they share a common language, there may be difficulties if they speak different varieties of that language. Awareness of the linguistic situation will help them to make informed choices regarding what language to use.

2.2 Learning Objectives

After completing this Unit, you should be able to master the following ideas and skills:

- Discuss the role of language in communication in general and how this affects nurse/midwife-patient interactions.
- Appreciate the diversity of languages that are spoken in Ghana, especially in the part of the country where you are likely to operate.
- Discuss the government policy regarding language use in the different spheres of our national life and how this impacts the healthcare industry.
- Appreciate the fact that people are very attached to their languages and dialects and that these are not to be belittled.

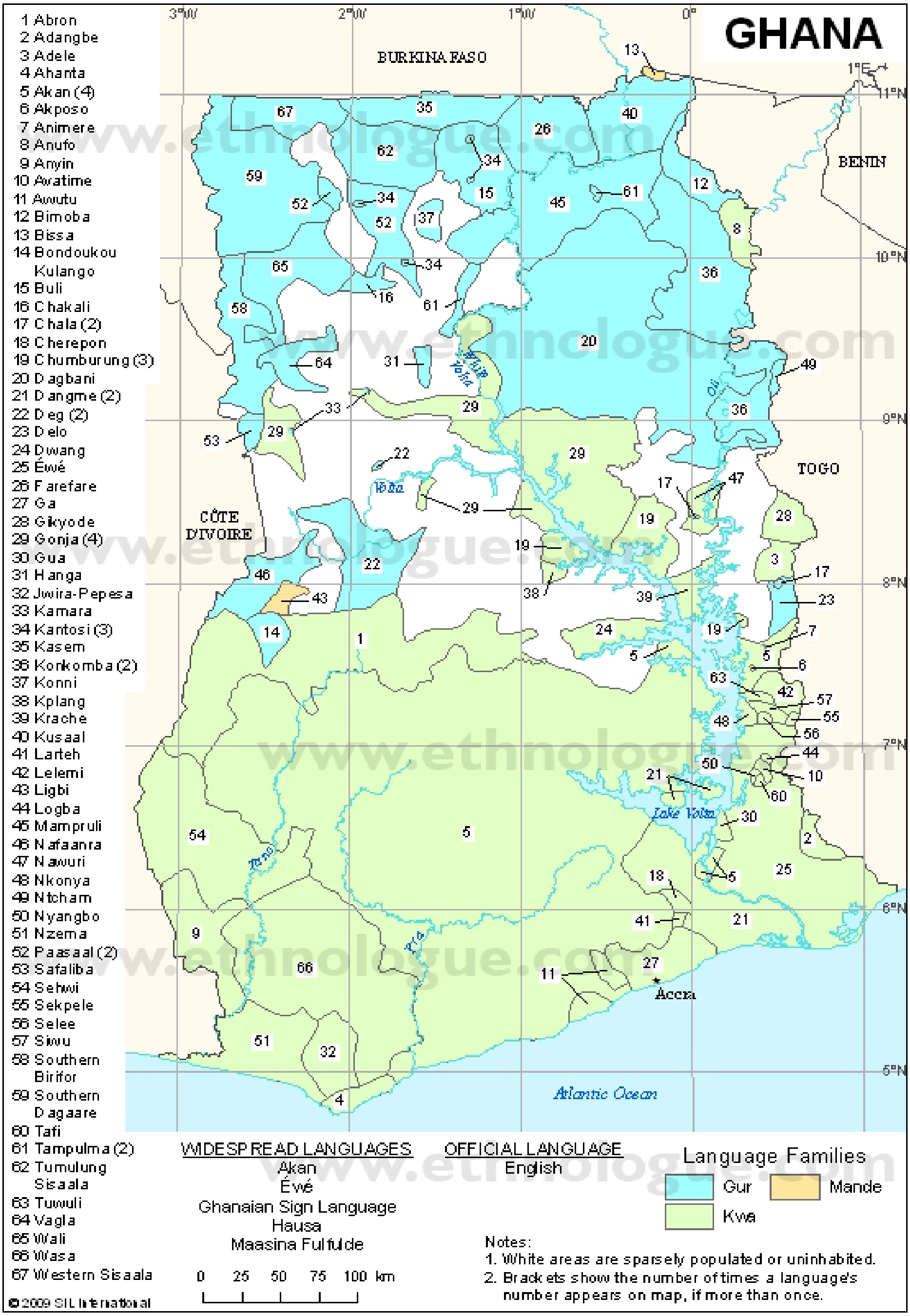
2.3 The Language Situation in Ghana

As we mentioned in the General Introduction, one of the surveys we conducted prior to the training of trainers workshops conducted in Tamale, Asante Mampong and Accra before the preparation of this textbook, suggested that "about 80% of respondents agreed that it is easier to trust a nurse who understands and speaks one's language." Unfortunately, this may not happen for some patients in Ghana, since the country is blessed with many indigenous languages and it is not always the case that a patient would walk into a healthcare facility and meet a nurse/midwife who speaks his/her language.

The exact number of indigenous language spoken in Ghana is difficult to pin down. According to Adika (2012, p. 151), "with a population of about 24.7 million (2010 Census), … Ghana has about 50 languages (Dakubu, 1996), the major ones being Akan, Nzema, Ewe, Ga, Dagaare, and Dagbani, with English as the official language." Some people, like Hall (1983) think that there are between 45 and 50 indigenous languages spoken in Ghana. Others, such as Dzameshie (1988), put the number between 45 and 60. According to Simons & Fennig (2017), "the number of individual languages listed for Ghana is 81. All are living languages. Of these, 73 are indigenous and 8 are non-indigenous. Furthermore, 13 are institutional, 46 are developing, 15 are vigorous, and 7 are in trouble." See the map below for the languages and where they are spoken in the country.

From these accounts, you can see that the number of indigenous languages spoken in Ghana varies according to who is counting and what they consider to be a language. Some of these languages are Akan, Ga, Ewe, Nzema, Dagbani, Kassem and others. Most of the time, speech forms that should be considered as dialects of the same language are often considered as separate 'languages'.

Look at the map below, and see if you can identify the language(s) or dialects spoken in the area where you are located. Note that to these languages we add Ghanaian Sign Language which is the language used by people with hearing impairment. It is as complex and sophisticated as spoken language.


GHANA
1 Abron
2 Adangbe
3 Adele
4 Ahanta
5 Akan (4)
6 Akposo
7 Animere
8 Anufo
9 Anyin
10 Avatime
11 Awutu
12 Bimoba
13 Bissa
14 Bondoukou Kulango
15 Buli
16 Chakali
17 Chala (2)
18 Cherepon
19 Chumburung (3)
20 Dagbani
21 Dangme (2)
22 Deg (2)
23 Delo
24 Dwang
25 Éwé
26 Farefare
27 Ga
28 Gikyode
29 Gonja (4)
30 Gua
31 Hanga
32 Jwira-Pepesa
33 Kamara
34 Kantosi (3)
35 Kasem
36 Konkomba (2)
37 Konni
38 Kplang
39 Krache
40 Kusaal
41 Larteh
42 Lelemi
43 Ligbi
44 Logba
45 Mampruli
46 Nafaanra
47 Nawuri
48 Nkonya
49 Ntcham
50 Nyangbo
51 Nzema
52 Paasaal (2)
53 Safaliba
54 Sehwi
55 Sekpele
56 Selee
57 Siwu
58 Southern Birifor
59 Southern Dagaare
60 Tafi
61 Tampulma (2)
62 Tumulung Sisaala
63 Tuwuli
64 Vagla
65 Wali
66 Wasa
67 Western Sisaala
BURKINA FASO
BENIN
TOGO
CÔTE D'IVOIRE
Lake Volta
Accra
Atlantic Ocean
WIDESPREAD LANGUAGES
Akan
Éwé
Ghanaian Sign Language
Hausa
Maasina Fulfulde
OFFICIAL LANGUAGE
English
Language Families
Gur
Mande
Kwa
Notes:
1. White areas are sparsely populated or uninhabited.
2. Brackets show the number of times a language's number appears on map, if more than once.
0 25 50 75 100 km
©2009 SIL International

(Lewis, 2009)

2.4 Language and Dialect

Ask two people - one who speaks say Akan and another who speaks Ewe - to communicate using his/her own language. Ask them whether they understood what the other had said. If they have not learned each other's language, they will not be able to understand each other because they speak different languages.

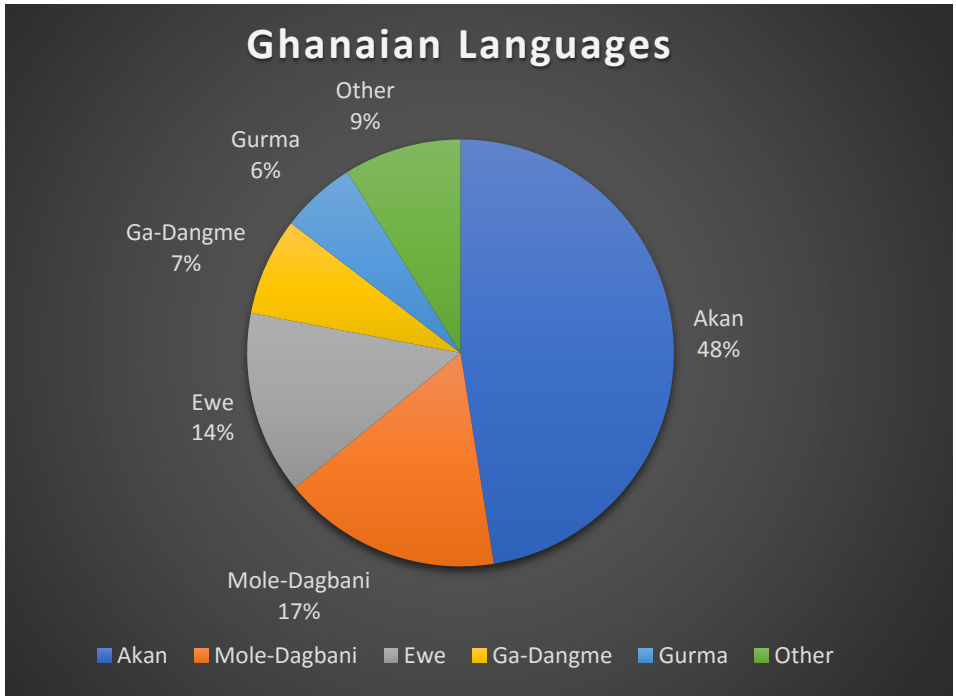
We did exactly that at the training workshop on Therapeutic communication at the N&MC offices in Accra. We asked a gentleman who identified himself as a native speaker of Ewe to engage a woman who is a native speaker of the Fante dialect of Akan in a conversation, each using his/her language. When we asked them whether they understood what the other had said, the Fante speaker said she did not understand what the gentleman has said in Ewe. The Ewe speaker, on the other hand, said he had learned Akan so he understood what the woman said. This goes to prove that Ewe and Akan, for example, are different languages. In the same way, Ga, Ewe, Nzema, and Dagbani are different languages. They are not mutually intelligible.

In the same experiment, we asked the Fante speaker to chat with another woman who speaks Akuapem (Twi). Both of them said that they understood what the other had said. This is because Fante and Akuapem are varieties or 'dialects' of the same language which is given the name Akan. Dialects of the same language are mutually intelligible, this means that speakers of the different dialects, like the Fante and Akuapem speakers in the experiment, understand each other. Asante, Akuapem, Fante, Akyem, Kwahu, Agona, Assen, Brong, etc., are mutually intelligible. This means that an Akyem speaker can communicate with an Akuapem, Asante or Fante speaker without a problem. Linguists (that is, people who engage in the scientific study of language) call these 'dialects' of the Akan language. They do not have to learn each other's 'language' in order to communicate.

Unfortunately, because Akuapem (Twi), Asante (Twi) and Fante have written forms and a lot of literature has been produced in them, people sometimes think of them erroneously as being separate languages even though they have a very high degree of mutual intelligibility. In linguistic study, because they are mutually intelligible, they will be described as dialects of the same language.

We must note, however, that sometimes varieties that are mutually intelligible may be classified as languages for political reasons, as is the case with the Scandinavian languages Swedish, Danish and Norwegian which are national 'languages' of three independent countries but are nevertheless mutually intelligible. In West Africa, Malinke, Mandinka, Mende, Bamana all refer to the same language but in different countries. Similarly, Fula, Pulaar, Pular, Fulani and Fulfulde refer to dialect varieties of the same language spoken by the Fulbe ethnolinguistic group in different countries.

By far Akan (Akuapem, Asante, Fante, Akyem, Kwahu, etc.,) has the largest number of native speakers. They constitute about 47.50% of the total population of Ghana. This is followed by Mole-Dagbani group 16.60%, Ewe 13.90%, Ga-Dangme 7.40%, Gurma 5.70%, and others 8.90%. The pie chart below gives the approximate number of speakers for some of the Ghanaian languages:



(Felipe, 2015)

2.5 Language Policy

Because of the large number of languages spoken in Ghana, governments since the colonial times to the present have tried to manage the use of these languages for the development of the country. Language management, according to Spolsky (2004, p. 11) 'refers to the formulation and proclamation of an explicit plan or policy, usually but not necessarily written in a formal document, about language use.' Language management includes three areas of activity: planning to establish what language needs there are and for what purposes, making policies to cater to those needs and more importantly, resourcing the languages concerned to enable them to fulfil the roles that are stipulated for them in policy documents. In the literature, a distinction is made between status planning and corpus planning. The first of these organises the many languages that exist in a multilingual country, like Ghana, by associating them with specific roles in development. For example, descriptions such as Official Language, National Language, Medium of Instruction are the result of status planning. In contrast, corpus planning entails the development of the resources of a language to enable it to meet needs across a range of practice areas. For instance, when we develop hitherto non-existent vocabulary for talking about Ebola and HIV/AIDS or for discussing development in information technology we are engaging in corpus planning. If we look at many of the world's languages today, we shall find new vocabulary entries that have emerged in the course of the last three decades. This is one proof that we have that it is a Western myth to say that African languages are not equipped to be used for science and technology. In this, we agree with Kobina Sekyi, one of the early Ghanaian nationalist intellectuals, who said:

> I do not endorse the views often expressed here, by those who cannot read or write Fanti, and who certainly are not capable translators, that our language is defective for expression of English ideas or expressions, especially in the presentation of abstract thought or scientific matter. Those who speak thus have not considered the extreme malleability of our language, like the Greek language in which it is easy to make neat verbal combinations to express new ideas. The Fanti language is rich in its vocabulary; but this is known only to careful students,

> who, as such, have no bias in favour of civilised people, so-called, and against backward people, so-called…. It seems to me that those who qualify languages as rude or polished are afflicted by a confusion of ideas (Kobina Sekyi, cited in Saah & Baku, 2011, p. 90).

Where Sekyi has Fanti, you can substitute your own language or dialect and this saying will be equally valid.

2.5.1. The Constitution of Ghana and Language Use

According to Yankah (2014, p. 10), "of all Ghana's constitutions, it is those of 1969 and 1979 that specify the language of parliament, and the level of proficiency required to be a Member of Parliament. The two constitutions required the Member of Parliament to be proficient in English." He quotes Article 71(d) of the 1969 Constitution which says:

> Subject to the provisions of this article, a person shall be qualified to be a member of the assembly if, and shall not be qualified unless, he is able to speak, and unless incapacitated by blindness or other physical causes, to read the English language with a degree of proficiency sufficient to enable him to take an active part in the proceedings of the assembly and goes on to state that [I]n the 1979 Constitution, Article 76 I(c) is similarly worded.

These two constitutions clearly specified that English was to be the official language for conducting business in the Ghanaian Parliament. This automatically meant that the inability to express oneself in that language barred one from becoming a member.

Though Article 26 (1) of the current 1992 Constitution guarantees that "[E]very person is entitled to enjoy, practice, profess, maintain and promote any culture, language, tradition or religion subject to the provision of this Constitution," it does not make any statement about the language to be used for the proceedings in the House. It is, however, in Standing Orders 47 of the 1992 Constitution that we find an explicit statement about the use of language in the House. According to Yankah (2014, p. 74),

[T]he orders commencing on November 30, 1995, for instance, states as follows under "Language for Proceedings": The proceedings of Parliament shall ordinarily be conducted in the English language, except that a member may exercise the option to address the House in Akan, Nzema, Ga, Ewe, Hausa, Dagbani, Dagaare or in any other local language provided facilities exist in the House for its interpretation.

This provision implies that though a Member of Parliament can exercise his/her right to use a local language for business in the House, this right is not without limitations. This right can only be exercised if an interpreter is available in the House. The situation, according to Yankah (2014) is different from what pertains in:

> countries where there are workable language policies such as Tanzania, which has replaced English in parliament with the national lingua franca, Kiswahili, as the sole language of parliamentary business, both written and oral. This has enabled the ordinary man or woman to compete with the so-called political elite, and join them to debate issues within the walls of parliament.

He also states that Kenya has a bilingual policy whereby English and Kiswahili are used in parliament. This allows the people to use either of the two languages to transact business in the House.

2.5.2 The Language Policy of Education in Ghana

It is in the field of formal education that we see efforts being made to manage the use of language(s) in Ghana for the effective education of the Ghanaian child. It is an accepted fact that a child learns better in his/her mother tongue. UNESCO (1953, p. 68) states among other things that:

- The mother tongue is a person's natural means of self-expression, and one of his needs is to develop his power of self-expression to the full.
- Every pupil should begin his formal education in his mother tongue.

Since the inception of formal education in this country, there has been a problem regarding which of the many indigenous languages to use (in addition to English) as the medium of instruction, especially from the early years when the child has not mastered the use of English. This problem has persisted from the colonial period to the present time with governments changing the policy as they deem expedient. Without going into the politics, let us examine how the issue has been handled based on a table provided by Owu-Ewie (2006, p. 77): (a) Castle Schools era, languages of the home country, Portuguese, Dutch, Danish and English were used. (b) The Missionary era, the vernacular was used as medium of instruction in the first three years.

- 1935-1951: Ghanaian languages were used in the first three years.
- 1951-1955: Ghanaian languages were used only in the first year of school.
- 1956-1966: No Ghanaian languages were used.
- 1967-1969: Ghanaian languages were used only in the first year.
- 1970-1973: Ghanaian languages were used in the first three years.
- 1974-2002 (September): Ghanaian languages were used in the first three years. A Ghanaian language in this case is the language of the locality where the school is situated and it includes one the following: Akan (Fante and Twi), Nzema, Ga-Adangbe, Ewe, Gonja, Kasem, Dagbani, and Dagaare.
- 2002-2008: No Ghanaian language was used.
- 2009 to the present: Ghanaian languages are being used.

2.6 Language Policy in other Sectors

There are no policies concerning language use in other spheres of life and so people are free to decide which language to use and where. In offices, in the market places, etc. people usually use the local languages for communication, resorting to English only when one of the parties does not speak the local language.

At home, some parents speak English to their children with the hope of giving them a head-start in the acquisition of the language. This

denies the children the right to acquire the language(s) of their parents and/or community. As a result, there are some Ghanaian children who cannot speak their local languages or do so with difficulty.

It is interesting to note that many early Christian missionaries to Ghana recognised the significance of the local languages. They therefore learned to speak them, studied them, and produced a range of relevant material in some of them. Most of these languages such as Akan (Akuapem, Fante and later, Asante), Ga, and Ewe, owe their written forms to the work of these missionaries.

Today, many churches continue to use Ghanaian languages and a high proportion of books published in these languages are produced by the churches. Local languages are used solely or side-by-side with English in church worship. These days, some churches employ the services of sign language interpreters for those of their members who suffer from hearing impairment. For many Ghanaians, Christian scriptures, hymn books and prayer books are the only means of maintaining literacy skills in their own languages.

The advent of local FM stations has seen some indigenous languages, especially the government-sponsored ones including Akan, Dagaare, Dagbani, Dangme, Ewe, Ga, Gonja, Kasem and Nzema being used. Unfortunately, newspapers in the local languages are virtually non-existent.

On the entertainment scene, musicians mostly use the local languages or local languages mixed with English in their lyrics.

2.7 Language Practices in the Healthcare Domain

As the UNESCO document referred to earlier states: "The mother tongue is a person's natural means of self-expression, and one of his needs is to develop his power of self-expression to the full" (UNESCO, 1953). In an ideal situation, it would have been best for a patient to walk into a healthcare unit and communicate he/she problems in the language he/she understands best with the healthcare providers. The desirability of this is confirmed by the findings of the survey mentioned in the General Introduction in which the respondents said they trusted a nurse who understood or spoke their language. Unfortunately, this desire may not

be fulfilled in many cases. Unlike formal education where governments have instituted, rather unsuccessfully, a policy on the language of instruction, nothing like that has been done in the healthcare domain to the best of our knowledge.

Close to what may be considered as a language policy in healthcare is the announcement of the then Minister of Gender, Children and Social Protection, Mrs. Nana Oye Lithur, in 2016 that her ministry "is to collaborate with the Ministry of Health to provide sign language interpreters at various hospitals in the country" (Graphic, 2016). At the institutional level, it is gratifying that in 2016, "thirty staff at the Winneba Government Hospital have been trained as sign language interpreters to ensure effective communication with speech and hearing [impairment, sic] patients" (GNA, 2013). The N&MC has also recommended the teaching of sign language in the Nursing and Midwifery training institutions and we are happy to report that at the training of trainers sessions we had in Tamale, Asante Mampong (Nsuta) and Accra, many of the participants reported that this is being done in their institutions.

Currently there are no trained interpreters in health facilities in the country. The parties in the communication process rely on anyone available to interpret. In some situations, important information may be lost during this informal translation. Nurses and midwives, like other professionals, must be encouraged to, at least, learn the basics of the languages spoken in the areas where they operate. Just a few words of greeting and asking about the health of patients in their own language or dialect will go a long way to establish rapport between nurses and midwives and their patients and pave the way for therapeutic communication to take place. Take note of Nelson Mandela's quotation which says: "If you talk to a man in a *language* he understands, that goes to his head. If you talk to him in his *language* that goes to his heart" (Mandela, 2006). We believe strongly that the local languages need to be given prominence in the healthcare domain to ensure effective therapeutic communication.

Before we end this Unit, we would like to report on an experiment we conducted during the training workshops in Tamale, Mampong (Nsuta) and Accra. We asked the participants to rank languages like Ewe, Akan, Ga and English on a scale indicating what they think to be the best or most important language. Almost invariably, everyone listed

English first before any of the Ghanaian languages and we disagreed with them completely. In the words of Saah and Baku (2011, p. 90), linguists (that is, people engaged in the scientific study of language) "do not rank languages on 'some scale of superiority', instead they view all languages as equal and capable of being used by their speakers to communicate and express their thoughts. No human language is 'crude' or uncivilised." We should, therefore, appreciate first our own dialects or languages and then other people's languages or dialects. We must not look down on them or ridicule them. Instead, where possible, nurses/midwives should explore how they can use some of our indigenous languages for effective therapeutic communication.

2.8 Summary

In this Unit, we have looked at the complex language situation in Ghana and the minimal role that the local languages play in official sectors such as governance. We have seen that even where there are policy guidelines in respect of the use of language, they are beset with problems as is evidenced by the language policy in education. In the healthcare sector, there is no known official policy on language use and nurses and midwives use whatever language will enable them to communicate with their patients/clients. We have also seen that the N&MC and other organisations have advocated the teaching of Ghanaian Sign Language in the nursing and midwifery colleges as a way of helping to bridge the communication gap between nurses/midwives and hearing impaired or deaf patients.

► Exercise

1. Identify and discuss some situations in a health facility where language can be a barrier to effective communication between a patient and a nurse/midwife.

2. What do you think can be done to make the use of local languages more prominent and effective in the healthcare delivery system?

3. Discuss some difficult communication experience(s) you could encounter or witness as a nurse/midwife as a result of language differences. How would you deal with the situation(s)?

Further Reading

Hall, Edward. (1983). *Ghanaian Languages.* Accra: Asempa Publishers.

Munoz, Cora and Joan Luckmann. (2007). *Transcultural Communication in Nursing*, 2nd edition. New York: Delmar Learning.

Simons, G. F. &Fennig, C. D. (eds.). 2017. *Ethnologue: Languages of the World, Twentieth edition.* Dallas, Texas: SIL International. Online version: http://www.ethnologue.com.

Spolsky, Bernard. (2004). *Language Policy.* Cambridge: Cambridge University Press.

UNIT 3:

INTRODUCTION TO THERAPEUTIC COMMUNICATION

3.1 Introduction

This Unit seeks to introduce the nurse/midwife to the concept of therapeutic communication. We present the view that therapeutic communication has a single agenda, which is to encourage or facilitate the expression of feelings, emotions and ideas by patients. When such a situation is created, health outcomes are significantly improved (Kelley J. M, Kraft-Todd, Shapira, Kossowsky, & Riess, 2014). We suggest strategies that permit the creation of a therapeutic communicative environment at healthcare facilities. Also, we identify some communication forms or methods that impede the creation of an enabling curative environment; one that facilitates improvements in healthcare delivery through the adoption of a system which allows for the free flow of ideas between the healthcare practitioner and the patient. We consider obstacles that nurses and midwives may be confronted with in practising therapeutic communication so that we can avoid or neutralise them even when they occur. Finally, we look at some challenges we may encounter when communicating with cognitively impaired patients. Essentially, the Unit is designed to equip the trainee nurse/midwife with adequate skills for a therapeutic communication experience, as well as the ability to anticipate trouble spots in communicating in the process of discharging their professional duties.

3.1.1 Why Nurses and Midwives Need this Knowledge

Patients come to healthcare facilities with the hope of receiving solutions for a myriad of health challenges. For effective health outcomes and proper administering of medication, patients and healthcare providers need to be able to create a conducive environment that allows for an

effective communicative encounter between patient and healthcare provider. The nurse/midwife is most likely to be one of the first healthcare providers that the patient will encounter. It is therefore critical that the first encounter begins the process of creating a therapeutic encounter for the patient. Beyond this initial encounter, whether as an outpatient or inpatient, the nurse is the most likely healthcare provider to spend a considerable amount of time with the patient during their visit to the healthcare facility. It is therefore of essence that nurse and midwife trainees have access to knowledge that will sharpen their therapeutic communication skills as they interact with patients as a core aspect of their duties.

3.2 Learning Objectives

After completing this Unit, you should be able to master the following skills and ideas:

- Understand the essence of therapeutic communication and how it aids the effective delivery of healthcare.
- Know various strategies that can be employed to make patients comfortable to freely express their feelings and ideas.
- Know the various strategies which have the tendency to block the free expression of feelings and ideas and avoid them.
- Recognise the signposts for trouble spots in communication and how to quickly remedy these such that the healthcare delivery process is not negatively affected.

3.3 Defining Therapeutic Communication

Therapeutic communication is defined by the National Commission on Correctional Health Care (NCCHC) as the "face-to-face process of interacting that focuses on advancing the physical and emotional wellbeing of a patient" (NCCHC, 2017). This definition by NCCHC seems to suggest that therapeutic communication is achieved solely through face-to-face communication. This definition is obviously based on an outdated assumption, as we are well aware that it is possible to have a meaningful therapeutic communication experience via other modes of communication such as telephone conversations, through

instant messaging platforms and video calls. *Mosby's Medical Dictionary* (2009a) actually counters this assertion when it suggests that therapeutic communication refers to "a process in which the nurse consciously influences a client or helps a client to a better understanding through verbal or non-verbal communication" (Sherko, Sotiri, & Lika, 2013, p. 457). This definition provides the recognition that communication is via verbal and or non-verbal means (see Unit 4 on verbal and non-verbal communication). Taking this a step further, Mosby (2009b) in their online *Medical Dictionary* refers to therapeutic communication as "an interaction between a health care professional and a patient that aims to enhance the patient's comfort, safety, trust, or health and well-being" (Mosby, 2009b). This definition is broad enough not to restrict the interactional process. There is a focus on the patient's overall wellbeing and positive health provision outcomes.

Generally speaking, therefore, therapeutic communication is a healthy interaction between a healthcare provider and a patient, which has the intention of making the patient feel relaxed, confident and secure, with the objective of enhancing healthcare outcomes. Within the Ghanaian and larger African context, the practice of therapeutic communication needs to take cognisance of linguistic, cultural and religious considerations with regard to what is humane and considered to be appropriate and good practice.

Therapeutic communication has only one agenda; it is to encourage or facilitate the expression of feelings, emotions and ideas by patients. The foundations of therapeutic relationships are trust, reassurance and reliability. A patient is most likely to open up to a nurse/midwife that he/she can trust and can rely upon. In return, the patient expects that he/she receives reassurance as part of the recovery process.

3.4 Therapeutic Communication Strategies

Therapeutic communication has a singular objective of facilitating the expression of feelings, emotions and ideas by patients. Trust, reassurance and reliability underlie therapeutic relationships. The core principles of a therapeutic engagement are gaining trust, and showing genuine concern and empathy. The patient gains trust in the nurse/midwife when he/she is perceived as informed, reliable, efficient and honest.

Genuine interest is evident in the nurse's sincere attempt to know the patient beyond the immediate problem that they present with. Empathy involved perceiving and communicating the patient's feelings, anxieties and concerns.

In order to create an environment that facilitates the expression of feelings and ideas, a number of strategies have been suggested by various authors on how this can be achieved. Nurse and midwife trainees ought to be aware of the use of specific strategies that encourage the expression of feelings and ideas by patients. We find the following strategies outlined by Sherko, Sotiri and Lika (2013) and Kearsley (2015) to be relevant in our context, and we elaborate as contextually appropriate:

- **Active listening** – Listening is the "active process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages. It involves the ability to retain information, as well as to react empathically and/or appreciatively to spoken and/or nonverbal messages" (ILA, 1995, p. 1). Active listening requires sustained attention to and focus on what the patient is saying verbally and non-verbally. (See Unit 4 for further discussion on verbal and non-verbal communication) It may require the nurse/midwife to be appropriately positioned facing the client, relaxed and maintaining eye contact.

- **Sharing observations** – The nurse/midwife shares his/her observations on how the patient looks, sounds or acts. This is important because the patient may often not be aware of certain behaviours or physical states. The nurse should however not attempt to be conclusive in his/her observations. The sharing of observations should be done in a manner that invites the patient to verify, correct or elaborate on the observations. Examples of such observations are 'you appear exhausted', 'you are trembling', and 'you seem to have lost weight'.

