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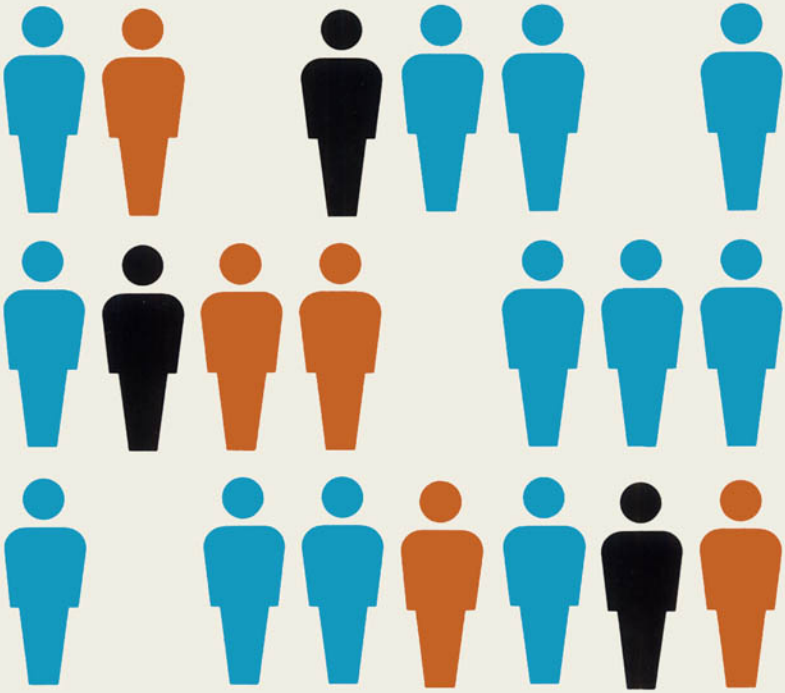
People, patients, and nurses

A guide for nurses toward improved interpersonal relationships



Jennie Wilting

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A guide for nurses toward improved interpersonal relationships

by Jennie Wilting

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Dedicated to Claire, who painstakingly reviewed my material, corrected errors, and tactfully advised and criticized, and to John, whose interest and support are greatly appreciated.

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Introduction

During my years of teaching, I have occasionally been asked to help nurses solve some of the problems they were having in the course of their work. Gradually, I have come to realize that the problems which nurses find the most frustrating and handicapping are not major nursing problems. For example, the care of a patient who has had open heart surgery or the patient who is suffering from a psychosis is not a major problem for them because they know where to go to find solutions. The problems that nurses have difficulty in solving have to do with communications and interpersonal relationships with patients and co-workers.

Often the nurse is unable to say exactly what the problems are which frustrate her and detract from her job satisfaction. They seem to stem from an accumulation of minor happenings or experiences. She may feel lost in her relationships with her patients. She is able to meet their physical needs but doesn't feel confident in meeting their emotional needs. At times, she isn't sure what these needs are, and at other times, she knows what they are but realizes that she isn't meeting them. There are also times when she *is* meeting the emotional needs of the patients but doesn't know how she is doing it or even that she is doing it. She may find herself in a vicious circle in her relationship with her patient. She behaves this way, the patient responds thus, and she retaliates in such and such a manner; or the patient behaves in a particular way, she responds thus, and the patient retaliates in a set manner. She recognizes that her relationship with her patient isn't therapeutic but she doesn't know how to stop the merry-go-round. Or, she may conclude that a particular patient or type of patient is impossible to work with or care for and decide that the problems caused by these patients are insoluble. Yet this patient or type of patient continues to come under her care, resulting in feelings of helplessness. What is she to do?

She may feel the same about her relationships with co-workers. She is aware that her relationships and communications with them are not conducive to meeting the needs of the patients and perhaps at times they are even detrimental to patient care, but she may not know how to change or improve them. In an attempt to resolve the situation, she may change her position or place of employment. Then she often finds herself encountering the same problems or types of problems wherever she works or in whatever position she holds. These problems can be grouped under three major headings; namely: problems arising from *relationship with self*; problems arising from *relationship with patients*; and problems arising from *relationship with co-workers.*

In the following pages, I have expressed some of my thoughts and ideas about these problem areas in the hope that they may be of some help and guidance to other members of the nursing profession who are struggling to overcome their difficulties. Throughout the book, I cite many examples of nursing experience. They are taken from all areas of nursing; however, a large number are taken from psychiatric nursing since most of my nursing experience has been in that field. Similar examples, I am sure, could be found in other areas. Therefore, the principles stressed should be applicable to them as well. Because "he/she" can become cumbersome reading, I have decided to use the female gender when referring to the nurse. It is not my intent to ignore or belittle the male members of the nursing profession but merely to promote ease of reading.

I hope this book will encourage readers to observe individual nursing experiences more closely and by examining their own feelings and behavior be able to work through some difficult nursing situations and give more effective nursing care. Furthermore, I hope that readers will be encouraged to find more effective and rewarding ways of interacting with their co-workers. If they are able to recognize and accept the fact that each nurse has skills and potentials which she hasn't used, and if she is encouraged to develop these, then my time and effort in preparing this book will be well repaid.

RELATIONSHIP WITH SELF

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Chapter I

Accepting Oneself

What does accepting oneself mean? A meaning often given to the word acceptance is to take, either with approval or with resignation. To many people, self acceptance means either to approve of oneself in every way or to be resigned to the fact that one is the way one is and there isn't anything that can be done about it.

I do not think accepting oneself necessarily means approval or resignation. To me, it means to take and own as is. It means acknowledging that I am the way I am, feel the way I feel, and act the way I act, taking responsibility without reservation for the person that I am.

Accepting oneself involves knowing oneself. We cannot accept what we do not know. Included in ourselves are our strengths and weaknesses; our talents and prejudices; our moral principles and values; our experience and knowledge or lack of them; our emotional reaction to situations; and our response to the behavior of others. Certainly the more we know about ourselves and the better we understand ourselves, the greater the possibility that we will accept ourselves. If we know and understand ourselves, we are better able to use our characteristics and talents to work effectively and care for patients in a therapeutic manner.

Let us take a list of characteristics and in our own mind carefully go over them and consider seriously which ones apply to ourselves. Here goes:

Ambitious
Intelligent
Kind
Shy
Hesitates to come forth with own ideas

Works well with peer group
Has difficulty working with authority figures
Prejudiced toward minority groups
Interested in learning and developing skills
Tends to move slowly
Organizes well
Pays special attention to details
Enjoys music
Plays piano well
Takes things seriously and frequently doesn't recognize humor
Has difficulty accepting verbal hostilities such as sarcasm, criticism, and swearing.

A complete list of possible characteristics would be endless and perhaps it would be more helpful if you made a list of your own. You may find as you make your list, that you feel confident about listing certain characteristics but rather unsure of others. You may find yourself adding them and then deleting them and perhaps adding or deleting them a second or third time. What happens here? Let's take the characteristic of kindness. Your first response might be—yes, I am kind toward patients and fellow workers. Then comes to your mind the incident just the other day when you cut a patient off in midsentence when he started telling you about his car accident for the third time. That wasn't very kind. So actually, one of your characteristics is that you are unkind to patients. But wait, how about the man who was very worried about his wife in the operating room. You brought him a cup of coffee and took five minutes out of your busy day to chat with him. That was kind. You are back where you started—one of your characteristics is kindness.

If you carry this a bit further, you can look at the times that you were unkind and explain your behavior by such remarks as, I wasn't myself that day. I had a terrible headache and therefore became impatient. Or everyone is nasty to that particular patient; he's impossible. On the other hand, is it possible that you weren't yourself on the day that you were kind to the man concerned about his wife? Most likely the truth is that your behavior in both situations was characteristic of you. Sometimes you are kind and considerate of others, and sometimes you are not.

From the incident cited above, we can say that you are kind to your patients and you are unkind to your patients. Probably one characteristic is stronger than the other; that is, you tend to be kind more often than unkind, or you may have to face the fact that you

are more often unkind. To develop your understanding of yourself further, it is helpful to note the circumstances and situations in which you tend to be kind or unkind. Also note the types of patients that you are caring for when your characteristic of kindness or unkindness is evident. This may give clues as to how you might increase or decrease one characteristic or the other.

The above list of characteristics is too general and vague to be of much help in specific situations in which we are having difficulty accepting ourselves. It may help us develop our skills and improve our nursing care in general, but in working through interpersonal relationship problems, we need to speak of self acceptance or the lack of self acceptance in specific incidents or at a particular moment.

In looking at specific incidents, self acceptance means to take or own that one said certain things, felt a particular way, and behaved in a definite manner. It does not mean taking or owning what one wished one had said, felt, or done; neither does it mean to take or own what others say one should have said, felt, or done. Self accepting to me means owning and taking what one said, felt, or did. To enhance self acceptance, it is important to be as honest with oneself as possible. This is the way I felt or feel, this is what I did or do, and this is what I said or say.

Equally as important as honesty is a non-judgmental attitude. A non-judgmental attitude enables us to view our feelings, words, and deeds as impartial facts not colored by right and wrong or good and bad. The following example demonstrates what often happens.

> It was Miss Redd's* first day of duty on a particular ward. The young nurse was instructed to go from room to room and ask patients to get ready for breakfast. The first room she entered was dark, the drapes were closed, and the patient was a vague lump in the bed. She walked over to the window and opened the drapes.
>
> An angry voice bellowed from the bed, "What the hell do you think you are doing? Close those damn drapes!"
>
> Miss Redd responded with, "Oh, excuse me," and she fled from the room. To use her own words, "I was scared spitless."

Now we will imagine Miss Redd discussing this incident with

* The names of the people used throughout the book have been changed to protect their privacy.

another nurse, possibly with a head nurse or instructor who we will call Mrs. Gray. The following scene may be familiar to many.

Mrs. Gray: How did you feel?
Miss Redd: Well, I was scared, I know I shouldn't be scared but I just couldn't help myself.

or

I was scared but that would scare anybody.

or

I was scared, I don't know why, I'm usually not like that.
Mrs. Gray: What did you say?
Miss Redd: I didn't say anything at first which was rather stupid of me but I wasn't thinking. I realized later that I should have explained why I was in the room before I opened the drapes.
Mrs. Gray: What did you do?
Miss Redd: I walked in and opened the drapes. I know that I should have knocked first and then spoken to the patient before opening the drapes. When he shouted at me, I ran out of the room. I shouldn't have let that scare me; instead I should have stayed in the room and apologized.

In the above examples, there is much judging, excusing, and condemning, but very little attempt to accept, understand, and profit from one's experience. Often we don't conduct discussions about such incidents with others, but instead, these little niggling debates go on inside ourselves. We judge, excuse, and explain our feelings, words, and behavior. But we do not accept or own them. We do not accept that this is what I felt, this is what I said, and this is what I did in a particular incident.

After having accepted ourselves and our behavior in a particular situation, we may want to ask ourselves the following questions. First, how can I use this experience to increase my understanding of myself and my patients? Second, how can I use this experience to improve my nursing skills and interpersonal relationships? Finally, how can I use this experience to grow and develop as a person?

From accepting oneself in particular incidents one can develop and grow to an overall acceptance of oneself. Thus accepting oneself would include accepting one's entire range of feelings, behavior, characteristics, and responses. We would be able to say, this is the person I am and I own and am responsible for this person.

How then can we describe a self-accepting nurse? A nurse who

is self accepting owns everything about herself; her feelings toward herself and her patients, her interactions with her patients and the care she gives them, and her feelings and interactions with her co-workers. By accepting her failures as well as her successes, she is able to profit from both and increase and improve her nursing skills. She is able to improve her interpersonal relationships from day to day. By accepting her strengths and weaknesses, she is able to grow and develop as an individual and use herself effectively.

A self-accepting nurse experiences an "okayness" about herself. She trusts herself to function to the best of her ability and has confidence in her ability to develop and grow. A self-accepting nurse is not a perfect nurse. She makes mistakes; sometimes serious ones. At times she lacks knowledge and skill and may find herself in nursing situations in which she is at a loss to know what to do.

A self-accepting nurse is aware of and owns the extremes about herself, the apparent contradictions. There is the contradiction of being acutely aware of herself on the one hand and going out of herself completely to become involved with others or to become a total part of an activity on the other. Growing out of the feeling of "okayness" and trust in herself is the knowledge that everything is in working order and attuned to what is being experienced. Therefore, the self-accepting nurse can forget herself to become totally engrossed in happenings outside of herself. It is as if for that period of time she *is* the other person or activity.

A second contradiction is that of always being the same but constantly changing. There is a basic sameness of being herself. Yet, every passing moment and every experience leaves their mark, however slight. Therefore, she is constantly changing.

There is the extreme of being just another person among millions and therefore of little importance. If her life was suddenly snuffed out or if she had never been, it would make little, if any, difference in this vast universe. Yet she is the most important person there is or ever will be because she is life itself. If she had never existed, life would not be as far as she is concerned. If her life suddenly ended, it would be as if the universe no longer existed. This awareness enables the self-accepting nurse not to take herself too seriously and yet to take herself very seriously indeed.

Another extreme of which the self-accepting nurse is aware is that of being similar to everyone and yet being different from them. People are more alike than they are different and this very fact enables people to understand and feel with other people. On the other hand, no two people are exactly alike. No person can be

completely understood by another. The self-accepting nurse is acutely aware of being a unique, separate, irreplaceable human being. She is a human being, the replica of which has never existed before and will never be duplicated. This gives her a role or spot all her own which cannot be filled by another human being.

Finally, I believe a very important characteristic of a self-accepting nurse is that the direction for her life and behavior comes from within. She will gather facts and information. She may seek and listen to the advice and guidance of others. But before making a decision, she checks within herself to verify what is *right for her,* thereby assuming responsibility for living her own life.

Chapter II

Do's and Don'ts

In the previous chapter, I spoke about accepting oneself. This acceptance includes feelings, words, and deeds. To do this it is necessary to put away do's and don'ts, shoulds and shouldn'ts, mays and may nots, and musts and mustn'ts. It is necessary to be non-judgmental.

Feelings are spontaneous and one feels the way one feels. Feelings cannot be controlled by laws and rules. We cannot decide or control how we are feeling or are going to feel. Words and deeds, on the other hand, can be controlled to a certain extent by laws and rules. We have the ability to decide what we will say and how we will behave. Consider the following three statements as possible rules in nursing.

1. A nurse must not sit on the patients' beds (having to do with deeds).
2. A nurse must call another nurse by her last name when on duty (having to do with words).
3. A nurse must like her patients (having to do with feelings).

The first two rules can be enforced by another person, at least to a certain extent. They can be enforced because their observance or non-observance can be seen or heard and, with enough pressure, obedience will most probably result, at least, in the presence of those in authority. In the third instance, however, only the person involved knows whether or not she is obeying this rule and in some cases even she doesn't know. Regardless of how this rule is presented or what attempt is made to enforce it, it can't be done. It can't be enforced by others, neither can it be enforced by the nurse herself. Most probably there are many patients that the nurse likes, and in

that case she accidentally obeys this rule. However, there are equally probably some patients she doesn't like, but if the pressures are strong enough the nurse can put on such an excellent act of liking them that she convinces others. If the pressures are still stronger the nurse may put on such a good act that she even convinces herself.

Perhaps the above sounds somewhat ridiculous or even comical. It would be comical if it wasn't for the handicapping effect these types of rules have on the nurses who try to obey them. By repressing, denying, or ignoring our feelings, we use a great deal of energy. This energy, if released, could be used to give more effective and therapeutic nursing care.

To emphasize the fact that feelings are not subject to law, an instructor informed her class that she was going to make a rule that would be enforced. The rule was that the students were to respect the instructor. If a student did not respect the instructor, that student would be dismissed from the class. Since the course was required for graduation, dismissal from the class would be a hardship for the student. The instructor wrote the rule on the blackboard and asked the students for their comments.

One student said, "Well, I've always respected you." Another student responded, "I can't understand what you're driving at." A third student asked, "If I was dismissed from the class, would I be given the opportunity to make up the course so that I would be able to graduate?" A fourth student asked, "How are you going to make me?"

Let's briefly examine these responses. The first student respected the instructor and probably would continue to do so. The rule was immaterial to her. The second student couldn't believe her ears. It sounded ridiculous to her and she assumed that she had missed the point that the instructor was trying to make rather than that the instructor had made a ridiculous rule. The third student wondered how important it would be for her to obey this rule. She was willing to go a long way to meet the requirements of the course. If necessary, she would put on a good act to convince the instructor that she respected her. In fact, she was prepared to convince herself that she respected the instructor, if necessary, to get credit for the course. Up to this point the probability that the fourth student would respect the instructor was good. However, after the rule was made the probability dropped. The student was all set for a fight. Interestingly enough, not one of the students pointed out that since their feelings were spontaneous they did not respond to rules and neither the student nor the instructor could control them.

Our society has rules for women. Our society and hospitals have rules for nurses. Sometimes, if the woman is a nurse, the two sets of rules contradict one another. What are some of these rules for nurses? They vary from place to place but the following are some of the more common ones.

A nurse must not let a patient's behavior upset her.
A nurse must not get too emotionally involved with her patients.
A nurse must be understanding and sympathetic toward her patients.
A nurse must not take the complaints or comments of a patient personally.
A nurse must not take a patient's problems to heart.

Not only does our society and hospitals have rules for nurses, they also have rules for patients. I will list a few.

Patients must trust their nurses.
Patients mustn't be afraid of surgery, treatments, or prognosis, at least not to the extent that they create a fuss or scene about it.
Patients must be co-operative.
Patients must not ask for too much attention and service.
Patients must treat their nurses with respect.
Patients must not ask their nurses personal questions.

These are just a few, the reader can probably add more. These rules usually are not found in the policy books nor in the textbooks. In fact, many of us may deny that these rules exist. Yet, by our behavior and sometimes by our conversation, we indicate that we believe these rules do exist and should be obeyed.

The following example may help illustrate how bogged down we can get with "shoulds" and "should nots."

Miss Ash was caring for a young male patient, Mr. Ferrell, who complimented Miss Ash on her cute figure. This embarrassed her and she felt angry toward the patient for the rest of the day. She remained cool toward him and tended to avoid his room. That evening when she reviewed the day, she scolded herself for her feelings and behavior. She brought this incident up for discussion at one of the ward meetings and expressed the following ideas. She was angry at herself. After all, she was a

nurse and shouldn't feel that way. On the other hand, Mr. Ferrell was a patient and, therefore, he shouldn't make a remark like that to her. She was aware that she made a special effort always to look her best and she watched her diet to keep her weight down. She believed that a woman should be particular about her appearance so that men would find her attractive. If this incident had happened socially, which it occasionally did, she would not be embarrassed or angry, but flattered. After all, she was a woman. In this discussion, Miss Ash was attempting to understand herself and the patient. At the same time, she was trying to follow the rules governing the feelings and behavior of both women and nurses. Perhaps she expressed the sentiments of many nurses in similar situations, when she threw up her hands and said, "Boy, am I confused!"

No wonder she was confused. When we try to feel what we should feel and expect others to feel what they should feel, we do become confused. To remove this confusion, it is necessary to feel what we feel, accept how we feel, and, then, decide how we are going to behave. At the same time we need to allow the patient to feel what he feels and accept his behavior.

Most of us have been indoctrinated with rules about feelings. The indoctrination started long before we entered the schools of nursing and for most of us it was continued during our nursing education. As a young child many of us were told, "You mustn't hate your playmate," or, "You shouldn't feel that way," or, "You should feel this way." We were led to believe that there were right and wrong ways to feel and we could control how we felt. Chances are that as adults we are still attempting to function under the influences of these rules and probably wasting much of our energy in an attempt to obey them. It is necessary to realize how tied down we are by these rules and to recognize which particular ones are most binding to us personally. If we are willing to work hard then it is possible to do away with these rules and accept ourselves and our feelings in a non-judgmental way.

Besides doing away with rules, it is necessary to recognize our feelings in order to accept ourselves. To accept how we feel, we need to know what we are feeling at a particular time and this requires that we be honest with ourselves. Honesty enhances our ability to recognize our feelings. Repressing, denying, or ignoring our feelings prevents us from knowing what they are. We learned to identify and label feelings when we were very young. Babies experience their feel-

ings but they aren't concerned with whether they are experiencing anxiety or hostility. They feel what they feel. How then do we learn to distinguish feelings? The same way that we learn many other things, namely, through interaction with our environment and the important people in it. Just as a mother teaches a child to label a chair or table, she also teaches a child to label feelings. A parent may say to a child: "Don't be afraid," "You needn't be afraid," or "Are you afraid?" If the child experiences the same or similar sensations at the times that the parent makes these statements, then eventually the child will be able to connect what he is feeling with what the parent is saying. The child will conclude that when he experiences these particular sensations then he is experiencing fear or he is afraid. Later, when he experiences these sensations, he will be able to say, "I'm afraid."

Since feelings can't be laid out on the table and examined, the mother cannot point to one and say to the child, "Look, this is fear," then pointing to another say, "and this is anger." For this reason there could be quite a difference between what the child is experiencing and what the mother thinks the child is experiencing, when she says, "You are afraid."