- **Sharing empathy** – To ensure a positive nurse/midwife-patient relationship, the nurse/midwife needs to let the patient know that his/her feelings, fears and anxieties are understood and accepted. An acceptance of the thoughts of the patient and the communication

of such, will enable the patient to open up even more to the nurse/midwife. The nurse/midwife's ability to demonstrate that he/she has understood and accepted the patient's reality is crucial in the development of trust and confidence in the relationship. Utterances such as 'I know that feeling, it can be frustrating' has the potential to facilitate the communicative encounter. *(See Unit 12 for more on active listening and a detailed description of empathy).*

- **Sharing hope** – Sharing hope with the patient involves communicating a sense of possibility to him/her. This gives the patient something to look forward to and to hold on to. Examples of utterances that may be used to share hope include 'I am sure there is a way out of this situation, let us see what the doctor has to say', 'I am confident we will find a suitable remedy'.

- **Sharing humour** – Sharing of humour has the potential of creating a relaxed atmosphere. It contributes to feelings of closeness and affinity. It may help to relax the patient and allow him/her to open up. The nurse/midwife however needs to be mindful of the kinds of humour to share. Socially sensitive humorous statements based on ethnicity, race, religion, political affiliation should be avoided. It may exacerbate, rather than ameliorate, the situation. In addition, he/she should be mindful of when to share humour so the patient doesn't feel his/her situation has been belittled.

- **Using culturally appropriate touch** – The use of culturally and religiously appropriate touch has a way of reassuring the patient. It evokes a sense of caring especially for patients who may be experiencing severe, chronic and terminal illnesses. When done appropriately, the use of touch is an effective means of communication. Note that when dealing with a patient of the opposite sex, a chaperone should be around so that one's actions are not misinterpreted.

- **Using silence** – There comes a time during the therapeutic communication encounter where the nurse/midwife ought to allow the patient to think through what has transpired and hopefully gain more insights. It is an opportunity for both the nurse/midwife and patient to consider what has been communicated already, and think about how to present what should follow. Given the consideration of time and space, the patient should not be rushed into speaking until he/she is ready.
- **Providing relevant and timely information** – One major cause of anxiety among patients is the lack of timely and relevant information with regard to their diagnosed conditions, treatment options, hospital routines, etc. Providing relevant and timely information will reduce anxiety levels significantly and create a safe and secure environment. For example, telling a woman who is due to undergo a caesarean section to deliver her first child how long the operation is likely to take, who will be performing the operation, and the length of her recovery period will go a long way to calm her down and reduce her level of anxiety. This requires the nurse/midwife to know his/her facts and not be speculative as this will break trust.
- **Clarification** – To check the accuracy of understanding, it is helpful for the nurse/midwife to restate an unclear or ambiguous

statement as soon as they occur. In doing so, the nurse/midwife prevents misunderstandings which may hinder effective communication. Additionally, it provides an indication to the patient that he/she is indeed listening and interested in what is being said. Statements such as 'Before you continue, can you tell me what you mean by 'burning pain in your tummy, how exactly does it feel?' may be used for clarification purposes.

- **Paraphrasing** – This requires the nurse/midwife to briefly restate the content and intent of the patient's statement. It involves the use of different words to express the essential ideas presented by the patient. For example, the nurse/midwife may restate a patient's submission 'I stay awake all night, tossing and turning in bed' as 'Do you mean you are having difficulties sleeping?'.
- **Asking relevant questions** – Asking the relevant questions allows the nurse/midwife to garner the necessary information that will be used in the shared decision-making process. The nurse/midwife is encouraged to ask one question at a time and fully explore one topic before he/she moves on to the next. The use of broad open-ended questions allows the nurse/midwife to focus on the patient while providing an indication that the nurse is ready to listen to the patient's challenges and concerns. Such open-ended questions are 'What is your biggest challenge now?', 'How has this diagnosis changed your daily routines?'
- **Summary** – It is important for the nurse/midwife to provide a summary to the conversation at the end of the encounter. The summary serves a number of purposes. It provides a basis for documentation. The nurse is able to pull together all the bits and pieces of information for coherent documentation. It gives an indication to the patient that he/she has been understood. Also, it serves as a review of the interaction and provides closure to that particular communicative encounter.
- **Providing self-disclosure** – By sparingly revealing certain true personal experiences to the patient, the nurse/midwife demonstrates true empathy and concern for the patient. The purpose may be to emphasise the similarities and sometimes differences of the experiences. It demonstrates the genuineness and humanity of the nurse/midwife. However, the nurse/midwife

should make sure that the patient rather than he/she is the focus of the discussion. A woman in labour who is experiencing severe pain will find some sense of relief in the fact that the midwife has had a similar experience in the past.

- **Confront** – This is a strategy that ought to be used carefully. The purpose is to let the client become aware of inconsistencies in his/her account of their pains, feelings and experiences. This strategy is to be used only after there has been establishment of trust, and it ought to be done gently and in a sensitive manner. For instance, a patient may present his/her condition as extremely painful and requiring strong pain relief. You realise her/his story is not consistent because he/she is able to carry out his/her daily activities without interruption. You could confront her/him by asking 'Don't you think you would be okay on a milder pain relief since the pain does not interfere with your daily activities?'

3.5 Barriers to Therapeutic Communication

There are a number of factors that may get in the way of therapeutic communication. An awareness of this is necessary in order to ensure that communicative efficiency and good practice is achieved by the nurse/midwife. Different authors have adopted different approaches in discussing these. For instance, McCabe and Timmins (2013) identify barriers associated with nurses, patients and the environment in talking about therapeutic communication. We take a more or less generalist approach and see barriers in relation to the communicative context rather than to the individual participants. In that regard, therefore, we address our minds to the following:

- **Lack of adequate listening skills:** This includes the absence of active listening techniques in patient-nurse/midwife interactions. These inadequacies will be reflected in the disjuncture evident in the nurse/midwife's responses to patients' utterances. This may further frustrate the latter and compromise any existing relationship between the parties. Backchannelling, as a feedback strategy, is one way of reassuring the patient that active listening is taking place. Back channelling consists of giving verbal and non-verbal cues to the speaker.

- **Inappropriate body language**: Postures and gestures may come across as dismissive, disengaged and thus indicate a nurse/midwife's disinterest in the views or experiences being expressed by the patient. This may occur if the nurse/midwife, on conviction from expert knowledge, adjudges that the view being expressed is a wrong one and so shows evidence of agitation and hurry to terminate the conversation.
- **Task-centred rather than people-centred communication**: Focusing on the task at hand rather than due recognition of the patient as a human being is problematic. This is a very mechanical approach to nursing and midwifery or any profession for that matter. Empathy is impossible to achieve with such an approach. Furthermore, where the society is culturally diverse, communication that works well in the performance of a task may not necessarily work without some degree of modification for the same task in another cultural context. In other words, attention to the people (patient) is necessary too.
- **Lack of recognition of patients' preferences and needs**: Lack of recognition of patients' preferences and needs (often based on sociocultural considerations) may hamper communication and the building of trust. This is similar to the preceding point but with a slight tilt towards citizens' rights. For example, a patient may prefer that a particular discussion be held without a family member present. A doctor once asked a patient if he wanted his wife to remain in the room for his consultation. We realise that the doctor was acknowledging the fact that the patient had rights and could exercise those rights and preferences around privacy and he did so on the occasion by choosing that his wife remained. Healthcare professionals should sometimes read the body language of their patients to appreciate their preferences. A patient may say yes to a relative staying in a consultation/conversation in order not to offend the relative but his/her facial expression may be saying the opposite. The nurse/midwife may intervene by saying for instance (to the relative) 'let me talk to him/her alone for a few minutes then you can come back in'.
- **Overuse of specialist language**: Overuse of specialist language including professional jargon is likely to hamper understanding

on the part of the patient. It is not always the case that the use of jargon encourages the patient to warm up to the nurse/midwife. Such overuse may alienate the patient as he/she may feel excluded. For instance, you may say 'pain relief' instead of 'analgesia' in discussing pain with a patient or instead of saying 'you are leaking liquor' to a pregnant woman you may say 'your water broke'.

- **Lack of accommodation for disadvantaged patients**: Sometimes our healthcare systems have been designed such that the presence of patients with hearing impairment or limited knowledge of the official language are not accommodated. Even when interpreters are used there are fears of misinterpretations and absence of confidentiality, as these interpreters may not be trained professionals. It is in situations such as these that the nurse/midwife is encouraged to explore the totality of their linguistic repertoire and momentarily overlook the official language policy for pragmatic purposes.
- **Low levels of literacy**: We use literacy here both in the broad and narrow senses. Public health information comes in spoken and written forms mostly. For the written form, reading and writing skills are important. Exclusion may be experienced without these skills. There is a narrower sense in which low levels of literacy may refer to cultural literacy on the part of nurses/midwives who get posted to work outside their own ethnic region. This point will surface again in Unit 7 where we discuss cultural competence.
- **Absence of public health information leaflets in relevant languages**: Empathy, trust and inclusion may be difficult to negotiate and ensure with monolingual resources in a language that is not equally available to all, especially to patients in rural Ghana. Sometimes, information may be transmitted better in the form of pictures or visual cards.
- **Unequal power roles**: The subordinate role of patients could hinder effective communication. Ghanaian society, like many others in West Africa, is very hierarchical. Professionals in general, nurses and midwives inclusive, are perceived to occupy a higher ledge socially. The good nurse/midwife often plays down the hierarchy, and language is the tool employed for this, recognising that subordination translates into silencing. Encouraging and

allowing the patient to express their views breaks down this hierarchy and facilitates communication.

- **Failure to individualise nursing/health care**: The inability or unwillingness of nurses/midwives to treat patients as individuals rather than as part of routine statistics could result in distancing. The patient then does not open up to express his/her feelings and ideas. This could result in professional distancing where the patient does not benefit effectively from the communicative encounter.

Kearsley (2015) and Sherko, Sotiri and Lika (2013) propose some specific strategies that could hinder communication with the patient. These tend to inhibit communication of feelings and ideas. The nurse/midwife needs to recognise these strategies so as to avoid them and by so doing create an enabling therapeutic communicative environment. Once again, the strategies have to be elaborated upon as we find appropriate.

- **Asking personal questions**: It is unprofessional for the nurse/midwife to ask personal questions which are not of direct relevance to the situation under discussion. The nurse/midwife should not seek to satisfy his/her personal curiosity. Questions such as, 'Is your companion your father or husband?', 'why did you divorce your first husband?' may be inappropriate and unacceptable in the professional setting. When personal questions may have a bearing on the discussion, the intent should be explained to the patient and the exploration should be carefully and professionally done in an atmosphere of trust.
- **Giving personal opinions**: When the nurse/midwife gives personal opinions, it prevents the patient from owning the solution to his/her problems. Instead of saying 'If I were you, I would opt for a laser treatment', the nurse/midwife could present it as 'Let's discuss the various options that are available to you in this situation and then you can choose the most suitable for you'.
- **Changing the subject**: The nurse/midwife's attempt to change the subject is likely to block further communication. It seems to suggest that the nurse/midwife does not care about what matters to the patient. Rather than saying, 'Don't talk now about your flabby stomach, it is time to take your medicine', the nurse/midwife may

consider this alternative 'Kindly take your medicine, and then we can talk about your flabby stomach'.

- **Giving false assurance**: Sometimes in the nurse's/midwife's attempt to offer hope to seriously ill patients, they may end up saying things like "Everything will be okay", "Don't worry, you will be discharged soon". Because such statements are inconsistent with the facts or the reality that the patient is faced with, he/she loses trust in the nurse/midwife and effective communication is blocked as the patient loses trust and is discouraged from the expression of further genuine feelings.
- **Asking for explanation**: It may appear natural for a nurse/midwife to ask a patient to explain why he/she feels the way he/she does, or behave in a particular way. However, such an approach is often interpreted by patients as accusations and may lead to recoil.
- **Showing approval or disapproval**: As a show of professional conduct, nurses/midwives are not expected to impose their values, beliefs and moral standards on patients. The use of words like 'ought to', 'should', 'good', 'bad', 'wrong', 'right' is indicative of a judgemental attitude on the part of the nurse/midwife. A show of approval may be taken as the only acceptable way of doing things, while a show of disapproval may suggest that the patient ought to meet a certain expectation of the nurse. The more professional approach will be to allow the patient to explore their own beliefs. A statement like this "Can you tell me more about this herbal medicine option that you are considering?" can pave the way for the exploration of some genuine available options within the belief and value system of the patient.
- **Giving defensive, passive or aggressive responses**: The nurse, in his/her interaction with the patient should avoid being defensive, passive or aggressive. Being defensive suggests that the nurse/midwife is not open to criticism and therefore not agreeable to change. A passive response is likely to trigger feelings of depression, sadness, anxiety and hopelessness, while an aggressive response provokes hostility.
- **Arguing**: Arguing with the patient suggests that the patient is misinformed, lying or simply uneducated in the topic being discussed. It is a denial of the patient's reality. Such an approach

does not create the environment where the nurse/midwife gets a genuine opportunity to provide relevant and useful information to the patient.

In addition to these obvious stumbling blocks to successful interactional engagement between nurses/midwives and patients, there are also difficult situations that the former must be aware of and handle with great care. We shall discuss these in the context of dealing with cognitively impaired patients.

This decision is especially apt because one subset of the population in sub-Saharan Africa who do not appear to benefit from effective healthcare practices are mental health patients. Society does not recognise the various shades of mental health challenges, treating all such cases simply as 'madness'. According to NHS Digital (Lerche, 2016) "One in six adults - 17 per cent - in England suffer from a common mental health disorder which could include anxiety and depression." There are no specific figures available for Ghana, but the estimation, according to the Director of Health Services at Ankaful Psychiatric hospital (personal communication), is that 10-20% of the population is expected to have one form of mental illness or the other. In many cultures, anxiety and depression are not articulated as mental ailments, so nurses and midwives are hardly prepped to relate to those who have these conditions. Thus, as far as these patients are concerned, therapeutic communication does not exist. They are marginalised and excluded.

Recall that in our definition of therapeutic communication, we had identified managing trust, anxiety and empathy as crucially significant. Occasionally, healthcare providers may avoid discussing difficult situations truthfully. Unfortunately, what seems to provide respite in the short term actually causes loss of trust in the professional in the long term. Other dos and don'ts include:

- Speaking directly to the patient rather than about him or her to a family member.
- Not providing more information than is required.
- Avoiding the use of endearment terms that may invoke social rather than professional relationship.
- Avoiding complex questions as they may attract no response from the patient.

With impairment, professionals must aim to balance the need to provide adequate knowledge and the patient's rights for dignity as Williams and Tappen (2008) point out. In the specific instance of cognitively impaired patients, they observe that *reality orientation* is an important strategy that helps the patient maintain contact with reality. The following statement is an illustration of the strategy of reality orientation:

> Good morning Mr. Acheampong, my name is Naana Asiedu and I am your nurse. Today is Monday January 9 and you are at Menaba Regional Hospital.

According to Williams and Tappen, statements of this kind reduce the patient's anxiety as it reinforces their orientation to space and time. As useful as the strategy is, it also flags up the last one of our list of barriers to therapeutic communication above; the failure to individualise nursing care. Dementia patients apparently are embarrassed by the fact that they are disorientated and have to be reminded of time and location. Thus, the reality orientation strategy may also be associated with negative feeling and so must be deployed with care otherwise it may become counterproductive. An alternative approach in such circumstances, Williams and Tappen's (2008) advice is to display a calendar and a clock which the patient independently turns to for reorientation. This avoids the embarrassment of having to be reminded by the nurse assistant and the consequent threat to the patient's face.

In Williams' eye-opening chapter, she distinguishes between 'task-focused communication' and 'emotion-focused communication'. The former is communication that is designed to effect the completion of a specific task such as eliciting information from or giving directions to patients.

Example: Elicitation:
'Where exactly do you feel the pain?'.
'For how long have you had the pain?'

Example: Direction:

'Take only one tablet' is preferable to 'Careful, don't take more than one tablet'
'Make an appointment for next week'.

'Hold the glass with both hands' is better than 'Careful, you don't want to spill that'

In contrast to task-focused communication, emotion-focused communication concerns encoding all manner of feelings that a cognitively impaired patient experiences and struggles to express within his/her cognitive limitations. What exactly do we mean by this? Sometimes, a patient who has cognitive impairment, that is problems with reasoning and the articulation and expression of their thoughts and feelings, may struggle a bit with conveying information to their carer. Recognition of this requires the nurse/midwife to be more tolerant and explore the full length of therapeutic communication strategies available to him/her in order to make encounter with the patient a truly fruitful and beneficial one for both parties.

3.6 Summary

This Unit introduced the nurse/midwife trainee to the concept of therapeutic communication. We suggested that therapeutic communication is an interactional process between the healthcare provider and the patient which is intended to have curative functions as it is expected to make the patient feel relaxed, confident and secure, making him/her able to share feelings, anxieties and concerns. Therapeutic communication strategies that make patients comfortable to freely express their feelings and ideas were presented. Additionally, strategies that could block the free expressing of feelings and ideas were suggested. Nurse/midwife trainers are expected to recognise signposts for trouble spots in communication and to avoid them or mange them in such a way as to ensure favourable health outcomes. Finally, interaction with cognitively impaired patients were considered.

► Exercise

18-year-old Adwoa, who is a primary school drop-out is pregnant and has been attending antenatal clinic at your facility. She sits in the regular morning antenatal lessons for all the pregnant women but does not seem to contribute much during the lessons. The midwives have noticed she does not understand the condition she is in and cannot repeat any of the danger signs to look out for in pregnancy. They (the midwives) pass comments that suggest she should have focused on her studies rather than get pregnant.

On one of her antenatal visits, she goes into the examination room to be examined by Akwele, a middle-aged midwife and whispers to her that she has challenges but is shy to discuss them when other (older) women are around. Akwele tells her she has a lot of patients to see and cannot dedicate time to her at that moment. She further asks her to feel free and ask her questions during the antenatal lessons since she was not shy to have unprotected sex and then walks back to her writing desk. Adwoa returns to the desk embarrassed and crying amidst scolding from her mother who was waiting in the consulting room. Akwele then makes the following statement and dismisses them (Adwoa and her mother) from the consulting room:

> "You are in your third trimester but your haemoglobin level is very low. You should be responsible and eat well because you will be a mother soon. If you cannot take care of yourself, how will you take care of the baby?"

From the scenario:

1. Identify and discuss the factors that led to the breakdown of communication between the midwives and Adwoa.
2. What strategies could Akwele have used to provide a better communication experience for Adwoa?

Further Reading

McCabe, C., & Timmins, F. (2013). Communication Skills for Nursing Practice. Basingstoke: Palgrave Macmillan.

Sherko, E., Sotiri, E., & Lika, E. (2013). Therapeutic communication. *JAHR*, 4(7), 457-466.

UNIT 4:

VERBAL AND NON-VERBAL COMMUNICATION

4.1 Introduction

In Unit 1, we mentioned the separation between verbal, non-verbal, written and visual modes of communication. In this Unit, we will look at aspects of verbal and non-verbal communication in detail and show their importance in therapeutic communication.

When we communicate with people, we share information with them. The information may be in the form of ideas, knowledge, our thoughts, feelings, and desires. Sometimes, we make choices in the way we communicate. We choose to speak or not to speak. "Whether you speak or not, it communicates the message to the other party" (Surbhi, 2017).

We communicate in two main ways: verbally and non-verbally. "**Verbal communication** is a form of communication in which you use words to interchange the information with other people. But, **Nonverbal communication** does not use words for communicating anything, but some other modes are used" (Surbhi, 2017).

We will look at the features of both verbal and non-verbal communication and some of the meanings expressed by them and how as a nurse/midwife you can utilise them effectively for the purposes of therapeutic communication.

4.1.1 Why Nurses and Midwives Need this Knowledge

When a patient goes to a healthcare facility, he/she does so because he/she has a problem and he/she believes that the nurse/midwife can help solve these problems. The healthcare professional needs to know what the problem is in order to offer the necessary help/solution, so there

must be a sharing of information between them. The nurse/midwife has to be competent in communication skills in order to draw out the information from the patient and to explain to him or her the measures that are needed to solve that problem. The sharing of information is done through verbal and non-verbal communication. Through a skilful blend of verbal and non-verbal communication cues, a good nurse/midwife would be able to discharge his/her duties effectively.

Nurses and midwives, being health professionals, need this knowledge because it is essential for communication between them and their patients to be clear and unambiguous. While non-verbal communication cues such as gestures, tone of voice, eye contact/ movement, etc., complement verbal communication, sometimes, they may contradict them. If this happens, it could lead to a break-down in understanding or communication which could have unpleasant or disastrous consequences.

4.2 Learning objectives

After reading this Unit, you should be able to master the following ideas and skills:

- Define verbal and non-verbal communication.
- Discuss the key components of the two modes of communication.
- Discuss such non-verbal communication cues as paralanguage, appearance, body movement, etc., and how they add meaning to verbal communication and shape the way we perceive other people.
- Identify ways you can improve your non-verbal communication skills for effective therapeutic communication.

4.3 What is Verbal Communication?

Verbal communication is defined differently by different people. One definition is:

> When messages or information is exchanged or communicated through words, it is called verbal communication. Verbal

> communication may be of two types: written and oral communication. Verbal communication takes place through face-to-face conversations, group discussions, counselling, interview, radio, television, calls, memos, letters, reports, notes, email etc. (TBC, 2017)

Another writer, Amy Lucas says this about verbal communication:

> Verbal communication encompasses any form of communication involving words, spoken, written or signed. The conversation we have with our co-worker at lunch, the morning news or the sports page we read in the morning-even the text message you send to your spouse telling him to pick up some milk is a form of verbal communication. Our ability to communicate with a language that is based on an organised system of words, rather than merely sounds, is what sets us apart from lower species. Not only do we have language, but we also have the technology that enables us to communicate with one another no matter the physical distance (Lucas, 2017).

These definitions tell us that verbal communication essentially involves the use of words, and the words may be either spoken or written. Again, verbal communication can take place in close proximity such as in face-to-face conversations, or over a distance through the use of the telephone, email, and other forms of social media. See Unit 9 for a discussion of some of these communication technologies. Either way, the intended receiver of the message hears it simultaneously as the sender speaks. In the case of written communication, the addressee may receive it days, sometimes weeks after it is posted.

As nurses and midwives, you will find that most of the time, you engage in face-to-face verbal conversations with your patients and their families as well as with your co-workers. People will form certain impressions about you depending on how they perceive you as speaking to them. These impressions may be positive: "He/she is nice, kind, good, etc.", or negative: "He/she is rude, bad, impatient, etc." It goes without saying that if a patient forms a positive impression about you, it will build trust and this will in turn impact positively on your communication and his/her response to your instructions. On the other

hand, a bad impression will create mistrust which will lead to lack of cooperation. It is, therefore important that you become knowledgeable about the features of verbal communication in order to create a favourable impression on your patients and co-workers.

4.3.1 Features of Verbal Communication

According to Hybels and Weaver II (2001, p. 113),

> When two people are engaged in conversation, they interact continuously and simultaneously. Both get and give information, form impressions, and respond to each other. On the basis of each other's responses, both can change their comments to explain, backtrack, hurry up, slow down, or do whatever is necessary to be understood.

Some of the features of verbal communication are:

- It involves the use of words and these words may be spoken or written.
- The words used and the manner in which they are used may be influenced by the state of mind of the speaker/writer.
- It may contain mistakes based on the person's competence in the language used.
- When spoken, verbal communication may be affected by the tone of voice, loudness, and rate of the speaker and this in turn, will affect how the message is received.
- Once a word is spoken, you cannot take it back, but in written language, you can always go back to edit what you have written and remove all offensive words and expressions.

Words are very powerful. The words we use can uplift, encourage, comfort and heal people. They can also hurt people, sometimes beyond repair. According to William Chapman, "[W]ords cut deeper than knives. A knife can be pulled out, words are embedded into our soul"(Chapman, 2017). A similar concept is found in the Akan proverb *Tɛkrɛmakam sen yiwankam* 'The scar of the tongue surpasses the scar of

the razor.' Perhaps the following quotation can help illustrate how the words used by nurses may trigger negative reaction from the public:

> The conducts [*sic*] of some of the nurses in the public hospitals are so awful and one wonders why the NMC still keep them on their register (i.e. if they even have one). Patients' rights are trampled upon with ease and are treated with so much indignity… Some of these nurses for whatever reason have developed razor tongues which they are good at using to slice patients into shreds. Their [mastery, sic] of foul languages [*sic*] will make you wonder if that is part of the modules they take at the nursing training colleges (Egu, 2009).

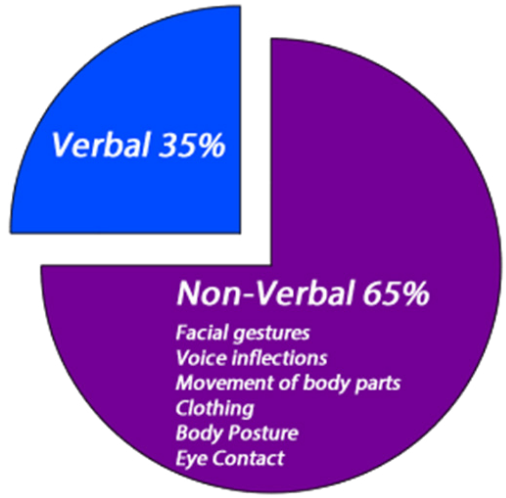
This quotation shows how the words some nurses use and how they use them can create a negative reaction from the very people they are supposed to serve. Surprisingly, when we presented this material at the training session at the N&MC offices in Accra, some of the tutors in the Nursing Colleges confirmed that what the writer said is true. Even if only one percent of the people does that, it still creates an unfavourable impression in the minds of the public and brings the name of the profession into disrepute. It overshadows all the good work you do as nurses and midwives.

4.4 Non-Verbal Communication

Verbal communication does not occur in isolation. The words we speak are usually accompanied by gestures, facial expressions, eye movement/contact and so on. These form part of non-verbal communication. Non-verbal communication does not involve the use of words. Though it does not involve words, non-verbal communication is very important in the everyday interactions between nurses/midwives and their patients. Hybels and Weaver II (2001, p. 128) assert that:

> As much as 93 percent of communication is non-verbal, with 55 percent through facial expression, posture, and gestures and 38 percent through tone and voice. With so much communication being non-verbal, it is essential that you understand how it works and how you can learn to communicate better when you use it.

Different experts on communication assign different percentages to verbal and non-verbal communication. For example, pie chart below indicates that verbal communication constitutes 35% while non-verbal communication takes 65% of the communication process:

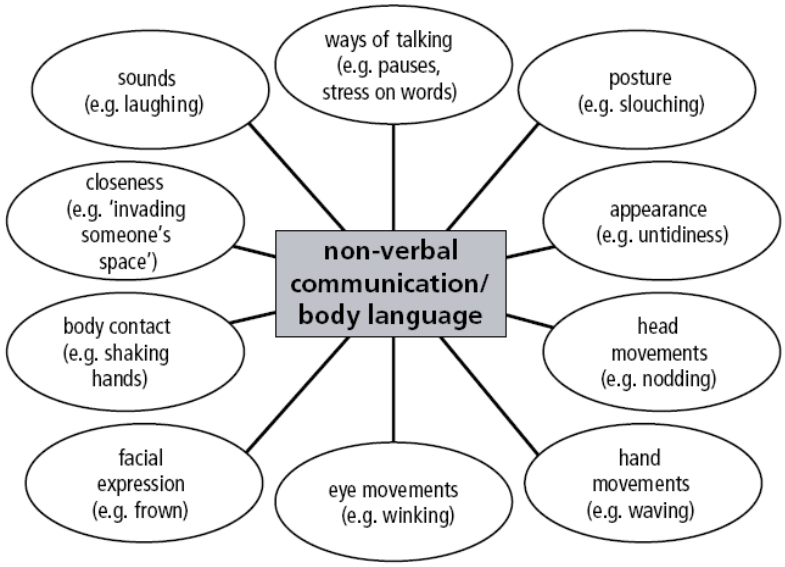


(PJCOSTAN, 2017)

According to Gendeh, (2016) "[T]he role of non-verbal communication is vital in the healthcare industry. Often, our facial expressions, gestures, eye contact, posture and tone of voice 'speak' the loudest to the patient''. It is important for a healthcare practitioner or trainee to be conversant with these non-verbal cues in order to use or interpret them accurately. Most of these may be interpreted differently in different cultures and communities.

4.5 Components of Non-verbal Communication

The diagram below shows the major components of non-verbal communication sometimes referred to as body language:



Prozesky, D., Stevens, S., & Hubley, J. (2006). Effective teaching and learning for eye health workers. Retrieved from https://www.cehjournal.org/resources/effective-teaching-and-learning-for-eye-health-workers-full-text/

We will take these one-by-one and comment on them, especially, appearance, head movements, hand movements, eye movements, facial expression, body contact, and see how they affect communication.

4.6 Appearance

Appearance includes things like untidiness, clothing and colour. Our appearance communicates certain messages to the people we meet on the street or in our workplaces. That is why people make an extra effort to groom themselves when attending job interviews. An untidy person will create a bad impression in the mind of a nurse/midwife in the same way that an untidy nurse/midwife will create an unfavourable impression in the mind of the patient. This message may not be intended and it is subjective. As one expert puts it, first impressions always count. Whether it is in a working or social environment, it always helps to be presentable, "a professionally dressed healthcare giver will instil a sense of confidence in patients. Confidence in the healthcare giver in turn influences their will to comply with advice given" (Gendeh, 2016).

Clothing is an important aspect of appearance. The clothes people wear send very clear messages to people. Bankers and other business people wear suits to project a certain image. Airline pilots and stewards wear uniforms that distinguish them from their passengers, soldiers and policemen and women wear uniforms and insignia to indicate their professions and rank. In the same way, nurses and midwives also wear uniforms to distinguish them from other healthcare providers. Patients are able to identify them by their uniforms; they do not have to ask, "Who is the nurse/midwife here?"

You will realise that just wearing the uniform is not enough. The way you wear it can make some impressions on the patient. It must be neat, clean and worn in the prescribed manner. A patient may not look favourably on a slovenly dressed nurse/midwife and this can undermine his/her confidence in such a person. On the other hand, nurses and midwifes should not let the appearance of a patient influence the way they interact with and treat him or her patients. A patient's appearance may also indicate the care he/she gets at home. For example, an elderly patient who is brought to the hospital shabbily dressed may have been neglected by family members.

The colours people wear have a lot of stories to tell all over the world. In our part of the world certain colours, usually black and red/brown depict mourning. Thus, when some people meet friends/colleagues dressed in black or red from head to toe, they ask whether that person has been bereaved. White is the colour for victory so a person clad in an all-white attire is likely to communicate to people that he/she is celebrating some happy occasion. Wearing excessively bright colours may also depict certain mental illness and may be the first indication for the health professional to probe further.

Note, however, that these days, young people do not adhere to this and they dress in any colours that suit their fancy and care must be taken not to draw the wrong conclusion from the colour(s) that a person is wearing.