As grownups we continue to use words when we try to convey our feelings to each other. Because we can't get into each other's skin and experience exactly what the other person is feeling we need to use words. Since words are inadequate in expressing feelings accurately, when we tell someone that we are afraid it is well to keep in mind that he is incapable of knowing exactly how we are feeling. We can assume that we are most likely experiencing similar sensations to those he experiences when he is afraid. However, this may be incorrect. To turn the situation around, someone may tell us that he is afraid. We can only understand to the extent that we recognize he is experiencing feelings which are probably similar to our own when we are afraid. But we must not expect to completely understand the feelings of others because this is just as impossible as it is for another person to understand our feelings completely.

Most of us have learned to repress, deny, or ignore at least some of our feelings. How then, can we become aware of what we are feeling? We can increase our awareness by staying with a feeling, rather than attempting to deny, ignore, or push it away. By staying with a feeling and experiencing it until we are familiar with it, we can know what we are feeling and we can say to ourselves, "I'm anxious or I'm afraid or I'm concerned, and it is okay. I own these feelings as mine."

Often when we stay with a feeling, we begin to experience a different feeling. This different feeling may have been covered up by the original feeling as often happens when the basic feeling is unacceptable to us. By staying with the original feeling, we may experience the underlying feeling or feelings. For example, I may be experiencing guilt and by staying with it uncover a feeling of hostility or hurt. At other times if we stay with our feelings we may notice that one feeling flows into another since feelings are dynamic rather than static. The process is a gradual flowing process in which changes take place in either the intensity or character of the feelings. By staying with feelings, we are being honest with ourselves and increase our ability to accept our feelings and ourself.

At the beginning of the chapter, I mentioned that accepting oneself included feelings, words, and deeds. Unlike feelings, words and deeds are not spontaneous. We can have conscious control over our words and deeds. As with feelings, if we are going to accept our words and deeds we need to do away with rules. We need to be nonjudgmental. Rather than classifying our words and deeds as good and bad, it is helpful to look at them as being more or less effective toward reaching the goal which we hope to achieve. If we decide that certain things we said or did were ineffective in causing the desirable results, we may decide to behave differently at another time. The same may be true if what we said or did prevented us from reaching certain goals. For example, if we rush through the care for a certain patient and thereby missed some important symptoms the patient was demonstrating, we might want to take more time when we care for him again. By looking at words and deeds as being more or less effective in achieving our goals rather than being either good or bad, we may eliminate the need to feel guilty, thereby increasing our ability to accept ourselves, which in turn increases our ability to change.

I would like to emphasize again that by doing away with rules, we can learn to recognize and accept our feelings. Once we have accepted our feelings we can decide how we wish to respond to them. By accepting our behavior we can decide to behave differently and choose behavior that will be more effective in helping us reach desired goals. Accepting our feelings and behavior is part of total self acceptance.

Chapter III

Constructive or Destructive Involvement with Feelings

In the previous chapter I mentioned that our behavior could be effective or non-effective in enabling us to reach our goals. Whether or not our behavior is effective is related to how we are involved with our feelings.

We can be constructively or destructively involved with our feelings. Whether we are constructively or destructively involved with our feelings is important to our personal growth and development, since destructive involvement can stunt our growth and development while constructive involvement can promote our growth and development. There are several ways in which we can be destructively involved in our feelings. We may deny or ignore a particular feeling we are experiencing or we may justify, excuse, or explain it away. This frequently happens when we are concerned with how we *should* feel rather than with how we *do* feel. We may soothe or cover up a certain feeling with a destructive habit or ritual of some kind. For example, we may cover up our anxiety by smoking a cigarette or tapping a pencil. If the feeling is a very unpleasant one we may avoid all situations or thoughts which may arouse that particular feeling. This can be very incapacitating and therefore destructive. For example, if a nurse experiences anxiety whenever she speaks up in a meeting, she may tend then not to speak up in meetings to avoid feeling anxious. She is robbing herself of the experience of expressing herself in a group and robbing others of the benefit of her wisdom and experience. If comments are made to her about the fact that she never speaks in meetings, she may actually begin to avoid meetings altogether. This can lead to more and more incapacitating behavior and be very destructive indeed.

Rather than being destructively involved, we can be constructively involved with our feelings so that we grow and develop. Again,

acceptance is of the utmost importance. It is constructive to accept whatever we are feeling at a particular time and to stay with that feeling. We may hesitate to experience our feelings because they are unpleasant, as when we are afraid. We may think that we must brush these feelings aside before they get the better of us and take control of us entirely, but our feelings cannot harm us, neither do they last forever. Since feelings are not constant but flowing and ever changing, even an unpleasant feeling doesn't last forever. Often we are concerned about how we will behave if we allow ourselves to feel and use this as a reason not to feel. Our behavior is influenced by our feelings, but our feelings have a greater influence on our behavior when we aren't aware of them. Experiencing and accepting our feelings allows us to decide how we wish to react to them, thus we are in control of our behavior.

Having experienced our feelings, it is constructive to examine them. Feelings can be examined by very specifically describing what we felt, how this feeling was experienced, and exactly when we experienced it. If we then allow our thoughts to flow, we may recall a similar situation when we experienced very much the same feeling. If we find ourselves experiencing the same feelings every time a certain type of situation presents itself, we may begin to understand why. For example, a nurse was called into the supervisor's office. When she opened the door and saw the supervisor sitting behind her desk, the nurse experienced a strong feeling of anxiety. Later, in examining her feelings, she discovered that she is always anxious when she is to meet someone in a position of authority. She then recalled that in her student days, the only reason she was ever called to her instructor's office was for a reprimand. Since then she has always experienced anxiety in the presence of authority figures. In examining her anxiety, she recognized that she becomes anxious because she anticipates a reprimand. She realized that she responds to these situations as if she were a student and the person in authority was her nursing instructor. Recognizing and accepting the fact that this was no longer so, she was able to be more comfortable in the presence of authority figures. It is often true, as in this example, that we carry feelings and responses with us that were appropriate at one time and in one situation but are appropriate no longer. Once we understand why we experience certain unpleasant or destructive feelings in a particular situation, we may not experience these feelings again, even though we are in similar situations. Furthermore, when we understand why we experience the feeling that we do, we can control our reaction to it and decide how we wish to behave. A simple

example will demonstrate what I mean. Supposing a nurse experiences anxiety every time she cares for a patient using a kidney machine and recognizes that this is because she only vaguely understands why the machine is helpful and has no idea how it works or whether it is working properly. She might then decide to learn the purpose and function of the kidney machine and, having achieved this, is more confident in her ability to care for the patient. As her confidence in herself increases, her anxiety decreases. In fact, she may find that she enjoys caring for patients using the kidney machines. She has acted upon the cause of her anxiety and increased her knowledge and skill in the process.

I mentioned that we can be constructively involved in our feelings by accepting, experiencing, examining, and acting on them. We may find at times that we experience intense feelings which seem to be out of proportion to the situation, and any attempt to understand the basis for it fails. When this happens it is wise to seek help. Sometimes this help can come from a friend or co-worker, at other times we may need professional help. It is important to select this help carefully. We should be reasonably sure that the person we ask for help can either give us the help we need or direct us to someone else who can. I will comment further on this later.

The following example shows a nurse who was constructively involved with her feelings.

> It was Mrs. Lewis's experience that when she brought her concerns about the patients to Dr. Jones he would frequently make light of them. In a joking manner, he would respond with something like, "So you're worrying about something again," or "What would you do if you didn't have anything to worry about?" For some reason, the doctor's opinion of her was very important to Mrs. Lewis, and when he responded this way she became extremely anxious. She would push her feelings of anxiety away immediately and pretend that she had been joking all along. Then she would laugh and say, "You know me, always fussing about something." But it wasn't a joke! She *was* concerned about the things she tried to bring to the doctor's attention. When she realized that she was always being left to solve the problems by herself, she became very angry at herself and the doctor. Finally she decided she was going to do something about it. A few days later she once more approached the doctor to discuss a problem she was having with a patient. "Fretting and worrying again, are you?" joked the doctor.

> Anxiety rippled through her. She took a deep breath and resisted the temptation to joke back. Instead, she concentrated on her anxiety. An overwhelming sensation arose from her stomach, surging through her entire body, and she broke out in a cold sweat. Her stomach churned and for a second she thought she was going to vomit. Then slowly the feeling faded away. She was left with a great calmness. Her body relaxed. She looked at the doctor and said calmly, "Doctor, I'm concerned about this patient and I want you to listen to me." Then she proceeded to discuss the patient. When she finished, the doctor said, "I think I will go see him before I leave."

In this incident, the nurse accepted her feeling and stayed with it; she was constructively involved with her feeling. The nurse looked back on the occasion as a great learning experience in which she grew emotionally. She learned that she was able to endure her feeling of anxiety. One of the reasons she had pushed her feeling of anxiety away in earlier incidents was because she was afraid that she wouldn't be able to endure it. She also thought that the feeling wouldn't go away by itself and the only way to rid herself of it was to push it away. However, she learned by following the feeling through that it didn't last forever. She didn't know how long the feeling lasted and to her it seemed an eternity. On the other hand, the doctor made no indication that he was aware of a break in the conversation. Therefore, the nurse assumed it must have been a second or two. The nurse noticed that when she accepted and respected her feeling the doctor took her seriously and took steps to solve the problem. After this, it was easier for her to accept her feelings and stay with them in other situations. This is another indication of emotional growth.

One might agree that this incident demonstrated constructive involvement with her feelings if the patient's problem was a major one that the nurse *should* be concerned about. But what if it was something minor or if the nurse actually did fret and worry about insignificant things? Here we are again involved with rules concerning one's feelings and how one *should* feel. I purposely made no statement in the example as to whether or not the nurse actually tended to worry about insignificant events. It was merely mentioned that the doctor in a joking manner made these comments and the nurse jokingly agreed with him. The important point in this situation is that the nurse attempted to report to the doctor the items she thought needed to be brought to his attention. She was concerned. However, because of her feelings about herself and the doctor, she

denied her concern and pretended to feel the way the doctor saw her. She was being untrue to her real self. By her response to the doctor, she was saying that she wasn't really concerned about the items she brought to his attention and that she purposefully worried him about insignificant things for a laugh. If we repeatedly either directly or indirectly tell people that our opinions don't count and not to take us seriously, they are bound to believe us eventually and act accordingly. Even if this nurse tended to be concerned about trivialities, there certainly would be times when the things she brought to the doctor's attention were major and definitely needing his concern. There is a danger that these also would be passed off as insigificant. By pretending she was joking, this nurse missed the opportunity to sort out which problems and concerns she was capable of handling herself and which she needed to bring to the attention of the doctor. If the doctor had thought she was serious, he would have taught her how to handle some of the problems by herself, thus helping her to develop and increase her nursing skills. During the period when she was not able to accept her feelings and behavior, she was not learning or growing. Like a broken record, the same incident was repeated over and over again. However, once she accepted her feelings and behavior and decided to change her behavior she was able to move on.

Now I would like to cite an example in which the nurse was involved with her feelings destructively.

> Mr. Harkley had cancer of the lung. A lobotomy was performed but the cancer was too extensive to be completely removed. During his stay in hospital a fairly close relationship had developed between Mr. Harkley and Miss Hill, the nurse who had cared for him almost daily. However, they never discussed the fact that Mr. Harkley had cancer and that his prognosis was poor. As far as Miss Hill knew, he was not aware of his condition. Mr. Harkley recovered from surgery and went home. Some weeks later he was readmitted and, meanwhile, his doctor had informed him of his condition. When Miss Hill walked into his room on the day of his readmission, Mr. Harkley said, in an angry tone of voice, "Why didn't you tell me I had cancer and was going to die?" The nurse replied harshly, "Because you never asked me." After this incident, Miss Hill felt extremely guilty about the way she had treated the patient. She reprimanded herself severely. She told herself that she should have known how to answer the patient's question and had no business

placing the responsibility for her behavior on the patient's shoulders. She realized that the patient's question had put her on a spot and she defended herself by attacking him. She recognized the unfairness of her remark. She had not been free to tell the patient about his condition even if he had asked her because at this particular hospital the doctors decided what the patients were to be told about their condition. What could she have done?

Just how was Miss Hill destructively involved with her feelings? I think we need to start with the patient's first hospitalization. At that time, she failed to accept and own her feelings. She was aware of the patient's condition and was afraid that he might ask her about it. This fear placed somewhat of a strain on the relationship, and Miss Hill became destructively involved with her feelings. Rather than experiencing them and trying to understand them, she denied her feelings and tried to repress them. If she had experienced her feelings fully so that she was completely familiar with them she could have decided how she wished to act. We cannot say how, because different individuals would act differently, but by accepting and owning her feelings she would have been in a much better position to consider the possibilities she had to choose from.

This is a difficult but not uncommon situation for a nurse to find herself in. Many nurses have experienced it. Had Miss Hill accepted her feelings, it might have been helpful for her to discuss her feelings with other nurses who had had similar experiences or perhaps with the patient's doctor. She might have studied the literature on this subject. Then, when she had taken advantage of the help that was available, she could have decided for herself what she wished to do.

Is there anything Miss Hill can do now that she has been forced to examine her feelings by Mr. Harkley's question? Certainly there is. It is not too late for her to accept her feelings and if she is going to give Mr. Harkley the support and help he needs, it is imperative that she work through them and decide how she is going to behave. Reprimanding herself is a destructive way of being involved with her feelings and it leads to denial and distortion. It is important for Miss Hill to forgive herself for the harm she has done and make amends if possible.

We all do harm to our patients at times and sometimes it is too late to make amends by the time we recognize what we have done. It is important to forgive ourselves and to go on from there. If it is too

late for one particular patient, we must remember that there will be other patients. By accepting and owning our feelings and behavior, we can learn and go on to develop our skills so that we will be more capable of meeting our future patients' needs. Unless we accept and act on our feelings we will tend to treat similar patients and similar situations in a similar manner regardless of how destructive this may be.

In conclusion, then, to be constructively involved in our feelings it is important to accept and experience them. When we accept and experience our feelings we are in the best position to act wisely on them. By tuning in on ourself, we can decide what is the "right" action for us personally to take and we can carry the responsibility for that action. I think Harry Overstreet clearly describes a desirable and healthy relationship with oneself. He states, "a genuine self-acceptance makes the individual feel, with new serenity! Well I am at least what I am. I may not set the world on fire. But I can be myself and see what comes of it."[1]

Earlier, I mentioned that it might be necessary at times to seek professional help to sort out our thoughts and feelings. This help needs to be selected with care. If you do not know anyone in this field, you may need assistance in selecting professional help. You can ask other professional people whom they would contact if they needed help and the reasons for their selection. If you know someone who has received help and you are aware of the personal growth this person has experienced, ask that person for the name of their helper. The following are some of the characteristics that are necessary in a helper: has an acceptance of you as a unique and responsible individual; feels comfortable within himself so that he will not be threatened by any material that you wish to discuss; is a good listener; expresses himself in an honest and open manner; demonstrates the ability to understand; and has the ability to help you with problem solving.

When you are in the care of a professional helper, you can expect to start feeling better after a reasonable amount of time. What a reasonable amount of time is can be difficult to define because it depends somewhat on the seriousness of your problems. However, much can be accomplished in six to ten hourly sessions. At no time should you feel worse about yourself and your worth as an individual. If you do not experience positive results from the help you are receiving, you may wish to discuss this with the helper. Any

[1] Harry and Bonora Overstreet, *The Mind Alive* (New York: W.W. Norton & Co., 1956), p. 67.

unwillingness on his part to discuss this would be an indication that your selection has been unwise and you need to seek help from another person. When you need professional help, accept the responsibility for your own emotional disturbance and take the active steps necessary to obtain the help that you need.

RELATIONSHIP WITH PATIENTS

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Chapter IV

Accepting our Patient

Many things that I have said about accepting oneself can be applied to accepting our patient. Accepting our patient means that we recognize our patient as a unique individual, who feels the way he feels, says the things he says, behaves the way he behaves, and is the way he is.

By spending time with our patient, listening to him, talking with him, and interacting with him in various situations, we can begin to know and understand him. We can hear what he says, see what he does, and listen to him tell us how he feels. There are times when instead of accepting the patient and the patient's behavior, we excuse or overlook it. We may excuse or overlook the patient's behavior by the comment, "This really isn't the way he is." But if this really isn't the way he is, then why is he that way? The fact of the matter is that in this particular situation, with everything that is involved in it, the patient responds in a distinct manner; therefore, this is the way he is. At other times the patient's behavior is excused or overlooked by the comment, "He didn't really mean it that way." Then we proceed to change and distort what the patient said or did to suit us so that we can accept the person and ourselves. As a last resort, everything can be made right by labelling the patients as demanding, hostile, immature, good, childish, or unco-operative. Feeling smug and secure because the patient is labelled, and having fooled ourselves into believing that we understand him, we go about our business. But we haven't accepted him. For example, take the well-known type of patient who we call the "demanding" patient. This is the patient who constantly has his light on or rings his call bell when the nurse is out of the room. When the nurse is in the room there is always one more thing he wants before he will be satisfied. The new, young nurse tries her best to please this patient and works

hard getting this for him and doing that for him. She answers his light as soon as possible. But the more experienced nurses may smile maternally at her and say to themselves, "How sweet, but she'll learn." Often by the time this nurse has another year of experience she "has learned." She has learned to leave "the demanding patient" immediately after completing the tasks she came to do; she has learned to ignore his light for as long as possible; she has learned and understands that this is a "demanding" patient. The older nurses may be pleased to note that she has "matured," yet somewhere deep within themselves there is a nagging feeling that the young nurse has lost something worthwhile in the process.

The above example is given to demonstrate how we attempt to make patients more acceptable to us or, at least, easier to tolerate if we can't accept them. We are deceiving ourselves if we think we are accepting our patients by labelling them and then reacting in a set pattern to that label. Instead, we are being dishonest, judgemental, and non-accepting.

Let's look at five examples of non-acceptance and the various ways in which the nurse reacts toward her non-acceptance. In the first example, the nurse excuses the patient's behavior.

> Mrs. Nickel reported that she had gone up to Mr. Jones, a patient, and said, "Mr. Jones, will you please help me get some supplies from the occupational therapy department?" Mr. Jones pounded his fist on the table and said, "Get your own d--- supplies, I'm not your d--- slave." On relating this incident, Mrs. Nickel said, "I felt that the patient's hostility wasn't directed at me; so it didn't upset me. I didn't say anything further but went for the supplies alone."

It isn't clear to me how Mrs. Nickel knew that the patient's hostility wasn't directed at her. She had asked the patient to do something which he didn't want to do and he told her so in no uncertain terms. If the patient's hostility wasn't directed toward the nurse, who was it directed toward? Perhaps it is understandable that the nurse wouldn't be upset at hostility which was not directed at her. But how would she react if she thought the hostility of the patient was directed at her? Could it be that Mrs. Nickel excused the patient's behavior and distorted the situation so that she could feel comfortable about herself and the patient? To help us look at this incident in a positive way, let's rewrite it without any explanations or excuses.

> Mrs. Nickel walked into Mr. Jones's room and asked, "Mr. Jones, will you please help me get the supplies for occupational therapy?" Mr. Jones banged his fist on the table and said, "You can get your own d--- supplies. I'm not your d--- slave." The nurse said nothing and went after the supplies by herself.

There are many things in this incident that aren't clear. To learn from this incident, it could benefit the nurse to clarify these issues. First of all, it could be helpful to know her purpose in inviting Mr. Jones to help get supplies. Was it merely a friendly gesture? Or was it an attempt to develop a closer relationship with Mr. Jones? Or was it because she didn't want to do the work herself? Secondly, it could be helpful if the nurse identified her feelings. How did she feel about herself and Mr. Jones when she extended the invitation? Was there any change in her feelings toward herself and the patient after he turned down her invitation? Why didn't she feel it necessary to respond verbally to his remarks? Finally, it could be helpful if the nurse would check out with the patient why he responded in this manner and why did he think it necessary to inform her that he wasn't her slave. Seeking answers to these questions might result in the nurse learning more about herself and about her patient. This increased knowledge and understanding could lead to a greater acceptance of herself and her patient and a more therapeutic nurse-patient relationship.

My second example of non-acceptance involves a nurse who has set up in her own mind particular standards of behavior to be met by a specific category of patients.

> Miss Badger, a patient and also a nurse with four years psychiatric nursing experience, was suffering from a depression and was being treated on a psychiatric ward. She remained in her room and refused repeated invitations from her nurse to come to the lounge and join the other patients. Her reponses to the invitations were, "Why should I be with the other patients in the lounge when I would rather stay in my room?" When the nurse, Miss Fost, was asked by her team leader, why the patient remained in her room, she replied, "Oh, she is just being unco-operative." "Why do you say that she's unco-operative?" asked the team leader. Miss Fost replied, "As a nurse, she knows how important it is to socialize with the other patients, but she refuses to come out of her room."

Thus the patient is neatly labelled as unco-operative and the nurse's work is done. We will answer the team leader's question for the nurse. The patient remains in her room because, according to her own statement, she sees no reason to be in the lounge with the other patients when she would rather stay in her room. It's as simple as that. If the nurse wishes to improve her nursing care for this patient, it would be beneficial for her to examine her feelings. How does she feel about having a psychiatric nurse for a patient? How do her expectations of this patient differ from that of other patients? When she describes a patient as unco-operative, how does this effect her relationship with the patient and how does this influence her nursing care? (A young nurse very aptly defined an unco-operative patient as "a patient who doesn't do what I want him to do.") Furthermore, it could be helpful if the nurse attempted to understand the patient's feelings. What is it about her room that causes the patient to prefer to stay there? What is it about the lounge or other patients in the lounge that causes the patient to feel she would rather not be there? It is likely that the patient knew the answers to these questions and would be willing to tell the nurse if she sensed that the nurse was sincerely interested in knowing.