Judging from appearance can be highly subjective, and healthcare professionals ought to rise above this and do their job professionally in accordance with the oath they have taken, part of which states, "*I promise to care for the sick with all the skill I possess, no matter what race, creed, colour, political, or social status, sparing no effort to conserve life, alleviate pain and promote health.*" See Unit 13 for a full discussion of The Nurses' Pledge and The Midwives' Prayer.

4.7 Body Movements

Body movements refer to the way people move parts of their bodies during communication. We will look at a few of these movements in the following sections.

4.7.1 Head Movement

Generally, when someone nods the head, it means 'yes' and when he/she shakes the head from left to right, it means 'no'. In an interaction with a patient, if he/she nods or shakes the head, it means he/she is saying 'yes' or 'no'. A very shy person or one in severe pain may resort to head movements as a way of answering your questions and it should not be seen as a sign of rudeness or refusal to answer your questions. Since most body movements may be subject to different interpretations in different communities, if you are new to an area, you should always ask colleagues to help you to understand some of these body movements.

4.7.2 Hand Movements

Hand movements vary across cultures. Generally waving is a way of acknowledging the presence of people. It can be a substitute for greeting especially when the person is far away. At funerals and other gatherings, usually people shake hands with those sitting in the front rows and within reach. Then they wave to those behind as a way of greeting them. Below are some hand gestures and their meanings in Ghana:

Hand movement	**Meaning/Interpretation**
Closing fingers repeatedly with palms toward the ground	Request to come
Flicking fingers away from oneself	Request to go away
Both hands placed on the head	Sign of grief, sorrow and mourning
Shaking finger at someone	Warning/admonition
Cupping hands on top of each other	I beg you or please
Biting one's index finger	Intense feeling of pain/regret/ forgetfulness

(adapted from NAWA, 2017)

It is possible that some of these gestures may be interpreted differently by different people in different parts of the country, so if you are operating outside your own cultural environment, you have to find out the meanings of these movements so that you can use or interpret them correctly.

4.7.3 Eye movements and contact

"The eye is an instrument of aggression," so says an African proverb quoted in Hybels and Weaver II (2001, p. 141). We can send many messages with our eyes, either consciously or unconsciously. According to Dobkin and Pace (2003: 161-2) "[Y]our eyes communicate a variety of emotions. You roll your eyes to indicate disgust or disapproval, bate your eyes flirtatiously to signal your attraction to someone, close your eyes as a sign of reverence, or wink at someone to indicate that you are talking in jest or kidding around. Eye contact, or how long you gaze or look at someone, is an especially powerful communication tool"(Dobkin & Pace, 2003). It is, therefore, important to be careful of, how, as a healthcare professional you use your eyes when communicating with patients. Some eye movements may be considered friendly while others may be hostile. These may differ from person to person (young or old, male or female) and from one community to another.

According to a Vermont Department of Health document on 'Cultural Differences in Non-verbal Communication':

> In mainstream Western culture, eye contact is interpreted as attentiveness and honesty; we are taught that we should "look in the eye" when talking. In many cultures, however, including Hispanic, Asian, Middle Eastern, and Native American, eye contact is thought to be disrespectful or rude, and lack of eye contact does not mean that a person is not paying attention. Women may especially avoid eye contact with men because it can be taken as a sign of sexual interest (VDH, 2017).

Generally, in Ghana, while it is important to look at the person who is talking to you, for a young person to look at an adult eyeball-to-eyeball may be seen as a sign of insolence or disrespect. In other instances, not looking at an adult in the eye may be interpreted as a sign of shyness.. Looking at a person who is speaking to you will

indicate to the person that you are interested in what he/she is saying. For therapeutic communication to succeed, it is important for the nurse/midwife to maintain eye contact with the patient. Failure to do this may signal to the patient that you are not interested in what he/she is saying and this will defeat the whole purpose. Maintaining eye contact with a patient is one of the skills used in counselling as we will discuss in Unit 12.

4.7.4 Facial Expression

The face can be seen as "a window with a view opening onto our emotions." According to Ekman, Friesen and Ellsworth (Ekman & Friesen, 1971, p. 1; Russell & Fernández-Dols, 1997, p. 3), "The human face – in repose and in movement, at the moment of death as in life, in silence and in speech, when seen or sensed from within, in actuality or as represented in art or recorded by the camera – is a commanding, complicated, and at times confusing source of information."(Russell & Fernández-Dols, 1997, p. 3).

The kind of information we can get from a person's facial expression could be anger, fear, surprise, hatred, sadness, happiness, pain, and so on. All these have specific facial expressions that go with them, such as smile, stare and so on.

(oremutdentist.com, 2017)

How would you feel if you met a person with such an infectious smile on his/her face? And how do you think your patients would feel if you met them with such a smile on your face? Regardless of whether the patient is young or old, male or female, you would agree that it would put them at ease, make them feel welcome, and minimise their pain.

On the other hand, what do you think would happen if you stared at a patient as shown in the picture below or if a patient stared at you like that?

Staring, that is, looking or gazing at someone fixedly, can convey a meaning of hostility or rudeness. Some parents and or people in authority use it as a non-verbal means of getting their children or other people to stop misbehaving. Teachers also use that to get students to stop fooling around and pay attention. In the healthcare domain do you think staring at people will be a positive and effective way to achieve therapeutic communication? Discuss a scenario where this will be possible.

(Puglisi, 2017)

Facial expressions are many and are subject to different interpretations by people of different cultures, age groups and gender. As some experts on non-verbal communication believe, 'your face is the richest source of non-verbal cues' (Dobkin & Pace, 2003, p. 161) and so it is important for

you to be mindful of the face you present to the patient who has come to you for help. While it is not easy to control your emotions, you have to be careful not to present a face that influences the attitude of the patient towards you in a negative way.

4.7.5 Physical contact

Physical contact may take different forms such as, a touch, a hug, or a handshake. Different cultures may have different ideas and norms about these. How, where and even when we touch or hug or shake the hand of somebody may be regulated by cultural and religious norms and/or practices.

Touch: According to *Communication that works* (DeVito, 2005, p. 119), a touch may "communicate *positive emotions* such as support, appreciation, inclusion, sexual interest, and affection." It may also be used to indicate "playfulness" or to "control or direct the behaviours, attitudes, or feelings of another person." The book also talks about *ritual* touching" which "centres on greetings and departures, as shaking hands to say hello or goodbye or hugging, kissing …", and "*task-related* touching" which "occurs when you are performing some function-for example, removing a speck of dust form another person's face or helping someone out of a car."

As healthcare providers, nurses/midwives cannot avoid touching patients. In fact, they have to touch them to find out where they hurt or to assure them that they care about their problems. Age, position, and gender play a role in how we touch other people. Adults find it easier to touch young children, but not other adults, especially those they are meeting for the very first time. In the same way, it may be easier to touch a child in a healthcare setting than an adult. Even in the healthcare setting, if you are not examining the patient, a touch may be appropriate or inappropriate. There may be some parts of the country or cultures where it may not be appropriate for a man to touch a woman or vice versa. To avoid any unpleasant situation in your function as a nurse/midwife, you would have to observe and practice what is permitted in the area where you work. If you find your patient trying to avoid touch, respect that and carry on with your duty.

Notice that if a patient or person touches any part of his/her body, it means that is the place he/she is suffering from. For therapeutic communication to take place between a nurse/midwife and a patient, the nurse/midwife has to be aware of these gestures and recognise the information they are being used to impart. It is also important to find out if these gestures have different interpretations and uses where you are operating or whether there are others that are relevant for communication with the patients and the people around you.

Hugging: Traditionally, hugging may not be as common or widespread in Ghana as it may be in other parts the world. In the past, adults used to hug children to welcome or comfort them. These days, people hug a lot, but you have to be careful about who you hug. There may be cultural or religious barriers to hugging in some areas and you have to be aware of that. Can a man hug another man or a woman? Can a woman hug another woman or a man? These may vary with religious and cultural practices and you have to be careful not to do the wrong thing even with the best of intentions.

Handshake: In Ghana, as in other parts of Africa and the world, handshake is the non-verbal component that often accompanies greetings. The use of the left hand is normally avoided in handshake. A man can shake the hand of another man or a woman and a woman can do the same, but there may be some places where a handshake between a man and a woman may not be culturally appropriate. It is considered offensive to refuse to shake the hand of someone who extends his/her hand towards you in greeting. While a handshake may open the door for therapeutic communication to take place, refusing to shake the hands of another person will shut that door. Of course, if there is a general ban on handshake, as it happened during the Ebola outbreak, then nothing can be done about it.

4.8 Paralanguage

Paralanguage is known variously as 'paralinguistic' or 'para-verbal' communication. It has to do with the way we talk, that is "the messages that you send with your voice."(Gamble & Gamble, 2013, p. 165). According to *Communication that works* (DeVito, 2005, p. 120), "Paralanguage is the vocal but nonverbal dimension of speech. It has to do with *how* you say something rather than what you say." It involves how you modulate your voice (pitch, loudness, speed, and so on). These are things we superimpose on the words we say or speak and they add certain nuances of meaning to the words. They may signal to the listener that you are angry, upset, afraid, etc.

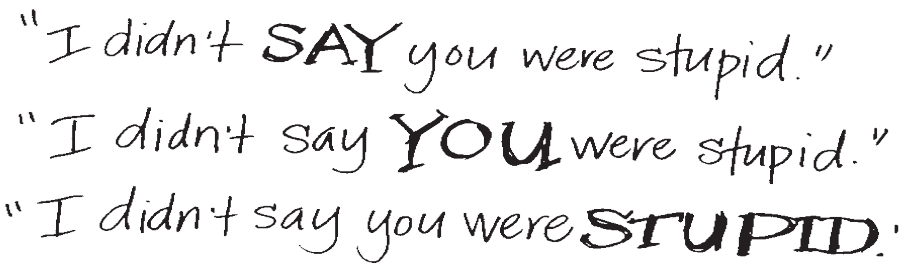
4.8.1 Pitch

Gamble and Gamble (2013, p. 166) define pitch as "the highness or lowness of the voice; it is similar to pitch on a musical scale." According to them, "[W]e associate low-pitched voices with strength, sexiness, and maturity, and high-pitched voices with helplessness, tension, and nervousness" (p. 166). These may differ from one culture to another and as a nurse/midwife, you should not let this influence the way you interact with your patient.

As a nurse/midwife, you have to be sensitive to how you control your pitch because:

> It is the voice's pitch that others use to determine whether you are making a statement or asking a question or whether you are expressing concern or conviction. Your pitch expresses your emotional state; for instance, it can communicate anger or annoyance, patience or tolerance. (Gamble & Gamble, 2013, p. 166).

Note that in our Ghanaian languages, we utilise pitch in another way. Our languages are what linguists (language scientists) call 'tone languages.' We use variations in tone: High, Low and/or Mid to distinguish between different words. On the other hand, in a language like English, pitch is used to put stress or emphasis on words. For example:



(Windle & Warren, 1999)

By putting stress on the words 'say', 'you', and 'stupid', the speaker contrasts these words with others in their class and therefore changes the meaning of the sentence. The emphasis on SAY means that the speaker is denying saying that the person is stupid. The emphasis on YOU means that though he said that somebody was stupid, he was not referring to the listener, and the emphasis on STUPID means that he is saying that the person is something other than stupid.

4.8.2 Volume

Volume has to do with the power of your voice; how loud you sound. Speaking loudly or shouting may signal to a person that you are angry, rude or impatient. This is especially important when dealing with older patients. It will not be appropriate to shout at or speak loudly to an elderly patient.

A patient may not want the communication between the two of you to be overheard by other people and you have to be sensitive to that. On the opposite end, if you speak too softly or with a whisper, the other person may not hear you properly and this may result in miscommunication. You have to strike a proper balance between the two. You have to speak clearly so that the patient can hear you without being intimidated, offended or embarrassed.

Asking a patient, in a soft voice, to wait for his/her turn to get a procedure done will be better than shouting at him/her. The latter will embarrass the patient and create a bad impression leading to mistrust.

4.8.3 Rate

Speaking rate refers to how fast or how slowly we speak. If you speak too fast it may affect comprehension. This may be more pronounced in a situation where you and the person you are talking to have varying degrees of proficiency in the language you are using. Speaking slowly, may indicate boredom or lack of interest or attention. As a nurse/midwife, you would have to take into consideration the language proficiency of the patient, the subject being discussed and so on and adjust your speaking rate to make room for comprehension. Where there is a language problem, the need for slow, deliberate speech is essential for effective communication between the nurse/midwife and the patient. According to Gamble:

> When talking about more serious subjects, we often slow down; on the other hand, our speaking rate usually accelerates as we shift to talking about lighter topics. In many ways, rate reflects the pulse of your words. It quickens to relay agitation, excitement, and happiness, and it falls to convey seriousness, serenity, or sadness. (Gamble & Gamble, 2013, p. 166)

As a nurse/midwife, you have to be careful about how fast or how slowly you speak to patients. For example, if you are explaining the dosage of a drug to a patient or the family of a patient, you have to do so at a rate that would be understood and remembered.

4.8.4 Hesitation and Silence

Hesitation refers to the situation where we pause because we have forgotten a word or expression we want to use. We usually insert some meaningless sounds like 'err, uh, you know' to fill the pauses. These have the tendency to slow down the natural flow of speech. It will in turn affect comprehension, the way people perceive us and also indicate lack of confidence on the part of the speaker.

At the same time, knowing when to pause is an important skill in communication. A pause gives you the chance to collect your thoughts and plan what to say next. A pause or a period of silence allows you to listen to what the other person is saying and also give them a cue

that they can enter the conversation. It is not polite to talk unceasingly without giving the other person the chance to speak. However, according to Gamble & Gamble (2013, p. 167):

> This is not to suggest that a pause's message is always positive. Sustained pauses—significantly extended periods of silence—allow us to give another the "silent treatment," a means by which we ignore a person, saying to him or her without using words, "As far as I am concerned, you do not exist."

Silence can be both positive and negative and must be used with care in order not to impair therapeutic communication.

4.9 Summary

In this Unit, we have discussed verbal and non-verbal communication and their importance in therapeutic communication. We have seen that verbal communication involves the use of words in speech or writing. Non-verbal communication, on the other hand, does not involve words, rather it takes the form of body language: appearance, posture, body movements, tone, rate of speech, volume and so on. Some of these are referred to in most of the units in this book.

As a healthcare provider, a nurse/midwife has to be skilled in the use of both verbal and non-verbal communication in order to create a congenial atmosphere for therapeutic communication to take place.

► Exercise

1. What impression(s) do you get when you see a neatly dressed patient, as opposed to one who is untidy? You may tend to be brusque and dismissive of an untidy person than with a neatly dressed patient. In the same way if a patient walks into a health-care institution and meets an untidy nurse/midwife, what do you think he/she will think of that nurse/midwife?

2. Read the following real story narrated by Nii Teiko about his experience as a student nurse:

   Mr. Kofi (real name changed) a 58-year old gentleman was admitted to Medical Ward Five at 9:00am through the Accident &

Emergency Department with acute chest pain that was described as 'crushing' in nature, which radiated to his left shoulder and around his jaw area. As a 3rd year student nurse on the ward, I was assigned to receive him and the family. He was also accompanied by a Member of Parliament of one of the constituencies in the Greater Accra Region and two of his children. During history taking Mr. Kofi said that he was a trader.

His vital signs were recorded as BP 160/90, P 134/min Respiratory rate 12/min. He was dyspnoeic at rest and complained of nausea. On admission he was clammy, pale and extremely anxious. He dressed neatly, had his side locker filled with a lot of "provisions" and he received a lot of visitors. I then concluded that he must be an important member of his family and also wealthy.

As usual, with an attitude of giving extra attention to people I perceived to be rich, I went out of my way to give Mr. Kofi all the time, attention and care he needed. My intention for doing that was to receive favours from him and his family. A day before his discharge however, I had the greatest shock of my life when I went to inform Mr. Kofi about his discharge. He then thanked me and said: "*Papa Nurse, in fact I am so grateful for your extraordinary service. Besides being a house keeper to a brother of the MP you saw when I came on admission, I am also a "coal pot maker" and when I go home I will prepare a nice one for you. Thank you so much."*

I stood there dumbfounded and after a few minutes I said, "That is ok. I don't cook at school and so I may not need the coal pot. All the same I did what I did for you as a nurse. God be with you."

For me that was a lie. I did all that expecting tips, gifts and favours. From that day on, I decided to avoid being selective in my treatment of patients under my care and vowed to treat all men equally regardless of their appearance, behaviour, and background.

1. Why did Nii conclude his patient was a rich and important person?

2. Do you think his reaction to the patient was appropriate? Why?
3. What do you think should be your appropriate response/reaction to people whose appearance is different from what you would expect?
4. Should appearance play a role in the way a nurse/midwife treats a patient? Explain your answer.
5. Apart from appearance, discuss three (3) ways by which you can communicate with your patient non-verbally.

Further reading

Dobkin, Bethami A., Roger C. Pace. 2003. *Communication in a Changing World.* New York: McGraw-Hill.

Hybels, Saundra and Richard L. Weaver II. (2001). *Communicating Effectively.* Sixth Edition. Boston: McGraw-Hill.

UNIT 5:

RECOGNISING DIFFERENT COMMUNICATION STYLES

5.1 Introduction

There are various ways of categorising communication styles including direct, indirect, circular, manipulative, submissive, person-centred, idea-focused, etc., (Saphiere, Mikk, & Devies, 2005: 18). According to the University of Kentucky Violence Intervention and Prevention Center there are passive (non-therapeutic), aggressive (non-therapeutic), passive-aggressive (non-therapeutic) and assertive (effective and therapeutic) communication styles (UKVIPC, 2014). This section will provide an overview of these four basic communication styles as patterns that, in many ways, may be relative and subjective based on the cultural context. In understanding these styles, it is important to keep the following 6 points quoted directly from Saphiere et al. (2005) in mind:

1. Communication style is a situational tendency, not a type.
2. The style we use is influenced by many factors.
3. As with culture, everything's relative with communication style.
4. Neutral descriptions are needed, yet those descriptions have their own weaknesses and liabilities.
5. Communication style provides a link between the observable and the unconscious—between our behaviour and its underlying motivation.
6. There are advantages and disadvantages to every style (Saphiere et al., 2005: 6-7).

With regard to the first point it is important to realise that people and cultures are multifaceted and dynamic and are not static and unchanging (Saphiere et al., 2005). Thus, while a person may tend to behave in a certain way in a given scenario, this does not mean that he/she cannot change or may not behave in a different way in another situation – especially when it leads us to over-generalise about a person or culture. Understanding these communication styles from this perspective will enable you to effectively involve other colleagues, health team members, patient and or family members in care decision-making. It will also help you to listen and empathise with patients' and/or family members' concerns. Finally, it will help you become aware of your emotions, control yourself and remain therapeutic in your responses.

5.1.1 Why Nurses and Midwives Need this Knowledge

Effectively involving other colleagues, health team members, patient and/or family in care decision-making by recognising and understanding communication styles helps them to appreciate and collaborate in treatment and/or procedural strategies. These skills help you to listen, empathise and understand your patient's concerns by ensuring that you take the time to effectively explain procedures, plans and reasons for taking specific nursing decisions or actions. Further, recognising and understanding communication styles enhance your self-control and self-awareness in a variety of communicative contexts.

5.2 Learning Objectives

After completing this Unit, you should be able to master the following ideas and skills:

- Recognise various tendencies and behaviour patterns associated with particular communication styles.
- Understand what communication styles are and how they impact therapeutic communication.
- Interact with those who exhibit different communication styles effectively for therapeutic communication.
- Maintain appropriate therapeutic speech and behaviour in the communicative context.

5.3 The importance of recognising the different communication styles

To involve other health team members, colleagues, the patient and/or family members in the healthcare decision-making process is important for several reasons. Primary among these is to help them to appreciate and collaborate in the treatment plans, procedures and strategies. Without this understanding, they may consciously or unconsciously disrupt the smooth flow of processes and procedures that are meant to be therapeutic. On the flip side, we as practitioners may lose out on valuable information and input that others may have in the healthcare decision-making. Part and parcel of effective communication are the skills of recognising and understanding different communication styles. In doing so, it is important to listen and empathise with concerns raised, while being sure to take the time to explain and provide coherent reasons for taking specific actions and decisions. The nurse/midwife's ability to listen, empathise and explain may profoundly affect the patient's desire and/or capacity to adhere to medical recommendations, collaborate with the healthcare team, and adopt preventive health behaviours. This translates to better healthcare outcomes as well as greater patient satisfaction with the overall healthcare experience.

As nurses and midwives, it is also very important to be aware of your own emotions and your communicative style. In terms of therapeutic communication, being assertive is a must. Being assertive is a major part of exhibiting effective therapeutic communication skills. This means that you must maintain awareness of how you communicate and how others perceive you. This allows you to adapt to changing situations as necessary. As the Akan proverb states *Berɛdane a, dane wo ho* 'You need to change with the times'. In the therapeutic context, this means that the nurse/midwife must have the ability to make others feel more comfortable by exhibiting appropriate therapeutic communication behaviours or styles that fit within the patient's values and the values of the profession.

5.4 The four basic communication styles

According to University of Kentucky Violence Intervention and Prevention Center, there are four basic communication styles (UKVIPC, 2014).

These are:

1. Passive (non-therapeutic)
2. Aggressive (non-therapeutic)
3. Passive-Aggressive (non-therapeutic)
4. Assertive (Effective and therapeutic)

Below, we will give an overview of each of these communication styles and how they impact therapeutic communication. Again, it is important to recognise these communication styles in others and in oneself.

5.4.1 Passive Communication

Passive communicators tend to communicate in vague and unclear terms. Alternatively known as submissive communicators they talk little and put themselves down while praising other people. Passivity in communication typically is the result of low self-esteem. Such individuals hold the idea that if they speak, they will be attacked or embarrassed. They tend to go along with any suggestion other than their own, even when they know that the decision will not work in their best interests. Because of this, passive communicators tend to hold their grievances in rather than conveying their concerns openly when they are hurt or angry. This repression may eventually lead to a one-off outburst once the transgressions finally become unbearable. Such outbursts are typically out of proportion given that they are reacting not only to the triggering event, but days, weeks, months or years of pain and anger. Once they finally reach that threshold and explode, in the aftermath, they tend to feel guilty or embarrassed about their behaviour (UKVIPC, 2014).

Passive individuals tend to refrain from expressing their true feelings for fear of the result of making waves or rocking the boat. Therefore, they may not disagree even when they have cause to do so. They also tend to hold the opinion that everyone else is more entitled or has more rights than they do. Those who communicate passively tend to be indirect. They tend to agree with almost every suggestion – provided that the suggestion comes from outside of themselves. They tend not to

speak up for themselves and are hesitant in communicative situations (UKVIPC, 2014).

As such, passive individuals may allow other people to impinge on their rights and encroach into their space. When they are transgressed against, they may fail to express themselves and how they feel about the situation. They may allow their needs and wants to go unfulfilled and their opinions to go unheard. They may also fail to trust in themselves while putting an unreasonable and unfounded amount of trust in others. The end result is that others make all of their important decisions for them. Thus, they don't get what they want or need while others do. This, in turn repeats the cycle of repressed resentment due to lack of fulfilment (UKVIPC, 2014).

Passive people can be recognised due to their tendency to speak gently and without conviction. They may also refrain from eye contact and maintain a slumped over posture while sitting or standing as opposed to being upright. This type of outlook leads them to sigh, ask permission and complain internally rather than taking responsibility for changing a situation. The typical passive communicator is more comfortable allowing others to make choices for them. In an argument, they may attempt to support both sides rather than taking a stand. Otherwise, they are prone to remain quiet to keep conflict and discord to a minimum. They may submissively withdraw from the group rather than to stand up for themselves within the context of the group. They harbour opinions that others would belittle their feelings and words if they shared them openly. They are people who act as doormat to be stepped on by others. They may appear to be shy and self-effacing while also having difficulty following through with their plans.

Such communicators may not react positively in the face of problems but will rather wait for others to take care of issues for them. Thus, they may postpone taking decisions by procrastinating whenever possible. They may also ignore issues or leave to avoid having to deal with a problem. When challenged, they may become quiet. They may nod their heads while thinking no. They may expend an overabundance of energy attempting to avoid the anxiety that comes with conflict. Also, rather than taking initiative, they may incessantly ask for advice or direction, ultimately agreeing with whatever is suggested rather than thinking things through for themselves.

The dangers of this tendency are many. For example, passive communicators may end up caving in whenever faced with decisions or challenges. They may lose their sense of identity and purpose in life. This may lead to low self-esteem. Further, they may build up a personal tendency to be dependent in relationships. They may appear capricious and fickle because of their aversion to taking a stance and sticking by it. Finally, they may advocate for unsound views just because those opinions are coming from other people.

It is important to know that each of these types of behaviours can manifest in otherwise communicatively competent people, including nurses and midwives. Thus, it is very important for you to be self-aware and ask yourself, "Am I behaving like a passive communicator?" Also, when interacting with others, recognising such behaviour in others is key to finding ways to communicate with them, to draw them out of their shell and help them become more effective and therapeutic communicators. A nurse/midwife who is a passive communicator can easily be manipulated by a patient into agreeing to do things that may not be professionally correct because of his/her fear of offending the patient.

5.4.2 Aggressive Communication

One of the primary characteristics of aggressive communication includes the tendency to violate the rights of others. This tendency is most notable when such communicators are advocating for their own needs and desires (UKVIPC, 2014). Other notable traits of this communication style include sarcasm, harshness, criticism, etc. Those who demonstrate this situational tendency are oftentimes also insecure, emotionally immature and suffer from low self-esteem. Contributing factors to aggressive communication styles include the communicators themselves having been abused physically or emotionally in the past, leading to emotional wounds that are unhealed and feelings of powerlessness with regard to healing them or about life in general (Benedict, 2017). Typical behaviours of aggressive communicators include the tendency to be disrespectful of others, be patronising towards others, and behaving like he/she is always right and cutting others off when they are talking (Benedict, 2017).

As a result of these types of character traits, aggressive communicators tend to be poor communicators and very close-minded towards other perspectives. This may, in turn lead to attempts to monopolise or make themselves the topic of nearly every conversation due to self-centredness (Benedict, 2017; UKVIPC, 2014). Moreover, this leads to a behaviour pattern where they may be domineering over others and attempt to control other people by a variety of tactics including humiliating, blaming, naming, shaming, etc., (Benedict, 2017; UKVIPC, 2014). Aggressive communicators have a low tolerance for people who annoy or frustrate them and they are quick to speak out against others. This type of behaviour can be particularly problematic when it leads to such communicators acting in a rude or threatening manner towards others (Benedict, 2017; UKVIPC, 2014). Threatening behaviours may include maintaining an intimidating posture and tone of voice, invading the personal space of others, making eye contact/physical contact in ways that make others uncomfortable. The result of such aggressive behaviour patterns is that aggressive communicators tend to alienate others and become alienated from others due to their tendency to generate feelings of anxiety, fear and hatred in other people (UKVIPC, 2014). They also have a tendency to blame other people rather than owning up to their own issues, which makes it difficult if not impossible for them to mature (UKVIPC, 2014). While it is important to note that not all aggressive communicators will demonstrate each and every characteristic all of the time, it is useful to note that these are tendencies that one should look for in oneself and others.

In all, aggressive communicators tend to try to achieve their own goals by trampling on the rights of others. Aggressive communicators bully other people. They domineer in an outright fashion or through sarcasm. They also tend to be arrogant and full of themselves. With regard to interpersonal communication, strategies employed by aggressive communicators will centre on win/lose propositions wherein they must win and others must lose. Aggressive communicators may also be "micro-managers" hovering over subordinates rather than allowing them to carry out their tasks unhindered. Such behaviour patterns may, in turn, lead to less productivity for themselves and subordinates. The upshot of all of the aforementioned characteristics and behaviours is that aggressive communicators tend not to be able to maintain enduring

relationships with other people due to rubbing them the wrong way. They use their energy not in forming rewarding, mutually beneficial relationships but rather in forming strategic alliances for the sheer sake of expediency. They also devote time to sabotaging and striking back at others who they think have offended them. This leads to them engendering resistance and defiance and a hostile work environment. When others resist their attempts at control, they are met with contempt and resentment rather than mutual understanding (Benedict, 2017; UKVIPC, 2014). In short, an aggressive communication style is wholly inappropriate for therapeutic communication and is, in many ways the opposite of what a nurse/midwife should strive for in interpersonal communication. A nurse/midwife who is an aggressive communicator is likely to impose his/her views and preferences on his/her patients.

5.4.3. Passive-aggressive Communication

As the name indicates, passive-aggressive communicators display attributes of two different communication styles. While, at first glance, such communicators may seem passive, they harbour feelings of anger and resentment (primarily due to their inability to confront issues head-on) that come out in very aggressive ways when they finally bubble to the surface. In other instances, they may attempt to get back at those who act against them in subtle and underhanded ways. The genesis of these types of behaviours is a feeling/reality of lack of power to challenge authority figures or even peers directly (Benedict, 2017; UKVIPC, 2014). The resentfulness that passive-aggressive communicators feel may also surface through acts of deliberate sabotage in which they act out their aggressions in ways not readily traceable back to them. They may also try to gossip or make fun of others who they harbour resentment against as a means of turning others against those people. All the while, these same people will smile in their faces and pretend that all is well. The root feelings that underlie these passive-aggressive behaviours include feelings of resentment and powerlessness, which are closely related to each other. Because they feel powerless, they are not ready, willing or able to address those they resent in a direct manner. As such, they turn their attention towards undermining the efforts of others (Benedict, 2017; UKVIPC, 2014).

People who display passive-aggressive communication patterns tend to behave in such a way that rather than speaking directly to someone about the actual or perceived issues, they would rather grumble or make snide or sarcastic comments about the person or situation (UKVIPC, 2014). Even when they are angry, they may deny that there is a problem and they ultimately have difficulty admitting it to themselves and/or showing it to others around them in the interest of keeping up appearances (UKVIPC, 2014). In short, the passive-aggressive communication style is also a way of relating with others that is fraught with pitfalls. In the interest of therapeutic communication, it is of the utmost importance that one is able to identify this often-maladaptive communication style in oneself and in others. While you do not have control over how others behave, you have control over how you will respond and react in any given situation. Be sure to steer clear of exhibiting passive-aggressive modes of communication in the interest of therapeutic communication.

5.4.4 Assertive Communication

Assertive communication is the optimal style for therapeutic communication. Those who are assertive articulate their rights, needs, opinions and feelings while being respectful and cognisant of those of others. Assertive communicators are able to be firm yet respectful; self-confident yet not arrogant, with a level of emotional maturity that is engendered by high self-esteem (Benedict, 2017). Assertive communicators are able to remain open minded and tend to be good listeners. They do not fear the words or ideas of others because they are able to communicate their needs in turn without interrupting others. This leads to them being both decisive and proactive when it comes to taking the initiative. In other words, they do not shy away from addressing challenges immediately rather than postponing decision-making. This is because they have the self-confidence, the skills and the plan to deal with issues as they happen. Note that this is in contrast to the traits of the passive-aggressive communicator who may waste valuable time and energy thinking negative thoughts or harbouring negative feelings about people or situations in which they may find themselves.