In my third example of non-acceptance, the nurse distorts reality so that she is able to accept both herself and the patient.

> Mrs. Hillcox was very much interested in helping her patient Miss Price get well. Miss Price was a young woman in her second year at University who had frequent fainting spells and was rude to everyone that she encountered, making sarcastic comments to both staff and patients. Often she would hurt herself by nicking her skin with a knife or burning herself with her cigarette. A puzzled co-worker asked Mrs. Hillcox, "Why do you like this patient?" Mrs. Hillcox replied, "I like her because I know that she really isn't like this." Her co-worker somewhat sarcastically replied, "Well, she certainly had me fooled."

The fact of the matter is that the patient is like this; her behavior indicates it. There are two facts that this nurse had difficulty accepting simultaneously. First of all, that the patient is the way she is and behaves the way she behaves. Secondly, that she likes the patient and wants to help her get well. The nurse can accept these facts separately; therefore, the nurse finds it necessary to explain or excuse either herself or the patient. She can accept that the patient isn't this way and she likes her. She can also accept that the patient is

this way and she doesn't like her. In this example, the nurse chose to excuse the patient and convinced herself that the patient wasn't really the way she was.

When we judge patients by the standards we have set for ourselves, we are non-accepting as the following incident demonstrates.

> Miss Manden was sent to check on a patient who was reported to be upset and crying. The patient, Miss Smith, was an eighteen-year-old unmarried girl who had given birth to two children, both of whom had been put up for adoption. Now she was in the hospital because of the spontaneous abortion of her third pregnancy. When the nurse returned from her visit to the patient, she said to the head nurse, "Miss Smith is acting like a baby. She is crying and upsetting the others in the room. I can't get her to stop." The head nurse asked, "What is she crying about?" Miss Manden replied, "I don't know. She won't say. She just says that she's upset because she lost her baby. But I know that isn't it."

Here again, the nurse was unable to accept the patient. She was unable to accept the fact that the patient was upset because she had aborted. To do so the nurse might have to examine and perhaps change her own feelings, ideas, and attitudes about sexual activities, motherhood, and the way this young girl conducted her life. But by calling the patient a liar, none of this was necessary. The nurse had thereby lost an opportunity to accept and understand her patient as well as an opportunity for her own personal growth.

The final example of non-acceptance describes a situation in which the nurse accepts the patient on certain conditions. Conditional acceptance is non-acceptance.

> Miss Charles reported at a conference that her patient Miss Black had stated that she felt she was a homosexual. One of the other workers said, "Well, Miss Black does have some of the characteristics of a homosexual. Maybe she is one." Miss Charles stamped her foot and shouted, "I won't believe it."

The nurse accepted this patient only on condition that she wasn't homosexual. In caring for this patient, the nurse attempted to gather information and evidence that the patient was not homosexual and point this out to the patient. Due to this lack of acceptance by the

nurse of herself and the patient, the nurse missed the important message of this communication, namely, that the patient *felt* as if she was homosexual. Whether she was or wasn't homosexual was not upsetting to the patient, but what was upsetting her was that she *felt* as if she was homosexual. Fortunately, this nurse recognized that she wasn't giving the patient the care she needed. To improve her care the nurse decided to examine her own behavior for clues. She learned that she had definite ideas about female homosexuals and about how another female *should* feel toward them. The feelings she had toward her patient were not acceptable to her if the patient was homosexual. Therefore, it was extremely important to her that the patient be heterosexual. Her ideas had such a strong hold on her that to entertain the thought, even briefly, that possibly the patient was homosexual was extremely threatening to her.

I have given several examples in which the nurse did not accept her patients. Now I would like to give two examples in which the nurse did accept the patient. In the first example, the nurse accepts both the patient and her behavior.

> When Mrs. Rogers came to work one morning, it was reported that her patient Mrs. Watts had been very upset the previous evening. She had torn her bed sheets, thrown her belongings around the room, and insulted her roommate so severely that her roommate had left the room in tears. The patient had behaved in a similar manner several times before. Mrs. Rogers was at a loss as to what to do for the patient but she went to see her immediately after hearing the report. "Mrs. Watts," she said, "it was reported to me that you were very upset last night." The patient, with tears in her eyes, looked at the nurse and said, "Nurse, why do I behave like this?" Mrs. Rogers replied, "I don't know, Mrs. Watts, I don't understand it. But I would like to understand and perhaps if we talk about it we could find out."

In this example, the nurse accepted herself and her feelings of inadequacy. She accepted the patient, her feelings, and her behavior, even though none of it made sense to her. Therefore, they were able to work together.

The second example of acceptance describes a situation in which the nurse, a man this time, accepts his patient and her feelings as she describes them.

> Judy, a young female patient, who from early childhood had

had many traumatic experiences with men, was very frightened of close relationships with them. If a male nurse indicated that he cared about her and wanted her to get well, she would soon point out to him that she didn't really think of him as a male but more as an "it." Many male nurses had responded to this by stating that they were males and she needed to recognize and accept this fact. The discussion usually ended up with an angry patient and an upset staff member. Mr. Ivan had worked with Judy for some time. One day she said to him, "You know, I like you but I don't think of you as a man, you seem to me more like an it." Mr. Ivan's nonchalant reply was, "Well, none of us are perfect."

This statement was rather ambiguous, but he did indicate that as far as he was concerned she could think of him in any way she wished and if she saw him as an "it" he wasn't about to get in a flap about it. The patient then went on to another topic of conversation.

I have given several examples in which I believe the patients were not accepted by the nurse and two examples in which I believe that the patients were accepted by the nurse. You may note that in the examples where nurses did not accept the patients there were also indications of a lack of self acceptance. This is frequently the case. A useful question to ask when we wonder whether we are accepting out patients is "Am I accepting myself in this situation?" It is also a helpful question to ask when there are conflicts between the nurse and her patients. Often a lack of self acceptance on the part of the nurse causes interpersonal conflicts between her and her patients.

To be able to accept others, I believe, it is necessary for the nurse to be self accepting. When the nurse is able to accept that this is what she felt, said, and did in a particular situation without judging or excusing, *only* then is she able to accept the patient. She is able to accept, without judging or excusing, that this is what the patient felt, said, or did in a particular situation. This will help her to look at the situation objectively. When a nurse can look at a situation objectively, she is better able to understand herself and her patient and plan more effective nursing care.

I believe a "patient-accepting" nurse has a basic trust in her patient. She believes in the "basic okayness" of her patient. She has faith in her patient and in her patient's body to use his healing powers to their fullest capacity. She trusts her patient to work with her toward their common goal—the goal of restoring the patient's

health or, if this is impossible, then to make life and this particular experience as meaningful as possible. Secondly, she sees her patient as a unique individual. He is different from any other patient or person she has ever known. On the other hand, he is very similar to herself and others. She recognizes her patient as a growing, developing, changing human being with a basic sameness which doesn't change. In other words, most of the things that a self-accepting nurse recognizes and respects in herself, she recognizes and respects in her patient. (See Chapter I on self accepting.) Furthermore, she respects her patient's frame of reference and the way he views life which often is very different from her frame of reference and the way she views life. Because of this difference, the patient's behavior may often appear senseless. But she knows that if it were possible to see things from the patient's point of view, his behavior would make sense. Finally, a "patient-accepting" nurse recognizes and appreciates the benefits she personally derives from caring for her patients. It is through caring for her patients that she learns and develops her nursing skills. The more difficult and unique the needs of the patient and the care he requires, the greater the opportunity to develop special nursing skills. Since the nurse recognizes and accepts the benefits she derives from caring for her patients, she doesn't demand or expect that the patient be grateful to her for the care she gives. But rather, she appreciates the opportunity to care for him.

Chapter V

Caring

Perhaps there are some nurses who don't care about their patients. But I believe that the nurse who gives the impression that she doesn't care is wearing a protective armor. She may relate to her patient in a careless, rude, and cold manner, thus giving the impression that she doesn't care, but this may be her way of covering up her personal feelings because she is unable to handle them. These may be feelings of anger, hopelessness, fear, inadequacy, or any one of the wide range of feelings that a human being is capable of feeling. If a nurse thinks that she as a nurse *shouldn't* feel this way in this particular situation or toward this particular patient, it will be difficult for her to recognize and accept her feelings. Therefore, she may lock her feelings away and put on an armor of indifference and non-caring.

Time and time again, I am impressed with the care and concern that nurses have for their patients. They want their patients to be comfortable and free from pain and worry. They want their patients to recover from their illnesses and they are interested in their welfare. But does the patient receive the message that the nurse cares about him? Frequently he does but there are far too many times when he doesn't.

The question now arises of how can we send the message to our patient that we care about him and be reasonably sure that the message reaches him? There are several steps involved here. First of all, there is the feeling on the part of the nurse—the nurse cares about the patient. Secondly, the message must be sent to the patient. Thirdly, the message needs to reach the patient. Finally, the patient must accept the message. Things can go amiss at any of these steps. If the nurse does not care about the patient, then naturally the other steps cannot follow. However, once we have established that we do care about our patient, there are several ways we can send this message.

The most obvious way to convey to our patient that we care is the verbal one, merely telling the patient, "I care about you," "I'm concerned about you," or "I want you to get well." Sincere statements such as, "I'll be thinking about you," "Have a good night's sleep," or "How did your day go?" all convey care and concern. It seems to me that we often hesitate to use the verbal route of saying, "I care." We reason that if we care about our patients then our actions will show this and words aren't necessary. Or we insist that actions speak louder than words, therefore, if our actions don't indicate that we care about our patient then our words won't convey the message. I agree that words falsely spoken very seldom can cover up for lack of feelings and this often does nothing more than confuse the patient. However, if the feelings are there and our behavior is in keeping with our feelings, then a verbal commitment is meaningful. It is one of the best ways to ensure that the message reaches the patient. But we may shy away from the verbal route because we are afraid of the reaction of the patient. The fact that we don't know how the patient will react or whether he will accept our message can be frightening. When we verbally commit ourselves we are open to our patient and in a vulnerable position. The patient is free to accept or rebuff our caring. To be rebuffed when we are being open and honest can be very painful. Therefore, I wonder whether perhaps our main reason for not using this method often is an attempt to protect ourselves from hurt. If we use a more subtle route and the patient is unable to accept or unwilling to accept our caring, his rebuff need not be that open and is easier to ignore. It is important to realize that a rebuff does not detract from our caring or make our caring futile. The patient is a person in his own right and it is his responsibility to react to the message as he wishes. It is worthwhile for each of us to examine why we use this method so seldom. When we understand ourselves in this respect then we can decide whether or not we wish to use it more often in the future.

The most common and possibly the easiest way to convey to our patient that we care about him is by meeting his physical needs. Such activities as bathing, feeding, changing soiled linen, and changing dressings is an important and effective method of conveying our care and concern to our patient. A good back rub to a bedridden, tired patient can do much more than relax tired muscles. It can say "I care about you." We can emphasize that we care about our patient by trying to meet his physical needs as an individual. This can be done by knowing specific facts about our patient and adjusting routine nursing procedures to meet his individual needs. Some of the

things we might know are, for example, what relieves his pain, what helps him sleep, and what makes it easier for him to void? It is important to remember that basic nursing skills which have become routine for us may be a unique and possibly frightening experience for the patient. Many times I have seen a nurse with gray hair and thirty years of experience behind her patiently and kindly explain a common procedure to her patient. Her manner and tone of voice indicate that this message is specifically for this patient as she says, "take a deep breath," when giving an injection or inserting a catheter. Then there are other nurses who give no explanation or give one in such a monotonous and bored tone of voice that she sounds like a recording. A nurse who can give individual care is a caring nurse. By meeting the physical needs of the patient willingly, cheerfully, and well, we say to our patient, "I care about you."

Another way of indicating that we care is by accepting and believing what the patient tells us without twisting, distorting, or analyzing his words and statements. We may not view things in the same way as the patient and since he is speaking from his frame of reference, it may seem to us that the patient is lying, but accepting and believing what the patient says indicates, "I care about you." Once this message has been sent, we may want to clarify some issues by asking the patient to enlarge on what he is saying or give the patient certain facts that he doesn't have which may then change his viewpoint. Perhaps there will be times when we might wish to explain the situation from our point of view after we have accepted and understood his. This may aid both our patient and ourselves to see a certain situation more clearly and perhaps differently. One may want to argue that there are times when a patient deliberately lies. This could be true. As far as I am concerned, however, that is the patient's responsibility, not mine. Who am I to judge? I think it is wisest to give the patient the benefit of the doubt. To point out to the patient that I think he is lying encourages him to hold on to his lie. On the other hand, accepting what he says can actually encourage the patient to be truthful. The following example involves a nurse who by failing to believe her patient missed an opportunity to express her care for her patient.

> Mrs. Kitt, a patient who was about to be discharged from the psychiatric unit, was given an afternoon pass to look for a job. When she returned to the hospital, her nurse, Mrs. Driver, asked how things had gone. Mrs. Kitt informed her nurse that she had sat in a restaurant all afternoon drinking coffee. When questioned

further she said, "Oh, I can't get a job. No one will hire me when they find out that I've been in here." Mrs. Driver replied, "That isn't true. You just don't want to work."

If the nurse had accepted what the patient had said, it would have been easier for the patient to examine her feelings and fears. Instead, the patient was encouraged to keep her feelings and fears to herself and repress them if possible. One might question why the nurse was so quick to deny the patient's statement and interpret the patient's behavior. Does the nurse have some strong feelings about people who have suffered from psychiatric disorders? Are these feelings so frightening to her that she is unable to accept and examine them? Does the nurse possibly have mixed feelings about whether or not she wants to work? Does she have particularly strong negative feelings toward this patient and hasn't recognized or accepted them? I don't know. However, I do know that it is easy to project our own feelings and attitudes on to others. If we find ourselves frequently explaining or labelling our patients' motives, it might be advantageous to examine our feelings and motives in that particular situation.

Accepting what the patient says includes the feelings as expressed by the patient. For example, a patient who is scheduled for minor surgery is experiencing anxiety and to us the anxiety is out of proportion to the situation. We need to remember that the anxiety that the patient is experiencing is not caused by the situation as it is or by the situation as we see it but rather by the situation as he sees it. Accepting the feelings which the patient is experiencing and conveying to the patient that it is all right to feel what he feels means, "I care about you."

A further way to express our care and concern for our patient is to make a sincere effort to see things from his point of view. To be able to see a situation from another's point of view or frame of reference is sometimes called empathy. We put ourselves in the other's shoes but at the same time realize that we are in another's shoes and not our own. By putting ourselves in the patient's shoes we can experience the situation as he experiences it while being fully aware of the fact that it is the patient's experience that we are involved in. This is different from identifying with the patient. If we identify with the patient, we experience the situation that the patient is experiencing as if it were our own experience. Seeing a situation from our patient's point of view is sometimes very difficult to do and especially in common everyday activities. For example, a patient, day after day, refused to take a tub bath. He was soon labelled as being un-

co-operative and having poor personal hygiene habits. Then one day a nurse took the time to try to find out just why he would not bathe. The patient, now sixty-five years old, had lived by himself since his teens in a small cabin in the woods. He had always bathed in the creek. He was completely unfamiliar with bath tubs and saw them as potentially dangerous. When the nurse volunteered to stay with him, he consented to taking a bath. To be able to see the situation from the patient's point of view, we need a good understanding of the patient as a unique individual. We also need to accept ourselves as an individual separate from the patient. A sincere effort on our part to understand the patient and see the situation from his frame of reference indicates to the patient, "I care about you." In the following example, the nurses were unable to see the situation from the patient's point of view.

> Mrs. Crosslind frequently collapsed on the floor in the lounge whenever there were several people around. She would roll around on the floor, her body going through convulsive-like movements. Her eyes would open briefly and look directly at the nurse. This behavior continued until the nurse would firmly command her to stop and get up on her feet. Many of the staff members felt antagonistic toward the patient. They voiced the opinion that this outrageous behavior was uncalled for and the patient should be forced to discontinue it.

Let's try to see this situation from the patient's point of view and put ourselves in the patient's shoes. Imagine yourself fully conscious of what you are doing. You are standing in a room with ten or twelve people. Suddenly you fall to the floor, moaning and groaning loudly while rolling from side to side. Can you visualize it? Most likely not. Your response might be that you wouldn't think of behaving in that way because you would feel like a fool. If any of us could get ourselves to behave in this manner, chances are that we would feel like a fool. In our society, we tend to shy away from making a spectacle or fool of ourselves. Therefore, it would be very difficult for any of us to consciously behave in this manner. However, in this situation we have an adult woman who did just that. She put herself in a position which would be extremely embarrassing to most of us. She left herself wide open for the criticism and nasty remarks she received from some of the staff members. Yet she chose this method to call for help. Surely her need must have been great. Should her call for help go unheeded? Are you able to place yourself in this patient's shoes?

Do you sense her desperation? If you can, I doubt that you would feel antagonistic toward her but, more likely, you would feel concerned for her. Whenever we have difficulty understanding and empathizing with a patient and find that we are annoyed or angered by the patient's behavior, I suggest that we try the above exercise. It may give us some inkling of what the patient is experiencing and feeling. Then by checking out our conclusions with the patient, we can validate whether we actually do understand. Another thing which we can do when we have difficulty in seeing the situation from the patient's point of view is to search for sense. We could ask ourselves, how would what the patient is saying or doing make sense, always keeping in mind that if we saw the situation from the patient's point of view, it would make sense. It is possible that even after making a sincere effort to understand, the patient's behavior still doesn't make sense to us. If so, rather than condemn him, we can always give him the benefit of the doubt by accepting the responsibility for our inability to understand.

We can also convey to our patients that we care about them if we recognize and comment on our patient's improvement and progress. Progress and improvement are relative. What may be progress for one patient may be regression for another. Walking once around the bed is progress for the patient who has been confined to his bed for many days. On the other hand, it is regression for the patient who has been walking up and down the corridor every day. For the mute patient to say, "Good morning, nurse," is a remarkable improvement. For another patient, it may merely be a habit. For a patient who has a low threshold of pain it is a greater achievement to tolerate and accept pain without complaining than for one who has a higher threshold. We know that it is uncomfortable to walk around after undergoing abdominal surgery. Yet, some patients do so with very little, if any, complaining; while others complain loud and long and some might even refuse to try. We might see the behavior of the complaining patient as extremely childish and reprimand him for it. But it isn't our duty to judge and condemn but rather to meet the patient's needs. Always remember that if we were in his shoes and were experiencing the situation exactly as he is, we would more than likely behave in precisely the same manner. By accepting the patient's behavior and recognizing any progress he makes, we are able to help him progress and improve more rapidly. The more willing we are to accept the patient as a unique individual and not just another patient, the easier it will be to note his subtle but important improvements. Recognizing the

improvements that our patient is making and delighting in them can convey to the patient the message, "I care enough about you to notice and appreciate your progress." In the following example the subtle improvement made by the patient could easily be overlooked.

> Miss Thomas's forearms were covered with small, round burns caused by the tip of a lighted cigarette. These burns were self-inflicted by this very hostile patient. One day she gave her cigarettes and matches to her nurse, with the comment, "Please keep these from me. I don't want to burn myself any more." Then she returned to her room, pulled her bedding apart, threw her things around the room, and broke a leg of a chair.

The latter behavior certainly is not socially acceptable and for most of us would show a regression in our behavior. However, for this particular patient, it was an improvement. How much healthier, even though somewhat more expensive, to take one's hostility out on inanimate objects such as the furniture rather than on oneself. However, unless we understand the patient and care about her, it is very easy to overlook these improvements. Then rather than encouraging the patient we may show disapproval and anger and thus encourage her to regress back to her former behavior.

Yet another way to convey to our patient that we care is by referring to earlier conversations or experiences which we have had together. For example, "Yesterday you stated that you were having severe pain in your back. How is your back today?" We could note changes in the patient's behavior; for example, "You seem very quiet today, I wonder if something is puzzling you?" These types of observations and comments indicate that you see and treat the patient as an individual and that the information he has given you is important to his care. In this way we can say to our patient, "I care about you."

One more way of conveying to the patient that we care about him is to give him information about his care and condition. How much and what type of information we give our patient depends on the patient as an individual. How much information does he need? What type of information does he need? How much and what type of information can he handle? Usually there are many people involved in different aspects of the patient's care. All these people may give the patient some information, making it difficult to know just exactly what the patient knows. Receiving bits and pieces of information may be very confusing to the patient and could leave him

misinformed. Usually, we, as nurses, are in the best position to help clarify things for him. We can get an idea what the patient knows by asking a general question, such as, "Is there anything about your care or condition that puzzles you?" This will give us the opportunity to tie up loose ends and clarify information which the patient has misunderstood. Knowing certain facts can often relieve the patient of anxiety. For instance, if he knows that the medication he is taking could cause him to feel dizzy, then if he becomes dizzy, he knows the cause of his dizziness. He need not worry that he is getting worse or wonder what is happening to him. Sometimes, there are symptoms that come with certain conditions and leave with it, although the symptom has not specifically been treated. For example, a degree of depression often accompanies certain conditions. If the patient knows this, then he is better able to accept his depression for what it is, namely, a part of his illness. Giving the patient the information he needs leads to a further step, that of allowing him to assume some responsibility for his care. For instance, if the patient understands the need for recording fluids taken in and fluids put out, then perhaps he can take the responsibility for recording this or reminding the staff to do so. But if the patient doesn't understand the importance of this aspect of his care, it is rather unlikely that he will carry any responsibility for it. Allowing the patient to carry as much responsibility for his care as he is able is a way of saying to the patient, "I care about you."

A very important and effective way to convey caring is by being a good listener. We are not automatically good listeners. If we wish to be good listeners, we need to develop the skill of listening. By being a good listener, we encourage our patients to talk freely. A patient who has a problem may try to talk to the nurse, but it can be very threatening to him and his problem may become more serious if the nurse doesn't listen. However, if the nurse is an attentive and sympathetic listener, the patient may be able to reveal deep fears and concerns. A good listener can also be used as a sounding board by the patient and in this way the patient may be helped to find a solution to his problems.

If we want to learn to be good listeners, we need to rid ourselves of poor listening habits. Some poor listening habits are faking attention, quickly dismissing a subject as unimportant, and avoiding difficult listening. By faking attention we may fool ourselves into believing that we are listening but the patients are very seldom fooled. Some patients need to talk about seemingly insignificant material before getting to the main topic. Or it may seem insignifi-

cant to us because we don't understand the importance of what the patient is saying. Others may be testing us to see whether we are really listening. Examples of difficult listening might be to listen to a patient who talks with a heavy accent, one who is a slow or hesitant speaker, or one who speaks in a shaky or low voice. It takes an extra effort and concentration on our part to listen to these patients.

In being good listeners, we are taking certain risks. For example, by listening to a patient's problems and ideas, our own ideas may be challenged. We may realize that some of our ideas aren't sensible or logical and need changing. Furthermore, listening to the patient talk about his problems may bring to mind some of our own problems which we haven't solved. Or the patient may bring up problems and ideas which we would rather not hear or think about, such as his fear of dying. Furthermore, what the patient tells us may require action on our part, thereby adding another task to our full schedule.

What is a good listener? I think the following are characteristics of a good listener. A good listener takes time to listen. She is attentive and hears what the patient says and what he doesn't say. She is alert to nonverbal as well as verbal communications. She refrains from probing for additional facts or information. She has faith in the ability of the talker to solve his own problems. While the patient is talking, she listens to what he is saying rather than preparing what she is going to say. She accepts what the person is saying rather than agreeing or disagreeing with what he is saying. She refrains from reassuring the patient until she understands clearly what he is saying. She tries to understand how the patient is feeling about what he is saying instead of trying to explain his feelings to him. Listening is a skill, a skill which must be developed and used if we are going to be good listeners.

When the topic of listening to patients is discussed, a comment that nurses occasionally make is that they don't have time to listen to their patients. Certainly we nurses are very busy and often don't have time to sit down with our patients. But I don't think this necessarily means that we never have time to listen. Sometimes it's a matter of recognizing opportunities for listening. We can listen during such activities as giving baths, making beds, walking with the patient, or meeting other physical needs. It may be necessary to let the patient know that we are listening even though we are busy doing something. It may also be necessary to indicate to the patient that we are prepared to listen. There are times when we may be aware that the patient wishes to talk but we don't have the time at that moment

to listen. If that is the situation, we can either tell the patient when we will be back to listen or make a point of bringing up the subject at a later time. For example, we could say, "Yesterday, you mentioned that your mother was in the hospital last year. I wasn't able to stay to hear about it. Now while I am giving you your bath, I would like to hear about it if you wish to discuss it."

The following experience was related to me by one of my students who I will call Gloria. Gloria was rushing through a hospital unit on the way to her own unit where an emergency situation awaited her. She noticed a patient who was obviously distressed. As Gloria passed her bed the patient said, "What am I going to do? I don't know what I can do?" Gloria was torn between the urgency of the situation awaiting her in her unit and the obvious need of this patient to talk. So she said as she walked on, "I know you need to talk but I can't stay to listen. I am off duty at three and will come to see you at that time." When her work was finished, Gloria went to this patient and said that she had time to listen. The patient took her hand and said, "Oh, thank you nurse, you were so kind this morning that I was able to work out my problem by myself."

What a delightful experience, and it has important implications for nurses. If identifying the need and indicating that we care can give some patients the strength to solve their own problems then certainly there is no reason why we can't do this regardless of how busy we may be.

It is to our advantage as nurses to be good listeners. Careful listening can help us keep quiet rather than sounding off foolishly. We can learn by listening and this in turn can help us create new ideas. Furthermore, we can gather much information while listening. We can learn about the patient and his condition. We may hear ideas which are different from ours. This will give us an opportunity to evaluate and develop our own knowledge and ideas. Finally, by being a good listener we can use our time more wisely by giving more personalized nursing care. Nursing and medical problems are sometimes prevented by a nurse who is a good listener. A good listener conveys to the patient, "I care about you."

I have mentioned many ways which we can use to convey to the patient that we care about them. There may be other ways we can increase our skills in conveying that we care by looking at ourselves and how we recognize when someone cares about us. We can use these same methods to send the message to our patients. Therefore, if we understand how we receive messages from others, it can help

us in selecting methods to convey to our patient that we care. Once the message has been sent, then it is necessary that the message reaches the patient. By trying different methods, with individual patients, I think we can assume that the message will reach him. Once the message has reached the patient, then the next step is that the patient receive the message. This I see as the patient's responsibility. How he responds to the message greatly depends on him as an individual. I don't think the nurse can do or need do much about this. Once we send the message, the responsibility of reacting to it belongs to the patient.

The nurse is in a unique position to express her care for her patient. She has the opportunity to interact with her patient at different times of the day in a variety of situations. This allows the nurse to express to the patient in many different ways, "I care about you."

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Chapter VI

Patients' Feelings

In an earlier chapter, I discussed accepting and understanding our own feelings. In this chapter, I will discuss accepting and understanding the patients' feelings. I will also discuss ways in which we as nurses can help patients accept and understand their feelings and be constructively involved with them.

A nurse can either encourage or discourage a patient to be constructively involved with their own feelings. If a patient was cared for by a nurse who accepted him and his feelings and encouraged him to talk about them, she would be helping her patient himself to be constructively involved with his feelings. Then this experience could be a positive experience for the patient. In spite of the pain and discomfort, the patient may look back on his hospital stay as a meaningful experience. However, a patient that is cared for by a nurse who doesn't accept or understand his feelings but rather encourages him to repress or distort them would be helping her patient to be destructively involved with his feelings. Then this experience could be a negative experience for the patient. Along with the pain and discomfort, the patient may look back on his hospital stay as a destructive experience.

I mentioned earlier that to convey feelings through words leaves something to be desired since feelings can't be seen or visually examined. How do we know that if the patient says that he is afraid that he is experiencing the exact same sensations that we do when we say that we are afraid? We don't know for sure. This is very important to remember when the patients talk to us about their feelings. At times, we may find that we cannot understand why under the circumstances a patient feels a particular way. One reason we don't understand could be that if we were experiencing the particular feeling that the patient is experiencing, we would label it differently.

We can never completely understand what the patient is experiencing.

At times these misunderstandings can be clarified by asking the patient to enlarge on what he is feeling. However, if we can't understand, this lack of understanding need not be destructive to our relationship with our patient. By conveying to our patient that we accept him and his feelings even though we don't understand may improve our relationship. But pretending we understand when we don't can be destructive since the patient may sense the falseness of our statements or our behavior may belie the fact that we understand.

First, I would like to discuss some of the ways we can inadvertently encourage patients to be destructively involved with their feelings. Even though it is not desirable to encourage patients to be destructively involved with their feelings, it does happen. If we understand the various ways we can encourage patients to be destructively involved with their feelings, it can help us recognize if and when we do so. Once we recognize the ways we encourage destructive involvement, we are in a better position to change our behavior.

One way we can encourage our patient to be destructively involved with his feelings is by behaving in such a manner that the intensity of the feeling is increased. This can be done by responding to the patient's feelings with the same feeling; for example, becoming anxious in response to the patient's anxiety or becoming angry in response to the patient's anger. Responding with the same feeling may increase the intensity of the feeling that the patient is experiencing. Responding with the same feeling might also encourage the patient to exchange one stressful feeling for another stressful feeling. For example, if the patient tells the nurse that he is anxious and the nurse becomes anxious in response to the patient's anxiety then the patient's feeling of anxiety may change to feelings of guilt. The patient may feel guilty about causing the nurse to become anxious. We can also encourage destructive involvement by giving pep talks such as, "Keep your chin up," or "There are brighter days ahead." This may result in the patient feeling guilty, angry, or depressed. Pep talks are of very little value to patients. Chances are he has already given himself several pep talks to no avail. Making rules about how the patient should feel will encourage destructive involvement with feelings. Such statements as "You shouldn't feel that way," or "You should feel this way," can increase a stressful feeling or exchange it for another. To give sharp commands such as

"Snap out of it," or "Forget about it," can be another destructive response to the patient's feelings.

Furthermore, in our efforts to reassure our patients, we can encourage destructive involvement by giving false reassurance. Trying to reassure the patient by telling him everything is going to be all right before we clearly understand what the patient is feeling is an example of false reassurance. This can be very destructive. The patient knows that we cannot predict with absolute certainty that something is going to turn out satisfactorily, especially if we don't understand the situation. He is quick to sense our lack of sincerity and the falseness of this type of assurance. Another example of false reassurance is to tell the patient that many people have had this illness or condition and recovered. People usually are painfully aware of the fact that they are a unique and separate individual in time of illness and pain. To be told that many people have the same type of condition is not always reassuring, in fact, it can increase the patient's feelings of anxiety, guilt, or fear. These facts can be reassuring to the patient only after he knows that we accept and understand his feelings and see the situation from his point of view.

These various ways in which we can encourage our patients to be destructively involved with their feelings have some things in common. First of all, there is a lack of acceptance of the patient and his feelings on the part of the nurse and this discourages the patient from accepting his own feelings. Secondly, the nurse by her behavior encourages the patient to repress, ignore, or distort his feelings rather than accept and experience them. If the patient represses, ignores, or distorts his feelings rather than accepting and experiencing them, he will have difficulty understanding his feelings and deciding how he wishes to respond to them. The following example demonstrates how a nurse can encourage her patient to be destructively involved with her feelings.

> Miss Trace, a twenty-eight-year-old school teacher, was a patient in a psychiatric unit. Her doctor told her that he wanted her to find a job before she was discharged. He would leave instructions with the nurses that she be allowed to leave the hospital every afternoon to look for work. Shortly after the doctor left, a nurse, Mrs. Larkee, walked into the room. The following conversation took place:
>
> Mrs. Larkee: Good morning, Miss Trace, how are you this morning?

Miss Trace: Oh nurse! Dr. Wilkins says I must get a job. But I know that no one will hire me when they find out that I've been in here.
Mrs. Larkee: That's not true. Besides, why need anyone know? It isn't written on your face that you've been here.
Miss Trace: Yes, I guess you're right.
Mrs. Larkee: What happened to the job you had before you came to the hospital?
Miss Trace: The principal said that I could have my job back. But I can't teach and I don't think it is fair to the kids to have such a poor teacher.
Mrs. Larkee: You've got to have a positive attitude toward it. If you believe you can do it, you'll be able to do it.
Miss Trace: Maybe. But they don't want to learn and I can't make them behave.
Mrs. Larkee: You can't blame yourself for everything that happens to your students. After all, that school is in a bad neighborhood. You can't expect those kids to behave.
Miss Trace: You're probably right.
Mrs. Larkee: Maybe you will be able to find something this afternoon when you go out.
Miss Trace: I don't think I'll go. I'll wait until I go home to look for a job.
Mrs. Larkee: But would you? It's human nature to put off until tomorrow what you can do today.

In this example, the nurse contradicts the patient, reprimands her for the ideas she has, and tries to give her a boost with pep talks, all the while encouraging her to deny, ignore, and repress her feelings. At no time does she attempt to understand what the patient is feeling. Neither does she help the patient to sort out her own feelings. We don't know why Mrs. Larkee doesn't help the patient work through her feelings. Perhaps she isn't aware of her own feelings toward the patient and her opinion of the patient's ability to find and hold a job. Perhaps she has some strong feelings toward the patient which are unacceptable to her and these are preventing her from helping the patient. For whatever reason, she definitely encouraged her patient to be destructively involved with her feelings.

But there are ways in which we can encourage patients to be constructively involved with their feelings. First of all, it is important to accept the patient's feelings and allow the patient to feel the way he feels. Secondly, it is necessary to recognize and accept

our own feelings which we are experiencing in response to the patient's feelings. It is necessary to recognize and accept our own feelings so that we will be able to decide how we wish to act on them. If we do not recognize and accept our own feelings, there is danger that we may behave in a manner which would encourage patients to be destructively rather than constructively involved with their feelings. If we do nothing more than accept the patient's feelings and recognize and accept our own, we are already strongly encouraging our patient to be constructively involved with their feelings. We can further help our patients by allowing and encouraging them to talk about their feelings. This is not the same as forcing or insisting that the patient talk about his feelings. If we want our patient to own and be responsible for his feelings then it is necessary to allow him to decide how he wishes to act on them. He may wish to talk about his feelings or he may wish not to talk about his feelings. By trying to force the patient to talk or by insisting that the patient talk, we discourage him from accepting the responsibility for his feelings. If we are accepting of the patient and his feelings, then it is easier for him to talk or not talk about his feelings, whichever he wishes. If he doesn't wish to talk about his feelings, we need to accept this decision. Sometimes it is difficult to know where encouraging leaves off and forcing begins. Being aware of this fact may help us to avoid inadvertently forcing the patient to talk. A simple rule which is helpful to follow is to try speaking for oneself and one's wishes rather than give an order to the patient. For example, we might say, "I would like to hear exactly how you feel," or "I would like to help but to do so I first need to understand how you feel." Statements such as, "If you talk about your feelings, you'll feel better," or "Get your feelings out in the open, you'll feel better," tend to be somewhat pushy and not necessarily true. Such comments may actually discourage a patient from expressing himself.

As the patient expresses his feelings, we can try to understand the patient's feelings from his point of view. Remember that the patient's feelings aren't based on the situation as it is or the situation as the nurse sees it but rather on the situation as the patient sees it. If we saw and experienced the situation exactly as the patient does, we would most likely feel the same way. Once we understand how the patient feels it is necessary to convey this to the patient. Sometimes this can be done non-verbally by a pat on the shoulder, a squeeze of the hand, or by the expression on our face. Verbally, we can convey understanding to the patient by rephrasing what the patient has said and asking the patient whether or not we understand correctly. If we

actually don't understand, it is far better to let the patient know we don't understand than lie and say we do. Even if we don't understand we can let the patient know that we accept how he feels. Once we understand the patient's feelings, we may realize that he is misinformed or has misinterpreted certain things. If so, we can help him by giving him the correct information or interpretation. For example, a patient became extremely anxious immediately after her abdomen had been shaved in preparation for surgery. When encouraged to express her feelings she said that she was concerned about the size of the incision that the doctor would make. She thought that the incision would go from one edge of the shaved area to the other. When this misunderstanding was cleared up, the patient's anxiety disappeared. Another patient was depressed because she thought she would not be allowed visitors during her hospital stay. When the rules were explained to her, she was no longer depressed. Still another patient was angry because he hadn't been served breakfast. Once he understood that he was scheduled for certain tests and for the test results to be accurate he was to go without food, he was no longer angry.

Finally, we can encourage our patients to be constructively involved with their feelings by recognizing and accepting our own limitations. If the patient's feelings seem to be out of proportion to the situation or if his problems are extremly difficult to handle and we don't know how to help, then it is important to recognize and accept this fact. Rather than blindly trying to help and possibly making things worse, we should refer him to someone who can help. This someone might be another nurse, social worker, psychiatrist, or friend, depending on the situation.

Before going on to specific feelings that a patient might express, let's look once more at the incident involving Mrs. Larkee and Miss Trace. How could Mrs. Larkee have encouraged Miss Trace to be constructively involved with her feelings? First of all, it would be necessary for Mrs. Larkee to recognize and accept her own feelings and decide how she wished to act on them. Miss Trace expressed some concern about her ability to get a job and she also hinted that her hospitalization would be a mark against her. Mrs. Larkee could have encouraged Miss Trace to express her feelings related to this idea more fully. Some comment such as, "You are wondering how people will treat you since you have been ill?" might encourage Miss Trace to talk. This would help Mrs. Larkee understand Miss Trace's point of view and assist Miss Trace in finding a solution to her problem. Later on, Miss Trace expressed her lack of confidence in

herself as a teacher. Perhaps she was expecting too much of herself as Mrs. Larkee suggested. However, it would be more valuable if Miss Trace could come to this conclusion herself as she talked about her ideas and feelings to Mrs. Larkee. Mrs. Larkee could help Miss Trace reach this conclusion by trying to understand Miss Trace's point of view and by expressing this understanding to Miss Trace. Miss Trace's problem is related to how she views the situation rather than how the situation is or how Mrs. Larkee views it. If Mrs. Larkee had allowed Miss Trace to talk about her feelings the conversation might have developed very differently.

Any feeling that a human being is capable of experiencing can be experienced by patients in the hospital. However, some seem to come to the attention of the nurse more often than others. I will discuss three which frequently cause problems in the nurse-patient relationship. The three feelings are anger, anxiety, and guilt. The methods which were suggested to encourage a patient to be constructively involved in their feelings applies to these feelings as well as any other. But there are some specific comments I wish to make about each feeling.

The first feeling I wish to discuss is anger. Patients express their anger about various things: the nursing service, medical service, the treatment received, and the hospital rules and regulations. It is not unusual for the nurse to become defensive and respond with anger, especially if the patient is angry about the nursing service. After all, it is an indirect if not a direct criticism of the nurse. However, by becoming defensive or judgemental we can increase rather than lessen the reasons for complaints on the part of the patient. Far better to hear the patient out and try to understand the situation from the patient's point of view. Once we have done this we may find a way to improve the nursing care and/or clear up misunderstandings. Allowing a patient to express his anger and then accepting and understanding it can be helpful even in situations where nothing else can be done. Many nurses become uncomfortable and defensive when a patient complains about another nurse and the care they receive from her. There is an additional conflict when the nurse has strong feelings, either negative or positive, about that particular co-worker's nursing ability. It is helpful to remember that the patient's opinion need not be ours. Furthermore, neither is the patient's opinion nor our opinion necessarily a fact. Another thing to keep in mind is that listening is not the same as agreeing. Some nurses tend to feel disloyal unless they defend their co-workers. Just because we listen to the patient's complaints doesn't mean that we agree or

disagree with what has been said. We need not come to her defence nor is this the time to express our opinion about this particular person. How we feel toward our co-worker is our problem to be worked out at another time. The situation in which we are involved here is between our co-worker and the patient. Once we understand how the patient feels and why he feels this way then we may be able to help the patient decide what he wishes to do about it. Often the direct route is the most satisfactory and you might suggest that the patient talk with the nurse. While discussing this the patient may reveal that he is unable to talk with the nurse about the problem. For this reason you may decide that this approach isn't feasible. Then you might ask for the patient's permission to talk with the nurse. Since it is a problem between the patient and another nurse we need the patient's permission to talk with the other nurse about the problem. If complaints are discussed with other staff members without the patient's consent we may increase the problems rather than solve them. There might be an occasion when one decides to talk with the nurse without mentioning this to the patient. We need to be convinced that it's the wisest action to take and that we are not trying to punish either the patient or the nurse. It is very easy to get in a triangle where the patient tattles to the nurse and the nurse tattles to the other nurse and the other nurse punishes the patient.

Another uncomfortable situation is one in which the patient is angry about the treatment prescribed. One doesn't need to work with patients too many years to recognize that treatment is more effective when the patient is co-operative and has faith in the treatment. Therefore, it is worthwhile to know how the patient feels about the treatment prescribed and the doubts he may have about it. Often, allowing the patient to talk and then attempting to clear up misunderstandings is all that is necessary. Sometimes it happens that the nurse doesn't understand the value of the treatment either. Rather than pretend, it is wiser to say you don't know but will try to find out or suggest that your patient ask his doctor. The fact that the nurse doesn't understand the value of the treatment doesn't detract from its value any more than that the patient doesn't understand. Due to mistaken ideas of loyalty or similar reasons, nurses occasionally find themselves defending treatments and procedures which they do not necessarily recognize as being helpful to the patient. The falseness of this type of behavior is often evident to the patient. Rather than helping the patient work out his feelings, this behavior on the part of the nurse can increase the patient's doubts and fears.

There are times when a patient is angry at us personally and expresses this anger. It is very easy to become defensive in such a situation. However, if we can allow the patient to express his anger and try to look at his anger objectively it is more likely to improve the nurse-patient relationship than if we become angry or defensive.