Assertive communicators set clear boundaries by setting clear limits when need be and expressing expectations when called upon to do so. Assertive communicators are able to make observations of others in a way that is not face-threatening or judgmental. Assertive communicators feel no need to label others or put them into boxes. In assertive communication, one is able to consider the feelings of others as they communicate their own honest feelings and opinions. They are also able to speak to others from their own point of view, but without an accusatory tone. This is a skill that comes from competence and the self-control that manifests itself in the posture, culturally appropriate manner of eye contact and tone of voice of the assertive communicator (Benedict, 2017; UKVIPC, 2014). Because of genuine sense of empathy and feeling connected to others, assertive communicators are able to respect opinions and points of view that may be different from their own. This leads to them being keen to learn new knowledge, adapt new attitudes and acquire new skills.

Although assertive communicators are not aggressive, they are also not passive and are not willing to allow others to manipulate or abuse them and will stand up for their rights, opinions and feelings (Benedict, 2017; UKVIPC, 2014). Rather than attacking people and their personalities, assertive communicators conscientiously focus their attention on problems and issues. This mode of behaviour is indicative of a level of maturity that tends to be absent in those who practice other communication styles.

One of the major characteristics of the assertive communicator is the ability to compromise to reach a mutually beneficial solution. This ability is born of their capacity for taking alternative opinions, perspectives and ideas into account as they form their own opinions on a subject. One of the most important outcomes of assertive communication styles is that such people are able to not only maintain their own self-esteem, but inspire others to be more confident. This is part and parcel of an overall positive self-concept that keeps them motivated even during the most challenging of times. As such, assertive communicators are able to build lasting meaningful relationships with other human beings.

The assertive style of communication is absolutely essential for fostering an environment in which therapeutic communication can take place. This is because assertive communication allows us to take care

of not only ourselves, but others as well in a way that is therapeutic for all parties. An assertive nurse is able to allow the patient to take his/her own decision after he/she has constructively presented his/her options to them. Thus, for nurses and midwives in the Ghanaian context and beyond, assertive communication is a must.

5.5 Summary

Although the communication styles in this chapter have been laid out as though each individual only practices one style, it should be noted that all of these styles may exist in you and other people in various contexts. This is why self-awareness is crucial in that one is able to ask oneself as a nurse/midwife, "Am I acting therapeutically? Was I being aggressive in my interactions with that patient? Was I overly passive in my conversation with that doctor"? No one is perfect, but by laying out general characteristics, we hope to provide an understanding by which one is able to evaluate one's own behaviour as well as that of other people. Once one is conscious of one's own behaviour patterns, it becomes easier to address how an assertive nurse/midwife would/should interact with someone who is being passive – as a patient may be, for example? How should one interact with an aggressive family member or a passive-aggressive colleague? Once you are aware of the various communication styles, you can comport yourself in a manner appropriate for addressing a given situation in context as it happens without holding onto negative energy or feelings.

► Exercise

Consider the scenario below:

A. 30 year old Madam Ekua Mansa was admitted by a midwife to the labour ward of a regional hospital in active phase of labour. She had no previous experience with labour and delivery. She kept screaming and crying uncontrollably whenever she had contractions and could not lie still during her reviews by the midwife. The midwife ignored her calls in between reviews and said she was not the only person she had to attend to. A midwifery intern on the ward, disturbed by the attitude of the midwife,

walked quietly to Madam Mansa's bedside and assured her that she was being monitored so she had nothing to worry about. The patient then informed the intern she knew her baby was being monitored and so was not worried about that. She was concerned about herself because the pain was unbearable and it was not like any pain she had ever experienced. Although she knew labour would be painful she thought it was something she could handle and therefore didn't bother much when her option for pain relief were not discussed during her antenatal visits. The intern assured her she would get a superior to attend to her. She proceeded to discuss Madam Mansa's case with another senior midwife on duty, and suggested she took a look at her and see what could be done to relieve her pain. The senior midwife informed the doctor on duty that he needed to review Madam Mansa. He did his review and found she was not progressing and had to perform a caesarean section to deliver the baby. Madam Mansa was grateful to the intern for her intervention.

Using the scenario above, answer the following questions:

i. Discuss the different communication styles you can identify from the scenario.

ii. Discuss what could have happened to Madam Mansa and her baby if the intern had not intervened.

B. After surgery, the husband of a patient came to the nurses' table and asked that his wife be moved to a side ward because she needed some privacy. Nurse Aku retorted by saying "We won't send her anywhere. After all she is not better than the other patients. She has to be here so we can take care of her".

The man got angry at Nurse Aku's reaction and an argument ensued.

The man went ahead and reported the incident to the doctor who then ordered the patient to be moved to the side ward.

1. What communication style(s) was/were exhibited by the patient's husband and Nurse Aku? How did you arrive at your answer?

2. How could Nurse Aku have managed the situation to avoid the argument?

3. Did the doctor do the right thing by ordering the movement of the patient to the side ward? Explain your answer.

4. Could the nurse have communicated her role post operatively to the doctor and salvaged the situation?

5. What should the nurse have done before and after the operation to offset the problem?

Further Reading

Benedict, C. (2017). "Assertiveness and the Four Styles of Communication". Serenity Online Therapy Retrieved 22 May 2017, 2017, from http://serenityonlinetherapy.com/assertiveness.htm.

Boyd, C., & Dare, J. (2014). Communication skills for nurses. Hoboken, NJ: John Wiley & Sons.

Nielsen, J. (2008). Effective Communication Skills: The Foundations for Change. Bloomington, IN: Xlibris Corporation.

Saphiere, D., B. Mikk and B. I. Devies (2005). Communication highwire: Leveraging the power of diverse communication styles. Yarmouth, ME, London, Nicholas Brealey Publishing.

UKVIPC. (2014). The Four Basic Styles of Communication. Retrieved from https://www.uky.edu/hr/sites/www.uky.edu.hr/files/wellness/images/Conf14_FourCommStyles.pdf

UNIT 6:

MANAGING DIFFICULT COMMUNICATION SITUATIONS

6.1 Introduction

Talking about health challenges could sometimes be face-threatening and emotionally challenging. Some health challenges such as mental illnesses, HIV Aids and other sexually transmitted diseases provide the basis for, sometimes, uncomfortable talk situations. The nurse/midwife has the responsibility of making the patient feel as comfortable as possible so that he/she is able to adequately talk about his/her symptoms, fears, and anxiety, and ultimately receive the needed healthcare. Other difficult talk situations have to do with the breaking of bad news, dealing with hostility and anxiety, and handling cultural differences. This Unit identifies some difficult communication situations and recommends ways in which the nurse/midwife is able to provide the needed care even under such circumstances.

6.1.1 Why Nurses and Midwives Need this Knowledge

Even though some situations mentioned above may generally be considered as difficult communication situations, the actual level of difficulty may vary from nurse/midwife to nurse/midwife. This is because different nurses/midwives have different levels of communication competencies. This may be related to their individual self-confidence, cultural competencies, past experiences and professional training. It is therefore important for nurses/midwives to be aware ahead of time of potential difficult communication situations in the healthcare setting and be provided with skills that allows them to professionally recognise and successfully deal with these situations in ways that bring satisfaction to the patients.

6.2 Learning Objectives

After completing this Unit, you should be able to master the following ideas and skills:

- Appreciate the different communicative contexts present in the healthcare provision context.
- Understand that different contexts may require different communicative approaches.
- Recognise and respond to cultural and individual differences as appropriate.
- Understand the need to be assertive as a nurse/midwife without being confrontational or rude.

6.3 Communicative Contexts

6.3.1 Communicating empathy professionally

The nursing profession is a 'helping' one. The nurse/midwife is expected to provide help for the patient/client under various circumstances. Empathy is fundamental to all relationships that involve help. Empathy is defined by Reynolds and Scott (2000, p. 226) as "the ability to perceive and reason as well as the ability to communicate understanding of the other person's feelings and their attached meanings''.

The skills involved in demonstrating empathy involve understanding and anticipation of the other person's needs. Without the demonstration of empathy, help is not achieved and the nurse/midwife will not be able to achieve his/her professional duty of providing help. In providing professional help, the nurse/midwife is expected to demonstrate and communicate (verbally and or non-verbally) that they understand the patient/client's conditions. The next step is providing help to cope with the conditions. Note that in demonstrating empathy, the nurse/midwife does not necessarily seek to solve all the patient's/client's problems. However, he/she demonstrates an understanding of the patient's health circumstances in order to determine the best kind of help to offer. The nurse/midwife shows empathy by the use of the following:

- Active listening skills.
- Appropriate questioning.
- Provision of requisite information when it is needed.
- The use of culturally appropriate gestures including touch.

Listening is an important communication skill that everybody needs. It is required in all kinds of work situations. A good listener is likely to be more effective in his/her job situation as a result of the quality relationship that he/she builds with clients and co-workers. The job of a nurse/midwife involves constant communication with patients and other health professionals, and therefore being an active listener is an important aspect of his/her job. Active listening involves a conscious effort on the part of the listener to hear the words of the speaker, observe his/her non-verbal messages, derive meaning from those and interpret them in the appropriate context. Active listening involves the ability to construct meaning, retain meaning and respond appropriately. See Unit 12 for further discussion of the ideas presented here.

In order for the nurse/midwife to ensure an effective communication process, there is the need to make use of appropriate questioning as part of the listening process. This means that the nurse/midwife should not make any assumptions about comprehension. Where he/she is not certain about what the patient or caregiver is trying to communicate, he/she needs to ask questions for clarification. This is expected to be done in a non-threatening manner. Over all, the nurse/midwife should not dominate the discussion at this stage; he/she should ask only clarification questions.

Within our healthcare set-up, and indeed in many places around the world, doctors spend relatively little time with patients and their caregivers. Nurses/midwives spend a longer period with them. Often patients may seek clarification from nurses/midwives rather than from other health professionals such as doctors, pharmacists or laboratory technicians. The expectation of every patient is that the nurse/midwife is both willing and able to provide the needed information regarding their health conditions and treatment options. Nurses/midwives should do their very best to calm patients and their caregivers down by providing them with requisite information when it is needed. However, they should not assume roles which go beyond their designated responsibilities. They should readily refer the patient to the relevant health professional, such as a doctor, psychologist, dietician, pharmacist, after they have calmed the patient down.

In the process of communicating empathy, nurses/midwives ought to be mindful of cultural expectations and boundaries particularly in the area of gestures. We have already mentioned the multilingual and multicultural nature of the Ghanaian society. There are some gestures that are nationally acceptable or otherwise. For example, in comforting a female patient, a male nurse will not be expected to give her a hug. A pat or light rub at the back should be sufficient. Beyond that, different ethno-religious groups have their value systems which need to be respected. Note that someone may be a Dagomba and a Christian or a Ga and a Muslim. The latter may have to observe the Muslim tradition where unrelated members of the opposite sex are not expected to have body contact, including shaking of hands. Therefore, the nurse/midwife in handling such a patient needs to be considerate of his/her values in that regard.

6.3.2 Anxiety

Anxiety, according to McCabe and Timmins (2013, p. 162), is "an emotional response that represents feelings of discomfort, insecurity or fear." Its physical manifestation can be seen through conditions such as nausea, sweating, headaches, general physical discomfort, etc.

Anxious persons have the tendency to be angry, hostile and generally uncooperative in the communication process. Often such persons may not be very conscious of their anxiety which is the foundation of the uncooperative attitudes. A nurse/midwife could be the anxious person. On the other hand, it could be the patient. It is also possible for both nurse/midwife and patient to display symptoms of anxiety. A nurse/midwife's anxiety could be the result of inexperience regarding the execution of a particular procedure. For example, a nurse who has to bed-bath a patient for the first time may be nervous that she may not do things as expected and cause the patient some discomfort. This may cause anxiety on his/her part. A patient may also be anxious due to uncertainty about a procedure he/she has to undergo or lack of adequate information about a diagnosed condition. For instance, a patient who has been diagnosed as diabetic, and has not received sufficient education on the condition, may display a certain level of anxiety, unsure of the ramifications of the diagnosis.

Generally, hospital admission has the potential to provoke anxiety in patients and their relatives. In such contexts, the nurse/midwife is expected to play a proactive role in addressing the concerns of the patient and his relatives. As much as possible, health professionals have to ensure that the patient are provided with adequate and up to date information about their condition, and done in a way that the patients understand and appreciate. The nurse/midwife has to regularly check on the patient, and refer to another professional such as a psychologist, certified counsellor or psychiatrist if the situation persists.

6.3.3 Breaking of Bad News

Within the healthcare setting, the breaking of bad news is the responsibility of the doctor. Such bad news includes the diagnosis of a terminal or chronic illness. It may also be some extreme treatment such as amputation. Usually, the doctor will break the news in the presence of the nurse. The role of the nurse then is to follow up the conversation with the patient and provide further clarification and explanation, if this is required. It is expected that the nurse provides physical and or psychological support and comfort. It is important for the nurse/midwife to note that people from different cultural backgrounds respond to grief and other difficult situations differently.

A key principle here is for the nurse/midwife to indicate their availability for further interaction even if they cannot stay with the patient for much longer at that particular moment due to the load of work. The nurse/midwife is expected to be guided by the following:

- They should indicate their availability for the patient/their family.
- They should not make the patient feel rushed.

Every nurse/midwife has to deal with the issue of death and dying as part of their work. Usually, the nurse will have to inform relatives of the demise of a patient. Even when the doctor has broken the news, the nurse, by the nature of their work, has to spend more time with the relatives and provide more information as needed. It is important to note that different people express their grief in different ways. The nurse should therefore not have any prior expectations in order to be able to offer the needed help. In their communication with bereaved family members and friends, it is critical for the nurse to observe the following:

- Family members should not be made to feel guilty. It worsens the stress created by the death of a loved one.
- Family members should not be hurried. They should be allowed time, at a suitable place in the facility.
- Nurses/Midwives should be willing and able to provide the needed information to help them through the ensuing process.
- Noisy relatives should be kept away from others without suppressing their grief.
- The use of non-verbal communication could be exploited, for e.g. keeping silent as an expression of sympathy, a rub on the back, etc.

The nurse should however be mindful of the cultural implications of some non-verbal acts. Ultimately, the nurse should demonstrate an inherent respect for other people's cultures.

6.3.4 Cultural/Linguistic Differences

A good communicator is one who not only knows what to say, but when to say it and how to say it. She also combines the use of verbal and non-verbal skills in an efficient manner to ensure that her addressee gets the most out of the communicative process.

Nurses need to constantly recognise that the Ghanaian context and many other African contexts in which they operate is indigenously multicultural and multilingual. According to Simons and Fenning (2017), there are 73 indigenous languages present in Ghana. This creates a conglomerate of languages intertwined with culture which the nurse/midwife needs to be mindful of. In addition, residents originating from Ghana's neighbouring countries such as Togo and Nigeria keep increasing, not to mention other nationals from Europe and Asia. Our indigenous cultural values have been fused with our religious values. For instance, someone is both an Asante and a traditionalist, or a Ga and a Muslim, or a Mumprusi and a Christian. These persons are often trying to blend their cultural and religious values in their daily practices. The nurse/midwife needs to recognise the various value systems at play and respect these in the communication process. As much as possible the medical team should include persons who have a sound appreciation of the patient's/client's language and culture. Alternatively, the nurse/midwife should be willing and ready to learn about other cultures, in addition to theirs. For example, an Asante nurse/midwife who had her education in the Ashanti and Greater Accra regions, and has been posted to Yendi in the Northern region, needs to spend her initial weeks appreciating some recurring cultural practices and possibly learning a few words in the language, such as greetings.

6.3.5 Difficult Patients/Clients

The label 'difficult patient' is used in reference to patients who exhibit certain behaviours including verbal abuse, aggression, non-compliance and deception. The exhibition of such behaviours may be the result of long-standing substance abuse, mental distress as a result of the health conditions they have to deal with, financial strain of healthcare, lack of support from family members and/or previous bad experience(s) with the healthcare system. A patient may be labelled 'difficult' as a result of an actual encounter with a nurse/midwife. Also, a nurse/midwife may label a patient as 'difficult' due to a preconceived opinion formed from what has been reported to the nurse by colleagues or other healthcare professionals. In the past, as reported by Brunero and Lamont (2010), in reference to Groves (1978), the response of nurses/midwives to such patients has been to demonstrate helplessness, be confrontational, and

unconsciously mete out punishment which may include exclusion from care. It must be noted that from both legal and moral perspectives, difficult patients are still entitled to healthcare. However, handling such patients/clients puts the professional and interpersonal skills of the nurse/midwife to test. This situation also tests the ability of the nurse/midwife to exercise power and observe appropriate limits.

Indeed, the label 'difficult patient' evokes some negativity on the part of the patient. Authors such as Manos and Braun (2006) point out that what makes a patient difficult is not inherent in the patient but it results out of the relationship with the nurse. A patient who is labelled by nurses as 'difficult' is seen to have demonstrated behaviour that conflicts with what is expected in the healthcare context. The behaviour of a difficult patient has the tendency to hamper effective communication between them and their nurse/midwife and may eventually compromise effective healthcare delivery by the nurse/midwife.

It is for this reason that nurses and midwives need to recognise the existence of this group of patients and take steps to ensure that they are not unduly denied the requisite healthcare. In handling such patients, nurses need to observe the following:

- Ensure that the requisite information is provided in a language that they understand well.
- Ensure that the patient is moved to a place where they are not a distraction to other patients. This does not necessarily mean putting the patient in an isolated place without supervision.
- Assist the doctor to fully assess the patient including doing a mental assessment.
- Use expressions that have the tendency to calm the patient down, for example, "I understand how you feel, but…."
- Allow the patient to give feedback and clarify situations they don't fully understand or appreciate.

6.3.6 Assertion without Confrontation/Conflict

In the exercise of their duties, nurses/midwives are one group of people found in the chain of healthcare delivery. They do not only have to deal with patients, but they have to constantly interact with doctors and other healthcare professionals. Nurses/midwives are expected to adhere to

strict guidelines and they are held accountable for the care they provide often directed by doctors. As a result, they are sometimes caught between the doctor and the patient. The nurse/midwife experience moments where they are required to demonstrate assertiveness to either the doctor or the patient or both. Below are some strategies that can be employed when one needs to be assertive, without being confrontational:

- Be confident, not loud: Often people equate confidence with being loud. That is not the case. The confident nurse knows what his/her patient requires and expresses so in clear terms to the doctor. On the other hand, they clearly communicate with their patient what they need to do and ensure that they are following the required recovery regime. Your confidence as a nurse/midwife should be based on your professional knowledge rather than emotive opinion.

- Listen to both doctor and patient: An assertive person not only communicates his/her views clearly but also listens to what his/her addressee has to communicate. Listening to the addressee actively provides the opportunity to correct any misjudgements or misconceptions. It also provides a reason for the patient/interlocutor to listen to you so that you collaboratively arrive at the most suitable healthcare solutions.
- Be clear in your communication: To get others (whether doctors or patients) to understand your point of view, it is important to communicate clearly and unambiguously. It is therefore critical for the nurse/midwife to gather the necessary information that forms the basis of their position.

6.4 Summary

This Unit has been concerned with situations that have the tendency to pose difficulty in communication for the nurse/midwife. The intention has been to let the nurse/midwife understand that the communicative contexts in healthcare provision vary, and there is the need to take cognisance of these. Also, there is the need to adopt different communicative approaches in the different contexts. Additionally, nurses/midwives need to be sensitive to and appropriately respond

to cultural, religious and individual differences. Finally, within the healthcare setting nurses/midwives are expected to be assertive without being confrontational.

The Unit therefore explained the principles of communicating empathy in the professional healthcare setting. It sought to identify the causes of anxiety on both the part of the patient and the nurse/midwife, and how these can be managed. It also looked at some techniques that can be adopted in the inevitable event of breaking of bad news by healthcare professionals to patients and the friends and relatives of patients, in the event of death. The management of cultural and linguistic differences, particularly within our multicultural and multilinguistic contexts, was addressed. The need to handle difficult patients in such a way as not to bring more distress to tensed situations and to still afford them the right to healthcare was addressed. Finally, the need for the nurse/midwife to be assertive while avoiding confrontation and rude behaviours was discussed.

► Exercise

1. 63-year-old man Mr. Addo is a retired security man who has to take care of his healthcare needs on his own. He was diagnosed with hypertension at age 45 and has been an attendant at your hospital but has not been taking his medications regularly despite several admonitions to do so. He has now been admitted to the medical ward with complications of hypertension. He has been on admission for 2 days and is yet to purchase all the medications prescribed for him to control his blood pressure. He gets angry and verbally abuses the nurses whenever they inquire about when he would purchase his drugs. The doctors are threatening to discharge him if he doesn't buy his drugs but he is unwell and not in a position to be discharged.
    a. How will you handle the verbal abuse from Mr. Addo?
    b. How will you ensure he gets his medications and takes them?
    c. How will you convince the doctors to keep him on admission?
    d. How will you ensure compliance with his medication even after discharge?

2. Mrs. Darko is a 30-year-old woman who is 37 weeks pregnant with her first child and reports to your facility for her routine antenatal check. She informs you she has not felt her baby move in 2 days. You are unable to hear a foetal heartbeat on examination and you call a doctor in to assess her. The doctor does an ultrasound scan on her and confirms there is no foetal heartbeat. The doctor breaks the news of the baby's demise to Mrs. Darko and her husband in your presence and informs her she would have to be induced to deliver. Mrs. Darko breaks down and says she cannot imagine going into labour and delivering a dead baby. Her husband angrily blames her for not reporting early enough to hospital.
    a. How can you assist Mrs. Darko to deal with the demise of the baby?
    b. How do you convince her to accept induction of labour in order for the baby to be delivered before further complications set in?
    c. How will you handle her angry husband and get him to support his wife through this difficult period?

Further Reading

Brunero, S., & Lamont, S. (2010). The 'difficult' nurse-patient relationship: Development and evaluation of an E-Learning package. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 35(2), 136-146.

Manos, P. J., & Bruan, J. (2006). *Care of the difficult patient: A nurse's guide*. New York: Routledge.

McCabe, C., & Timmins, F. (2013). *Communication Skills for Nursing Practice*. Basingstoke: Palgrave Macmillan.

UNIT 7:

NURSING COMMUNICATION IN OTHER CULTURAL ENVIRONMENTS

7.1 Introduction

Our purpose in this Unit is to explore nursing and midwifery practice in other cultural environments in order to better understand the extent to which we can defend a claim of universal professional practice. We can boldly assert that the general principles of the professions (nursing and midwifery) are the same. Every nurse should know this from 'GNS 101'. However, there are certain things that will change depending on the specifics of the cultural environment. In this Unit, we will present an understanding of nursing communication in different cultural environments. In doing so, you will come to understand how nursing and midwifery may change when different cultures meet or in other places. You will also learn about what is appropriate and what is not when interacting with people of different cultural backgrounds and in different situations. You will learn more about how cultural and social values have an impact on practice. Finally, you will learn why cultural awareness is of the utmost importance when therapeutic communication is the goal.

7.1.1 Why Nurses and Midwives Need this Knowledge

Nurses/midwives need this knowledge to understand professional universals and cultural particulars as well as how to communicate appropriately, effectively and therapeutically when in other cultural environments. This will ensure that you are culturally aware and are able to appreciate different cultural and social values when practicing. This will also help you communicate appropriately based on your context. It will also help you to understand the impact of cultural difference on therapeutic communication.

7.2 Learning Objectives

At the end of this lesson, you should be able to master the following ideas and skills:

- Uphold the significance of cultural awareness for Nursing and Midwifery professionals.
- Learn to explore the social and cultural values of the context of practice.
- Be able to determine what is appropriate and what isn't in relation to persons and places - situational contexts.
- Be appreciative of the impact that cultural difference between nurse/midwife and patient may have on practice.

7.3 Tenets of International Practice

7.3.1 Transcultural healthcare

There are various considerations in transcultural healthcare of which the nurse/midwife should take note. These relate to practices that may be deemed to be universal in contrast to those that may be specific to a culture or locale. According to Leininger (1997, p. 342), "Formal areas of study and practice in the cultural beliefs, values and life ways of diverse cultures and in the use of knowledge to provide culture-specific or culture-universal care to individuals, families and groups of particular cultures." This is to say that it is important for you to take note of general knowledge as well as what relates to the unique cultural environment in which you practice nursing and midwifery. In this section, we will look at transcultural healthcare and specifically transcultural nursing and midwifery. In this Unit we will follow the definition provided by Herberg (1989), which relates to nursing that is sensitive to individual, family and group needs. This definition accounts for those who represent integral segments of the diverse society.

7.3.2 Transcultural Nursing

In Britain, multiculturalism is, to a large degree, a consequence of colonisation, and later immigration with its resultant creation of a racially

diverse community of people. Each racial group has different concerns. For example, the Black population may have a greater incidence of sickle cell, heart disease, etc. Such concerns may lead to unique healthcare considerations related to genetics, race-based blood donation, bone marrow transfer etc. This situation may also necessitate the need for political correctness with regard to racial, ethnic, and even religious sensibilities. Indeed, according to Narayanasamy (2006), it is necessary for healthcare providers to deliver culturally sensitive and appropriate services to meet unique needs within such ethnically diverse societies.

A similar situation holds in Ghana. Especially in metropolitan areas like Accra, Kumasi, Sekondi-Takoradi, etc, but also in others regions throughout the country, we can find Ewe, Akan, Ga, Dagbamba, Dagaaba, Mamprusi, Guan and other Ghanaians and non-Ghanaians alike. Thus, it is extremely important for a nurse/midwife to be culturally competent. Sometimes, this may just be in the form of knowing greetings and protocol of the people of the area in which you work. Other times, it may be a cultural practice in terms of how to show respect to elders in a given locale. In Unit 10, we will discuss ways to use technology to find some of this information. However, there are also low-tech ways to learn just by asking neighbours, colleagues, consulting with the Nursing and Midwifery Council or an immediate superior. These techniques and more can be leveraged in the interest of therapeutic communication.

7.3.3 Impact on Therapeutic Communication

Therapeutic communication requires a therapeutic relationship as its foundation! This means that there must be a sincere connection to the patient based on empathy and understanding. When this is not the case, there can be numerous breakdowns in communication and understanding, all of which can make truly therapeutic communication difficult if not impossible. For example, in the UK, it has been noted that the British health service "reflects the cultural norm of not only the white majority but the middle class white majority" (Parfitt, 1998, p. 50). As a result, it is often difficult for healthcare providers to form normal relationships with Black clients. Again, it has been observed in the British context that "Nurses who hold ethnocentric views will be unable to interpret their patients' behaviour appropriately as they will

judge it according to norms of their own behaviour" (Parfitt, 1998, p. 52). As such, it is impossible for such nurses to be empathetic to patients that they can't relate to.

In Ghana, while our nation stands as a beacon for peace in Africa, there are still tensions that may flare up, especially around elections or with regard to land inheritance or chieftaincy succession disputes, for example. It is important for nurses and midwives not to allow things like a patient's (or your own) ethnic background or political affiliation to stand in the way of therapeutic communication as this is part of our sworn sacred duty and responsibility.

7.3.4 Cultural Competence

For nurses and midwives to display cultural competence, there are 5 elements that are necessary.

- Valuing diversity.
- Having the capacity for cultural self-assessment.
- Being conscious of the dynamics inherent when cultures interact.
- Having institutionalised culture knowledge.
- Having developed adaptations to service delivery reflecting an understanding of cultural diversity (Cross, Bazron, Dennis, & Isaacs, 1989).

Valuing diversity is about attitudes. For example, someone who wants everyone to be the same or just like himself/herself is not someone who values diversity. In terms of understanding the benefits of diversity, one can think about it even in terms of genetic diversity. Imagine that you are part of a population with little genetic diversity. If a disease comes along, it could wipe out that whole population due to the lack of diversity. One can think of ideas in the same way. When there is little or no diversity of thought, there is a chance that a problem – whether natural, social, etc. – may become an insurmountable challenge due to the lack of a diversity of voices capable of handling whatever the issue may be that presents itself.

The second point is having the capacity for cultural self-assessment. When this trait is lacking in an individual, one only sees

oneself (and perhaps people like oneself) as the norm or standard against which all others must be measured. However, one must be able to honestly assess one's own cultural background as just one of a mosaic of different possibilities that exist within a given nation or society.

You should also be conscious of dynamics inherent when cultures interact. In such cases, questions may arise such as who comes from the bigger group? Whose language is dominant in the society? Who hails from a more prestigious locale? Beyond these types of concerns, there may be more practical issues such as who is to greet first and how? Should you look directly into the eyes of the other person or should eye contact be avoided. How do men and women interact within the cultural groups in question? These and other questions may contribute to the nuanced dynamics present when cultures interact. Being conscious of such factors is a key to achieving therapeutic communication in nursing and midwifery practice.

Because of these factors, whenever possible, is also necessary to institutionalise cultural knowledge and internalise this knowledge on individual and group levels. In other words, if you are in a cultural context, such as Ghana, where traditionally greetings are taken to be signs of respect, it is incumbent on institutions to make culturally appropriate greetings and other such formalities a necessary part of nurse and midwifery training. When cultural knowledge is institutionalised, this means that it is not subject to the whims of any individual to act or not act in a certain way. All of these considerations form the basis of cultural competence.

According to Betancourt et al. (2002), as cited in Jiwa et al. (2011), "**Cultural competence** in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs". This is the fundamental understanding of cultural competence that we will use in this Unit.

This Unit will therefore focus on diversity. The workplace of nurses and midwives is characterised by such diversity of all kinds – one never knows who may come in the door in need of care. By the same token, colleagues and others may come from any variety of backgrounds. Thus, for the nurse/midwife, going to work entails a cross-cultural

experience on a regular basis. For this reason, cultural competence is of the utmost importance for nurses and midwives. Cultural competence can be thought of as the measure of employees' and employers' level of awareness of difference and diversity. It also encompasses their attitudes towards that diversity as well as their willingness to embrace these to facilitate harmony within that context.

7.3.5 The Nightingale Pledge and Cultural Competence

The Nightingale Pledge can be thought of as a universally institutionalised way to account for diversity and difference when giving healthcare. Within this pledge, four incredible sentences define your lives as professionals and as a matter of fact as human beings – your professional and social lives are inevitably interlinked. It was composed by Lystra Gretter (1893), an instructor of nursing at the old Harper Hospital in Detroit, Michigan. Apparently, it was first administered to her graduating class of 1893. It is named in honour of Florence Nightingale and is thus referred to as "The Nightingale Pledge."