Another feeling that often causes problems between nurses and patients is anxiety. Most patients, if not all, experience a certain amount of anxiety when they are in the hospital. Some patients experience a great deal of anxiety. Anxiety can be expressed through physical, emotional, social, and intellectual symptoms. It may be helpful to briefly review these. Some of the physical symptoms are unsteadiness of voice, rapid pulse, perspiration, flushing, restlessness, and nausea. Some of the emotional symptoms are feelings of anger, disgust, and annoyance toward self and others. When these particular feelings are symptoms of anxiety, they cover up the anxiety itself which then may go unrecognized. The social symptoms of anxiety are demonstrated in such behavior as belittling others, verbally attacking others, and withdrawing from others. Some of the intellectual symptoms are difficulty in thinking clearly, inability to recall what one knows, difficulty in expressing oneself accurately, inability to grasp what another person is saying, and confusion. If we keep in mind the symptoms of anxiety this can help us in caring for the patient who is anxious. Allowing the patient to express what he is feeling sometimes enables him to uncover his anxiety and deal with it. When the nurse is aware of what the patient is experiencing she can plan her nursing care to more effectively meet the patient's needs. Difficulty in thinking clearly would indicate the need for simple directions and explanations. Inability to recall what one knows tells us that this patient will need assistance and encouragement to speak openly. Confusion and inability to grasp what another is saying calls for extra time and simple and repeated comments. When a patient manifests social symptoms of anxiety, we can be accepting and encourage him to talk about his anxiety rather than responding with anger or in a punitive manner. Using simple nursing measures, we can often relieve the symptoms of anxiety and prevent the building of anxiety upon anxiety.

The next feeling I wish to discuss is guilt. Frequently, our patients experience guilt feelings and we have difficulty in helping the patient deal with these feelings in a constructive way. If the patient states that he is feeling guilty, the first step is to find out what he is feeling guilty about. Patients often feel guilty about being in the hospital. They may believe that they brought the illness on them-

selves. Sometimes the reasons they give for being guilty of bringing the illness on themselves are rather vague; such as, I never looked after myself. Other times the reasons are quite specific; such as, disobeying doctor's orders or taking unnecessary risks. We need to allow the patient to speak freely about his guilt feelings and the circumstances surrounding them. If we do not grasp the relationship between the deed and the illness, we may wish to express this to the patient. However, when we do understand the relationship between the deed and the illness, it may be helpful to convey this understanding to the patient.

When working with patients who are experiencing guilt feelings, it is necessary to clarify in our own mind what our goal is. Are we trying to relieve the guilt feelings? Are we trying to help the patient see that there is no need to feel guilty? Are we trying to get the patient to repress his guilt feelings? Are we trying to help the patient accept his guilt feelings? Or are we trying to help the patient forgive himself? Our goal will largely determine how we will try to help the patient. Many nurses have difficulty helping the patient deal with his guilt feelings in situations in which the patient's behavior definitely has bearing on his condition; for example, if the patient had been driving under the influence of alcohol and caused a car accident which resulted in severe injuries. In trying to help these patients, we frequently err by working toward encouraging the patient not to feel guilty. It seems to me a healthy reaction on the part of the patient to the situation. Therefore, I don't think we are encouraging the patient to be constructively involved in his feelings if we try to remove his guilt feelings. But we can help by encouraging him to accept his feelings and behavior and forgive himself and face life ahead. Certainly it is false to tell a patient that he need not feel guilty when we realize that we would most likely also feel guilty in that situation, but we can convey to him that a mistake or unwise behavior doesn't make him a bad person.

If the patient's guilt feelings are overwhelming, he may need help that we can't give and it is our responsibility to try to get the right help for the patient. We may need to help the patient understand that even though he may have directly caused the situation, he still is entitled to receive help in working through his problems arising from his behavior. There are situations which are so overwhelming that even a very healthy person cannot work through them by himself and we should not expect it of him. For this person to seek professional help is a sign of health. We can be a great sup-

port to our patients if we are aware of this and try to convey this message to them.

I have discussed some of the ways we can influence how patients are involved with their feelings. Since how a patient is feeling has definite effect on the progress and/or outcome of his illness, it is important that we as nurses learn the skills required to help patients to be constructively involved with their feelings.

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Chapter VII

Telling the Truth

When we plan care for our patient, the question often arises as to what the patient should be told about his condition, care, and/or prognosis. We wonder, should the patient be told the truth? In general, nurses believe that lying and dishonesty are undesirable in our relationship with patients. However, frequently in individual cases, we decide it is necessary to lie or recommend to others that the truth not be told. We justify our lying and dishonesty by saying it is for "the good of the patient." So what should we tell the patient?

When this problem arises, it is important to clarify what the truth is before deciding what the patient should be told. Could it be that many of our problems and conflicts in this area stem from the fact that we don't know what the truth is at a given time? We ask, should the patient be told the truth? We say, I didn't think that I should tell the patient the truth. But, I wonder, is it clear what the truth is and why it should or should not be told? For example, your friend asks you, "What do you think of my hat?" You might reply, "I don't like it," or "I love that shade of blue," or "The color goes well with your coat," or "I prefer your other hat," or "The style is different," or "I wouldn't think of buying a hat like that," or "I hate large hats." All these statements could be true at one and the same time. However, the reaction of your friend to each statement could vary greatly. If you made one of these statements would you be honest and truthful or would the fact that you didn't make the other statements mean you were lying and dishonest? Would you be honest if you said, "I love that shade of blue" or is this not enough? To be honest would you need to say to your friend, "I don't like it and prefer your other hat because I hate large hats and wouldn't think of buying one like that but the style is different and that pretty shade of blue goes well with your coat."

When we are struggling with the question of whether or not to tell the truth to a patient, often we are thinking of one particular truth. Usually it is a particular truth that we don't want to tell the patient and/or believe that the patient should not be told. It could be that it would be better for everyone concerned, including the patient, not to tell that particular truth. However, just because we do not tell a particular truth does not mean that we have no other choice but to tell a lie. There are probably many other truths that it would be valuable to tell the patient and valuable for the patient to hear. Using the example above, perhaps you would prefer not to tell your friend that you wouldn't think of buying a hat like that. Besides, it might be to your advantage and the advantage of your friend if you didn't tell that particular truth. However, there are several other truths which might improve your friendship if you passed them on. What I am suggesting is that one of the reasons we get into a bind about whether or not we should tell the patient the truth is that it is not clear in our mind just what the truth is and how best to be honest and truthful with our patients.

All of us have probably been in a variety of situations in which we experienced conflicts because we didn't know what to say to the patient. At the time, it seemed that the only choice we had was to tell the truth, which we didn't feel comfortable doing, or tell a lie, which conflicted with our moral principles. Below are several examples of interactions between nurse and patient. In the first example, the nurse changed the subject to avoid answering the patient.

> Miss Grass had been caring for Mrs. Woods, a patient who had been married for twenty years. The marriage was an unhappy one. Mrs. Woods and her husband fought frequently. Through the years, the conflict in the home had been very disturbing to the children. The husband left home many times for long periods but always returned. Seldom during the twenty years of marriage were they without serious money problems. Mrs. Woods had been in the hospital for ten days, when Mr. Woods unexpectedly dropped dead. Miss Grass happened to be off duty that day. But the next day, after hearing the news, she went to see her patient. She expected to find Mrs. Woods upset and possibly crying. Instead, she was singing when Miss Grass entered her room. "Oh, Miss Grass," she said when she saw the nurse, "did you hear the good news? My husband is dead. I'm so relieved. All our fighting is over. Finally, I'm free. Now I can start my life

> over." Mrs. Woods's comments surprised and shocked Miss Grass. In response to the nurse's silence, Mrs. Woods said, rather defensively, "Well, how would you feel if you were in my shoes?" Miss Grass replied, "Let's go to the lounge for awhile."

Later, in discussing this situation with other nurses, Miss Grass said, "I didn't know what to say. I didn't think that I should tell her the truth." In further discussion it became obvious that the nurse wasn't aware of the truth. She was twenty years old. She had never been married, let alone been married for twenty years. She had never been unhappily married, let alone been unhappily married for twenty years. The truth was that she didn't know how she would feel if she were in the patient's shoes. The particular truth that Miss Grass thought she shouldn't tell the patient was, "You shouldn't feel that way." (Our culture frowns on rejoicing over someone's death.) So instead of answering the patient's question, the nurse said, "Let's go to the lounge for awhile." How much more helpful she could have been if she had said, "I don't know how I would feel if I were in your shoes, but I would like to understand more clearly how you feel. I'll stay and we can talk about it."

The next example shows a situation in which the nurse found it necessary to lie.

> Mrs. Yule was caring for Mrs. Luck, a patient who made many demands; for example, "Bring me a drink of water; help me to the bathroom; open the window." Mrs. Yule was getting more and more impatient to get out of the room and attend to her many other duties. Finally, Mrs. Luck asked, "You think I'm a nuisance don't you?" This was exactly what Mrs. Yule was thinking at that moment but she quickly answered, "Oh, no, I don't think you're a nuisance at all."

Mrs. Yule later stated that she was upset because she hadn't been able to cover up her feelings well enough to prevent the patient from recognizing them. What would have happened if she had replied, "Yes, I am thinking that you're a nuisance." Would the results necessarily be undesirable? It is possible that stating the truth could have helped the patient and nurse to understand themselves and each other better? Could the truth help to improve the relationship between the nurse and patient? Who knows? However, we do know that in this incident telling a lie didn't improve the relationship between the nurse and the patient. It left the patient confused and

the nurse felt uncomfortable and guilty about her behavior.

The next example involves a situation in which the nurse didn't know the answer to the patient's question and instead of telling the patient this, she bluffed her way through.

> An order was left that Miss Usher, a patient, was to be up and dressed every morning by eight o'clock. She was to make her own bed and straighten her room. Miss Usher objected to this. "Why should I get up every morning and make my bed when I don't feel like it?" she asked. Miss Ball, the nurse, explained in rather vague and general terms that this would help her get well. The more Miss Usher insisted that she didn't understand how this would help her get well and that she didn't want to get up, the more Miss Ball insisted that it would help her to get well.

The fact of the matter was that Miss Ball herself didn't understand how this particular activity would be beneficial to this patient. However, she didn't think she should say this to the patient. Therefore, she responded with generalizations and vague statements. But why not tell the patient that she didn't know the answer to her question? What would have happened if the nurse had said something like the following, "I don't know why this is important for your recovery. However, I do know that this is ordered for many patients. The patients who carry out the order even though they would rather not seem to recover more rapidly than those who stay in bed most of the day. It seems to me that it is worth a try and certainly can't do any harm." Would this be less desirable than insisting it would be helpful when one is unable to give the patient a clear picture of how or why?

I have given several examples in which the nurse avoided the truth. Now I would like to give some examples in which the nurse was honest with the patient. The first example demonstrates how the nurse struggled with her own feelings before she was able to decide how she was going to respond to the patient.

> Mr. West, a patient in a general hospital, who was suffering from a mental illness, was legally committed to a mental institution. The police were to transfer him from one hospital to the other. It had been suggested that he not be told until the police were at his side and could quickly carry him away if he became upset. Mrs. Smith, the nurse, was in a dilemma. She realized that the patient was unpredictable; he could be abusive both verbally and

physically. If the police picked him up without warning, it might be possible to avoid the scene the patient might create if he knew about his transfer ahead of time. On the other hand, would this be fair to the patient? Didn't he have a right to know what was going to happen to him? Was it right to assume that he would be hard to handle if he knew the truth? What would it do to him as a person and to his feelings about himself if his fellow patients saw him being carried off by the police? After serious thought, Mrs. Smith decided to talk with Mr. West. She explained the situation and told him that he had no choice but to go. He could go willingly or he could struggle and fight but eventually he would go. After receiving this information Mr. West was quiet for several seconds. Then he said, "Thank you for telling me, nurse. I'll go pack my bag. Let me know when the police come and I'll go with them, but I would appreciate being allowed to meet them off the ward." When the police arrived, Mrs. Smith asked them to wait in the outer hall and she would bring Mr. West. Just before leaving, Mr. West took Mrs. Smith's hand. There were tears in his eyes as he said, "Thanks, nurse." Then he walked calmly and bravely along, his dignity intact.

In this example, the nurse didn't merely tell the patient the truth. Before she talked with the patient, she checked out her own feelings. She accepted and owned these feelings and decided how she wanted to act on them. She decided that it wouldn't be "right for her" to allow the police to carry this patient away without telling the patient in advance what was going to happen to him. Why wouldn't it be right for her? Because when she checked her own feelings she realized that deep down she would not feel good about herself and her behavior if she carried out the suggested plan. Her behavior would not be in keeping with the way she wanted to interact with patients. Therefore, it would not have been "right for her" and she based her decision about how she would behave on what was "right for her" to do. This is not to say that to carry out the suggested plan would be wrong for everyone. The nurse by disobeying the orders given her took a considerable risk. There was no guarantee that the patient would react the way he did. He could have responded with violent behavior. If he had done so, the nurse could not expect emotional support from her co-workers since she had disobeyed orders. She was fully aware of this when she decided how she was going to deal with the situation.

The following example demonstrates how telling the truth eased a rather awkward situation.

> Miss Toby, suffering from drug addiction, obviously had access to drugs but no one knew where she was getting them. One possibility was that her visitors were bringing them to her. The doctor left an order that a nurse was to be with her at all times to prevent her from receiving and taking drugs. One day her boyfriend came to visit her. The patient said to Miss Roth, the nurse, "Surely you don't have to stay with me while I have visitors." Miss Roth replied, "Yes, I do. I am to stay with you at all times." The visitor, half joking, said, "She probably has to stay because I might slip you some drugs while I'm here." Miss Roth replied, matter of factly, "That's right, we are concerned that you might be receiving drugs from your visitors." Then the subject was dropped and everyone seemed relaxed and comfortable during the remainder of the visit.

In this example, because the nurse told the truth, everyone knew where they stood and there was no need to cover up or pretend. This openness alleviated much of the awkwardness of the situation.

In my final example, both the nurse and the patient were honest with each other.

> Periodically, Mrs. Adams would fall on the floor, in full view of her nurse, Mrs. Sadd. She would moan and thrash about but never lose consciousness. Puzzled, Mrs. Sadd said to her, "I'm at a loss to understand why you behave like this." Mrs. Adams replied, "I do it because you never pay any attention to me except when I'm having one of these spells."

Since both the nurse and patient were truthful with each other in this situation, the nurse was able to understand the patient better. Now she could plan her nursing care so that she could meet the patient's need and it would be unnecessary for the patient to behave in this socially unacceptable manner.

You may note that in the examples given in which the nurse was honest, the nurse-patient relationship improved. However, the nurse-patient relationship did not improve in the examples where the nurse was dishonest or evaded the truth. Moreover, in the examples in which the nurse was honest, she seemed to recognize and accept the responsibility for her own feelings and behavior. But

in the other examples, the nurse didn't seem to be aware of her own feelings and certainly didn't take the responsibility for them.

How then can we be more honest and open with our patients? I think there are several things we can do which will make it easier for us. First of all, it is important to try to keep in touch with our own feelings. How is one feeling about oneself and toward the patient? How are we feeling about the patient's behavior, illness, or prognosis? How are we feeling about our ability to function in relation to these? Once we understand and accept our own feelings, it is easier to pinpoint the "truths" that we do not wish to tell our patient. We are better able to recognize whether these "truths" are actually truths or merely opinions, values, and/or guesses. Certainly we have a right to our own opinions and values but these are not synonymous with truth and, therefore, are not to be passed on to the patient as such. When we know what it is that we are trying to keep from our patient, we may need to work through our feelings about this. By checking our "shoulds" and "shouldn'ts" we may find that our idea of the truth is nothing more or less than a rule which we are trying to impose on ourselves and/or others; for example, that one should be sad when a member of one's family dies.

Or perhaps, we may find that we are involved in a type of situation in which we feel very uncomfortable or inadequate. Some nurses feel somewhat guilty carrying out constant observation on a patient. Other nurses have strong feelings about working with patients who have different moral standards or lifestyles than they do. Many nurses feel extremely inadequate working with a dying patient. It is important to accept and recognize these feelings so that we can decide how we wish to deal with them. When we strongly believe that a patient should not be told the "truth" and haven't recognized and accepted our own feelings about this, we can become afraid that the patient will ask to be told the "truth." Then, instead of hearing what the patient is asking or saying, we hear what we fear he is asking or saying. Some of the examples cited earlier brought this out. The more we recognize and accept our own feelings, the more likely we will hear exactly what the patient is asking and wanting to know. If we hear what the patient is saying then we can decide what is the right response for us to make to our patient. In making a decision, it may be helpful to answer three questions. The first question is, how will I feel about myself if I react in a certain way? The second question is, what are the effects or problems that I can anticipate if I react in a certain way? The third question is, will I be able to handle the patient's or other people's reaction to my

behavior? The answers to these questions can help us decide what is the right response for us. To clarify what I mean, take the example of the patient who was to be transferred. The following are some questions which the nurse might have asked herself. What if the patient becomes very aggressive after I've told him? What will I do? Can I handle the situation? How will the staff react to me when they know I did not carry out agreed procedure? How will I receive their comments? Will I be able to function effectively? Then, how will the patient react if he isn't told? How will I feel about myself if I do not tell him? Every situation is different, of course, and this is just an example of some things which we might want to clarify for ourselves before deciding what is right for us to do.

To be more open and honest with our patients, we need to keep in touch with our own feelings. We need to know what is true and what is merely opinion, or our own or other people's values. We need to know what it is that the patient is saying or asking. This puts us in a position to decide how we wish to behave and frequently we will find that telling the truth will be the most natural and helpful response.

Chapter VIII

Specific Nursing Problems

During my years of teaching, many nurses have come to me with specific nursing problems which they encounter in their relationships with patients and have asked for help in solving them. Of the problems brought to my attention, three seem to come up time and time again. These three problems are how to work with a patient who manipulates, how to set limits for a patient, and how to help, in a general hospital setting, a patient who has attempted suicide. Therefore, I have devoted this chapter to the discussion of these problems. I hope that many of the things which I mention will also be helpful in solving other nursing problems.

The first problem area has to do with manipulation. What do we mean by manipulation? When manipulation is discussed in nursing circles, it is very seldom defined. Yet it is assumed that everyone knows what is meant when someone says that a patient is manipulative. When we speak of manipulation it has a negative connotation; it involves undesirable behavior on the part of the patient. There seems to be an unwritten or unspoken agreement that to allow oneself to be or inadvertently find oneself being manipulated is bad and reflects seriously on one's nursing ability. The impression is given that a "good nurse" does not allow herself to be manipulated and the seriousness of being manipulated is only exceeded by a drug error. It has been my experience that nurses have difficulty in defining manipulation. The following is my definition of manipulation. Manipulation is the attempt of one person to use another person to obtain their own goals in ways that are unhealthy for one or both persons involved.

Perhaps one of the best ways to discuss manipulation is to look at a situation in which the nurse said she had been manipulated.

> Miss Hayes had been sitting with her patient, Mrs. Green, for some time, talking about various things with her. She got up to leave and as she reached the door, Mrs. Green said, "I often think about killing myself."

The nurse in relating this situation stated that the patient had manipulated her into staying with her. According to the nurse, once the patient had made this statement, the nurse did not dare leave the patient alone and had no choice but to stay. Therefore, the nurse concluded that she had been manipulated.

First of all, I would question the nurse's interpretation of the patient's behavior. It may be correct but certainly there are other possible explanations. One might be that after talking with the nurse for some time the patient felt safe enough to express some of her more frightening thoughts. Another might be that the patient did not trust herself when she was alone and, when she realized that the nurse was leaving, she expressed her feelings about this. There are other possibilities but I think two are enough to point out that the nurse's statement was not necessarily correct.

Furthermore, I disagree that the nurse had no choice in what to do. She had several choices. She could have stayed with the patient and tried to find out more about her thoughts of suicide. She could have stayed with the patient to protect the patient from herself. She could have called another nurse and asked her to stay with the patient. She could have acknowledged the information the patient had given her and informed her that she would be back to discuss this further. Or she could have done whatever it was that she had intended to do before the patient made that statement. I don't think we have exhausted the possible choices that the nurse had available but the point I wish to make is that the nurse had a choice as to how she wished to react to the patient's behavior. Therefore, the patient did not force the nurse to stay. In this situation, the nurse holds the patient responsible for the nurse's behavior, "She made me stay with her. I had to do it because she hinted that she would kill herself if I didn't." If we don't want to take responsibility for our own feelings, thoughts, behavior, and decisions, we often try to place it on another person. If we see others as being responsible for our feelings, thoughts, behavior, and decisions, then it is understandable that we think we are being manipulated. Sometimes, rather than deciding for ourselves what is best to do, we counteract this feeling or idea of being manipulated by doing the exact opposite of what we think the patient is trying to make us do.

Often we build up defences against being manipulated because we have the idea that it is a reflection on our nursing ability if we are manipulated. One defence is to label the patient. For example, we may label the patient as demanding. Once we have labelled the patient, we assume a certain attitude and use a specific approach which we have learned to use with patients bearing this label. Another defence we use is to explain the patient's behavior without verification by the patient or ruling out other explanations. For some reason behavior that is explained seems less threatening to us than unexplained behavior. Here again, we can behave toward the patient in a set manner. Once it is explained, it seems easier for us to tolerate it or handle it in a particular way. These are false defences and actually the nurse is allowing herself to be manipulated because she has turned over her initiative to the patient. She has placed the responsibility for her behavior on the patient.

There are probably times when we are manipulated by patients, but I don't think it happens nearly as often as we think it does. Neither do I think it is necessary to get upset when this happens occasionally. Actually, I am more concerned about the fact that we are so very much afraid of being manipulated and, because of this fear, we use much energy to guard against manipulation. At the same time, we fail to recognize that we have the ability and the responsibility to make a choice as to how we wish to react to the patient's behavior. Far better that we accept the fact that we will occasionally be manipulated than to waste energy guarding against it.

Another concern of mine is that perhaps we treat the "manipulative patient" in such a way that he must use unhealthy means in an attempt to have his needs met. If the patient is driven to using devious ways to obtain what he needs because open and honest ways are not tolerated, then are we correct to say that he is manipulative? Would it not be more correct to say that the nurse is manipulating the patient to behave in a manipulative way? For example, is the patient who is constantly ringing her call bell and making minor requests manipulating the nurse to run errands for her, or is the nurse, by not meeting this patient's needs, manipulating the patient to constantly ring her call bell?

What then can we do about manipulation? First of all, we can accept the fact that now and then we will be manipulated. Secondly, we can recognize the fact that this isn't too serious and usually very little harm is done either to us or the patient. Thirdly, we can accept the responsibility for our own feelings, thoughts, behavior, and deci-

sions and not surrender this responsibility to the patient. Finally, we can try to develop, as clearly as possible, our goals in caring for a particular patient. Keeping these goals clearly in mind helps us decide how we wish to react to the patient and his behavior. If we have clearly defined goals in our nursing care, our reaction to the patient's behavior will be greatly influenced by our attempt to meet these goals, rather than by whether or not we are being manipulated. So that these goals can be met, we may need to set limits for our patients. Which brings us to the second problem area that I want to discuss, namely, setting limits.

I differentiate between rules, regulations, and limits. *Rules* are overall policies governing an institution and not based on individual patients. For example, lights are to be out at ten p.m., or there is to be no smoking in bed. *Regulations* are established practices such as dinner being served between eleven and one, or visiting hours being from two to four. For this discussion, *limits* are referred to as boundaries set for the nurse and/or the patient's behavior. For limits to be useful as a therapeutic tool, they need to be set on an individual basis. It involves a commitment on the part of the nurse and ideally on the part of the patient. Limits can be stated as follows: if you behave in this manner, I will behave in this manner, but, if you behave in this manner, then I will behave in this manner. For example, if you report to me before leaving, I will allow you to go off the ward by yourself, but, if you go off the ward without reporting to me, then I will come after you to bring you back. We might wish to set limits in such areas as behavior, emotional involvement, time allotted for care, and responsibility for meeting patients' needs. Our purpose for setting limits should not be to control the patient but rather a means by which, in partnership with the patient, to reach our nursing goals. So that limits can be used to this end, we need to have a clear understanding of our nursing goals before we can set realistic limits. We need to know what we are trying to limit and whether this is what we actually are limiting. It is important to discuss with the patients the limits that are being set so that he has a clear understanding of what is expected of him. If the patient understands the need for limits, it is likely he will do his best to abide by them. However, there are times when a patient doesn't understand the need for certain limits even though we have tried to explain them to him and, consequently, he may repeatedly test these limits. When this happens we must be firm and consistent or we will not be able to meet our nursing goals.

I have found that nurses have mixed feelings about setting

limits. Some tend to feel guilty about imposing them and others tend to think they are forcing the patient to behave in a certain way. Certainly the bases for these feelings are highly individualized, yet there are certain things that may affect how we feel about setting limits that I think are worthwhile mentioning. One could be that we don't have a clear understanding of our goals or how these particular limits are going to help us reach them. Another could be that we haven't worked through our own feelings about the patient's lack of acceptance of the limits. Some nurses view setting limits as punishment. If limits are being used to punish a patient, they should be discontinued and we need to try to understand why we think it is necessary to punish this patient. Some nurses view being firm and consistent as punishing, which is not necessarily so. The purpose of limits is to aid in meeting nursing care goals. If they do this, they are necessary and valuable. If they are not doing this, they may be destructive. Sometimes we do set limits that are unrealistic and/or unnecessary and need to guard against this; at other times, we may set limits to meet our own personal needs rather than to reach goals in nursing care. For example, if we have a need to control patient activity then we might set limits on their activities even though it is not necessary. Anyone who is experiencing difficulties in setting and carrying out limits may benefit from examining and working through their own feelings in this regard.

Often several people are involved with maintaining the limits set for a particular patient. To prevent problems from arising, communication is extremely important. Everyone involved with the patient's care needs to have a clear understanding of the limits that have been set and their therapeutic value. Some problems can be prevented if the nurse who has the greatest responsibility for supervising the limits is the one that discusses the limits with the patient. For example, she might say to the patient, "You may stay up as late as you wish this evening, but you are to be out of bed at seven. I personally will be here in the morning to remind you." As a general rule, this is more effective than saying, "You may stay up as late as you wish this evening, but you are to be out of bed at seven. Someone will be here in the morning to remind you." When several people are involved in maintaining limits, the patient needs to know that the rest of the staff understand them.

Occasionally limits are set by the doctor or team leader and their value isn't clear to another staff member. Before that member has had an opportunity to clarify things, the patient may question the value of the limits. Rather than making a guess as to the value of

the limits, it is far more satisfactory to say, "I don't know what effect this will have on your progress or why these limits have been set. I will try to find out but meantime I trust your doctor's judgement and I except you to abide by the limits that he has set."

The action we plan to take if the patient does not adhere to the limits must be reasonable and within our ability to carry out or limits lose their therapeutic value and become nothing more than idle threats. When used wisely, limits can be a valuable tool in nursing care and serve as guides in directing us toward our nursing goals. Following are some examples of situations in which limits were set:

Whenever Miss Morris spent time with her patient Mr. Stonewell, who was a forty-year-old man, he would make such comments as, "You have a beautiful figure, you have shapely legs. My, you are pretty when you blush." Miss Morris became very uncomfortable when these comments were made and she found it difficult to spend time with him. Therefore, she told him, "I become uncomfortable when you say such things. I would like to spend time with you but I will leave whenever you make comments like that."

Miss Mann controlled her anxiety with physical symptoms. The doctor left an order that she was not to be allowed to discuss the pain in her side. Her nurse, Mrs. Forrester, explained this to her, adding, "I will remain with you as long as you do not talk about your pain. However, if you start talking about your pain I will walk away."

Mrs. Reed's visiting privileges were limited to ten minutes. Mr. Reed tended to exceed the limits. Miss Starr informed the patient and her husband that he might visit if he stayed no longer than ten minutes. If he stayed longer, he would not be allowed to visit the following day.

The following patient set her own limits:

Miss Gold, a patient who had made several attempts on her life, handed the nurse a small pocket knife. She said, "You keep this for me, I don't trust myself with it."

Limits are aids in meeting nursing goals. To use them effectively,

we need to recognize our feelings about setting limits and understand the therapeutic value of the limits we have set. Furthermore, it is desirable that the patient understands the limits and their value.

The third specific problem area I wish to discuss is that of caring for the "suicidal" patient. This is the patient who has made an attempt on his life, or one who indicates in some way that he is seriously contemplating suicide. These types of patients can be found on medical and surgical units and my remarks are mainly directed toward the care of such patients. For the care of the "suicidal" patient on a psychiatric unit, I refer the reader to one of the many psychiatric nursing texts.

Often the patients are not in the hospital to be treated for their suicidal tendencies, but rather for some physical disorder. The disorder may or may not have been caused by their suicide attempt. Furthermore, these patients for some reason or other are not being psychiatrically treated, perhaps because there are no facilities or personnel in the area for this type of care. Another reason might be that either the patient or the patient's family refuses to sanction psychiatric care. In spite of the improvement in the care and facilities offered to patients suffering from emotional illnesses, this type of situation arises occasionally. Whatever the reason, the conscientious nurse is left with the problem of caring for this patient. She isn't happy to see this patient discharged after his physical condition has been treated, yet she doesn't know what she can do or could have done to help the patient. She is acutely aware of her lack of skills, lack of time, and her many other nursing responsibilities. I hope I will be able to suggest some guidelines which will be helpful to nurses in this area.

A nurse in this situation is limited in what she can do for the patient but this doesn't mean that there is nothing she can do. Her main handicap may be her own feelings of inadequacy. By accepting the fact that she is limited in time and ability but by being determined that she will do what she can, there is a good possibility that she will be able to help the patient at least in a limited way. Much energy is wasted in bemoaning the lack of time, lack of skills, and lack of facilities. This energy could better be used toward helping the patient.

Once again, the first step is recognizing and accepting our own feelings about the patient and the patient's behavior. Attempted suicide is a serious matter. How do we feel about it? To some of us it is a moral and/or religious issue. Unless we are fully aware of our feelings and ideas about suicide and accepting of them, they may in-

advertently affect our relationship with our patient. We may believe, for example, that suicide is morally wrong or a sin. It is important that we are aware of our belief and at the same time realize that it is not our responsibility to judge the patient or his behavior, neither is it our responsibility to punish him for wrong doing. Our responsibility is to meet the patient's physical and emotional needs.

We need to recognize and accept our own feelings about suicide in general but also about the specific patient we are working with and his behavior. Following are two situations in which a person attempted suicide:

> Mrs. Brown took thirty sleeping pills. Her husband had gone out of town and wasn't due back for two days. Unexpectedly, he arrived home an hour after Mrs. Brown had taken the pills. He took her to the hospital and in a few hours she was physically out of danger.
>
> Mrs. Black took thirty sleeping pills at 9:30 p.m. Her husband came home as usual at 10:00 p.m. After she told him what she had done, he took her to the hospital. In a few hours, she was physically out of danger.

What is your reaction to these two situations? The main difference beween them is that Mrs. Black took the pills shortly before she expected her husband to come home, while Mrs. Brown took the pills when she expected her husband to be gone for a few days.

At one time, I asked a group of nurses to plan nursing care for these two patients. They found it much easier to plan care for Mrs. Brown than they did for Mrs. Black. In discussing this problem, it became clear to them that the difficulty in planning care for Mrs. Black centered around their assumption that Mrs. Black had expected to be found before the pills took effect. However, they assumed that Mrs. Brown expected the pills to take full effect before her husband came home. The nurses felt that Mrs. Black had used her husband in some way and they needed to guard against her doing the same with them. She was given such labels as—sneaky, dishonest, insincere, and manipulative. During the discussion, it became obvious that the difficulty the nurses were having in planning nursing care for Mrs. Black was due to the way they felt about Mrs. Black and her behavior. Somehow, attempted suicide was more acceptable to them if they thought the patient fully

expected to die than if they thought the patient expected someone to save her.

I would like to pose two questions for the reader to answer. First, if a person plans an attempted suicide in such a way that she will most likely be found in time to save her life, is she being insincere? And secondly, if she is being insincere, would our nursing care need to be different than for a patient who made a sincere attempt?

Patients have told me that it is very difficult to get family or friends to take them seriously when they say that they are going to kill themselves. Our society tends to joke about suicide. How many of us after a hard day or unpleasant experience haven't commented, "Oh, well, I guess I'll just kill myself." If someone calmly told a relative or friend, "I am thinking of killing myself," a likely response might be, "You've got to be kidding?" Sometimes the only way a person can get the message across is by making some gesture in that direction. So I repeat, the first step is to understand and accept our own feelings and ideas about suicide and the specific patient under our care. Then we are in a position to try to help the patient. What I have said earlier regarding accepting patients, caring for them, and setting limits also applies to the care of these patients.

For someone whose life is going fairly well, in spite of some problems and hardships, it is difficult to understand why a person would attempt suicide. So it is common to not understand, but our responsibility is to try to understand rather than judge. We can remind ourselves that if we saw life from the patient's point of view, we would be able to understand and the patient's behavior would make sense. Any suicidal gesture is a call for help. This may become clear if we imagine ourselves attempting suicide and the conflicts we would need before reaching this point. A "suicidal" patient is a desperate person, but even the most desperate person tends to want to live rather than die. Suicide is their solution to their problems and it is the best solution from their point of view at the time. Usually, they would welcome a more satisfactory solution and sometimes we, as nurses, may be able to help them find it. For example, a change of attitude, frame of reference, or circumstances might be a satisfactory solution. By accepting the person as an individual, we can aim toward building a relationship that fosters trust and confidence. This can be accomplished if we remain calm and sincerely interested, if we act as a sounding board for the patient's feelings without reacting personally to his anger, frustration, or guilt, and if we give

him support and encouragement. We can try to help the patient to be as realistic about himself and his situation as possible. We can try to convey to our patient that we accept and care about him and want to understand. By being alert for signs which indicate that the patient wants to talk, we can encourage him to talk without insisting that he talk. It may be helpful if we allow the patient to express his feelings of anger, grief, resentment, or whatever deep feelings he is experiencing.

An attack on one's own life is an expression of severe hostility. It is hostility turned inward. An encouraging sign is when the patient begins to turn this hostility outward. Often the nurse is the first object of this hostility. Unless we recognize what is happening, we may fail to help the patient at this time. This expression of hostility needs to be accepted in a calm and caring manner. By responding in a hostile or defensive manner, we discourage the patient from expressing hostility and encourage him to turn it inward again, thereby increasing the danger of suicide. Often there is some basis for the expressed hostility. If we can be realistic and accept our share of responsibility then we may be able to help the patient to be more realistic. We also need to be alert to any signs which would indicate that the patient is planning further harm to himself. This can often be gathered from the patient's conversation or behavior.

As a general rule, these patients do not need advice. If they were able to think clearly, they would be able to see the same solution to their problems that we might be able to suggest. As long as they are not thinking clearly, it is hard for them to accept and carry out any advice they might receive. However, there may be an occasion when we think that some advice might be helpful. If this is given, we should clarify that it is general advice and may not necessarily solve his problem. An example of general advice might be "many people receive much satisfaction from developing some type of hobby. While working on their hobby they are able to view life in general more realistically. You also might find a hobby helpful." Sometimes, in their attempts to help their patients, nurses may make promises which they aren't able to keep. For example, when the patient is discharged they may tell the patient to call if they want to talk. Consequently, the patient may be calling frequently, taking a great deal of the nurse's time. She may begin to resent this and thereby reject the patient. It is wise not to promise more or commit ourselves to more than we are able and willing to carry out.

In conclusion, then, it is important that we do what we can for these patients, using the amount of time and skill we have without

neglecting the care of other patients for whom we are responsible. However, if the person does end his life we need not necessarily hold ourselves responsible. Ultimately no adult can be responsible for the suicide of another adult. Whether to live or take one's life is a decision each one must make for himself.

Much has been written about suicide and research in the area is going on at the present time. I would urge the reader to study the topic further. What I have written here are basic guidelines for a busy nurse whose first responsibility toward patients is to meet their physical rather than emotional needs. I hope that she will be able to follow these guidelines while giving physical care to her patients.

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RELATIONSHIP WITH CO-WORKERS

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Chapter IX

Healthy Work Environment

Many of us work with a large number of people with a wide variety of personalities among them. Furthermore, the degree of responsibility each person carries may differ greatly. Often part of the workforce carries some responsibility for the work done by others, and how well one group of workers does their work affects how well the others can do theirs. It is important that everyone works well together and yet frequently this is not the case. Problems arise in interpersonal relationships that hinder us from working at our best. It seems to me that problems in interpersonal relationships cause more unhappiness and discontent in working situations than any other problem. Often we give low pay, long hours, shift work, or lack of recognition as reasons for our unhappiness in our work. Certainly these things can contribute to unhappiness, but frequently the basic problem is poor interpersonal relationships rather than low pay or long hours. In situations where nurses work well together there seems to be less complaining about any of these other hardships.

When we are unhappy in our work, it may be difficult to recognize that this is due to poor interpersonal relationships, and even if we do recognize it we may not know what to do about it. Difficult as it may be, it is up to each one of us to improve our relationships. It is very easy to convince ourselves that other people need to change so that relationships will improve. It may be true that if other people changed their attitude or behavior the situation would improve; however, it is rare for someone to change their behavior or attitude merely to please us. If we do nothing but wait for other people to change, the situation will most likely remain unchanged or possibly get worse. Neither can we make someone change. The only attitude and behavior we can change is our own. Regardless of how unpleasant someone's behavior or attitude is, it is

our own attitude or response to their behavior that is the basis for our unhappiness and discontent. For example, a person may be very critical of others. Although no one may be particularly happy about this behavior, yet each person reacts in their own individual way. One person may listen half-heartedly and let what she says pass by her, another person may remain silent but be very hurt and upset about the criticisms, while a third person may spend much time defending herself against the criticism.

In discussing the influences that may affect how well a group of people work together, it may be helpful, first of all, to look at some of the goals we are trying to reach in our work. Each individual has individual goals. I think the most important is that of meeting personal needs. We have physical needs such as the need for oxygen, food, shelter, and safety. We have emotional needs such as the need for love, self esteem, and a feeling of worthwhileness. We also have a need to experience a feeling of accomplishment. It is commonly accepted that patients have needs which must be met, or problems will arise. Yet the fact that the nurse also has needs which must be met if things are to go well is not nearly as widely accepted. Frequently, comments are made that a nurse should not meet her own needs, that she should think about the patient rather than herself, that she is selfish and non-caring if she is concerned with her own needs, or that a nurse should not meet her own needs but instead she should meet the needs of her patient. Often the impression is given that a nurse can only do one and not both at the same time; that is, if she is meeting her own needs she cannot meet the needs of the patient. Or if she is meeting the needs of her patient, she cannot meet her own needs. I don't agree with this. In the first place, I believe that it is almost impossible for us to meet the needs of our patients if we have many unrecognized and unmet needs ourselves. Secondly, I believe that by meeting our own needs we can meet many of the patient's needs and that by meeting the patient's needs we can meet many of our own needs. Furthermore, it is necessary for one's own needs to be met to a certain degree before one is capable of meeting another person's needs. For example, if our own need for worthwhileness has not been met, I think that it is nearly impossible to meet this need in our patients. The only way that it may be possible to meet our patient's needs without having our own needs met is if we can recognize and accept our unmet needs. For example, let's say that a particular nurse's need for belonging isn't met in the work situation. She recognizes and accepts the fact that this need isn't met and is prepared to go for some time with the need unmet. If this is the

case, then I think that she would be able to meet the patient's need for belonging and her own unmet need will not necessarily affect her nursing care in a negative way. A self-accepting nurse accepts the fact that she has certain needs to meet. Furthermore, she takes the responsibility upon herself to try to have these needs met and doesn't wait for another person to meet them for her.

Certainly the work situation isn't the only place where our needs can be met. They can be met in our home life, community life, and social life. Since a large part of our life is spent at work, however, it seems logical to me to expect many of our needs to be met there. But people who attempt to have all their needs met in their work are placing too large a burden upon it. Those people are bound to have problems at work, if for no other reason than that they are expecting too much from it. On the other hand, I think it is rather foolish for people to stay in a job where very few, if any, of their needs are being met, unless it is absolutely impossible for them to work elsewhere. The people who have almost no expectations of job satisfaction are just as likely to have problems in their work as those who are expecting job satisfaction to fill all their needs.

The idea that if we are meeting our own needs we cannot be meeting the needs of the patient doesn't make sense to me. How better to meet our needs for self esteem, worthwhileness, and accomplishment than by meeting the needs of the patients. If the patient's needs are met, our nursing care will be more effective. The patient has a better chance of getting well and/or feeling more comfortable and satisfied. I think the same is true regarding individual needs and group needs. The better the needs of the individual are met, the better the needs of the group are met; the better the needs of the group are met, the better the needs of the individual are met.

The second goal is the welfare of the patient. I place this second rather than first because I believe that the nurses' needs must be recognized and met to a certain extent before they can be honestly concerned about the patient and the patient's welfare. However, once the nurse recognizes her own needs and accepts responsibility for meeting them, then her next goal is the patient's welfare. Without patients to care for, we could not be nurses.

The third goal is that of personal growth. This goal is directed toward meeting our need for a feeling of accomplishment. We need to develop ourselves as unique individuals through developing our potential. If there is no personal growth, then one's work can be expected to deteriorate. We do not remain stationary. If we are not growing, we are regressing. When we are regressing, we are troubled

with such problems as boredom, frustration, and ritualism. Our regression may become evident through such behavior as physical complaints, absenteeism, non-productive complaining, grumbling, and commitment to rituals such as unwillingness to consider change in routines or habits. A self-accepting nurse accepts responsibility for her personal growth and does not place this responsibility on other personnel or the work environment. What applies to the individual also applies to the group of workers as a whole. If the work of the members of the group deteriorates, more and more problems will arise. Therefore, it is important that each member, regardless of their degree of responsibility, has the opportunity for personal growth and progress.

A healthy working environment is one where the worker is able to meet many of her needs, where the patient is able to receive the best possible care, and where each worker has the opportunity for personal growth and development of skills.

Chapter X

Constructive Work Habits

Regardless of the working situation, some people seem to be more happy and content than others. Each one of us has the ability to make our working environment more or less unpleasant than it actually is. In other words, we can to a certain extent create a pleasant working atmosphere for ourselves regardless of general unpleasantness or we can can create an unpleasant working atmosphere for ourselves regardless of the pleasantness around us.

High on the list of constructive working habits is making a practice of enjoying minor events. Every day we have many momentary experiences which can be enjoyable such as a pretty flower, a compliment, a relaxed patient, or a well-made bed. All too often, we allow these things to go by unnoticed and unenjoyed while we are waiting for something outstanding or special to happen to us. Special or outstanding things happen only occasionally but every day many pleasant things are available for us to enjoy. Closely connected to enjoying minor events is making a habit of appreciating the humorous side of our experiences. Two people can have the same experience, but one will laugh about it while another may get upset. Certainly it can be a bit disconcerting to drop a dinner tray in the middle of the hallway. However, deriding or condemning oneself isn't going to make the cleanup job any easier; in fact, it can make it much harder. After all isn't there something funny about the sight of a mixture of food and broken pottery spread over a newly polished floor?