A pledge to God

1. "I solemnly pledge myself **before God** and in the presence of this assembly, to pass my life in purity and to **practise my profession faithfully**."

   That is, every nurse has a covenant with God when they make the pledge, the assembly are witnesses. The Florence Nightingale Pledge is discussed in full in Unit 12 together with the International Pledge, The Ghanaian Pledge and the Midwife's Prayer.

Empathy

2. "I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug."

   That is, no insensitive acts of wickedness – even in little things like giving injections – silently say 'you won't dread needles because of me'. As will be discussed in Unit 10, the earliest of these statements of non-malfeasance dates to ca. 2458-2446

BCE right here in Africa where a healthcare practitioner named Nenkh-Sekhmet recalls "Never did I do anything evil towards any person" (Booth, 2011:164). Beyond healthcare practice, it is important to remember that a caring member of society is likely to be a good citizen.

Professionalism

3. 'I will do all in my power to maintain and **elevate the standard of my profession**, and will hold in confidence all personal matters committed to my keeping **and all family affairs coming to my knowledge in the practice of my calling**.'

   Nurses are included in a **'Circle of Trust'** and must manage personal and professional relationships. This circle must not be broken! Central in this idea is the importance of co-operation and trust and the foundation of working together in a therapeutic way.

4. 'With loyalty will I endeavour to aid the physician, in his work, and devote myself to the welfare of those committed to my care.'

   Two concepts in the above statement that deserve special attention are "devotion" and "care." Devotion speaks to an inner drive to care for others. Indeed, this is the pledge that nurses and midwives have made and to which we must hold ourselves accountable. The Florence Nightingale Pledge, The International Pledge, the Ghanaian Pledge and the Midwives' Prayer are discussed in detail in Unit 13.

7.3.6 International Practice

In spite of sharing the universal principles above, some differences may exist based on any number of factors. Some of these include budget, trust, and expertise. In terms of budget, this means that funding may play a role in the different modes of communication available in developed and developing countries. With regard to trust, it is easier to entrust our lives to a nurse we understand than one we do not. So, when, as a health professional, you can reassure a patient by using your local language, do

so. To not do so is to alienate the patient. Also, expertise may factor into differences in international practice. We have expertise but sometimes we're unable to draw on it because we lack the language for conveying it. It would just have been much easier and straight forward to say it in the language we know. In other words, language carries culture and, therefore, being culturally competent for nursing communication may require the nurse/midwife to understand multiple languages or, at the very least, the main indigenous language of the caregiving environment. This is to say language is an integral part of effective delivery. Expertise can be thought of as that special place where content knowledge meets effective delivery. Nelson Mandela (2006) said, "If you speak to a man in a language he understands, it goes to his head. If you speak to him in his language, it goes to his heart." In other words, language is local and personal. This corroborates the World Health Organisation's lesson from Ebola – **local knowledge is significant**; and local knowledge is often transmitted in an indigenous language (Leach, 2010).

7.4 Summary

This Unit has attempted to present a snapshot of aspects of nursing and midwifery practice that are international as well as aspects that vary between countries/cultures. The bottom line is that therapeutic relationships and therapeutic communication are situated in social and cultural contexts.

► Exercise

Akwele, a young nurse, who grew up and trained in Accra has been posted to a small village in a remote part of the country. She is about to inject a little boy, with an antibiotic. The boy looks obviously terrified. She says the following in an attempt to calm the boy down:

1. 'I'm going to find out if you're a man'.
2. 'Let me see if you're braver than John who was crying'.
3. 'Would you like a lollipop after this?'

Answer these questions:

a. What do you find right or wrong with each of these statements?

The boy refuses to calm down and Akwele addresses the boy's grandfather who accompanied him as follows: 'Hold him down while I give the injection'. The boy's grandfather gets upset that the nurse who is a 'small girl' did not address him properly. He rants that he is a respectable Alhaji and had not been accorded enough respect.

i. Is the grandfather justified in being upset?

ii. What about the statement made by Akwele do you think upset the grandfather?

iii. How could Akwele have avoided this situation?

Further Reading

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: emerging frameworks and practical approaches* (Vol. 576): Commonwealth Fund, Quality of Care for Underserved Populations New York, NY.

Gretter, L. (1893). The Nightingale Pledge. *A Tribute to Florence Nightingale*.

UNIT 8:

CULTIVATING CONVERSATIONAL SKILLS

8.1 Introduction

This Unit is about describing what is meant by carrying out effective conversation by nurses and midwives with the different personalities or clients/patients, their families and even colleagues. It will explain how you can 'use' conversational skills to communicate with each patient as a unique individual taking into consideration his/her condition, cultural values and communication strengths or limitations.

It is important to understand that conversation is a method of self-expression and human interaction that helps to build trust and credibility between people by building rapport (PGDM, 2012, p. 3). The development of conversation skills requires consistent effort, focus and constant practice, but these skills can be mastered (PGDM, 2012, p. 4).

In this Unit, we are going to reflect on how to carry out conversations with patients with specific conditions, and case scenarios or situations that have taken place during clinical work experience and use them to develop the concept of effective conversational skills.

8.1.1 Why Nurses and Midwives Need this Knowledge

To be a successful nurse/midwife, one major skill required is the ability to engage in therapeutic conversations with the client/patient. Excellent conversational skills help the nurse/midwife to connect and build relationships with patients, colleagues and other health care professionals. When conversations are properly and therapeutically carried out during the care of clients/patients this helps to reassure the client/patient, prevent misinformation, misconceptions, or medical errors and the provision of care in partnership with the client/patient.

Excellent conversational skills support the establishment of successful nurse-patient relationships, and can make a difference in positive patient outcomes and lessen medical errors.

8.2 Learning objectives

After completing this Unit, you should be able to master the following ideas and skills:

- Describe the features of a good conversation.
- Identify the important techniques in carrying out conversation with clients/patients bearing in mind their background and condition.
- Apply the conversational techniques in any given situation.
- Carry out conversation appropriately and effectively during various interactions with clients/patients in different care delivery contexts.
- Communicate effectively, ethically, therapeutically and responsibly.
- Effectively monitor, and adjust your own conversational behaviour.
- Describe the changes you can make to your practice to improve conversation with clients/patients, their family and other colleagues.
- Be able to model therapeutic conversational competence.

8.3 Cultivating conversation skills

As we strive to cultivate conversation skills, it is useful to first outline some of the features of a good conversation so that we may know the goal for which we are aiming. Firstly, a good conversation should be a balanced one in which the participants are able to take turns in a reciprocal manner. These concepts of reciprocity can be traced back over 4,000 years ago to ancient Kemet 'Land of Black people' (i.e. ancient Egypt) in axioms like "Do unto another so that he might do likewise" (Bak, 2016, p. 160). In terms of content and delivery, a good conversation should provide clarity and be concise while ensuring that there is resolution as

the message is delivered completely and there is mutual understanding (PGDM, 2012).

8.3.1 Tips for Improving Conversations

There are several ways to improve conversations. Primary among these is striving to listen more than you speak (PGDM, 2012, p. 6). This makes the other person feel important and respected. Additionally, it is a helpful tool to help you succeed in various social settings, work and in a whole host of interpersonal relationships (Dawn & Smith, 2009). Although it may seem difficult at first, the first step to becoming a better listener is to simply stop talking (Dawn & Smith, 2009). For some, this may require a greater degree of self-control than for others. It is also helpful to make use of open-ended questions to keep the conversation going and let the other person know that you are interested in finding out more about them or what they have to say (PGDM, 2012, p. 6). Another way to do this is to paraphrase what your conversation partner says. Of course, to do this it requires you to pay attention and be listening. The affective dimension of this is that it lets the speaker know that you are listening and that you understand what is being said. Additionally, it helps you to exude self-confidence in your dealings with other people. This is also a useful technique to avoid dominating the conversation by showing that you are genuinely interested in what the other person is saying. In an ideal situation, the other conversant will reciprocate this behaviour.

Another aspect of improving the nature of conversations is to pay close attention to your own body language and that of the listener (PGDM, 2012). It is possible to look for specific cues to let you know whether your conversation topic or style is engaging. For example, does the person look bored or ready to go to sleep? In such an instance, you may become aware for the first time that you are taking the lion's share of the conversation. With regard to your own body language, you should look out for other people's personal space. Are you too close? Are you too distant? Is your body posture one of openness or are you standing with your arms crossed in front of you – often taken as a clear sign that you are not receptive to what the other person has to say? In terms of your own body language, you should attempt to remain active and dynamic, keeping the listener engaged in what you are saying. By the same token, you should be seen as being interested when it is time for the other person to speak. There is also a technique of mirroring in which you match the body language of others i.e., you lean forward when they do (Dawn & Smith, 2009). Such techniques are part of the small nuances that may make the other person feel more at ease by being able to identify with you. By showing through one's actions that one is an active and engaged participant in the conversation, conversations can be greatly improved and can lead to a mutually beneficial exchange of information.

Other tips for improving conversations are:

- Care
- Courtesy
- Consideration (PGDM, 2012, p. 8)

With regard to care, this is, as mentioned previously, showing that you are interested in what the other party is saying. Courtesy is most readily expressed in the willingness to take turns and listen to what the other person is saying, and vice versa. Consideration can take multiple forms, but, most notably it can be shown in listening to another person's point of view and respecting their perspective (even if you don't necessarily agree with it).

You should also work towards being fluid and fluent in your speech. While pauses can be used for stylistic effect, generally speaking you want to take the time to think through what you have to say and how exactly you intend to articulate it. One way of building fluency is by working on your vocabulary so that you know what to say and how to say it.

It is also important to stay with the thread of the conversation. Backtracking to previously discussed topics or going off on random tangents that are unrelated to the topic at hand should, generally speaking, be avoided. In other words, to show that you are an active participant who is engaged in the flow of the conversation, you should avoid parallel conversations and try to follow along with the "sequential sharing of ideas" for greater clarity and understanding (PGDM, 2012, p. 8).

8.3.2 Becoming a good conversationalist

To become a good conversationalist, there are several things that you should do. One of these is to be sure to exchange greetings. Especially in the Ghanaian context, it is generally frowned upon to just walk up to a person and start a conversation without the formalities of greeting properly. Whether in an indigenous African language or a colonial/neo-colonial language of Europe, it is very necessary to greet as it shows the other person that you acknowledge him/her as a human being.

In your conversations, it is also necessary to reciprocate. This can be done by "backchanneling," giving verbal or non-verbal cues that you are listening to what the other person is saying. This can also be done by being sure to give the other participant a chance to speak when the time comes. This goes back to not trying to dominate the conversation by making everything about yourself and what you think about something. Remember the Akan maxim *Tikoro nkɔ agyina*, 'One head does not go into council'. In other words, you may never know the valuable advice or opinions you may lose out on if you become the sole speaker in what is supposed to be a mutually engaging and reciprocal conversation.

Another tip is to be polite and courteous to the other participant in the conversation. This can be done in a variety of ways, including by using phrases like *meɖe kuku* (Ewe), *mepa wo kyɛw* (Akan) or *ofainɛ* (Ga) 'please/excuse me'. You should also pay close attention to your tone of voice (Dawn & Smith, 2009). This comes with a level of self-awareness wherein you can ask yourself whether you may be raising your voice unnecessarily in a tense situation, for example. Once you are cognisant of how you are communicating, you can take steps to rectify any missteps. You will also become better at recognising the communication styles of others whereby you can take steps to deescalate a situation that may otherwise get out of hand. It should be recognised that for many people the old adage holds that "It's not what you say, but how you say it". In other words, it is not only your words that carry meaning for others, but your manner of expressing those words. Tone of voice can communicate boredom, anger, sarcasm, having a condescending attitude, etc. If you are not careful, you may alienate others and, equally, find yourself alienated from co-workers, family, patients, etc.

Remember that mutual respect is the key to improving your conversations. This can also be done by showing the other person that you are extending the courtesy of a listening ear as they are speaking. This may mean maintaining eye contact instead of looking off distractedly into the distance or playing with your smartphone. Giving someone your undivided attention is one of the main ways to make sure that

the person feels respected. If for any reason, you may need to interrupt the conversation – for example to answer an emergency call – this can also be done in a polite way that shows that you are aware that you are breaking the flow of the conversation. The core of being courteous and polite is to recognise and care about the feelings of others and to have that care manifest in one's behaviour towards others.

It is also recommended to be concise. A big part of losing the attention of the other participant in a conversation is due to talking endlessly without giving the other person a turn to talk. As such, it is recommended that we be concise in our statements to others. This helps us to be clear in our communication and also ensures that we do not dominate the conversation to the detriment of the other person's input or our own opportunity to hear what the person has to say, which may actually be valuable. Getting valuable input can also be achieved by asking questions to help the conversation to move forward, to get clarity or to request additional information (Dawn & Smith, 2009).

Clarity can also be achieved by avoiding vague language. If you have something to say, for the sake of clear and concise communication, it is in your best interest to try to be specific and vivid in your language use. This can be enhanced by using appropriate body language to convey exactly what you are trying to say. Also, be sure that you do not end abruptly, but rather give some degree of forewarning that you will need to bring closure to the conversation (PGDM, 2012).

A hallmark of good conversational skills is the ability to express what you feel rather than to attempt to please others by catering to what you think they may want you to say (Dawn & Smith, 2009). This is a key to honest communication and dialogue. Part of being honest is having the self-confidence to open oneself up for reactions, responses and, perhaps even criticism. Being open to these will help you to grow as a person and further cultivate your conversation skills.

8.4 Summary

In this Unit, we learned that cultivating conversation skills involves more than just focusing on speaking. Other key elements are engaging in greeting formalities, listening, body language, questioning, being courteous and doing your part to make sure that mutual respect is

maintained at all times (Dawn & Smith, 2009). While these skills are useful in improving conversation skills, they are also the key ingredients to making you a successful person all around, regardless of the social setting. For nurses and midwives in particular, it is necessary to practice implementing these tips and suggestions on a daily basis to achieve therapeutic communication in which everyone is a winner.

► Exercise

Yaw Manu, a trainee nurse, reported to a health facility with common cold, which he said was not resolving. He spoke with Nurse Adjoba, and the following ensured.

Yaw Manu: Madam I have done all I know but the cold remains. I did inhalation with a herbal liniment.

Nurse Adjoba: But you should know better! Who asked you to use that when there are other better ways. Now you are here complaining!

Yaw Manu: Please, the fact that I am a nurse trainee does not mean I know everything. I was desperate and did what I know best to give me some relief.

Nurse Adjoba: Well, you should have known better! Did you read the label on the herbal liniment? You people, you take anything at all. If you were a lay person, I can understand but not you a nurse trainee who should have some knowledge of safe health practices.

Yaw Manu then started sneezing and blowing his nose.

Nurse Adjoba: (Giggling) Eiii! Please don't come and infect us ooo.

Question:

Was the nurse's remarks therapeutic? Give reasons for your choice of answer.

Further Reading

Antai-Otong, D. (2008). Nurse-Client Communication: A Life Span Approach: A Life Span Approach. Burlington, MA: Jones & Bartlett Publishers.

Boyd, C., & Dare, J. (2014). Communication skills for nurses. Hoboken, NJ: John Wiley & Sons.

Falvo, D. R. (2010). Effective Patient Education: A Guide to Increased Adherence. Burlington, MA: Jones and Bartlett.

Kidd, J., Patel, V., & Peile, Y. C. (2005). Clinical and communication skills: Need to be learnt side by side. BMJ: British Medical Journal, 330(7488), 374-375.

Kourkouta, L., & Papathanasiou, I. V. (2014). Communication in nursing practice. Materia socio-medica, 26(1), 65.

Nielsen, J. (2008). Effective Communication Skills: The Foundations for Change. Bloomington, IN: Xlibris Corporation.

UNIT 9:

COMMUNICATION TECHNOLOGIES/INFORMATICS

9.1 Introduction

Some 4500-5000 years ago, the first physicians in the world were found in Africa; Africans of Kemet 'land of Black people' like Hesy-Ra, Imhotep, Peseshet, Merit-Ptah, Penthu, Qar and others were also some of the composers of the first medical texts in world history (Nunn, 2002; Obenga, 2004). These texts – such as the Kahun Gynaecological Papyrus – form the foundation of the practice of healthcare in the world and, as such, healthcare informatics would not exist if not for Africa and African people. Healthcare informatics may be understood as "the integration of healthcare sciences, computer science, information science, and cognitive science to assist in the management of healthcare information" (Saba & McCormick, 2015, p. 232). According to Guenther (2006), nursing informatics (NI) involves "electronic information combined with nursing and any aspect of clinical practice, administration, research, or education" (Guenther, 2006, p. 93). In brief, informatics connects people to healthcare in new, exciting and innovative ways with technology as an integral part of making that connection (Taylor, 2015).

9.1.1 Why Nurses and Midwives Need this Knowledge

Nurses and Midwives in Africa, specifically, need this knowledge to stay abreast of the technology originated by their own African Ancestors. This should be done in the interest of individually and communally beneficial therapeutic communication. This thrust to utilise Nursing Informatics should be undertaken for the benefit of each of us individually, for our communities, for Africa and our global race as a whole.

9.2 Learning Objectives

After studying/reading this unit, you should be able to master the following ideas/concepts and skills:

- Understand nursing informatics from its ancient African origins to its various contemporary manifestations today.
- Describe what an informatics nurse is and what he/she does.
- Articulate what nursing informatics consists of.
- Appreciate clinical applications of nursing informatics.
- Recognise the importance of mobile health/e-health applications in various contexts.
- Comprehend the role of product development in Nursing Informatics.
- Understand the role of education and research in the development of evidence-based Nursing Informatics.
- Understand the relevance of quality reporting in Nursing Informatics.

9.3 Nursing Informatics

Before going into the specifics of Nursing Informatics, it is necessary to provide a substantive definition of what is meant by the term. According to the American Nursing Association (2014):

> Nursing informatics (NI) is the specialty that integrates nursing science with multiple information management and analytical sciences to identify, define, manage, and communicate data, information, knowledge, and wisdom in nursing practice. NI supports nurses, consumers, patients, the inter-professional healthcare team, and other stakeholders in their decision-making in all roles and settings to achieve desired outcomes. This support is accomplished through the use of information structures, information processes, and information technology (2014, p. 10).

This brings us to what an informatics nurse/midwife actually does. There are several roles that an informatics nurse plays. For example, an informatics nurse must collect comprehensive data and information in

order to keep abreast of emerging evidence in the field (Curran, 2003). Once this data are gathered, it must be assessed and analysed in order to fulfil the various tasks for which the informatics nurse is responsible (Curran, 2003). This includes identifying potential diagnoses, problems, issues, needs, and opportunities for growth and improvement (Jastremski, 1999). This information gathering using high and low-tech technology allows the informatics nurse to identify potential and expected outcomes based on research and evidence. Further, information gathering, supported by technology, allows the informatics nurse to help other members of the healthcare team to develop individualised plans for treatment on behalf of the patient in a manner that is relevant and appropriate to the specific situation. The informatics nurse, in developing this plan, is able to use information gathered to prescribe strategies, methods, best practices, alternative courses of action, and other recommendations in order to accomplish goals and attain expected outcomes with patient safety in mind (Bakken et al., 2004). The informatics nurse is also responsible for the implementation of the plan once identified. Additionally, the informatics nurse/midwife coordinates activities that are a part of the therapeutic plan (Parker, 2015).

An informatics nurse/midwife is at the forefront of using informatics as a tool for devising solutions and strategies for education with the ultimate goal of ensuring a more healthy and safe environment for patients as well as all members of the healthcare team (Parker, 2015). Further, the informatics nurse functions as a consultant helping to influence the therapeutic plan in order to help others in their various roles and bring about positive change when and wherever necessary. Once desired goals are identified, the effective informatics nurse/midwife serves to evaluate progress towards these goals (Parker, 2015).

It is also of the utmost importance to note that the informatics nurse must practice ethically as the informatics nurse is responsible for information and bio data about a whole host of patients (Association, 2001; McGonigle & Mastrian, 2014). Ethics, therefore, must go hand-in-hand with security in making sure that information gathered is protected from those who may want to use it illegally or immorally (Kokol, Zazula, Brumec, & Kolenc, 1999). With regard to ethics in informatics practice, considerations of consent as well as intent are of the utmost importance to keep in mind (Blais, 2015; Goodman, 2010).

The informatics nurse must be there to provide consultation to have a positive influence on the overall plan of therapy that is decided upon by the healthcare team based on information that the informatics nurse/midwife has procured. In doing so, the informatics nurse/midwife serves to enhance the abilities and knowledge of others and thereby encourages positive change in the lives of co-workers and patients alike. The informatics nurse attains knowledge and competence reflective of best practices that are current with regard to both nursing and informatics. The informatics nurse must not only gather information, but must be at the forefront of integrating new evidence and research findings into therapeutic practice in the healthcare environment (De Gagne, Bisanar, Makowski, & Neumann, 2012). In so doing, the informatics nurse is able to contribute greatly to the effectiveness as well as the overall quality of nursing and informatics practice. As practice informs theory and theory informs practice, new lessons and experience in the healthcare environment make the informatics nurse not only a recipient of information, but also a generator of knowledge, information, experience and wisdom that can then be imparted to the nursing informatics community and beyond (Matney, Brewster, Sward, Cloyes, & Staggers, 2011). As such, the nursing informatics specialist is able to learn and teach in a variety of settings and modalities. Because this is a necessity, the informatics nurse must communicate effectively in many different formats and media as well as in all areas of practice relevant to nursing and informatics (Parker, 2015). The informatics nurse/midwife must also build a tradition of demonstrating leadership both in the setting of professional practice as well as in the profession as a whole (Parker, 2015).

The informatics nurse/midwife must also build a tradition of collaborating with the healthcare consumer or patient, family, and other stakeholders in the implementation of nursing and informatics (Goodman, 2010). Desired healthcare outcomes are also the result of multi-faceted relationships between the patient, the patient's family, the nurse/midwife, and the information gatherer (Goodman, 2010). In the interest of self-reflection, the informatics nurse should evaluate his/her own nursing theory and practice against the backdrop of standards accepted with relation to professional practice. Guidelines, laws, rules, regulations and statutes should also be considered in the context of

implementation and a specific environment. The informatics nurse/midwife should also endeavour to employ resources that are appropriate in the interest of planning and implementing services related to nursing informatics that are known to be effective, safe, and financially feasible and responsible. In so doing, the informatics nurse/midwife is able to support and be an integral part of healthcare practice helping to create an environment that is safe and healthy (Parker, 2015).

These standards with regard to nursing informatics amount to a new shift of focus in the field. There is now a stronger emphasis on performance and identification of potential problems and issues using documented evidence (Parker, 2015). Nursing informatics is also an integral part of overall therapeutic program management. Nursing informatics of today is also highly concerned with methodologies that are evidence-based (Desjardins, Cook, Jenkins, & Bakken, 2005; Weaver et al., 2005). Further, the new focus of nursing informatics deals with the integration of technology into practice in new and innovative ways on a scale that has been heretofore unprecedented (Ball et al., 2011). This is seen most clearly in the dissemination of health-related information across various media, platforms and devices. Because effective nursing care has always been and continues to be dependent on the gathering of relevant data, documentation and storage of information come to be extremely important in terms of nursing informatics (Polit & Beck, 2008). With the unprecedented introduction of progressively higher levels of technology and informatics, one of the benefits of the new thrust in nursing informatics relates to new abilities to access information quickly and efficiently. This access to information, in turn, helps to improve equality and consistency of the nursing workflow. These new innovations are part and parcel of an overall strategy that lends itself to greater patient engagement as relates to nursing informatics practice (Parker, 2015).

9.3.1 Information Systems and Information Flow

Comprehensive information systems are also necessary to facilitate and improve workflow for nursing and midwifery (Breslin, Greskovich, & Turisco, 2004). This can allow for the faster and easier transmission of information necessary for efficient and effective documentation and processing. This is part of the overall system incorporating electronic

patient records, wherein information technology is used to improve quality of patient care and healthcare outcomes (Häyrinen, Saranto, & Nykänen, 2008). Part of the overall system may incorporate email, smartphone apps, text messaging, teleconferencing, telecare, and other social networking platforms, which have come to play important roles and the provision of healthcare from the standpoint of interpersonal communication (Knight, 2014). Such modalities serve to keep healthcare teams connected to each other and to their patients.

9.4 Use of Communication Devices

General devices such as smartphones as well as healthcare specific devices are useful in digitally capturing, storing, processing, and sharing health and patient-related information between healthcare team members and patients (C. Smith, 2004). Such devices can play an integral role in the prevention of disease as well as in treating or managing the patient's condition.

Communication devices can also serve to shorten or eliminate the time necessary to travel to share information between health team members and the patient. Because electronic transfer transmissions occur instantly, now rather than having to walk or drive to various places to get information, information can be shared at the click of a button or tap of a screen by smartphones, SMS, email, video, etc. (Shortliffe & Cimino, 2013).

9.5 Four Domains of Nursing Informatics

Nursing informatics as it relates to using communication technology can be broken down into four primary domains. The first of these relates to engagement tools and strategies.

9.5.1 Engagement tools/strategies

This involves the use of smart phones, one-to-one electronic connection or peer-to-peer devices such as tablets and computers. These assist in information sharing and healthcare support (tele-medicine and tele-care systems).

Such devices assist in easy and quick targeted sharing of information between health team members in supporting each other to play their distinct roles, seek clarity of diagnoses and treatment plans. Further, these assist in counselling, education, and communication with clients/patients.

9.5.2 Electronic Clinical Decision Support Systems

This is where an automated software or artificial intelligence (AI) programme is used to provide information and support to nursing professionals and other health team members in their practice to access industry best practices, care guidelines and information that helps in providing evidence-based care to patients (Berner & La Lande, 2016; Coiera, 2003; Hyun, Bakken, Douglas, & Stone, 2008). According to Coiera (2003), potential benefits of electronic decision support systems may include enhanced safety of patients, better quality of care, and improved efficacy in the delivery of health care.

9.5.3 Information Systems

This is the use of technology (Internet, intranet, peer-to-peer such as Bluetooth, infrared, torrents, etc.) to gain access to health information, therapies, guidelines and lifestyle information (Wyatt & Liu, 2002). It

involves website resources and e-health portals and m-health apps that aid in the retrieval of necessary information (e.g. hospital websites, Twitter, invited Facebook/WhatsApp groups, etc.) (Brownrigg, 2015).

9.5.4 Information Management Systems

These types of electronic (digital-based) systems, e.g., e-health portals, e-records, etc. are used for gathering, storing, transmitting and displaying health, administrative and patient information from different sources (Niland, Rouse, & Stahl, 2006).

9.6 Security in Nursing Informatics

Due to the ethical demand for confidentiality, personal-patient health records should be secured and protected from unauthorized persons (McNeil et al., 2005). To this end, only authorised persons with password should have access to patient information or where possible systems must use Virtual Private Networks (VPNs) or other security measures.

It is worth noting that digital media can also be used to access cultural knowledge about new and existing work environments (Smith, 2001). This is especially useful in the Ghanaian context where a nurse/midwife may be assigned to a region other than the one of his/her birth or which he/she is familiar with. As such, it becomes necessary to gain information about cultural practices in the community in which one works. For example, a nurse/midwife from Accra who begins working in the northern region of Ghana may be used to certain customs and practices, and beliefs that would be different from that which he/she would experience in the North. In terms of gaining cultural knowledge about the new environment, he/she could rely on academic articles available online, YouTube videos, WhatsApp groups in which people from the environment could share information directly, etc. Information should be picked from reliable and trusted sources before used. The only impediment to getting such knowledge and information in the current digital age is really the imagination and creativity of the nurse/midwife as well as the attitude with which a healthcare practitioner approaches the cultural environment in which he/she works. As such, openness to learning and interacting with patients or potential patients is of the

utmost importance. This is why we must continue to use digital media to access cultural knowledge about new work environments.

Summary

In this chapter, we have discussed nursing informatics, from its ancient African origins to its modern-day applications. As such we have provided an understanding of what nursing informatics is and how it is used in today's workplace environment for various aspects of therapeutic communication. As technology develops, so too will the field of nursing informatics. Also, opportunities will arise in the future for the continued development and deployment of various aspects of nursing informatics to assist in the process and practice of therapeutic communication.

► Exercise

1. Write up a convincing case to a supervisor about the need for a move from paper-based nursing care systems to a modern informatics-based approach in a healthcare facility.
2. Discuss the potential benefits of nursing and midwifery informatics in the Ghanaian context.
3. Discuss how the African origin of medical practice is relevant to the contemporary Ghanaian health worker.

Further Reading

ANA. (2014). *Nursing Informatics: Scope and Standards of Practice*. Washington, DC: American Nurses Association.

Bakken, S., Cook, S. S., Curtis, L., Desjardins, K., Hyun, S., Jenkins, M., Roberts, W. D. (2004). Promoting patient safety through informatics-based nursing education. *International Journal of Medical Informatics*, 73(7), 581-589.

Ball, M. J., Douglas, J. V., Walker, P. H., DuLong, D., Gugerty, B., Hannah, K. J., Skiba, D. J. (2011). *Nursing informatics: Where technology and caring meet*. New York: Springer Science & Business Media.

Blais, K. (2015). Professional nursing practice: Concepts and perspectives. London: Pearson.

Breslin, S., Greskovich, W., & Turisco, F. (2004). Wireless technology improves nursing workflow and communications. CIN: Computers, Informatics, Nursing, 22(5), 275-281.

UNIT 10:

CONSTRUCTIVE CRITICISM

10.1 Introduction

Whether we like it or not, there may be a time when we may find ourselves offering or receiving criticism at home, school or at work. When handled in the appropriate manner, criticism can be beneficial or rewarding. In this unit, we will talk about what is meant by offering and receiving positive feedback or criticism. We will focus on how as a nurse/midwife you will be able to give, and receive constructive criticism or feedback.

10.1.1 Why Nurses and Midwives Need this Knowledge

The role that nurses and midwives play in the healthcare delivery continuum involves a lot more of delivering and receiving messages from clients/patients, their family, colleagues and other healthcare team members. Nurses and midwives are often at the receiving end of criticism and in the hectic schedule of their daily work, constructive and specific feedback from their patients or other team members may go a long way to help them to acquire the necessary know-how and experience that will help them to discharge their duties efficiently to the benefit of the patients.

When a nurse/midwife offers his/her opinions on, or evaluations of, a patient, subordinate or colleague's behaviour or performance that is criticism. When a nurse/midwife receives the opinion of a client/patient, subordinate or colleague about his/her behaviour or performance, it is also criticism. The ability to give and receive constructive criticism or feedback is crucial for the success of the nurse/midwife's work. This is because constructive criticism is an essential and effective tool in boosting morale, supporting behaviour change, and encouraging

effective teamwork or service delivery. There is an Akan proverb that says, *Nea ɔretwa sa no nnim sɛ n'akyi akyea* 'The one that is constructing a path does not know that it is crooked behind him.' In other words, when things are going wrong with your work, attitude, behaviour or performance, you may not see it. It takes those working with you or close to you to observe these things. They are the ones, if they have your interest at heart, who will make you aware of these shortcomings to help you to correct them.