Another constructive working habit is to care enough about ourselves to occasionally compliment ourselves on a job well done. It seems much easier to recognize our deficiencies than our assets. Do you ever indulge in what I call a "I'm a good nurse" day? This is a day when one lists everything one has done well during that day. At

times we seem to be totally unaware of the many things we do well every day. To many of us it seems much easier to look at the things we failed to do or the things we did that we regret, yet we probably did more things well than badly. A conscientious nurse can always find something in her day that she wishes she had done or wishes she had done better or differently and certainly she can improve and grow by being aware of how she can improve her performance. However, I don't think constantly punishing or criticizing ourselves is going to help. I do believe that by appreciating what we do well, we can develop and maintain self respect and self confidence. This in turn can increase our job satisfaction and performance.

Another constructive work habit is to leave a day's frustrations and disappointments with that day rather than collect frustrations and disappointments and carry them for days and days. Each day has enough difficulties of its own without borrowing from days gone by. I am not suggesting that we repress unpleasant experiences. All I am suggesting is that we let them go. Forget them. We can forget by reversing the process of remembering. We remember events and experiences by recalling them frequently, thinking about them, and discussing them time and time again. We can forget them by not allowing them to occupy our mind. If they come into our mind, we can turn our thoughts immediately away to something pleasant. As I have pointed out, there are many pleasant things occurring in our day which could better occupy our minds. By accepting the fact that all will not be pleasant at work and that we need to work toward satisfaction and fun in our job, we can more readily dismiss unpleasant happenings.

Earlier I said that a self-accepting nurse recognizes her own needs and accepts the responsibility for meeting them. To be able to do this, it is necessary to understand our needs, to know which needs we are trying to meet in our work situations, and to develop a plan as to how we are going to go about meeting these needs. It is also important to understand when our needs are being threatened and how we react when this happens. Working toward meeting one's needs is a constructive work habit.

Setting and attempting to reach realistic goals is a constructive work habit. We can err in setting goals in two ways. We can set goals which are too high because they are beyond our ability or beyond possibility in our particular setting. Or we can set goals so low that they are easily obtained and do not present a challenge. By setting goals too high, we are in danger of becoming discouraged and developing a feeling of hopelessness. Moreover, by setting them too

high we may overlook many lower and more reasonable goals which we could reach and find satisfying. For example, nurses are concerned about the emotional needs of their patients. But usually they are so busy meeting the patient's physical needs that they have very little time left to meet the patient's emotional needs and become discouraged and decide that it can't be done. However, if she sets her goal lower and tries to meet some of her patient's emotional needs as time allows and is alert for opportunities to meet emotional needs while meeting physical needs, perhaps she would not become as discouraged. All days are not equally hectic and there are days when we do have free time. This time would be available to meet the patient's emotional needs if we had not allowed ourselves to feel hopeless about reaching this goal. Setting our goals too low can result in a feeling of dissatisfaction and boredom. An example of this might be to set as a goal to complete one's work as early and rapidly as possible. With this goal there is a danger of our days becoming rather ritualistic and stereotyped.

It is important to try to assess one's work situation as accurately as possible and then decide how one is going to work in it, not only by deciding what one's behavior is going to be but also one's attitude. More harm is done by not making a decision than by making the wrong decision. Once a decision is made, one derives a sense of direction. If a decision is made and proves to be unwise, it can very often be changed. Some people fool themselves into thinking that as long as they do not make a decision about a certain situation then they are not responsible for what happens. They don't realize that by not making a decision they have made a decision, namely, to do nothing and take no responsibility. This can greatly affect one's work and work satisfaction.

Finally, trying to have a positive attitude toward things is a constructive work habit. Any given situation can be looked at in a positive way or a negative way. To say that you feel terrible because you have a headache or to say you feel well except for a headache is saying the same thing. However, one statement indicates a negative attitude and the other a positive attitude. If you do not believe that this makes a difference to one's general feeling about one's work, I suggest that you do the following task. For a day try to look at everything positively and say things in a positive way. Then for a day try to look at everything negatively and say things in a negative way. Note the effect this has on your entire work day.

What are destructive work habits? I have already mentioned several while discussing constructive work habits but they warrant

repeating. Dwelling on the negative side of experiences is destructive and can turn a pleasant working environment into an unhappy one very rapidly. Setting goals which are too high or unrealistic soon results in feelings of hopelessness and worthlessness. Expecting too much from one's work as far as meeting one's emotional needs is concerned is a destructive work habit. Setting one's goals so low that we are only doing what is necessary can lead to dissatisfaction and boredom. Finally, carrying grudges or unpleasant experiences for days or even months or years can bring much unhappiness and work dissatisfaction.

I want to cite an example which demonstrates a destructive work habit. I had the following encounter with a nurse who had graduated twenty-five years before. In a workshop which I was conducting she told about an experience she had had as a student with a head nurse. The student thought the head nurse was determined to make her life on that unit as miserable as could be. This head nurse criticized her unmercifully and often reported things about her that were untrue. The student vowed that she would never work in that particular field of nursing as long as she lived. "Even today," she said, "I wouldn't consider working in that area of nursing. Hardly a week goes by that I don't think about that head nurse. When I do, I get angry and upset all over again." As this nurse was relating this experience, her face became very red, her eyes grew dark, and she shook her clenched fist in the air. Obviously this had been a very traumatic experience for her. "You've spent much time and energy thinking about this head nurse through the years," I said.

"Yes, I have," she replied.

"How often do you think she thinks about you?" I asked.

The nurse looked at me as if I had taken leave of my senses. "Probably never," she replied, "I think she forgot about me the minute I left her unit."

It wasn't necessary for me to say any more. After a brief period of silence, the nurse realized what had happened. Through the years she had held onto the unrealistic hope that the head nurse would pay for the wrong she had done. This nurse believed that by recalling and thinking about this experience and refusing to let it die, somehow the head nurse was suffering. Now she suddenly realized that it was she personally who had been suffering because by not giving up this experience, she had allowed this head nurse to have a strong hold on her.

"What a fool I've been," she said. "That woman wasn't worth a moment of my time and I wasted all this time and energy on her!"

She was silent for a few minutes and then said, "But this is the last time that I am going to think about her."

And I am sure it was.

In this example, I don't think it matters whether or not the head nurse was as unreasonable as the student perceived her to be. The significant thing is that the nurse carried this hurt and anger with her all those years. She kept it alive by repeatedly thinking about her experience with the head nurse. The experience itself was traumatic enough, but by refusing to let go of it, the suffering was increased immeasurably and a destructive influence had been at work in her life for twenty-five years. The energy she had tied up in remembering this experience could have been used constructively to meet realistic goals.

An individual who practises constructive work habits is giving herself the best possible opportunity to enjoy her work. Since few nurses work alone, one's work habits affect the other people in the work situation. The more people there are in a group that practise constructive work habits the more likely they will work well together and the more likely the members of the group will receive satisfaction in their work. We can practise constructive work habits in relation to the group also. One way is to share more pleasant things with each other rather than unpleasant things. Another is to recognize and comment on work well done by others and to set realistic goals for the group. Finally, everyone should try to look on the positive side of things rather than the negative.

If we realize that we have been creating much of our own unhappiness in our work situation by using destructive work habits, is there anything that we can do to improve or change our work habits? I think there is. It won't be easy because habits have a strong hold on us but I think it is possible to change work habits with the result of eventually enjoying our work more. Naturally this can't be done overnight and unless we realize this we may become extremely discouraged. The first step again is to accept the fact that we have used destructive work habits and to accept this with a non-judgmental attitude. Blaming ourselves or scolding ourselves will only make matters worse.

The second step is to assess the situation and decide which habit we are going to work on first. It is impossible to work on all destructive work habits at the same time. We need to select one at a time. Possibly we might choose the one which is the easiest for us to overcome or perhaps the one which is the most destructive. If we are successful with the easier one, we will probably gain confidence to

work on the harder ones. We may decide to work on the one that has the greatest effect on our working environment first. As we change this habit, we may find that other habits change also. If we have been using the destructive work habit of collecting frustrations and unpleasantness from day to day, we may have quite a collection by now. We need to find a way to release the energy we have tied up in these experiences. But to release it all at once can be disastrous. There is a danger of overreacting to a minor incident, thus creating problems which could be difficult to solve. By recognizing that this is energy tied up in destructive work habits, we can find a way to release this privately in a non-destructive manner. Some people find one method more effective than others. We can talk it out, write it out, and/or take it out on inanimate objects. However we decide to do this, it is wise to do so in a place and in such a way that it will not be destructive or cause us embarrassment. Some people find that while they are releasing this energy, they receive an added bonus, namely, gaining new insights into themselves and/or their behavior.

After we have given up our destructive work habits for constructive ones we must guard against slipping back to our old destructive ways. It is very easy to slip back, especially if we are working with other people who use destructive work habits. Therefore, it is necessary to check on our attitudes from time to time to be sure that they are constructive. Constructive thinking can do much to make our work more interesting and enjoyable and put us in a better position to assess our overall work situation. If we find that we are still unhappy, perhaps we are in a job that is not good for us and it may be time for a change.

So, in conclusion, there will be some unpleasantness and problems in our work since no area of work is problem-free. But by developing constructive working habits we often can cut down and minimize the severity of the problems encountered. To remain healthy we need to find satisfaction, fun, and happiness in life and since much of our day is spent working, it is realistic to expect to meet some of these needs during it. Furthermore, by not overrating the importance of any particular incident, we can let the day's frustrations and upsets go with that day.

Chapter XI

Promotions

One area where problems arise in working together is that of promotion. When there is a change in staff and one member is promoted to a different position, there is a need for a period of adjustment on the part of the people involved. I will first discuss the person who received the promotion. Usually this person was working well in the area she was in and was promoted on the basis of her work record. She leaves an area where she felt secure, confident, and had attained feelings of accomplishment. Now she is in a position in which, due to the newness alone, she may feel insecure, not as confident, and as yet has no sense of accomplishment. Also if she has been wanting that position, she has now reached the goal toward which she had been striving. She may find herself without goals for a period of time. Because of the anxiety all this can create, she may become overly concerned about what others think of her and what others expect of her. She may be overly concerned about the opinion of those above her and below her. When a person is promoted, or starts any new job for that matter, the adjustment period can be less painful and perhaps shortened if the person knows that these feelings are to be expected. This may prevent anxiety arising out of being anxious. After a promotion I think it is important for the person to set new goals as soon as possible. These goals should be such that they can be obtained fairly easily so that the person once again begins to get a feeling of accomplishment and job satisfaction.

Not only are problems created by the fact that one's goal is reached when one has been promoted and that one's needs are not being met in the accustomed way, but also one's expectation of oneself may create problems. It is more than likely that the person had some opinion about the job and how it should be performed. Perhaps she had been somewhat critical of the person holding

the position before her or had some ideas about how the job could be done better. When she is in the position herself she discovers that the position brings with it problems of which she was unaware. These problems may prevent her from doing some of the things she thought she could accomplish in the position. This can be very disheartening and it is important to guard oneself from feelings of hopelessness. Furthermore, the person may have certain expectations for herself because of what the position means to her. She may attempt to change her behavior to conform with her ideas of how a person in that position should behave. For example, if she thinks that a person in that position should know all the answers she would hesitate to ask questions and would have difficulty saying, "I don't know." Therefore, if she has a stereotyped idea of a person holding this position it will affect her behavior and problems are likely to arise.

Where do these stereotyped ideas originate? They originate from past experiences with people in similar positions. After having had a number of similar experiences with people holding certain positions a person may develop an idea of how people in this position behave. She may generalize and believe that all people in that particular type of position behave the same. Without being aware of it she may conclude that this is the way a person in that particular situation and position should behave. When she is promoted to this position it is possible that she will act like "this type of person should act" even if she doesn't approve of that behavior and recognizes that it is destructive. This could undermine one's self esteem. Reflecting on her past, she would probably find that many of these ideas developed during the period she was a nursing student or young graduate. Incidents that should never have happened to any nursing student have happened to almost every nursing student and often a person of authority is involved. These experiences may greatly influence one's behavior as a graduate nurse and one's reactions to authority figures. It is not the events which go on influencing a person but the attitudes and ideas one derived from them. To minimize or erase the effects these past experiences have on one's present behavior a person needs to drop the attitudes she has carried with her since. The solution to her problem is to drop the attitudes she derived from them. Attitudes influence behavior and behavior changes if attitudes are dropped or changed. To drop attitudes one must be aware of what they are. The first step is to try to recall upsetting experiences one has had in the past which involved a

person who held a similar position. After having recalled the experiences one needs to recall the feelings one experienced at the time. If on recalling the feelings one experiences them again, one can safely assume that the experiences are still affecting one's behavior. The next step is to learn to let go of the feelings and attitudes attached to that experience. I find it rather difficult to describe how this is done. However, one knows when one has achieved this by feeling relief, relaxation, and calmness. It may be necessary to look at the experience from all angles. What was so terrible about it? How could the authority figure have prevented this experience from being upsetting? What could the authority figure have done to undo the ill effects of the experience? What were the feelings one had about one's self during this experience? By looking at the situation from various angles, one may learn a great deal about the experience and how it has affected one's life through the years. Up to this point a person may have been totally unaware of the effect these experiences have had on her present behavior. But by re-experiencing her feelings she may be able to pinpoint the attitudes she has developed and the unrealistic ideas she has carried since that time.

If we drop the attitudes and ideas we have collected about the position we hold and about persons who hold that type of position then we will be able to look at it more realistically. We can decide what we want to get out of our work, what we hope to achieve, what we can achieve, and what are some of the real obstacles in our way.

Not only does the person who received the promotion have problems adjusting, but often the rest of the staff do too. When someone has been promoted from out of a group the remaining members frequently have high expectations of that person. If they were dissatisfied with the previous incumbent then they will probably expect things to change now that someone else has the position. If they don't change then the other staff members may be left with a sense of disillusionment and betrayal. Furthermore, it may be that without being aware of it, they will begin to treat the person who has been promoted differently. They may treat her as the "person who holds that position" because they also have stereotyped ideas about how that particular person is expected to behave and how they are to behave toward her. They may have some of the same unrealistic ideas about the position as the person who was promoted and, therefore, they reinforce each other's ideas.

Another problem that may arise with promotion is the possibility that another staff member wanted that position. This

staff member may express her frustration and disappointment by being unco-operative and trying to undermine what the person who has been promoted is trying to do. This can create a very unpleasant situation. It will probably be up to the person who received the promotion to take steps to improve things. It is necessary to be accepting and understanding of the other person's feelings. Secondly, she must be honest and open about her own feelings, accepting the fact that the other person wanted the position and yet pleased that she got it herself instead. There is no need for her to feel guilty or apologize for getting the position. She may wish to discuss her feelings with the other person and encourage her to express her feelings in return. Finally, she should try to treat that person fairly and allow her plenty of time to get over her disappointment. However, it should be made clear that the same quality of work is expected from her that is expected from the rest of the staff, even if she is unhappy with the situation.

An increased responsibility for leadership often accompanies promotion. An effective leader practises constructive working habits. She cultivates a positive attitude and looks for positive characteristics in her staff. People often tend to do what is expected of them so when a good performance is expected, they tend to perform better than when a poor performance is. If by attitude and relationship with staff one has attempted to create a reasonable working climate, then one must trust the staff's ability to develop their own and each others' potentials.

The person in the new position will probably wish to make some changes. One of the greatest difficulties in trying to make changes is that one is working with people who already have learned to do things in a certain way. Therefore, it is not only necessary to sell the new ideas but also to wean the staff away from the old ones. People tend to be more willing to change if they see the change as a benefit to them. If they believe that the change will make their work easier, more pleasant, or more efficient they will be more ready to change. But if they see the change as increasing their workload without any benefits for them they will resist. People also tend to resist change if they feel they are being pushed. An effective leader gives her staff an opportunity to help plan and suggest changes if feasible and an opportunity to discuss and question new changes that are introduced. An effective leader also gives her staff time to adjust to changes.

Along with promotion comes problems of adjustment. There is

a need to assess the new position, examine our ideas regarding the new position, and formulate goals. Promotion also brings the responsibility of leadership. To give effective leadership we need to know our staff and treat them as individuals in the work situation.

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Chapter XII

Personal and Interpersonal Problems

No one is problem free. At all times of our lives, we have problems. Sometimes they are large and serious problems such as sickness in the family and sometimes they are small and nagging problems such as a blister on the foot. But they are problems just the same. When several people are working together and everyone has some type of problem, it is no wonder that occasionally these problems cause difficulties in the work situation. Learning how to deal with our own problems and the problems of others can greatly increase our job satisfaction.

Our problems are part of us. Occasionally we hear people say that they don't let their problems interfere with their work or that they leave their problems at the door when they come to work. This sounds wise but personally I wonder whether this is possible. Our problems are part of ourselves and I don't think we can lay them down and pick them up any more than we can do this with an arm or leg, unless it is an artificial one. I do believe, however, that we can control to a certain extent the effect that our problems have on our work.

The first step is to identify our problem. This may sound too simple to even need mentioning. Certainly we know what our problems are otherwise we wouldn't have them or at least they wouldn't bother us. This is not necessarily true. At times what we label as the problem is not what is giving us the difficulty. For example, we have a sick child at home, who we have left with a baby sitter. We are worried about the child and our worrying is affecting our work. That could be so, but perhaps the problem is deeper; perhaps we feel inadequate as a parent, or feel that we have caused the child's illness, or we resent the inconvenience that the illness is causing. These are just some possibilities and there could be others.

The point I am trying to make is that what seems to be the problem isn't necessarily the problem. Two people may have a sick child at home but only one has a problem. Again, the situation isn't the problem but rather our attitude or reaction to it is, and if we are going to influence the effect our problems have on our work, it is necessary to clearly identify them. This is not easy to do. It requires that we look at our situation as realistically as possible and attempt to be honest with ourselves in relation to it. Next it is necessary to accept this problem. Rather than belittling the problem or ourselves for having it we need an attitude of "I have this problem and that is the way it is." I am not suggesting an attitude of resignation, which includes a belief that there's nothing I can do about the problem so I might as well live with it. Acceptance means owning the problem and taking responsibility for one's behavior in relation to it. By accepting our problem wholeheartedly we are in a better position to act upon it and we are also more capable of controlling our behavior in the work situation. For example, if we are irritable and short tempered because of a particular problem, it is reasonable to anticipate that we may misinterpret the behavior and attitude of others toward us. If we are aware of this then we can decide not to respond with anger and hurt toward our co-workers. If we aren't aware of how our problem is affecting us it would be simple to distort situations at work and decide that everyone was doing their best to make our day unpleasant.

It helps to keep our problems in proper perspective by reminding ourselves that there are certain tasks that are so important that they need to be done regardless of how we feel or how large our problems are. For example, patients need to be attended to, medications need to be given, babies need to be fed, and classes need to be taught. By allowing ourselves to become completely involved with the task at hand our personal problems tend to fade into the background, giving us momentary relief from them.

Furthermore, there are times when one's personal problems can be upsetting enough to warrant staying home. If we have a physical problem such as a severe cold or flu we don't hesitate to notify our place of employment and inform them that we will not be able to carry out our work responsibilities and therefore are staying home. On the other hand, many of us don't feel right about doing this when our personal problems other than physical are upsetting us to the extent that it will be difficult if not impossible to concentrate on our responsibilities and carry them out. We seem to think that we should be able to cope. Consequently, it happens, at times, that by going to

work we cause problems there. We owe it to ourselves and others to recognize when we are in no condition to handle our responsibilities in the work situation whether it be for emotional or physical reasons.

Not only do we have personal problems that affect our behavior in the work situation, but the people we work with have their own personal problems which are going to affect their behavior and attitudes. It is just as important for us to accept the problems of others in a non-judgmental way as it is our own. If we do, we can decide how we are going to allow the problems of others to affect us and our behavior.

It is possible to use our problems in such a way that it seems to be to our advantage to have problems. We can excuse or justify our behavior (which may be undesirable) on the basis that we have a problem, or we may even expect special favors because we are so upset. Furthermore, we can react to others in the same way. Rather than accepting the fact that they have a problem and allowing them to carry the responsibility for it, we can encourage them to remain in an upset state by giving them special consideration or doing special favors for them. I think that we need to guard against this. For example, a certain nurse was married to an alcoholic. This created many problems in her personal life. At work she was often short with other members of the staff, tending to criticize them severely, and she frequently came late. Everyone knew about her home situation and excused her behavior on the basis that she had problems at home. The nurse excused herself on this basis and made no effort to change. There was no incentive to change since her co-workers were allowing her to behave in ways that were upsetting and hurtful. Since she had problems, she wasn't expected to show the same consideration to her co-workers that they were expected to show to each other and to her. At the same time, members of the staff who did not have personal problems or didn't broadcast their personal problems were being punished. They were expected to tolerate the nurse's behavior and to be understanding and sympathetic, thus encouraging her to hold on to her problems instead of solving them. If this nurse had been told that the staff realized that she had problems and that they were sympathetic and willing to help in any way they could but that they were not prepared to allow her to disrupt the harmony in the working situation or relieve her of the responsibility for her own behavior, then perhaps she would have been ready to try harder to solve her problems. We can question whether the behavior of the nurse was due to her problems or whether her problems were

used as an excuse to avoid changing her behavior. I am not suggesting that we react to others and their problems in a hard and unsympathetic manner. Far from it. It seems reasonable to do anything that can be done to lighten a co-worker's burden as long as the rights of others are not being infringed. But we need to look at the problems of others objectively and not allow them to be used either to the advantage or disadvantage of the person or her co-workers.