The reason why understanding and applying constructive criticism is essential in your work as a nurse/midwife is that it can be an effective tool for monitoring and evaluating your performance and that of others in order to allow for correction, improvement and growth.

10.2 Learning objectives

After studying/reading this unit, you should be able to master the following ideas/concepts and skills:

- Understand the differences between constructive criticism and destructive criticism and why it is important to cultivate the former.
- Learn how to prepare to deliver constructive criticism.
- Identify the proper steps to be taken when offering constructive criticism.
- Recognise how emotions and certain actions can be negatively impacted when criticism is done wrongly.
- Determine the appropriate atmosphere, communication style and time in which criticism should take place.
- Be able to accept criticism in a more positive manner.
- Be able to apply the best techniques for offering criticism.

10.3 Types of criticism

When it comes to criticism, we have all been criticised before at home, at school, at work or even at play and we have also dished out criticism to others. The word *criticism* is derived from the verb *criticise.* One of the

meanings of this word as found in the *Chambers 21st Century Dictionary* (Robinson & Davidson, 1997, p. 320) is "to find fault; to express disapproval of someone or something." Criticism, itself, is defined by the same dictionary as "fault-finding" among others. *The New Penguin English Dictionary* (Allen, 2000) also defines criticism as "the act of criticising, usually unfavourably." It is no wonder, therefore that the word has a bad reputation. More often than not, we think of criticism as finding fault with somebody or something, or somebody finding fault with us, but it should not always be the case. Criticism can have both positive and negative effects on us depending on how it is given and how we receive it.

Criticism falls into two main types: **Destructive Criticism** and **Constructive Criticism.** In the following sections, we discuss these two types further.

10.3.1 Destructive criticism

Criticism made out of envy or anger and with the intention of hurting or demeaning the person being criticised without offering any suggestion as to how the particular problem, behaviour or situation may be improved, is destructive and must not be encouraged. The following two quotations give us some of the essential characteristics of destructive criticism: "Destructive criticism is **feedback that can be understood more as blunt accusations that make the person feel hurt and angry**. In most situations, destructive criticism fails to highlight the mistakes of the individual so that he can improve himself" (DB, 2015).

The other one is, "**Destructive criticism** offers no help or support for improvement, [it] simply sets out the problem as seen by the person giving the criticism. It is usually expressed as a comment about the recipient, their skills or attributes and not their behaviour. You can think of it as tending to bring someone down, and making them feel bad, whether this is deliberate or not" (SYN, 2017b).

If you tell a subordinate or colleague, "You're always late for work and you don't finish your tasks before going home. I always have to do what you're supposed to do in addition to mine," you're merely accusing the person of being lazy, you're not helping him/her to change.

He/she will rather be on the defensive. If done properly, as we shall see in the next section, it can cause the individual to realise his/her mistakes and make an effort to change.

From the two quotations above we can list the following characteristics of destructive criticism:

- It is blunt.
- It makes the person being criticized feel hurt and angry.
- It fails to highlight the mistakes of the individual so that he/she can change them.
- It targets the individual, his/her skills or attributes, but not the behaviour.
- It brings down the individual.

This kind of criticism is harmful and counter-productive and must be avoided at all cost if a nurse/midwife wants to promote therapeutic communication between him/her and other colleagues or patients and patients' families.

10.3.2 Constructive criticism

Constructive criticism, as the name implies, is one that helps an individual to change or improve. Constructive criticism can be defined as one that:

> … is designed to point out your mistakes, but also show you where and how improvements can be made. Constructive criticism should be viewed as useful feedback that can help you improve yourself rather than put you down. When criticism is constructive it is usually easier to accept, even if it still hurts a little. In either scenario always try to remember that you can use criticism to your advantage (SYN, 2017a).

Harpreet Duggal, a psychiatrist and author, calls constructive criticism *valid criticism* and describes it as:

> … when people offer you helpful suggestions for improvement based on accurate perception of events. The intent of the person giving this criticism is to help you. Usually, a criticism

> is valid if you have heard it from a person who is rational and balanced in their thinking and emotions, is knowledgeable about the subject they are giving feedback on, and also if you have heard it from more than one person. … An example of a valid criticism is when your supervisor points out to you that you have been forgetting to copy them on certain kinds of emails (Duggal, 2017).

We see from these definitions/descriptions that unlike destructive criticism which has the potential to humiliate a person, constructive criticism is:

- Motivated by the desire to help an individual to improve himself/herself, not done with an intent to hurt or humiliate.
- Done in a rational and balanced manner, not in anger or hatred.
- Done from the viewpoint of knowledge and experience, not ignorance.

For criticism to be constructive or valid, therefore, it must have all of the above qualities. Its principal objective is to promote change and improvement in the individual.

10.4 How to offer constructive criticism/feedback

As we have stated already, you may have occasion to criticise somebody's work, performance or behaviour in the course of your work as a nurse/midwife or as a friend, parent or counsellor. The way you do it will show whether your criticism is destructive or constructive. Lauren Diamond, writing in the *Reader's Digest* lists the following "8 Ways Successful People Criticize Others Without Offending Them":

- Start with praise.
- Don't make it personal.
- Be specific.
- Be kind.
- Lead by example.
- Criticise your own behaviour first.

- Ask questions instead of giving orders.
- Pick the right time (Diamond, 2016).

We find these very helpful, so we will take them one-by-one and discuss them. Other writers state essentially the same things though in different ways.

10.4.1 Start the criticism with praise

Whether it is your child, colleague, patient or subordinate that you are criticizing, it is important to start by praising something the person has done which you find commendable. This approach softens the blow and makes it easier for the person to accept the criticism. For example, your child comes home with one A, two Bs and a lot of Cs on his school report card. Instead of criticizing him for getting Cs, praise him for the A and Bs he has got and encourage him to keep up the good work in order to improve upon his grades in the other subjects. The criticism, according to Lauren Diamond (2016) should be "about the work or behaviour you'd like to change, not the personality or personal attributes." Avoid using abusive language and always let the person know why it is important to change or improve upon a particular behaviour.

10.4.2 Don't make it personal

Your criticism must target the work or behaviour that you want the individual to change or improve upon, not his/her personality or personal attributes. Lauren Diamond (2016) puts it this way: "Give criticism without being critical of the other person and recognise barriers that might be in their way. Follow up with offering up why it'll be beneficial to the other person to change their behaviour." In other words, do not criticise and leave it at that. Let the individual know why you are criticizing him/her and how you think he/she can change or improve upon that particular behaviour.

10.4.3 Be specific in your criticism

You have to be specific about the behaviour you want the individual to change. For example, in the case of a parent commenting on his/her child's performance he/she could say something like, "I'd love to see you make As in the other subjects too. Perhaps if you cut down on the time you spend in watching TV and spend more time on those subjects, you'll do better in them." This gives the person a clear indication of how and what to improve or change. Merely saying, "There's more room for improvement," as teachers often write on report cards, will not do the job because it is too vague.

10.4.4 Be kind when offering criticism

The criticism must be offered in a kind and gentle manner. You must put yourself in the place of the person you are criticizing. We all do not like it when our work, behaviour or performance is criticized, so do not be abrasive, be respectful of the feelings of the individual. As Diamond (2016) puts it, "think about how you would receive the same criticism."

10.4.5 Lead by example

When you want a co-worker, child, or patient to do something in a particular way, you will achieve better results by leading by example. For example, if you want a child to brush his/her teeth in a particular way, you can say, "Let me show you how I brush my teeth, it has helped me to keep them clean." According to Lauren Diamond (2016), "Showing rather than telling is typically a well-received way to improve someone's behaviour."

10.4.6 Criticise your own behaviour first

One thing you can do when you are criticizing constructively is to talk about your own mistakes. This helps the recipient of your criticism to know that you are not just criticizing for the sake of it, but you are offering him/her a suggestion from your own life. For example, you may say something like this, "When I was in Nursing/Midwifery Training

College, there were some courses I didn't like so I didn't pay attention to them and I got very low grades in them. But when I started spending more time on them and asking the teachers and my friends to explain things to me, I understood them better and my grades/performance also started to improve." By doing this, you are showing the person that you have been there before and that you turned things around when you realized what you were doing wrong and decided to change. The individual will know that you are not a superman or woman who did not make mistakes, but a man or woman like him/her and that you have a sincere desire to help him/her to turn things around and improve himself/herself, like you did in your case.

10.4.7 Ask questions instead of giving orders

In giving constructive criticism, it is better to ask questions than to give orders. According to Diamond (2016) phrases like the following allow "others to make their own decision:"

- You might consider this …
- Do you think that would work?
- What do you think?

Such utterances will help the individual to realise and learn from his/her mistake, stimulate creative thinking and lead him/her to the necessary solutions.

10.4.8 Pick the right time

The place and timing are important when giving constructive criticism. Criticism (whether destructive or constructive) is hard to take. It is worse if done in the presence, or to the hearing, of others. It is important, therefore, to choose a place where your conversation will not be overheard by others. You would also have to pick a time that is suitable for the individual. Criticism done in private in a kind and respectful manner is easier to accept and act upon than one done in public.

10.4.9 How to deal with constructive criticism/feedback

Your attitude, if you are being criticized, is very important. You can choose to learn something out of it or ignore it. As Geoffrey James puts it, "whether criticism or feedback is destructive or constructive is entirely up to you. If you use it to learn something about yourself or the other person, it's constructive. If you beat yourself over it, it's destructive" (James, 2016). This means that we can decide to turn all criticism to our advantage or make it bother us.

Another author, Walker (2003), has this to say about how we should handle criticism: "Criticism may occur within conflict situations or can foster conflict. Criticism, or the generation of 'evaluative judgments,' is often painful or difficult to 'give' or 'receive.' If handled appropriately by both the person criticizing and the person being criticized, critical feedback can promote constructive growth in individuals and relationships."

How do we deal with criticism so that it can help us to grow and improve upon our performance? Here is an answer to this question, "You respond to a valid criticism by one of the following four ways: acknowledging, thanking, apologizing, and disarming, i.e., agreeing to what appears accurate to you in the criticism." The four ways of dealing with criticism mentioned here are:

- Acknowledging
- Thanking
- Apologizing
- Disarming

Gregg Walker also lists the following ten "Guidelines for the criticized:"

- Recognise the value of constructive criticism.
- Engage in perspective taking or role reversal.
- Acknowledge criticism that focuses on your behaviour.
- Listen actively.
- Work hard to avoid becoming defensive.
- Welcome criticism.

- Maintain your interpersonal power and authority to make your own decisions.
- Seek constructive changes to the behaviour that prompted the criticism.
- Insist on valid criticism.
- Communicate clearly how you feel and think about the criticism and receiving criticism (Walker, 2003).

In the following sub-sections, we will examine a few of these and other guidelines that can help you to deal with criticisms that may be directed at you so as to derive maximum benefits from them.

10.4.10 Don't take it personally

First of all, don't take criticism directed at you personally. In the words of Thomas (2012), "Don't take it personally if someone doesn't immediately like your work. Even if you feel you're being criticized unfairly, don't retaliate with an extreme knee-jerk reaction or else you can irreparably damage your prospect of working with that client or audience and can even harm your reputation as well."

Instead of taking the criticism personally, "recognize the value of constructive criticism" as something that will help you to improve your behaviour and "productivity" (Walker, 2003).

10.4.11 Acknowledge the criticism

Acknowledge the criticism, especially, the one that focuses on the behaviour that you need to change and thank the individual who made the criticism.

10.4.12 Listen actively

To make the most of the criticism, you have to listen actively. This means that you have to do the following:

- Paraphrase what the other is saying.
- Ask questions to increase your understanding.
- Check out the non-verbal displays (Walker, 2003).

10.4.13 Seek constructive changes to the behaviour that prompted the criticism

When you have understood the behaviour that prompted the criticism, you must take concrete steps to change or improve upon it. This may take a lot of time and effort on your part, but it can be done if you have the desire to change.

Summary

In this unit, we have discussed two kinds of criticism, namely destructive criticism and constructive criticism. We have seen that destructive criticism is not aimed at behavioural change, but rather, it hurts the person who is criticised and should be avoided. We saw that constructive criticism, on the other hand, is offered in a kind and considerate manner and it is aimed at getting the individual to change a particular behaviour or attitude. We discussed some guidelines that will help you to offer constructive criticism as well as to receive it. We believe that by following these guidelines you will become skilful at offering constructive criticism that you can also benefit from.

► Exercise

1. Case One

   You are part of the morning shift and while sitting at the nurses' table with two other nurses, three relatives of a patient who has been on the ward for one week barge into the ward outside the visiting hours and head towards the part of the ward where their relative is lying without greeting anyone or saying a word to you at the nurses' station. One of your colleagues, Nurse Mina, then shouted, "Hey, hey, didn't you see us sitting here?" One of the relatives approaches the nurses' table and the following ensues:
   Relative: Madam we are sorry. Please can we go and see him?

   Nurse Mina: See who?

   Relative: Mr. Ako.

Nurse Mina: So now you know that you are supposed to see us so we can grant you permission, eh? You can't see him. You people are fond of doing that. You always come in at odd times to see your relative. It's not visiting hours, moreover, the doctor is in there examining him. If there's anything, you can tell us and we will let him know. You people don't respect nurses at all. Can I just walk into your house without greeting you? You people should sometimes learn to respect us. After all, we are sacrificing our time to take care of your relatives and we deserve some respect. One of the relatives who felt offended replied saying, 'The fact that we came outside the visiting hours does not give you the right to talk to us like that,' Having said that the relatives walked off the ward.

a. What is wrong with the way Nurse Mina criticized the relatives of the patient?

b. What were the results of this style of criticism?

c. As a colleague, you have noticed Nurse Mina's interactions with patients and their relatives do not really end up well because of how she presents her case. How would you constructively criticise this behaviour of Nurse Mina?

2. Case Two:

I had just joined this organisation from another job where things were done haphazardly and the first thing I had to quickly adapt to was how to receive criticism constructively. I was the "boss" in my former workplace so I called the shots. Joining this new organisation meant that I had to learn to accept criticism just as a child learns to walk or I find myself booted out.

I remember how in one of our numerous seminars, the CEO outlined the values every staff member had to adhere to in order to move the organisation from "Good to Great": Innovation, integrity, growth, and focus. These values did not only become our "corporate tree" that brought us under one shade, but I realised that as individuals, we all exhibited these values in our personal lives.

There were a few moments in my early days with this organisation that I felt, "No, this talk about everything I do is becoming too much." Nevertheless, it was with a sober reflection and a desire to grow that made me overcome my pride and resolve to use criticism to help me become better person and worker.

An experience I would always remember is when I decided to write a memo to the CEO. This was one thing I was not used to doing. Yet I did my best in the circumstance to write one.

When the CEO received it, he called me to his office and said, "I realise you are not used to writing memos and other official documents. I will assist you to rewrite this memo so you can use it as a learning experience. I would also like to nominate and sponsor you as our participant for an upcoming workshop on 'Writing memos and other official documents.'" Although I was embarrassed by the CEO's criticism of my memo, I acknowledged my challenges and accepted the offer of additional training.

The lesson learnt was simple: My ability to absorb his criticism reformed my sense of responsibility, accountability and administrative judgment and reasoning. Within a year in that organisation, I found fulfilment, thanks to the constructive criticism I received from this CEO.[1]

► Question

From the scenario above discuss the actions of both the narrator and the CEO that led to the achievement of desired results.

Further reading (Websites)

Diamond, L. (2016). 8 Ways Successful People Criticize Others Without Offending Them: No hurt feelings necessary. Retrieved from https://www.rd.com/advice/relationships/give-constructive-criticism/

[1] The narration here is a true story. Both the narrator and the boss are known to the authors.

James, G. (2016). 7 Ways to Turn Destructive Criticism to Your Advantage. Retrieved from https://www.inc.com/geoffrey-james/how-to-handle-destructive-criticism.html

Walker, G. (2003). Dealing with Criticism. Retrieved from http://oregonstate.edu/instruct/comm440-540/criticism.htm

UNIT 11:

PRESENTATION SKILLS

11.1 Introduction

The consensus among scholars is that language originated in Africa an estimated 300,000-150,000 years ago (Perreault & Mathew, 2012, p.5). Language forms a major foundation for human communication – especially in the context of presentations. Presenting information is a skill and, for many, it requires lots of practice to develop that skill. In this chapter, we will go over general and specific information on presentation skills that will be of use to nurses and midwives in the overall context of therapeutic communication. As with other units of the coursebook, we will begin by providing learning objectives for the section followed by a short discussion on why nurses and midwives need this knowledge. This Unit will also provide information on characteristics of effective presentations, research and effective preparation for a presentation, developing presentation structure, good communication skills, verbal communication, visual communications, and non-verbal communication (Chivers & Shoolbred, 2007). We will deliver this information in such a way that the nurse and midwife can understand the various characteristics that may help to contribute to the overall effectiveness and impact of the presentation.

11.1.1 Why Nurses and Midwives Need this Knowledge

At various stages in the career of a nurse/midwife, one may be called upon to present information either in a formal or informal setting. This information must be communicated effectively for optimum results. At times, the presentation may be done to colleagues or superiors. And other times presentations must be done to co-workers or patients. Other interested stakeholders such as family members of the patient may also require information given in the form of a presentation. The degree to which such a presentation may be interactive or a monologue may vary depending on context. The goal of this Unit is to provide nurses and midwives with an understanding of the skills and ideas that come together to make an effective presentation. These presentation skills can then be leveraged in the interest of therapeutic communication.

11.2 Learning Objectives

After studying/reading this Unit, you should be able to master the following ideas/concepts and skills:

- Research and prepare effective presentations.
- Develop a presentation structure.
- Internalise the development of good communication skills.
- Improve your verbal, non-verbal and visual communication skills.

11.3 Characteristics of effective presentations

There are various characteristics that contribute to developing effective presentations (Comfort, 1998). At the top of the list is employing good communication skills in one's presentation. A supporting factor is the use of a clear structure with relevant documentation to support points made. In addition to this, it is necessary to have well researched content that is relevant to the topic at hand and which the audience would find interesting and useful. Of course, the latter point requires an understanding of the audience (Haber & Lingard, 2001). Are they experts in the field or are they newcomers? Another characteristic of a good presentation is the use of technology to account for various learning styles including those who learn best by listening, visual learners, auditory learners, etc. (Halawi, McCarthy, & Pires, 2009). Tied to this point is the importance of working audience participation into the presentation. To what degree can you make your presentation interactive as appropriate for the situation? Such considerations, when appropriate for the context, may help to keep the audience engaged and interested in the topic (Greusel, 2002). To make an effective presentation, there is also a need for time management to make sure that the presentation does not fall short or run long (Forsyth, 2010). All of these considerations that go into making an effective presentation are predicated on careful planning and thorough preparation.

Depending on the context and the overall objective of the presentation, some of the afore-mentioned characteristics may become more prominent than others. In this Unit, we will go over the characteristics of good and effective presentations in order to ensure that the nurse and midwife are able to present what they know for effective communication with patients and with healthcare team members and the public at large (Chivers & Shoolbred, 2007).

11.4 Research and effective preparation for a presentation

One of the main considerations in terms of developing and delivering an effective presentation is thorough research. Research can be carried out using a number of techniques. Nursing informatics may come into play at this stage of planning, preparation, and research. As such, the nurse/midwife would do well to incorporate the use of digital as well as analogue technologies including libraries (physical and digital), databases, websites, electronic articles, and more. Other useful resources for research include conducting research using primary and secondary data, interviews, testing and experimentation, information from government studies, reputable organisations, and more. Research can also be done in the context of a group wherein colleagues support each other in a type of peer review system where knowledge is shared and feedback is given (McCarthy & Hatcher, 2002).

11.5 Developing presentation structure

In developing the structure for a presentation, it may be useful to develop an outline (McCarthy & Hatcher, 2002). At this point, time can be allocated for various aspects of the outline to make sure that all relevant topics are covered within the specified time frame. This outline should follow a logical progression which allows you the presenter to formulate your thoughts and it also helps the audience to follow along with the ideas that you are trying to convey (McCarthy & Hatcher, 2002). In the case of a formal presentation with knowledge dissemination as the goal, it is useful to start off your presentation by stating the learning objectives explicitly (Harris, 2013) as we have been doing for each Unit of this book. This prepares the audience to look out for the most important points of your presentation knowing what they would be expected to learn by the end.

In terms of structure, an effective presentation should begin with a clear introduction (Bienvenu, 2000), again as is done in this book. The introduction should ease the audience into the topic. The discussion section of the presentation should be where most of your relevant and interesting content would be placed. However, it is worth noting that studies show that often contents at the beginning and the ending of

presentations tend to be more easily recalled than information in the middle (see Chivers & Shoolbred, 2007, p. 25). Techniques to overcome the challenge of memory may include having several points in the presentation in which a new and a clear point of the outline is introduced to refresh the audience's memory with regard to the overall objective of the presentation (Chivers & Shoolbred, 2007).

11.6 Good Communication Skills

In Unit 3 we provided an introduction to therapeutic communication skills. It goes without saying that good communication skills are invaluable to the delivery of effective presentations. Nurses and midwives are often required to interact with the general public. Further, as professionals, they may need to address colleagues. Good communication and presentation skills include an understanding of the overall objective of the presentation and what needs to be communicated.

Another key point is understanding how much time is given for the presentation. A ten-minute presentation is not the same as a two-hour interview. Taking note of the differences as well as the steps that should be taken to maximise the effectiveness within the allotted time are all necessary for good communication (Kaye, 2002). It is also necessary for the presenter to know his/her audience. In assessing the audience one of the primary questions will be centred on the knowledge level of audience members. Are they experts in the field or are they new to the topic? In either case, the effective presenter must ask himself/herself what new knowledge should be conveyed that is appropriate for the knowledge level of the audience (Mandel, 2010; Weiss, 2015). What should be the takeaways? It is also important to think about the most effective ways to achieve the objective of the presentation. Here, it is useful to keep Bloom's Taxonomy in mind (Anderson, Krathwohl, & Bloom, 2001; Bloom, 1956).

The key point of Bloom's Taxonomy and subsequent revisions of it is that there are various types of learners with different learning styles. Some people learn best when learning is accompanied by visual aids. Others are auditory learners who learn by listening. Others may be kinaesthetic learners who need to be moving in order to assimilate knowledge best. Such considerations translate to asking oneself the

degree to which one should use aids such as sound and music, text, pictures, diagrams, three-dimensional models, and others as appropriate (McCarthy & Hatcher, 2002).

Such considerations can be grouped into three (3) areas including:

- Non-verbal Communications,
- Verbal Communications
- Visual Communications (Chivers & Shoolbred, 2007, p. 25)

It is useful to deploy all three of these as appropriate based on considerations of audience, context, and objectives of the presentation. See Unit 5 for a discussion of aspects of verbal and non-verbal communication.

11.7 Verbal Communication

In terms of verbal communication, it is useful to either avoid or clearly explain medical/nursing jargons or terminology for those who may not be familiar (Siddons, 2008). This is particularly true for nurses and midwives who may need to constantly shift between medical jargon and down-to-earth language that a patient and/or her family will easily understand and relate to. For instance, when informing a group of pregnant women attending antenatal clinic about the tests they need to do, you may say we will check your blood level instead of saying we will do an FBC[2].

It is also necessary to speak clearly. Whereas in an everyday conversation with friends, one may not enunciate one's words clearly, in a public presentation, which may include listeners from various backgrounds, it may be necessary to speak more slowly than in an informal conversation with friends. This allows listeners to adjust to your accent, style of speaking, and cadence. One's tone of voice should also be engaging to help the audience become enthusiastic and/or receptive to the information that you are sharing (S. Hall, 1997). Appropriateness is key; obviously announcing a birth would require different verbal communication skills from reporting the death of a loved one.

[2] FBC is a commonly used abbreviation for full blood count in the Ghanaian healthcare setting. It is a test that includes among other things checking the level of haemoglobin in the blood.

11.8 Visual Communication

For visual learners, images are essential (Lescault, 2011). From the standpoint of the presenter images can also help to save time. This is especially true in the case of a complicated concept that may be grasped easily with an effective diagram or picture. Images that are relevant and tailored to the presentation can help to bring about a greater understanding for the audience. They may also help to retain the interest of listeners by calling on them to use senses other than merely their auditory faculties (Lescault, 2011).

Images can also be used to underscore a point in order to provide maximum impact. When this is done, a lasting impression can be made. At times, whereas what was said maybe forgotten, the image may be imprinted into a person's memory. At the end of the day, an effective presentation leaves audience members/message recipients with something that they can take away and remember. This is the lasting impression, which should always be in the back of the presenter's mind in terms of desired outcomes (Lester, 2013). Visuals chosen by the Ghanaian nurse/midwife should also be culturally appropriate such that the recipient of the message can relate to it and see himself/herself in what is being conveyed. To help first time pregnant women understand labour and delivery, it may be better to show them a video or pictures of various stages of delivery rather than just do an oral presentation.

11.9 Non-Verbal Communication

As discussed in Unit 5, non-verbal communication is also very important, especially in the Ghanaian context (Abugre, 2011). There are certain gestures that may be considered offensive in a specific culture that may not be so in another culture (Jones & Mixon, 2016). It becomes incumbent upon the nurse/midwife to familiarise himself/herself with such expectations which may vary from locale to locale. When one is presenting, it is also useful to take note of conventions including whether or not hand gestures would be appropriate.

In the Ghanaian context, many people speak with their hands. While this is considered normal, one should be cognizant of not allowing gestures to be overdone to the point that they may take away from the message that one is trying to convey. This is especially the case in the

context of nervous fidgeting, tapping one's foot, repeated movements, etc. (Budinski, 2005). These and other movements may come about as a result of nervousness when one is giving a presentation. Such feelings of anxiety and emotion may be compounded in the case of a nurse/midwife when other factors are added in such as health challenges, conveying difficult news, or speaking about uncomfortable and/or socially taboo topics. For example, it might be necessary to mention body parts that, in a normal context, may be regarded as impolite to mention. This is where cultural competence comes in, in that the presenter can and should learn euphemisms when appropriate and necessary versus when anatomical specificity is required (Dreachslin, Gilbert, & Malone, 2012). All of these considerations boil down to the nurse/midwife's judgement.

Additionally, it is necessary for the presenter to decide whether to sit or to stand in order to make a presentation. Sometimes the context or conventions will make this decision for you. For example, it may be necessary to sit down with a patient or a patient's family in order to convey empathy (Weissman, 2011). What is expected may vary from one context to another. It is a necessary feature of any successful presentation for the presenter to exude confidence in oneself and in what one is saying. This confidence lends itself naturally to the building of trust and bonds with the recipient of the message being presented (Bienvenu, 2000). This is especially necessary for nurses and midwives who are constantly entrusted with the lives of loved ones.

It is a good general rule to face the audience in the case of a group or the individual in the case of making a presentation one-on-one. When this is done, it allows the presenter to keep a gauge on reactions and facial expressions as part and parcel of real-time feedback. Does the audience look bored? Does the audience seem engaged? All of these considerations will come into play as the presenter may need to adjust and adapt based on the feedback loop coming from the audience and back to the presenter (Ford, McCullough, & Schutta, 2012). When nurses and midwives often are called upon to present some information to family members this feedback loop involves gauging the impact of what one is communicating verbally and non-verbally as communicated by the listeners.

11.10 Summary

In this Unit, we have covered information on presentation skills useful for nurses and midwives in the overall context of therapeutic communication. We further articulated reasons why nurses and midwives need the knowledge included in this chapter. We presented learning objectives related to researching, presentation structure, verbal, non-verbal and visual communication skills and filled in the gaps in each of these areas. At this point, the necessity for presentation and communication skills should be clear to nurses and midwives working in the Ghanaian context.

► Exercise

1. A new nurse/midwife has recently joined the staff at your workplace. Explain to her/him the need for presentation skills as a professional nurse/midwife.
2. How does presenting one-on-one differ from presenting to a larger audience? How are these two contexts also similar?
3. Discuss different types of communication skills useful for various learning styles. Give examples of how to tailor one's presentation to the different types of learning styles that the recipient of the message may prefer.

Further Reading

Abugre, J. B. (2011). Perceived satisfaction in sustained outcomes of employee communication in Ghanaian organizations. *Journal of Management Policy and Practice*, 12(7), 37.

Chivers, B., & Shoolbred, M. (2007). *A Student's Guide to Presentations: Making your Presentation Count. Thousand Oaks, CA: Sage Publications*.

McCarthy, P., & Hatcher, C. (2002). *Presentation Skills: The Essential Guide for Students. Thousand Oaks, CA: Sage Publications*.

UNIT 12:

INTRODUCTION TO COUNSELLING

12.1 Introduction

In this Unit, we will discuss the basics of counselling that will assist you in your work as a healthcare worker. Though some healthcare facilities may have professional counsellors, as a nurse/midwife, you may find yourself called upon to play the role of a counsellor on health-related matters to patients, relatives, neighbours, friends and colleagues both at home and in a healthcare facility. The way you do this may have a positive or negative effect on the person receiving the counselling service. It is important, therefore, that as a healthcare giver, you arm yourself with the fundamentals of counselling so that you can assist those who come to you for help.

Some of the topics we will discuss include: What is counselling? Who needs counselling? The role of the nurse/midwife in counselling, basic counselling skills and others.

12.1.1 Why Nurses and Midwives Need this Knowledge

Whether working in a small village health post, a district, regional or national healthcare facility, nurses and midwives come into contact with people of varying educational, cultural, ethnic and social backgrounds. One time or another, some of these people may approach the nurse/midwife with problem concerning their own health or that of a child or relative. The problem may have to do with the physical or mental wellbeing of the person and the nurse/midwife would have to find a way of helping to resolve this issue. As (Freshwater, 2003, p. 8) puts it,
"[M]uch nursing work is concerned with health promotion, which in turn is about providing support and helping people to change behaviours

that are detrimental to their health, such as smoking or drinking too much alcohol." For the nurse/midwife to be able to effectively support and help such people he/she must have the necessary counselling skills. This is the reason for the inclusion of this Unit in this course book.

12.2 Learning Objectives

After reading this Unit, you should be able to master the following ideas and skills:

- Understand the nature and function of counselling.
- Know when, where and how to counsel.
- Know the dos and don'ts of counselling.
- Determine the kind of counselling appropriate for a particular individual, situation, or condition.

12.3 What is counselling?

According to a WHO/UNICEF document:

> The word `counselling' is new to many people, and it can be difficult to translate. Some languages use the same word as `advising'. However, counselling is different from simple advising. When you advise someone, you may tell the person what you think he/she should do. When you counsel a mother, you do not tell her what to do. You help her to decide what is best for her. You listen to her, and try to understand how she feels. You help her to develop confidence, so that she remains in control of her situation... (UNICEF, nd).

This quotation clearly tells us that counselling is not the same as advising. Most of the time, when friends come to us with their problems, we tell them what to do. That is not counselling, it is advising. In advising, we prescribe a particular course of action for the person, but in counselling, we help them make their own decisions.

Another definition of counselling states: "Counselling is an interaction between a health worker and a client. Counselling is teaching. It requires patience, understanding and knowledge. Counselling requires the skill of communication which are mainly listening, understanding and imparting knowledge" (WHO, 1995, p. 4).

This definition situates counselling in the healthcare domain and shows that it is an interaction between a healthcare provider and a client or patient.

Counselling also involves teaching as the nurse/midwife finds "a way to help individuals and families understand and cope with their situation so that they make decisions and actions for better health" (WHO, 1995, p. 4).

According to the Counselling Directory, UK:

> Counselling falls under the umbrella term 'talking therapies' and allows people to discuss their problems and any difficult feelings they encounter in a safe, confidential environment. The term can mean different things to different people, but in general it is a process people seek when they want to change something in their lives or simply explore their thoughts and feelings in more depth (CD, 2013).

From all these definitions, we can say that counselling is a way of helping another person deal with and find solutions to a problem (mental, physical, or emotional) through talk.

12.4 Who Needs Counselling?

Everybody, young or old, male or female, rich or poor, educated or not-so-educated may find themselves in situations where they would need counselling. A document from The Shanti Counselling Centre of Vancouver, British Columbia, Canada, indicates that counselling is for:

- People who want more joy in their lives.
- People who want more solid and/or intimate relationships.
- People who want better sex lives.
- People who want to experience more peace of mind.
- People who want greater self-awareness.
- People who are curious about knowing and understanding themselves in greater depth.
- Everyone! (SC, 2016).

To this list we can add:

- Counselling is for people who want solutions to their health problems or that of their families, be it physical, emotional or mental.

The issues for which a person may need counselling are many and varied. The common problems that may require counselling include: addictions, bereavement, bullying, illness, mental health issues, relationships, trauma and many others (CD, 2013). Addiction may be in the form of substance abuse or an activity that may have harmful effects on the physical and emotional wellbeing of a person.

As a nurse/midwife, you may come across people who are burdened by any of the problems listed above and in most cases, you may have to step in and help as best as you can before consulting to a professional counsellor. In situations where the services of a professional counsellor cannot be obtained, the nurse/midwife may have to take up that responsibility.

12.5 The role of counselling in nursing and midwifery

Nurses and midwives are at the forefront of the healthcare delivery system. In most cases before a patient sees a doctor, he/she would have been seen by a nurse/midwife. In such situations, it is the nurse/midwife who "encourages the patient to examine his/her problems, conflicts or difficulties and develop an awareness and understanding of these issues. Through addressing these problems, the patient is encouraged to work through them toward an awareness of the conditions essential to his/her health and wellbeing and how these conditions can be achieved"(Freshwater, 2003, p. 6; Slevin, 1995, p. 415). The nurse/midwife's counselling role is not to advise the patient, but to help him/her to gain awareness of the problem or condition and decide on the appropriate solution.

A patient who is helped through counselling to realise that much of his/her health problems are related to his/her eating habits, for example, would be able to decide that eating the right things in the right amounts and at the right time would be beneficial to him/her and follow through with it. On the other hand, the one that is warned or sternly advised not

to eat this or that at certain times of the day, may be likely to ignore it or follow the advice/warning for a few days and go back to the bad old habits.

12.6 Basic Counselling Skills

Researchers on counselling and counselling practitioners have come up with some of the basic skills needed for counselling. These skills may differ in number and name from one person to another. Drab (2014) mentions listening, empathy, genuineness, unconditional positive regard, concreteness, open questions, counsellor self-disclosure, interpretation and information giving and removing obstacles to change among the top counselling skills, (see also Freshwater, 2003). Understanding these skills and being able to apply them would make it easy for the nurse/midwife to function effectively as a counsellor. We will take these skills in turn and discuss them.

12.6.1 Listening

Communication is very important in counselling. Both the person being counselled and the counsellor share what is on their minds through talk. To know and understand what the other is saying, one must listen. Listening, therefore, is very important in counselling. It is the means by which the counsellor learns about the patient's problem. By listening, the counsellor indicates to the patient/client that he/she is interested in his/her problem, cares about him/her and is willing to support and help. When the patient knows that the counsellor (nurse/midwife) is listening to him/her, he/she will feel appreciated and valued and this will help him/her to open up and give details that will help in finding solutions to the problem. Listening helps to build confidence and trust between the two.

A question you ask is: "How do I let the person know that I'm listening to him/her?" We all pretend to be listening to someone sometimes. We make a show of listening while we fidget or play with our phones or read or do something else. Sometimes we listen but we do not pay attention to what is being said. Effective listening is active, not passive. If the patient suspects that the counsellor is pretending to

be listening or is not paying attention, he/she would feel ignored and would stop talking. It would be difficult to get the co-operation of such a person.

For active listening to happen, the counsellor must first of all position himself/herself in such a way that it would "indicate one is aware of the patient, and in fact, the client has your full, undivided attention and that you care" (Drab, 2014).

The Counsellors' Guide, UK says:

> Active listening requires more than just listening to what a client says. It involves taking an interest in the other person, making sure they are comfortable about disclosing personal information and providing support and understanding. It also requires that a counsellor also takes into account the body language that is being displayed, and also the tone, speed and pitch of voice (Martin, 2017a).

Active listening involves attending to the patient. It involves having the patient in view so that you can listen to the verbal part of the communication (i.e., what is said, the actual words spoken by the client) and observe the non-verbal cues (how it is said/the body language) as well. See Unit 4 for a discussion of verbal and non-verbal communication.

The counsellor may use verbal and non-verbal cues of his/her own to assure the patient that he/she is attending to him or her. The verbal cues may include responding appropriately with utterances like "mm…", "uh-hu", etc. The non-verbal cues may be in the form of making eye contact, touching, nodding of the head, and so on.

12.6.2 Empathy

Empathy is another key factor in counselling. The *Collins English Dictionary* defines empathy as "the power of understanding and imaginatively entering into another's feeling." An effective therapeutic counsellor is one who is able to perceive what the patient is feeling or experiencing and "communicate that perception back to the individual to clarify and amplify their own experiencing and meaning" (Drab, 2014).

Gherardo Della Marta, a counsellor in Holborn, London Bridge and Queens Park says:

> Empathy has been described in different ways: walking in another's shoes, entering into another person's frame of reference or having the ability to experience life as the other person does by entering the person's world of thoughts, feelings, emotions and meanings. In counselling, empathy is an expression of the regard and respect the counsellor holds for the client whose experiences maybe quite different from that of the counsellor. The client needs to feel "held", understood as well as respected. To hold a client therapeutically means the counsellor is capable to accept and support the client through any issues, concerns, problems she/he can bring (Marta, 2012).

Empathy is different from sympathy. "With empathy to an extent you are placing yourself in the persons place, you have a good sense of how they feel, and you also understand their feelings to some degree." While "[W]ith sympathy though, you feel for the person. You pity or feel sorry for them but you do not necessarily understand what they are actually feeling" (Kumar, 2011).

One way of communicating empathy to the patient/client is by:

- Paying close attention to what the patient is saying, observing both the verbal and non-verbal communication cues.
- Paraphrasing content of client communication.
- Reflecting on patient's feeling and implicit message (Drab, 2014).

We have already talked about the first one.

12.6.3 Paraphrasing

Paraphrasing the content of client communication is a way of letting the patient/client know that you are listening to what he/she is saying and it is important in active listening. It is defined as "repeating back your understanding of the material that has been brought by the client, using your own words. A paraphrase reflects the essence of what has been said" (CT, 2013).

Some of the common expressions used by counsellors in paraphrasing are:

- What I hear you saying is…
- In other words…
- So basically, how you felt was…
- What happened was…
- Sounds like you're feeling…
- To put it in a different way, you seem to be saying…
- As I understand it…
- It seems like…
- So, from where you sit…
- I'm not certain I understand you; you're feeling…(Thangavel, 2009)

By paraphrasing the client's communication, the counsellor shows that he/she understands the client. It conveys a feeling of empathy on the part of the counsellor and this creates the necessary conditions for the client to speak about his/her condition.

12.6.4 Genuineness

The nurse/midwife counsellor must be genuine in his/her interaction with the patient. You cannot say one thing to the person you are counselling while your behaviour says another thing. "For example, if the helper claims that they are comfortable helping a client explore a drug or sexual issue, but their behaviour (verbally and nonverbally) shows signs of discomfort with the topic this will become an obstacle to progress and often lead to client confusion about and mistrust of the helper" (Drab, 2014).

The quotation above means that the counsellor cannot fake it. His/her words must match his/her actions, where actions refer to the way he/she speaks as well as the body language.

12.6.5 Unconditional positive regard

For therapeutic counselling to take place, the counsellor must show that he/she cares for and accepts the patient irrespective of his/her situation/condition and that he/she is prepared to help the patient to find a solution to the problem. The counsellor signals acceptance by responding or reacting to the patient's story/narration in a non-judgmental and non-critical manner either verbally or non-verbally (Drab, 2014).

This means that the counsellor must not do or say anything that will give the slightest hint that he/she is judging or criticizing the patient/client. By accepting the client the way he/she is, the counsellor demonstrates to him/her that he/she is valued irrespective of his/her "weakness, negativity or unfavourable qualities" (Martin, 2017b).

The nurse/midwife counsellor must convey warmth and understanding through the skilful use of body language (posture, making eye contact, touch, etc.) and by the careful way he/she speaks (tone of voice, speed of speech, etc.) (Martin, 2017b). These are the things that will help the patient/client to relax and to trust the counsellor, conditions that are necessary for good therapeutic communication to take place.

In addition, the counsellor must show respect for the patient/client by communicating to him/her that we are all different and that each of us has his/her own "inherent strength and capacity to make it

in life, and that each person has the right to choose his own alternatives and make his own decisions" (Drab, 2014).

12.6.6 Concreteness

Concreteness has to do with keeping the communication between the nurse midwife counsellor and the patient/client "specific-focused on facts and feelings of relevant concerns, while avoiding tangents, generalisations, abstract discussions, or talking about the counsellor rather than the client" (Drab, 2014). In other words, the communication should be focused on those issues that are relevant or of importance to the problem. The counsellor should not bring in extraneous matters (things that do not directly address the issue at stake) neither should he/she make himself/herself the focus of the discussion.

According to Kevin Drab, the counsellor should take the following steps:

- Assist the client to identify and work on a specific problem from the various ones presented.
- Remind the client of the task and re-describe the intent and structure of the session.
- Use questions and suggestions to help the client clarify facts, terms, feelings, and goals.
- Use here-and-now focus to emphasise process and content occurring in current session, which may be of help to elucidate the problem being worked on or improving the problem-solving process (Drab, 2014).

12.6.7 Open questions

One of the skills you will need as a nurse/midwife counsellor is questioning. The ability to ask the right kind of questions is an essential skill in counselling. It is the tool the counsellor uses to get the client to speak or disclose information about himself/herself. In human communication, we use different types of questions for different purposes. One main type of question that is useful for counselling is open questions. These are not used to elicit specific information, neither do they elicit responses like 'yes' or 'no'. Open questions are used by

counsellors to allow the patient/client to express himself/herself and clarify or explore his/her thoughts and feelings (Drab, 2014).

The Australian Institute of Professional Counsellors has this to say about open questions:

> Open questions are those that cannot be answered in a few words, they encourage the client to speak and offer an opportunity for the counsellor to gather information about the client and their concerns.
>
> Typically, open questions begin with: what, why, how or could. For example:
>
> 1. What has brought you here today?
> 2. Why do you think that?
> 3. How did you come to consider this?
> 4. Could you tell me what brings you here today?
>
> "How" questions tend to invite the client to talk about their feelings. "What" questions more often lead to the emergence of facts. "When" questions bring about information regarding timing of the problem, and this can include events and information preceding or following the event. "Where" questions reveal the environment, situation or place that the event took place, and "Why" questions usually give the counsellor information regarding the reasons of the event or information leading up to the event (AIPC, 2009b).

12.6.8 Closed questions

When there is the need for the counsellor to obtain specific information, he/she can use what is called closed questions. These are questions that usually demand 'yes' or 'no' answers in English. Examples of such questions are:

1. Do you have a job?
2. Do you like your job?
3. Are you married?
4. Have you had breakfast this morning?

Researchers and practitioners in the counselling warn about over-use and misuse of questioning. Again, the Australian Institute of Professional Counsellors has this to say about the issue:

> While questioning techniques can be used positively to draw out and clarify issues relevant to the counselling session, there is also the very real danger of over-using questions or using questioning techniques that can have a negative impact on the session. The wrong types of questioning techniques, at the wrong time, in the hands of an unskilled interviewer or counsellor, can cause unnecessary discomfort and confusion to the client (AIPC, 2009b).

There is the need, therefore, to avoid asking too many questions.

12.7 Counsellor Self-Disclosure

It is important, sometimes, for the counsellor to share his/her feelings and experiences with the client with the aim of helping them to understand and accept their condition or feelings. This is referred to as **self-disclosure.** According to Dr. Barbara LoFrisco, a Tampa, Florida-based counsellor, "Self-disclosure in therapy is when a therapist shares their own personal views or experience with a client with the purpose of improving the client's emotional or mental state. It should be done solely for the purpose of helping the client, and not to meet the needs of the therapist" (LoFrisco, 2012).

She gives the following example:

> ... if a client is upset over their divorce, the therapist may disclose that they, too, have survived a divorce. The intention would be that the therapist not only has a deeper understanding of the client's situation, but might be able to offer some insight (LoFrisco, 2012).

If self-disclosure must be used, it must be used judiciously. Nurse/midwife counsellors must know that the counselling session is not about them, but about the client/patient.

12.8 Interpretation

Interpretation, also referred to as reframing, is "a statement to the client which goes beyond what they have said or are aware of" (Drab, 2014). The Australian Institute of Counselling Professionals has this to say about interpretation/reframing:

> Through interpretation/reframing, the client is encouraged to perceive their experience in a more positive fashion. The counsellor encourages this shift by offering alternative ways of viewing their experience. For example, a client who is upset about having to move away from home is likely to be focusing on the loss of her support network and the familiarity of her community. The counsellor, while acknowledging the client's loss, could reframe the event to be perceived as an opportunity to experience new places, people and things: an opportunity for growth. Interpretation/reframing encourages the client to view life situations from an alternative frame of reference. This strategy does not change the facts of a situation, nor does it trivialise the hurt or pain the client may be experiencing (AIPC, 2009a).

12.9 Information Giving and Removing Obstacles to change

A counsellor may offer "data, opinions, facts, resources or answers to questions" (Drab, 2014) that may help them in some way.

> "Information giving involves providing the client with factual information that may assist them in some way (such as details of a community support group or accommodation option). Sometimes clients are not sure where to start to look for the information they need, so counsellors can help their clients find that starting point".

By sharing information with the client/patient, the nurse/midwife can assist the client/patient to think about issues and "identify possible solutions and alternatives" to the problem (Drab, 2014).

12.10 The Attributes of a Good Counsellor

From what we have said so far, it can be seen that a good counsellor must have certain attributes in addition to having good communication skills, both verbal and non-verbal. According to the Counsellor's Guide, UK:

At all times counsellors must show a commitment to:

- Human rights and dignity.
- Supporting and alleviating personal distress.
- Appreciating the differences in culture and human experience, and remaining non-judgmental.
- Providing adequate counselling services whilst ensuring the integrity of the client/counsellor relationship.
- Maintaining client confidentiality and ethical principles (Martin, 2017c).

12.10.1 Human rights and dignity

At all times, the counsellor must uphold the human rights and dignity of the client/patient. The counsellor must not do anything that will infringe upon the patient's rights or degrade him/her.

12.10.2 Supporting and alleviating personal distress

The counsellor must at all times demonstrate in word and action that he/she supports the client/patient and is committed to helping him/her to alleviate his problem.

12.10.3 Appreciating the differences in culture and human experience, and remaining non-judgmental

It is important to remember that as a nurse/midwife, you will be working with people whose culture, language, education, religion, political affiliation or belief, age and experience are different from yours. You must respect these differences and not allow them to influence the way you treat the patient. You must not be judgmental, but rather accept people as they are.

12.10.4 Providing adequate counselling services whilst ensuring the integrity of the client/counsellor relationship

Following from what we have said above, as a counsellor, you must provide adequate counselling to the client as best as you can while respecting the client/counsellor relationship.

12.10.5 Maintaining client confidentiality and ethical principles

The Oxford Living Dictionaries (2017) define confidentiality as "the state of keeping or being kept secret or private." In your work as a nurse/midwife or counsellor, clients or patients will tell you things about themselves or their condition. These are not meant to be told to other people; they are confidential and must be kept secret or private. Before reading on pause for a while and do this exercise:

Activity: Confidentiality

You tell a friend an embarrassing situation you found yourself in one weekend and ask him/her for advice. You go to work the next day and as soon as your colleagues see you they start giggling or laughing. At once you know that your secret is out. How will you feel? What will you do? How will you react?

What we have described above has to do with the issue of confidentiality. You told your friend a secret trusting that he/she will not tell anybody, but he/she has betrayed this trust and made you a laughingstock. Would you trust this person again?

The relationship between a counsellor and a client is based on trust. Whatever the client tells you should not be told to other people. Just as you would feel betrayed if somebody tells other people what you have told him/her in confidence, so will a client feel if you did the same to him/her. Once you do that, you destroy the counsellor-client relationship and cause a termination of the counselling. Confidentiality is so important in the work of the nurse/midwife that it is enshrined in the Ghanaian Nurses' Pledge:

> I promise to hold in confidence all personal information entrusted to me.

Confidential client information may only be shared with other healthcare professionals if it is going to help in the patient's treatment. Permission should be sought from the patient before information is shared and the identity of the patient should be concealed as much as possible.

12.11 The Counselling Process

Counselling is not something that is done in a day. It is a process that has a beginning, a middle and an end and is spread over a period of time. Researchers and counselling professionals have different ideas about the stages involved with counselling. For some, the counselling process has six stages, namely,

Stage One: Relationship building
Stage Two: Assessment and diagnosis
Stage Three: Formulation of counselling goals
Stage Four: Intervention and problem solving
Stage Five: Termination and follow up
Stage Six: Research and Evaluation (Barrett, nd)

We will discuss the first five of these stages in the sub-sections that follow.

12.11.1 Relationship building

Counselling cannot take place without good rapport between the counsellor and the client/patient. Right from the beginning, the nurse/midwife counsellor must create a condition that will generate trust between himself/herself and the client. The counsellor must outline the structure of the counselling relationship and the roles that both the counsellor and the client have to play in the process.

By showing empathy, respect for the client, and unconditional positive regard as discussed in Section 12.10 and its subsections, the counsellor paves the way for a congenial atmosphere which makes it possible for the client to willingly express himself/herself. Using active listening skills (see section 6.3.1), the counsellor gets to understand the client and the issues at stake without being judgmental.

12.11.2 Assessment and diagnosis

At this second stage, the counsellor gathers the necessary information that will enable him/her to understand the client's situation and the kind of change sought. The counsellor's task is to help the client to articulate the problem as well as to see it in the context of the client's larger world. He/she should note the patient's strengths, weaknesses and resources.

12.11.3 Formulating Client goals

At this third stage, the counsellor helps the client to articulate his/her goals. These goals, according to Barrett include the following:

1. To change an unwanted or unwelcome behaviour
2. To better cope
3. To make and implement decisions
4. To enhance relationships
5. To help client's journey of growth toward achieving potential

(Barrett, nd, p. 6; Nystul, Goldmark, Padilla, & Roth, 2003)

12.11.4 Intervention and Problem solving

After setting the goals for the counselling, then intervention stage kicks in. The counsellor collaborates with the client to fashion a plan that works best for the client. The counsellor helps the client to gain new perspectives on the way the client has looked at the problem and alternatives in solving them.

12.11.5 Termination and follow up

Once the counselling goals have been established and a plan for solving the problem has been established, preparation for termination begins. There must be an open-door plan or policy to cater for future needs of the client and for follow up. According to Barrett (nd) termination is "considered not just at end of successful relationship, but also is considered when it seems counselling is not being helpful".

12.12 Summary

In this Unit, we have looked at the nature of counselling, who needs counselling, some of the skills a nurse/midwife needs to cultivate in order to become a successful counsellor, the attributes of a good counsellor and the counselling process. Counselling is a broad topic and involves a wide range of theoretical and philosophical underpinnings all of which we cannot talk about here. What we have done is to give you the barest minimum of information/knowledge that will help you to offer counselling assistance to a patient/client.

► Exercise

Afia Ansah is a Public Health nurse, who was invited by a secondary school to give a talk on "Teenage Pregnancy and its Effects." After the talk, the school invited her to extend some services to them on part time basis. The senior house mistress brings one of the girls to her on one of her visits and tells her the girl has been found to be pregnant but has challenges dealing with her condition. She speaks to the girl alone and she (the girl) starts to tell her about the shame she feels, her fear of informing her parents and the attempt she has made at aborting the pregnancy. Afia recollects her own difficulties when she got pregnant in secondary school and how her school nurse then was a source of comfort and support for her. She realises she would have to take the girl through several counselling sessions to help her deal with her situation. Considering the story above:

a. Discuss four counselling skills Afia needs in order to successfully counsel this girl.

b. Describe the steps they will have to go through during the counselling process.

Further reading

AIPC. (2009). Counselling Microskills: Influencing. Retrieved from http://www.counsellingconnection.com/index.php/2009/11/12/influencing/

Barrett, K. M. (nd). The Counseling Process. Retrieved from http://ww2.usj.edu/faculty_pages/rhalstead/The%20Counseling%20Process.ppt

Freshwater, D. (2003). Counselling skills for nurses, midwives and health visitors. New York: McGraw-Hill Education (UK).

UNIT 13:

THE NURSES' PLEDGE, THE MIDWIVES' PRAYER AND THERAPEUTIC COMMUNICATION

13.0 Introduction

In this final Unit of the coursebook, we journey back to the philosophies and core values upon which both nursing and midwifery rest as professions, the Nurses Pledge and the Midwives' Prayer. Just as doctors are formally inducted into the medical profession by taking the Hippocratic Oath, nurses and midwives are inducted upon taking the Nurses' Pledge and Midwives' Prayer. The oath-taking requirement, as a solemn and seriously regarded event is evident in the fact that professional discipline and sanctions are directly anchored to it.

Making the pledge at the commencement of the nursing and midwifery career is a ritual of lifetime commitment to service as a professional and to the community that will be served in the course of a career. In fact, by importance, The Pledge or Prayer is arguably no less sacrosanct than marital vows. And in some faiths, there is only a way into marriage and no way out; divorce is not recognised. Thus, the idea of a lifetime commitment to the professions is not to be taken lightly.

13.1 Why Nurses and Midwives Need this Knowledge

As we have stated in the introduction above, the professional discipline and sanctions pertaining to the nursing and midwifery professions are anchored in the Pledge/Prayer. It is therefore important for nurses and midwives to be conversant with the pledge they make or the prayer they say at commencement of their professions. This will serve as a daily reminder of what they have pledged to do and help them to focus on the job no matter the circumstance/condition under which they work. It will

also strengthen their resolve to give of their best and perform above and beyond the call of duty.

13.2 Learning Objectives

After reading/studying this Unit, you should be able to master the following ideas/concepts and skills:

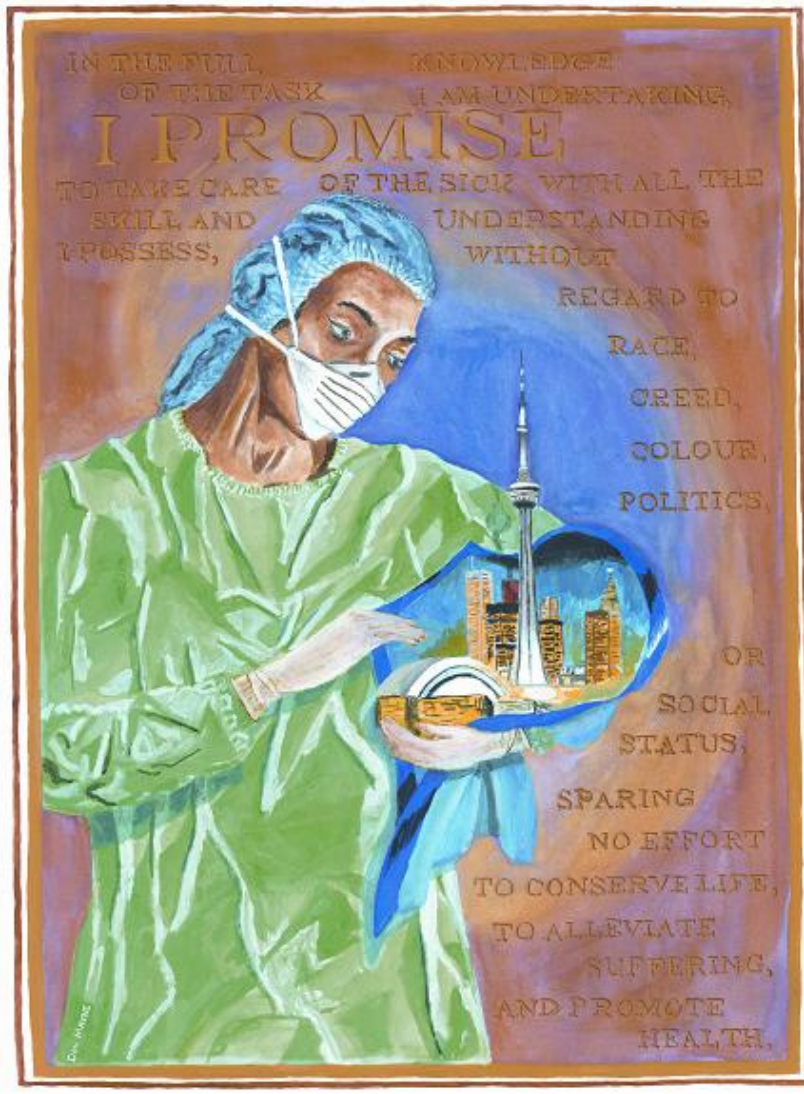
- Learn the wording of the Pledge/Prayer.
- Know the history of the Pledge/Prayer.
- Determine the purpose and implications of the Pledge/Prayer.
- Resolve to abide by the Pledge/Prayer in the discharge of your daily duties.

13.3 The Pledge

Although we have referred so far to The Pledge, there are as a matter of fact three versions of it, two are international and one is national (Ghanaian). The international versions of the pledge are the International Council of Nurses' Pledge (ICN, 1899) and the Florence Nightingale Pledge (Gretter, 1893). Both of these are recognised and applied across national boundaries and constitute a binding cord that unites all nurses and midwives around the world. The third pledge is the Ghanaian Nurses' Pledge and the Midwives' Prayer. The Ghanaian Pledge conveys the same spirit as the International Council of Nurses' Pledge and the Florence Nightingale Pledge but has some local accoutrements which make it more applicable to the specific Ghanaian context of professional practice. Time to meet both versions!

13.3.1 The International Pledge

The International Pledge is depicted in the painting below:



(ICN, 2009)

The detailed text in the painting is as follows:

> In the full knowledge of the task I am undertaking, I promise to take care of the sick with all the skill and understanding I possess, without regard to race, creed, color, politics, or social status, sparing no effort to conserve life, to alleviate suffering, and promote health.
>
> I will respect at all times the dignity and religious beliefs of the patients entrusted in my care, holding in confidence all personal information entrusted to me and refraining from any action which might endanger life or health.
>
> I will endeavour to keep my professional knowledge and skill at the highest level and give loyal support and cooperation to all members of the health team.

In a nutshell, there are three actions indicated in the above pledge – a promise to care for the sick, to respect diversity and confidentiality and to work as part of a team. These are the same tenets that are differently captured in the wordings of the other pledges in the Unit. They define professionalism in nursing and midwifery to the highest.

The International Council of Nurses is a professional federation established in Geneva in 1899 and its membership comprises the national nurses' associations from over 130-member countries, including Ghana.

13.3.2 The Florence Nightingale Pledge

> I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician in his work, and devote myself to the welfare of those committed to my care (Fowler, 1984).

According to the American Nursing Association, "This modified "Hippocratic Oath" was composed in 1893 by Mrs. Lystra E. Gretter and a Committee for the Farrand Training School for Nurses, Detroit, Michigan. It was called the *Florence Nightingale Pledge* as a token of esteem for the founder of modern nursing" (AANA, 2014).

13.3.3. The Ghanaian Pledge

We are unable to ascertain the origin or authorship of the Ghanaian pledge, but it is contained in the documentation of the Nursing and Midwifery Council of Ghana. It is not too different from the two other pledges discussed above but in tenor it consists of a number of cogent promises and seems a bit more elaborate.

Ghanaian Version

1. I acknowledge that the special training I have received has prepared me as a responsible member of the community;
2. I promise to care for the sick with all the skill I possess, no matter what their race, creed, colour, political, or social status, sparing no effort to conserve life, alleviate pain and promote health;

3. I promise to respect at all times the dignity of the patient in my charge;
4. I promise to hold in confidence all personal information entrusted to me;
5. I promise to keep my knowledge and skill at the professional level and to give the highest standard of nursing care to my patients;
6. I promise to carry out intelligently and loyally medical instructions given to me;
7. I promise that my personal life shall at all times bring credit to my profession;
8. I promise to share in the responsibility of other professions and citizens for promoting health locally, nationally and internationally.

Apart from the acknowledgement of professional commitment in the opening pledge, the rest of the document comprises a series of promises by the nursing and midwifery professional. The significance of promise in social interaction cannot be treated with levity. Across cultures promises are regarded as binding to a large extent. As a consequence, they frame a set of principles and expectations by which standards and quality of practice may be assessed.

Let us go through each of the promises one by one to examine their real import.

> *I promise to care for the sick with all the skill I possess, no matter what their race, creed, colour, political, or social status, sparing no effort to conserve life, alleviate pain and promote health;*

This is a particularly important promise especially in a diverse and multicultural society such as Ghana where the professionals may find themselves serving people from varied social and cultural backgrounds. It speaks to the sanctity of life irrespective of physical and other noticeable differences. This speaks to the non-discriminatory nature of nursing and midwifery practice.

> I promise to respect at all times the dignity of the patient in my charge;

This promise demonstrates the 24/7 nature of nursing and midwifery practice and the recognition of human dignity in spite of any form of frailty brought on by ill-health.

> *I promise to hold in confidence all personal information entrusted to me;*

Healthcare institutions are a repository of a wealth of personal information for the society and those who work in them are bound by the ethics of confidentiality. Thus, the professional nurse and midwife have a calling for information handling and management and a commitment to ensure that these are safely kept.

> *I promise to keep my knowledge and skill at the professional level and to give the highest standard of nursing care to my patients;*

This promise speaks to the recognition and upholding of professional standards. It is a direct link to the regulators who are the watchdogs of practice who can invoke sanctions in cases of violation. But notice that the promise is still directed at the patient or healthcare recipient. In other words, the latter is always at the centre of all considerations.

> *I promise to carry out intelligently and loyally medical instructions given to me;*

This promise says that the nursing and midwifery practitioner is not a robot in the operation of healthcare delivery as they deal 'intelligently' in their duties. It is an interesting one though from the point of view adopted throughout this coursebook about healthcare delivery being one of partnerships and collaborations. The promise represents the nurse/midwife as being in a subordinate relationship to other professionals who may give instructions that are supposedly carried out 'loyally'. Carrying out the instructions intelligently and loyally gives the nurse/midwife the room to suggest alternative ideas or inputs to the superior when she thinks something is amiss in order to arrive at the best decision in the interest of the patient.

> *I promise that my personal life shall at all times bring credit to my profession;*

This promise stipulates that nursing and midwifery practice as a profession is inseparable from the personal life of the practitioner.

In other words, this is a calling and a way of life. What we do in our personal lives may impact our profession and practice.

> *I promise to share in the responsibility of other professions and citizens for promoting health locally, nationally and internationally;*

This final promise locates the nursing and midwifery professional in a community of practice that encompasses local/community, national and international networks that are committed to the promotion of healthcare. This is important because as nurses and midwives, the patients you deal with may not always be people from your own country and also you may find yourself working in a foreign environment.

13.3.4 The Midwives' Prayer

Have mercy on me, oh Lord
And in all my actions
Let me have thy fear before my eyes

> That I may be careful for both rich and poor
> To do good and not hurt
> To save lives and not destroy
> Help my infirmities and imperfections
> And grant me skill and judgement
> Happily to finish every work
> So help me God.
> Amen (Arko, 2016).

The Midwives' Prayer is profound in the sense that it appeals to God to come to the aid of the midwife in the discharge of his/her professional duties. Lines 3 and 4:

> *Let me have thy fear before my eyes*
> *That I may be careful for both rich and poor show that all patients are equal in the healthcare domain.*

Midwife is praying that he/she would be able to discharge his/her duties effectively and efficiently irrespective of the social status of the patient.

Lines 5 and 6 affirm the sanctity of life and the desire of the midwife to do good and not hurt the patient or destroy life:

To do good and not hurt
To save lives and not destroy

In most cases, midwives are present when a baby is being born. Any mistake or negligence on the part of the midwife could result in the death of the baby or the mother or both. It is important, therefore, for the midwife to be aware of this sacred duty entrusted to him/her and for him/her to resolve to do all he/she can to protect the life of the baby and the mother.

Lines 7 to 9 speak to the fact that like all human beings, healthcare providers (in this case, midwives) are not infallible, therefore, there is the need for divine assistance to improve upon their skills and performance and to finish every work they set out to do:

Help my infirmities and imperfections
And grant me skill and judgement
Happily to finish every work

This solemn prayer is a desire on the part of the midwife to improve upon his/her professional skills, emotional and personal character so as to offer service to people who come their way. Upon a reflection on these lines, one ought to feel humbled and this should reflect in the way the midwife sees and treats his/her patients. This would remind him/her that there is no room for the snide remarks that are sometimes directed at patients by some nurses/midwives.

13.4 Summary

The pledge and the prayer indicate the importance of maintaining high professional standards in the healthcare delivery system and it is imperative that every nurse/midwife learns it or refers to it from time to time. This will remind them of the need to work hard in the discharge of their professional duties for the good of all.

There are no exercises for this Unit, but we encourage you to learn the pledge and the prayer so that you can remind yourself of the oath you have taken and renew your professional commitment.

REFERENCES

AANA. (2014). Florence Nightingale Pledge and Brief Biography. Retrieved from http://www.aana.com/newsandjournal/News/Pages/Florence-Nightingale-Pledge-and-Brief-Biography.aspx

Abugre, J. B. (2011). Perceived satisfaction in sustained outcomes of employee communication in Ghanaian organizations. *Journal of Management Policy and practice, 12*(7), 37.

Adika, G. (2012). English in Ghana: Growth, tensions and trends. *International Journal of Language, 1*, 151-166.

AIPC. (2009a). Counselling Microskills: Influencing. Retrieved from http://www.counsellingconnection.com/index.php/2009/11/12/influencing/

AIPC. (2009b). Counselling Microskills: Questioning. Retrieved from http://www.counsellingconnection.com/index.php/2009/07/10/counselling-microskills-questioning/

Allen, R. (2000). *The New Penguin English dictionary*. Location: Penguin.

ANA. (2014). *Nursing Informatics: Scope and Standards of Practice*. Washington, DC: American Nurses Association.

Anderson, L. W., Krathwohl, D. R., & Bloom, B. S. (2001). *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives*: Allyn & Bacon.

Antai-Otong, D. (2008). *Nurse-Client Communication: A Life Span Approach: A Life Span Approach*. Burlington, MA: Jones & Bartlett Publishers.

Arko, J. (2016). The Nurses' Pledge, The Midwives' Prayer. Retrieved from https://nursinginghana.com/nurses-pledge-midwives-prayer

Association, A. N. (2001). *Scope and standards of nursing informatics practice*: Amer Nurses Assn.

Bak, S. (2016). *Smi n Shty Pn*. Popenguine, Senegal: Per Ankh.

Bakken, S., Cook, S. S., Curtis, L., Desjardins, K., Hyun, S., Jenkins, M., Roberts, W. D. (2004). Promoting patient safety through

informatics-based nursing education. *International Journal of Medical Informatics, 73* (7), 581-589.

Ball, M. J., Douglas, J. V., Walker, P. H., DuLong, D., Gugerty, B., Hannah, K. J., Skiba, D. J. (2011). *Nursing informatics: Where technology and caring meet*. New York: Springer Science & Business Media.

Barrett, K. M. (nd). The Counseling Process. Retrieved from http://ww2.usj.edu/faculty_pages/rhalstead/The%20Counseling%20Process.ppt

Beimborn, E. A. (nd). Principles of Communication. Retrieved from https://www4.uwm.edu/cuts/bench/commun.htm

Benedict, C. (2017). Assertiveness and the Four Styles of Communication. *Serenity Online Therapy.* Retrieved from http://serenityonlinetherapy.com/assertiveness.htm

Berner, E. S., & La Lande, T. J. (2016). Overview of clinical decision support systems *Clinical decision support systems* (pp. 1-17): Springer.

Bernhardt, J. M. (2004). Communication at the core of effective public health. *American Journal of Public Health, 94*(12), 2051–2053.

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: emerging frameworks and practical approaches* (Vol. 576): Commonwealth Fund, Quality of Care for Underserved Populations New York, NY.

Bienvenu, S. (2000). *The Presentation Skills Workshop: Helping People Create and Deliver Great Presentations*: American Management Association.

Binder, P., Borné, Y., Johnsdotter, S., & Essén, B. (2012). Shared language is essential: Communication in a multi-ethnic obstetric care setting. *Journal of Health Communication, 17*, 1171-1186.

Blais, K. (2015). *Professional nursing practice: Concepts and perspectives*. London: Pearson.

Bloom, B. S. (1956). *Taxonomy of educational objectives. Vol. 1: Cognitive domain*. New York: McKay.

Booth, C. (2011). *The Ancient Egyptians For Dummies*. Hoboken, New Jersey: Wiley.

Breslin, S., Greskovich, W., & Turisco, F. (2004). Wireless technology improves nursing workflow and communications. *CIN: Computers, Informatics, Nursing, 22*(5), 275-281.

Brownrigg, V. J. (2015). Health information technology for the APRN. *Advanced Practice Nursing: Core Concepts for Professional Role Development*, 257.

Brunero, S., & Lamont, S. (2010). The 'difficult' nurse-patient relationship: Development and evaluation of an E-Learning package. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 35*(2), 136-146.

Budinski, K. G. (2005). *Preparing and Delivering Technical Presentations*: ASTM International.

CD. (2013). What is counselling? Retrieved from http://www.counselling-directory.org.uk/what-is-counselling.html

Chapman, W. (2017). "Words cut deeper than knives. A knife can be pulled out, words are embedded into our souls.". Retrieved from https://www.goodreads.com/quotes/994623-words-cut-deeper-than-knives-a-knife-can-be-pulled

Chivers, B., & Shoolbred, M. (2007). *A Student's Guide to Presentations: Making your Presentation Count*. Thousand Oaks, CA: Sage Publications.

Coiera, E. (2003). Clinical decision support systems. *Guide to health informatics, 2*(1).

Comfort, J. (1998). *Oxford Business English Skills–Effective Presentations*: Oxford University Press.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed* (Vol. Volume I). Washington, DC: Georgetown University.

CT. (2013). Reflecting and Paraphrasing. Retrieved from http://counsellingtutor.com/basic-counselling-skills/reflecting-and-paraphrasing/

Curran, C. R. (2003). Informatics competencies for nurse practitioners. *AACN Advanced Critical Care, 14*(3), 320-330.

Dakubu, M. E. K. (1996). *Language and Community*. Accra: Ghana Universities Press.

Dawn, & Smith, A. (2009). How to Develop Great Conversation Skills. Retrieved from https://www.slideshare.net/AnnaTheEnglishTeacher/conversation-skills-2495776

DB. (2015, November 23, 2015). Difference Between Constructive and Destructive Criticism. Retrieved from http://www.differencebetween.com/difference-between-constructive-and-vs-destructive-criticism/

De Gagne, J. C., Bisanar, W. A., Makowski, J. T., & Neumann, J. L. (2012). Integrating informatics into the BSN curriculum: A review of the literature. *Nurse Education Today, 32*(6), 675-682.

Desjardins, K. S., Cook, S. S., Jenkins, M., & Bakken, S. (2005). Effect of an informatics for evidence-based practice curriculum on nursing informatics competencies. *International Journal of Medical Informatics, 74*(11), 1012-1020.

DeVito, J. A. (2005). Communication that works *Essentials of Human Communication* (5th ed.). Boston, MA: Pearson Custom Publishing.

Diamond, L. (2016). 8 Ways Successful People Criticize Others Without Offending Them: No hurt feelings necessary. Retrieved from https://www.rd.com/advice/relationships/give-constructive-criticism/

Doak, L. G., & Doak, C. C. (2004). Pfizer Principles for Clear Health Communication. Retrieved from http://aspiruslibrary.org/literacy/PfizerPrinciples.pdf

Dobkin, B. A., & Pace, R. C. (2003). *Communication in a Changing World*. New York: McGraw Hill.

Drab, K. J. (2014). The Top Ten Basic Counseling Skills. Retrieved from http://www.people.vcu.edu/~krhall/resources/cnslskills.pdf

Dreachslin, J. L., Gilbert, M. J., & Malone, B. (2012). *Diversity and Cultural Competence in Health Care: A Systems Approach*: Wiley.

Duggal, H. (2017). 4 Types of Criticism and How to Handle Them. Retrieved from https://www.linkedin.com/pulse/4-types-criticism-how-handle-them-harpreet-duggal-md-fapa

Dzameshie, A. K. (1988). Language policy and the common language controversy in Ghana. *Research Review, 4*(2), 16-27.

Egu, F. K. (2009). Nurses in Korle Bu and Komfo Anokye hospitals: Why are some so abusive? Retrieved from https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Nurses-in-Korle-Bu-and-Komfo-Anokye-hospitals-Why-are-some-so-abusive-163035

Ekman, P., & Friesen, W. V. (1971). Constants across cultures in the face and emotion. *Journal of personality and social psychology, 17*(2), 124.

Falvo, D. R. (2010). *Effective Patient Education: A Guide to Increased Adherence*. Burlington, MA: Jones and Bartlett.

Felipe, F. (2015). Words of African Origin in Jamaican Patois. Retrieved from https://tracingafricanroots.wordpress.com/2015/04/28/words-of-african-origin-in-jamaican-patois/

Ford, N., McCullough, M., & Schutta, N. (2012). *Presentation Patterns: Techniques for Crafting Better Presentations*: Pearson Education.

Forsyth, P. (2010). *Successful Time Management*: Kogan Page.

Fowler, M. D. M. (1984). *Ethics and nursing, 1893-1984: the ideal of service, the reality of history.* (PhD), University of Southern California, Los Angeles. Retrieved from http://www.truthaboutnursing.org/press/pioneers/nightingale_pledge.html

Freshwater, D. (2003). *Counselling skills for nurses, midwives and health visitors*. New York: McGraw-Hill Education (UK).

Gamble, T. K., & Gamble, M. W. (2013). *Interpersonal communication: Building connections together*. Thousand Oaks, CA: Sage Publications.

Gendeh, H. S. (2016). The art of non-verbal communication in healthcare. Retrieved from http://www.star2.com/living/viewpoints/2016/02/21/the-art-of-non-verbal-communication-in-healthcare/#xZeaVcg1XPEAzyGZ.99

GNA. (2013, June 20, 2013). Winneba Hospital trains sign language interpreters. Retrieved from https://www.ghanabusinessnews.com/2013/06/20/winneba-hospital-trains-sign-language-interpreters/

Goodman, K. W. (2010). Ethics, information technology, and public health: new challenges for the clinician-patient relationship. *The Journal of Law, Medicine & Ethics, 38*(1), 58-63.

Graphic, D. (2016, 29 April 2013). Hospitals To Be Provided With Sign Language Interpreters. Retrieved from http://www.peacefmonline.com/pages/local/health/201304/162599.php

Gretter, L. (1893). The Nightingale Pledge. *A Tribute to Florence Nightingale*.

Greusel, D. (2002). *Architect's Essentials of Presentation Skills*: Wiley.

Groves, J. E. (1978). Taking care of the hateful patient, New England Journal of Medicine 298 (16): 883-887.

Guenther, J. T. (2006). Mapping the literature of nursing informatics. *J Med Libr Assoc, 94*(2 Suppl), E92-E98.

Haber, R. J., & Lingard, L. A. (2001). Learning oral presentation skills. *Journal of General Internal Medicine, 16*(5), 308-314.

Halawi, L. A., McCarthy, R. V., & Pires, S. (2009). An evaluation of e-learning on the basis of Bloom's taxonomy: an exploratory study. *Journal of Education for Business, 84*(6), 374-380.

Hall, E. (1983). *Ghanaian Languages*. Accra: Asempa Publishers.

Hall, S. (1997). Integrating Pronunciation for Fluency in Presentation Skills.

Harris, J. (2013). *Presentation Skills for Teachers*: Taylor & Francis.

Häyrinen, K., Saranto, K., & Nykänen, P. (2008). Definition, structure, content, use and impacts of electronic health records: a review of the research literature. *International Journal of Medical Informatics, 77*(5), 291-304.

Herberg, P. (1989). Theoretical foundations of transcultural nursing *Transcultural concepts in nursing care* (pp. 3-92). Glenview, IL: Scott, Foresman.

Hybels, S., & Weaver, R. L. (2001). *Communicating Effectively* (Sixth Edition ed.). Boston: McGraw-Hill.

Hyun, S., Bakken, S., Douglas, K., & Stone, P. W. (2008). Evidence-based staffing: potential roles for informatics. *Nursing economic$, 26*(3), 151.

ICN. (1899). Above all other things-unity. *Nurses of all nations. A history of the International Council of Nurses, 1999*.

ICN. (2009, October 2009). International Council of Nurses' Pledge. Retrieved from http://www.oocities.org/ipromiseposter/pledge.html

ILA. (1995). On competent listening. *The Listening Post*(54), 1.

James, G. (2016). 7 Ways to Turn Destructive Criticism to Your Advantage. Retrieved from https://www.inc.com/geoffrey-james/how-to-handle-destructive-criticism.html

Jastremski, C. A. (1999). Nursing informatics: issues for critical care medicine. *Critical care clinics, 15*(3), 563-576.

Jiwa, M., Davidson, P., McGrath, S., Newton, P., DiGiacomo, M., Delfos, W. C. S. P., Thompson, S. (2011). *Report on Lung Cancer in Australia: Literature review and consultation on factors impacting on lung cancer outcomes*. Retrieved from Barton, Australia:

Jones, K., & Mixon, J. R. (2016). *Intercultural Responsiveness in the Second Language Learning Classroom*.

Kaye, E. (2002). *Maximize Your Presentation Skills: How to Speak, Look, and Act on Your Way to the Top*: Crown Publishing Group.

Kearsley, K. (2015). Student Nurse Journey. Retrieved from http://www.studentnursejourney.com

Kelley J. M, Kraft-Todd, G., Shapira, L., Kossowsky, J., & Riess, H. (2014). *The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized control trials*. San Francisco, CA: Public Library of Science.

Kidd, J., Patel, V., & Peile, Y. C. (2005). Clinical and communication skills: Need to be learnt side by side. *BMJ: British Medical Journal, 330*(7488), 374-375.

Knight, D. N. (2014). *Digital Channels in Healthcare Service Provision: A study of midwives and women's understanding of and engagement with information and communication technologies (ICT).* University of Otago.

Kokol, P., Zazula, D., Brumec, V., & Kolenc, L. (1999). Nursing informatics education for the next millenium. *Future Generation Computer Systems, 15*(2), 211-216.

Korsah, K. A. (2011). Nurses' stories about their interactions with patients at the Holy Family Hospital, Techiman, Ghana. *Open Journal of Nursing, 1*, 1-9.

Kourkouta, L., & Papathanasiou, I. V. (2014). Communication in nursing practice. *Materia socio-medica, 26*(1), 65.

Kumar, M. (2011). Difference Between Sympathy and Empathy. Retrieved from http://www.differencebetween.net/language/difference-between-sympathy-and-empathy/#ixzz4slovJyTR

Leach, M. (2010). Time to put Ebola in context. *Bulletin of the World Health Organization, 88*(7), 481-560.

Leininger, M. (1997). Transcultural nursing research to transform nursing education and practice: 40 years. *Journal of Nursing Scholarship, 29*(4), 341-348.

Lerche, O. (2016). Shocking mental health figures reveal one in six in adults have anxiety or depression. Retrieved from http://www.express.co.uk/life-style/health/715782/depression-anxiety-one-in-six-adults-England-suffer-mental-health-disorders

Lescault, A. J. S. H. J. (2011). *Present with Power, Punch, and Pizzazz!: The Ultimate Guide to Delivering Presentations with Poise, Persuasion, and Professionalism*: iUniverse.

Lester, P. M. (2013). *Visual communication: Images with messages*: Cengage Learning.

Lewis, M. P. (2009). Ethnologue: Languages of the World. 16. Retrieved from http://archive.ethnologue.com/16/show_map.asp?name=GH&seq=10

LoFrisco, B. (2012, 1 November 2012). The Skill of Self-Disclosure: What You Need To Know. Retrieved from https://www.mastersincounseling.org/self-disclosure-what-you-need-to-know.html

Lucas, A. (2017, 13 June 2017). The Importance of Verbal & Non Verbal Communication. Retrieved from http://www.livestrong.com/article/156961-the-importance-of-verbal-non-verbal-communication/

Mandel, S. (2010). *Presentation Skills: Captivate and Educate Your Audience*: Axzo Press.

Mandela, N. (2006). Learning English - Moving Words: Nelson Mandela. Retrieved from http://www.bbc.co.uk/worldservice/learningenglish/movingwords/shortlist/mandela.shtml

Manos, P. J., & Bruan, J. (2006). *Care of the difficult patient: A nurse's guide*. New York: Routledge.

Marta, G. D. (2012, 22 March 2012). What is Empathy? Retrieved from http://www.counselling-directory.org.uk/counsellor-articles/what-is-empathy

Martin, A. (2017a, 13 July 2017). Active Listening Skills. Retrieved from http://www.thecounsellorsguide.co.uk/active-listening-skills.html

Martin, A. (2017b, 15 April 2017). Attitudes and Qualities of a Counsellor. Retrieved from http://www.thecounsellorsguide.co.uk/attitudes-qualities-counsellor.html

Martin, A. (2017c, 13 July 2017). Attitudes and Qualities of a Counsellor. Retrieved from http://www.thecounsellorsguide.co.uk/attitudes-qualities-counsellor.html

Matney, S., Brewster, P. J., Sward, K. A., Cloyes, K. G., & Staggers, N. (2011). Philosophical approaches to the nursing informatics data-information-knowledge-wisdom framework. *Advances in Nursing Science, 34*(1), 6-18.

McCabe, C., & Timmins, F. (2013). *Communication Skills for Nursing Practice*. Basingstoke: Palgrave Macmillan.

McCarthy, P., & Hatcher, C. (2002). *Presentation Skills: The Essential Guide for Students*. Thousand Oaks, CA: Sage Publications.

McGonigle, D., & Mastrian, K. (2014). *Nursing informatics and the foundation of knowledge*: Jones & Bartlett Publishers.

McNeil, B. J., Elfrink, V. L., Pierce, S. T., Beyea, S. C., Bickford, C. J., & Averill, C. (2005). Nursing informatics knowledge and competencies: A national survey of nursing education programs in the United States. *International Journal of Medical Informatics, 74*(11), 1021-1030.

Mosby, I. (2009a). *Mosby's medical dictionary*. Edinburgh, London and Oxford: Elsevier Health Sciences.

Mosby, I. (2009b). Mosby's Medical Dictionary: Therapeutic communication. Retrieved from http://medical-dictionary.thefreedictionary.com/therapeutic+communication

Munoz, C., & Luckmann, J. (2007). *Transcultural Communication in Nursing* (2nd ed.). New York: Delmar Learning. .

Narayanasamy, A. (2006). The impact of empirical studies of spirituality and culture on nurse education. *Journal of clinical nursing, 15*(7), 840-851.

NAWA. (2017). Nonverbal Communication and Gestures. Retrieved fromhttp://www.noworriesghana.com/sections/etiquette/item/1503-nonverbal-communication-and-gestures

NCCHC. (2017). National Commission on Correctional Health Care Retrieved from http://www.ncchc.org/

Niland, J. C., Rouse, L., & Stahl, D. C. (2006). An informatics blueprint for healthcare quality information systems. *Journal of the American Medical Informatics Association, 13*(4), 402-417.

Nunn, J. F. (2002). *Ancient Egyptian Medicine*. Norman, OK: University of Oklahoma Press.

Nystul, T. G., Goldmark, J. P., Padilla, P. A., & Roth, M. B. (2003). Suspended animation in C. elegans requires the spindle checkpoint. *Science, 302*(5647), 1038-1041.

Obenga, T. o. (2004). *African Philosophy: The Pharaonic period, 2780-330 B.C*. Popenguine, Senegal: Per Ankh.

oremutdentist.com. (2017). Zimbabwe Kids. Retrieved from https://www.pinterest.com/pin/379428337328195824/

Owu-Ewie, C. (2006). *The Language Policy in Education in Ghana: A Critical Look at the English-only Language Policy of Education.* Paper presented at the 35th Annual Conference on African Linguistics, Somerville, MA.

Parfitt, B. A. (1998). *Working across cultures: A study of expatriate nurses working in developing countries in primary health care* (Vol. 17). Aldershot: Avebury.

Parker, C. (2015). New Nursing Informatics Scope and Standards of Practice. Retrieved from http://www.nenic.org/assets/documents/Fall_Winter_Program_Materials/2015-new%20ni%20scope%20and%20stds%20of%20practice%20pdf.pdf

Perlmutter, D. M., & Soames, S. (1979). *Syntactic argumentation and the structure of English* (Vol. 231). Oakland, CA: University of California Press.

Perreault, C., & Mathew, S. (2012). Dating the origin of language using phonemic diversity. *PloS one, 7*(4), e35289.

PGDM. (2012). Conversation Skills. Retrieved from https://www.slideshare.net/pgdmstudent/conversation-skills-15755307

PHAST. (2017). Principles, theories and methods of effective communication (written and oral) in general, and in a management context. Retrieved from https://www.healthknowledge.org.uk/public-health-textbook/organisation-management/5a-understanding-itd/effective-communication

PJCOSTAN. (2017). Improving Non-Verbal Communication. Retrieved from https://pjcostan.wordpress.com/about/non-verbal-communication/improving-non-verbal-communication/

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*: Lippincott Williams & Wilkins.

Prozesky, D., Stevens, S. & Hubley, J. (2006). Effective teaching and learning for eye health workers. Retrieved from: https://www.cehjournal.org/resources/effective-teaching-and-learning-for-eye-health-workers/

Puglisi, R. (2017). People Staring at Someone Else. Retrieved from https://www.pinterest.co.uk/pin/434949276495170012/

Reynolds, W., & Scott, P. A. (2000). Nursing, empathy and perception of the moral. *Journal of Advanced Nursing, 32*(1), 235-242.

Robinson, M., & Davidson, G. (Eds.). (1997). *Chembers 21 Century Dictionary*. New Delhi: Allied Publishers.

Russell, J. A., & Fernández-Dols, J. M. (1997). What does a facial expression mean. *The psychology of facial expression, 1*.

Saah, K. K., & Baku, K. (2011). Do not rob us of ourselves: Language and nationalism in colonial Ghana. In H. Lauer, N. A. A. Amfo, & J. Anderson (Eds.), *Identity meets Nationality: Voices from the Humanities* (pp. 74-99). Accra: Sub-Saharan Publishers.

Saba, V., & McCormick, K. A. (2015). *Essentials of Nursing Informatics, 6th Edition*: McGraw-Hill Education.

Saphiere, D., Mikk, B., & Devies, B. I. (2005). *Communication highwire: Leveraging the power of diverse communication styles*. Yarmouth, ME London: Nicholas Brealey Publishing.

SC. (2016). Counselling is for everyone: Who Needs Counselling? Retrieved from http://www.shanti-centre.com/who-needs-counselling/

Sherko, E., Sotiri, E., & Lika, E. (2013). Therapeutic communication. *JAHR, 4*(7), 457-466.

Shortliffe, E. H., & Cimino, J. J. (2013). *Biomedical informatics: computer applications in health care and biomedicine*: Springer Science & Business Media.

Siddons, S. (2008). *The Complete Presentation Skills Handbook: How to Understand and Reach Your Audience for Maxi*: Kogan Page.

Simons, G. F., & Fennig, C. D. (Eds.). (2017). *Ethnologue: Languages of the World* (Twentieth edition ed.). Dallas, Texas: SIL International.

Slevin, E. (1995). Student nurses' attitudes towards people with learning disabilities. *British journal of nursing (Mark Allen Publishing), 4*(13), 761-766.

Smith, C. (2004). New technology continues to invade healthcare: What are the strategic implications/outcomes? *Nursing Administration Quarterly, 28*(2), 92-98.

Smith, L. (2001). Evaluation of an educational intervention to increase cultural competence among registered nurses. *Journal of cultural diversity, 8*(2), 50.

Sperber, D., & Wilson, D. (1995). *Relevance: communication and cognition*. Oxford: Blackwell.

Spolsky, B. L. P. C. C. U. P. (2004). *Language Policy*. Cambridge: Cambridge University Press.

Surbhi, S. (2017, 2 April 2015). Difference Between Verbal and Nonverbal Communication. Retrieved from http://keydifferences.com/difference-between-verbal-and-non-verbal-communication.html#ixzz4sgGvZaVZ

SYN. (2017a). Dealing With Criticism. Retrieved from https://www.skillsyouneed.com/ips/dealing-with-criticism.html

SYN. (2017b). Offering Constructive Criticism. Retrieved from https://www.skillsyouneed.com/ips/constructive-criticism.html

Taylor, K. (2015). Connected health: how digital technology is transforming health and social care. *London: Deloitte Centre for Healthcare Solutions*.

TBC. (2017). What is verbal communication and non-verbal communication? Retrieved from https://thebusinesscommunication.com/what-is-verbal-communication-and-non-verbal-communication/

Thangavel, R. (2009). Listening Response 2: Paraphrasing. Retrieved fromhttps://2105rocks.wordpress.com/the-beginning-stage/listening-response-2-paraphrasing/

Thomas, M. (2012). Six reasons why criticism is a good thing. Retrieved from https://www.theguardian.com/culture-

professionals-network/culture-professionals-blog/2012/feb/09/reasons-tips-criticism-arts

UKVIPC. (2014). The Four Basic Styles of Communication. Retrieved fromhttps://www.uky.edu/hr/sites/www.uky.edu.hr/files/wellness/images/Conf14_FourCommStyles.pdf

UNESCO. (1953). *The use of vernacular languages in education*. Paris: UNESCO.

UNICEF. (nd). *Breastfeeding Counselling: A Training Course*. Web: World Health Organization CDD Programme Retrieved from http://www.who.int/nutrition/publications/bf_counselling_directors_guide.pdf.

VDH. (2017). Cultural Differences in Non-Verbal Communication. Retrieved from http://healthvermont.gov/family/toolkit/tools/F-6%20Cultural%20Differences%20in%20Nonverbal%20Communic.pdf

Walker, G. (2003). Dealing with Criticism. Retrieved from http://oregonstate.edu/instruct/comm440-540/criticism.htm

Weaver, C. A., Warren, J. J., Delaney, C., Association, I. M. I., Group, N. I. S. I., & Group, E.-B. P. W. (2005). Bedside, classroom and bench: collaborative strategies to generate evidence-based knowledge for nursing practice. *International Journal of Medical Informatics, 74*(11), 989-999.

Weiss, M. (2015). *Presentation Skills: Educate, Inspire and Engage Your Audience*: Business Expert Press.

Weissman, J. (2011). *Presentation Skills That Work: Expert Advice from Jerry Weissman (Collection)*: Pearson Education.

WHO. (1995). *Health workers' manual on Counselling for Maternal and Child Health*. Manila: World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/206794/1/9290611391_eng.pdf.

Williams, C., & Tappen, R. (2008). Communicating with cognitively impaired persons. In C. L. Williams & C. M. Davis (Eds.), *Therapeutic interaction in nursing* (2nd Edition ed.). Burlington, MA: Jones & Bartlett Learning.

Windle, R., & Warren, S. (1999). *Collaborative Problem Solving and Dispute Resolution in Special Education. Training Manual.* Web: Education Resources Information Center (ERIC)

Wyatt, J., & Liu, J. (2002). Basic concepts in medical informatics. *Journal of Epidemiology and Community Health, 56*(11), 808-812.

Yankah, K. (2014, Saturday, 8 March 2014). Point of Order: A note on the language of Parliament. *Daily Graphic,* p. 10.

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