There are several ways in which we encourage ourselves or others to perpetuate problems or to use them to advantage. One is by constantly talking about them or allowing others to constantly talk about theirs. Talking about one's problems and allowing others to talk about theirs can be helpful under certain circumstances; at other times, it can prevent personal growth or discourage problem solving.

Talking about "the problem" can be used to mask inadequacies in interpersonal relationships. It is an effective way of maintaining one's distance from another person and never getting to know them. It is also a way of eliminating silence. Some people have great difficulty in handling silence. Talking constantly about problems prevents silence. Closely related is the fact that talking about problems gives one something to do. If one cannot tolerate silence and does not talk about problems, there is an awkward gap to be filled. People who are accustomed to interacting with others by talking about their problems and who suddenly stop may find themselves with nothing to do. This can be a very upsetting and threatening situation to be in.

Moreoever, talking about one's problems can be an indirect way of expressing hostility. Subjecting people who want to relax and enjoy themselves when they are on their coffee or lunch break to a running commentary on one's problems is a very effective way of expressing hostility. Most people find it difficult either to get up and move away or to state that they do not want to hear about it. They seem to have no other choice but to sit and listen. Finally, constantly talking about one's problems can be a way of transferring responsibility. The person who listens has to do something, if nothing more than being sympathetic or getting up and walking away. These are some of the secondary gains that we can get from talking about our problems, and therefore we are discouraged from trying to solve them. Talking about them is not helpful or growth promoting. If we wish to discourage this in ourselves or others, we need to under-

stand and recognize how personal problems can be used to one's advantage even unwillingly.

On the other hand, if a person sincerely wants to solve their problems it can be very helpful to talk about them to an accepting and understanding person. If we wish to help others by listening, I suggest that we find a place which is conducive to listening. Certainly the center of a large noisy dining room or coffee shop with other people at the table is not such a place. In an earlier chapter I have talked about the skills required in listening to patients. The same principles apply when listening to a co-worker. A good listener is an accepting and non-judgmental listener, thus allowing the speaker to use the listener as a sounding board. Advice is often of little or no help since the person would probably be able to solve the problem if it belonged to another or if they were not emotionally involved. Even though the speaker is sincerely interested in working out her problem and the listener is sincere about trying to help, there is still the danger of getting into a habit of going over the same material again and again. As a listener we can be helpful by setting limits on how often we will listen to the same material even though we continue to be supportive and understanding.

But what about people who don't want to solve their problems? People have the right to keep their problems if they wish. This is a decision every person needs to make for herself, but sometimes it can be very difficult to allow her to make that choice. Often we think that people *should* solve their problems, especially if we think we have the answers. Everyone has the right to keep their problems but they also have the right to reap the effects of that decision. We can influence them, to a certain extent, by making their problems more or less desirable. Whether or not we allow our co-workers to receive secondary gain from their problems greatly influences their decisions regarding them. On the other hand, we also have the right to decide whether we wish to be affected by other people's problems and how much, if any, of their burden we wish to carry.

There seems to be much confusion as to who has the problem. Often we are concerned about trying to solve another person's problem instead of our own, or we think another's problem is ours. Sometimes we place our own problem on another's shoulders and call it theirs. The person who is behaving in an undesirable way but isn't upset about it doesn't have a problem. Neither does the person who isn't upset about the undesirable behavior of another or about what is happening. It's the person who is upset and unhappy about

what is happening or about the behavior of others who has the problem. In many situations, we can either have a problem or be a problem. If we have a problem then it is up to us to do something about it and if we are a problem then it is up to the person who sees us as a problem to do something about it. Perhaps the following example can be used to clarify what I am trying to say.

> Mrs. Hayes, the supervisor, wanted to be called whenever extraordinary things happened on the unit and before any decisions were made about handling them. Such situations as a death of a patient, a definite change in a patient's condition, an admission, or a serious complaint from a relative were considered extraordinary situations. Mrs. Coates, the charge nurse, resented this ruling. Frequently, she would make a decision first and then call the supervisor at her convenience. Without fail, the supervisor would reprimand Mrs. Coates. It didn't matter whether the decision was one that Mrs. Hayes would have made herself or not. The issue was that the supervisor should be called first and she was to make the decision. However, when Mrs. Hayes had a day off or was on holidays, Mrs. Coates was acting supervisor and made the decisions at those times. Mrs. Coates couldn't understand why she would be considered capable of making the same decision on one day and not on the other. This was such a problem for Mrs. Coates that she seriously considered resigning from her job even though there were many things that she enjoyed in her work. She felt that Mrs. Hayes was being unreasonable and degrading toward her. She thought that she was being treated as if she had no ability or good judgement. She thought that Mrs. Hayes should be pleased that she used good judgement when situations arose rather than reprimand her because she wasn't notified. In the same hospital, Mrs. Boyd was the charge nurse on the afternoon shift on the same unit. She often needed to call Dr. Gordon to come and see several patients. By the time Dr. Gordon arrived on the ward Mrs. Boyd would have already assessed the patients and decided in her own mind which were more urgent than others for the doctor to see. She would report this to Dr. Gordon who would ignore this information and proceed to see the patients in any order he wished. This upset Mrs. Boyd terribly. She interpreted his behavior to mean that he didn't trust her judgement. Since she thought her judgement was good, she reasoned that he should trust it and follow her suggestions. One day, Mrs. Boyd told

Mrs. Coates about this. Mrs. Coates was surprised. She said, "Does that bother you? He does that to me too but it doesn't bother me. As far as I'm concerned I've carried out my responsibility by reporting my observations and suggestions to him and then it is his responsibility to decide what he wants to do with the information."

I think we can learn several things from this example. First of all, it points out that problems are personal. Both Mrs. Coates and Mrs. Boyd experienced the same situation with Dr. Gordon. Yet Mrs. Boyd had a problem while Mrs. Coates did not. However, Mrs. Coates's problem with Mrs. Hayes was very similar to the problem that Mrs. Boyd had with Dr. Gordon. Why did Mrs. Coates have a problem with Mrs. Hayes and not with Dr. Gordon? Why did Mrs. Boyd have a problem with Dr. Gordon when Mrs. Coates did not? It was their attitudes and reactions which determined whether or not Mrs. Coates or Mrs. Boyd had a problem.

Looking at the problem Mrs. Coates had with Mrs. Hayes, some of us may react by saying, "I don't blame Mrs. Coates; I'd be angry and upset too. Mrs. Hayes is being unreasonable by belittling Mrs. Coates and is impressed with her own importance." Or some of us might react with, "I don't blame Mrs. Hayes for reprimanding Mrs. Coates. How can she do her work well if she isn't kept informed about the ward situation." Be that as it may, justifying, interpreting, and judging either Mrs. Hayes's or Mrs. Coates's behavior does not give us a clearer picture of the problem. We often make this mistake when attempting to solve problems. For some reason we seem to think that if a person's behavior or reaction can be justified, or if blame can be put on another, then the problem is solved or at least transferred. However, the problem remains. What if we can establish that Mrs. Hayes was at fault? What if we can agree that Mrs. Hayes was being unreasonable? What if we agree that since Mrs. Coates made these decisions when Mrs. Hayes was off duty she should be allowed to make them when Mrs. Hayes was on duty? What if we agree that it doesn't make any difference who makes the decisions as long as the decisions are wise? What if all of us realized that we would be upset if we were treated like that? Does that solve Mrs. Coates's problem? Of course not! Mrs. Hayes, in all probability, will continue to behave the same way and Mrs. Coates will continue to be upset. All the justifying, understanding, or blaming in the world won't make any difference.

How then can Mrs. Coates's problem be solved? The only way

is for Mrs. Coates to change her attitude, behavior, or reaction. She could change her attitude by accepting that as long as she continues to make decisions without notifying Mrs. Hayes first, Mrs. Hayes will reprimand her. She could change her attitude by accepting that Mrs. Hayes's demands have no bearing on whether or not she, Mrs. Coates, is capable of making these decisions responsibly. She could change her behavior by following the direction given her by Mrs. Hayes. She could change her behavior by talking to Mrs. Hayes and explaining her side of the situation and requesting that the ruling be changed. I will enlarge on this later when I talk about problem solving.

Before going into that, however, I would like to discuss Mrs. Boyd and her problem. What was Mrs. Boyd's problem? Was the problem that Dr. Gordon did not follow her suggestions but rather ignored them and went his own way? He did the same thing to Mrs. Coates. Therefore, if this was the problem then Mrs. Coates would have had it too. But there was a difference in the attitude and reaction of the two nurses toward Dr. Gordon's behavior. Mrs. Coates offered the information to Dr. Gordon because she felt that this was her responsibility and therefore she carried it out. However, as far as she was concerned, he was free to use the information as he wished. What he did with the information had no influence on her feelings about herself. Mrs. Boyd, on the other hand, interpreted the doctor's behavior to mean that he did not trust her judgement. Now certainly this is only one of the many ways that his behavior could be interpreted. But Mrs. Boyd chose to interpret it this way. So what, if he didn't trust her judgement? What difference did it make? I don't know, but it made a difference to Mrs. Boyd. Somehow or other, whether or not Dr. Gordon trusted Mrs. Boyd's judgement influenced the way Mrs. Boyd felt about herself. So I would say that Mrs. Boyd's problem was that she needed Dr. Gordon to trust her judgement so that she would feel good about herself.

Assuming that this is accurate, what can Mrs. Boyd do about it? Mrs. Boyd has the problem and Dr. Gordon is the problem. I think Mrs. Boyd can begin to resolve matters, first of all, by accepting and owning the problem; secondly, by trying to understand it; and, thirdly, by looking at all the possible solutions. I have mentioned earlier that we can only change ourselves and not others. Therefore, suggesting such solutions as making Dr. Gordon trust her judgement or proving to him that her judgement is sound is unrealistic. We don't know whether or not Dr. Gordon trusts Mrs. Boyd's judgement. Neither do we know why Dr. Gordon behaves the way

he does. What would happen if Mrs. Boyd changes her attitude? If she accepts Dr. Gordon the way he is? If she accepts the fact that his reaction to her doesn't make her judgement any more or less sound than it actually is? Once she accepts this she no longer has a problem and now can decide whether or not she wishes to continue to behave in the same manner. Perhaps she will decide that she will discontinue giving Dr. Gordon information he doesn't use. Or she may decide to continue giving it to him regardless of what Dr. Gordon does with it. Certainly there are other ways this situation could be approached. Mrs. Boyd could discuss her feelings with Dr. Gordon. This would give Dr. Gordon an opportunity to give his reason for his behavior and that might help Mrs. Boyd understand him better. Dr. Gordon might even change his ways and follow Mrs. Boyd's suggestions even though people seldom change their behavior merely because it disturbs someone else. Be that as it may, the main problem has to do with the way Mrs. Boyd feels about her own judgement and her reaction to Dr. Gordon's behavior.

I want to go on now to discuss being a problem. In the example above, while Mrs. Boyd and Mrs. Coates had problems, Dr. Gordon and Mrs. Hayes were problems. Sometimes when a person is a problem they are not aware of it. Other times they may deny it or in the same situation they may see the other person as being a problem. Another possibility is that the person who is the problem is aware of being a problem and decides to continue to be a problem.

We can use the example to illustrate these points. First of all, a person can be a problem and not be aware of it. This might be the case with Dr. Gordon. It could be that he was going about his business, doing his job, totally unaware that his behavior was extremely upsetting to Mrs. Boyd. Secondly, a person may deny being a problem or see the other person as the problem. If we heard Mrs. Hayes's side of the story, we might find this the case with her. Perhaps she found it very difficult to deal with Mrs. Coates, who was constantly breaking the rules, and didn't realize that Mrs. Coates found her behavior upsetting. Viewing the situation from Mrs. Hayes's point of view, she has a problem and Mrs. Coates is it. Finally, a person can be aware of being a problem and decide to continue in the role. Either Mrs. Coates or Mrs. Hayes could make this decision. Mrs. Hayes may know that her behavior is very upsetting to Mrs. Coates, yet she may also decide that she will continue to behave in this manner and accept the responsibility of being a problem. The same could apply to Mrs. Coates. Once a person has decided to remain a problem then the other person no longer is a

problem to them. If Mrs. Coates decides to be a problem then she accepts that Mrs. Hayes will be upset by her behavior and will continue to reprimand her. This will then become a part of the day's routine. However, if a person decides to be a problem, they must not expect to be accepted and understood by the person whose problem they are. Mrs. Coates need not expect Mrs. Hayes to approve of and understand what she is doing.

There are some advantages to being a problem rather than having one. The main advantage is that one doesn't have a problem and therefore one's behavior need not change. Mrs. Coates need not change her behavior once she has decided to be a problem. But if, instead, she doesn't want Mrs. Hayes to have the advantages of being a problem, she can change her behavior. She can follow the rule to the letter, calling Mrs. Hayes to the unit every time something happens and not doing anything about anything until Mrs. Hayes arrives to give her directions. Mrs. Hayes might find that now she has an entirely different problem, namely, being constantly interrupted to go to the unit to assess situations. There is still another advantage to *being* a problem and that is that one makes a difference. One can create a stir by being a problem.

If a person has a problem, how can one go about solving it? I want to outline a method which I find helpful and which I have passed on to others who have found it useful. The first step is to identify the problem. Be sure you have clearly in your mind what the problem is. As I have pointed out, usually the problem is not the behavior of others but rather our attitude or reaction toward the behavior or toward the situation caused by the behavior. The second step is to ask yourself the question, if I could change this situation the way I would like it to be, how would I change it? This isn't a simple question to answer and will probably take some thought. I think it is important to know how we would like things to be so that we can work toward that. It frequently happens that people want one thing but are working toward another. An example of this would be the situation cited earlier regarding the nurse who was married to an alcoholic. The staff wished that her behavior would change. However, their reaction and behavior in this situation actually encouraged the nurse to continue to behave in the same way. The third step is to list all the things you can do to eliminate the problem. Use your imagination here, regardless of how ridiculous or unacceptable the methods might be, all the way from having a temper tantrum to slipping arsenic into someone's coffee. If we have been involved with a problem for a long time, our understanding of

the problem tends to become very narrow. We go over and over the same ground and never come up with a solution. By listing all the things we could do, we can break up the thought pattern we have developed regarding this problem. Even though we would decide not to do most of the things on the lsit, we may come up with ideas that we hadn't thought of before which might solve the problem in a satisfactory way. Or some of the ideas might be useful if we modify them somewhat. As we list our ideas, more will come to mind. Listing all the possible solutions to the problem helps break up what I call the "nothing can be done" syndrome. By that I mean the idea that there is absolutely nothing one can do about a situation or problem. Very seldom, if ever, does one have a problem about which nothing can be done. In fact, the reverse is often true. There are so many things one could do that it is difficult to decide what. The fourth step is setting a goal toward which you are going to work. This goal would be similar to how you would like the situation to be as identified in step two. Once your goal is set, discard all those ideas on your list which would either bring you more problems or bring you further from your goal. Many of the ideas would probably be eliminated. But chances are that at least one and possibly several solutions will remain after you have discarded the ones which would either bring more problems or take you farther from your goal. Finally, select the solution which you think you are capable of carrying out and would most probably enable you to reach your goal.

In selecting a plan of action in an attempt to solve your problem, try to be realistic. For example, there is no point in deciding to fire someone, if hiring and firing isn't part of your responsibility. Your plan must also be in keeping with your abilities. It is fine to decide to talk with the person who is a problem to you. But if you know that you are so frightened of this person that you are speechless when she is around, then you may add to your problems by talking with her. You would be wiser choosing some other solution, at least until you have worked through your fear of her.

Sometimes in trying to solve our problems we may go from one extreme to the other. We may start out thinking that there is nothing we can do and then switch over to attempting to make major changes which we cannot handle. Therefore, it is very important that we are realistic about ourselves and the situation so that we can select the solution to the problem which is best for us at the time. Perhaps the solution will involve only small change on our part yet its impact may be great. Any change in our behavior or attitude influences or provokes changes in the behavior and attitudes of

others. A very small change may eventually make a big change in a particular situation. Furthermore, a small change may uncover an aspect of the problem of which we were not aware before. Once it is uncovered, we can decide how we wish to deal with it.

Finally, it is possible that after taking the steps in problem solving suggested above, we may decide that anything we do would make the situation worse. Then we may decide not to do anything. This is a far cry from the "nothing can be done" syndrome. This involves the making of a decision. We have decided what we are going to do about our problem and what we have decided to do is to do nothing.

It is realistic to expect some interpersonal relationship problems in a busy work situation where many people work together. By changing our feelings, thoughts, or behavior, it is often possible to eliminate many of them. By using a simple problem solving approach we can determine what we are able to change and what we need to accept as inevitable.

Chapter XIII

Responsibility

There is some confusion about the meaning of "responsibility" and what characterizes a "responsible person." There are certain aspects of responsibility and our understanding of it which influence our ability or inability as nurses to work effectively and comfortably together.

Very often when the subject of responsibility is raised, the first thought that comes to mind is blame. If someone asks, "Who is responsible for this," then we tend to hear, "Who is to blame for this." When something undesirable happens we feel more comfortable once we know whose fault it is and where to place the blame. In fact, frequently, we believe that we have solved a problem when all we have done is place the blame. In reality, we haven't begun to solve the problem or to accept the responsibility for it. Neither have we guaranteed that the same thing won't happen again. What we have done is found someone to point our fingers at so that others will stop pointing their fingers at us. The following example demonstrates this:

> Miss Welsh, who had been discharged from a psychiatric hospital, returned for an appointment with her therapist. She reported that she was very upset because the people at her place of employment knew that she had been treated for psychiatric disorder. It seemed that someone who worked at the hospital had told someone who worked with the patient. The patient's therapist reported this to the head nurse. The head nurse immediately called a meeting with the other nurses to discuss this situation. It was concluded that a certain person, not on the nursing staff, had given out this information. It was decided that the head nurse would talk with this person so that this would not happen again.

In the above example, all that was done was to place blame. It would be far more worthwhile to accept the fact that this had happened and attempt to view the situation as realistically as possible so that the problem could be identified.

What is the problem that is being dealt with here? Is it important to know how the information got out? If so, why? Can we prevent this type of information from getting out? If we can, is this what we want to work toward? Is it possible to improve our nursing care so that our patients are prepared to meet these types of situations when they are discharged? Is this, perhaps, what we wish to work toward? Is this a more realistic goal? Would it be easier to reach? Would it be healthier for everyone concerned? These questions are an example of the different angles from which this situation could be viewed. By looking at the situation from various angles, the nurses would be in a position to decide what action, if any, they wished to take.

Responsibility involves accepting ownership and being accountable or answerable for a certain trust, duty, or obligation. If there is confusion among nurses as to the responsibility of one individual nurse and the responsibility of other nurses, problems arise in interpersonal relationships. Self acceptance and responsibility go hand in hand. A responsible person accepts the responsibility given to us all in trust by our creator, if you will, or by life, circumstances, whatever. Our obligation or responsibility as a person is to accept what we are and be accountable for it. Having accepted what we are, it is our responsibility to decide what we are going to do with what we are. It is our responsibility to decide how we are going to live day by day and moment by moment. A person who takes the responsibility for herself as a person is very little concerned with blame but rather more concerned with ownership. As we have mentioned earlier, there are many sides to a person. There are strengths, weaknesses, talents, lack of talents, feelings, thoughts, and behavior. Being responsible means owning all these things about oneself and being accountable for them. Certainly there are many things that have a bearing on what we are today, including such things as heredity, home environment, and life experiences. These do not subtract, however, from our responsibility for ourself as a person. As an example, suppose you have strong feelings of inferiority. If we look at your life as it has been lived and experienced thus far, it may be very obvious why you have strong feelings of inferiority. Perhaps your parents favored your older sister, your school teachers very seldom praised you but were always ready to criticize, and your girl

friends were much prettier than you. You may say your parents or teachers are to blame for your inferiority feelings. Placing blame doesn't change your feelings of inferiority. True, your parents and teachers probably did have a strong influence on the development of these feelings; however, they are your feelings. They belong to you and the responsibility is yours to decide how you will allow them to affect your life and behavior. As a responsible person, you accept and own these feelings of inferiority. I chose this example because I think that most people occasionally, if not frequently, suffer from feelings of inferiority.

As I mentioned earlier, a self-accepting person knows what is right for her. In relationships with others, work situations, and various problems, she is able to come to a decision and when her heart is in agreement with her head, she knows that the decision is right for her. She feels herself the active force in her life and, therefore, takes the responsibility for herself as a person. Once she knows what is right for her, she has no hesitation about going ahead and doing what is right.

When my son was six years old, he said to me, "Mom, do you know what I used to think when I was little?" Suppressing a smile, I said, "No, son, what did you think when you were little?" "Well, I thought that the red light stopped the car. But now I know that it is the driver that stops the car," was his reply. It happened that one day, when he was three or four, he was riding in the front seat of the car. He saw the traffic light change to red and the car stopped abruptly, nearly sending him through the windshield. He concluded that the red light stopped the car but he later learned that the driver stops the car when the light changes. This may illustrate what has happened to many of us. While we were growing up we thought that father, mother, teachers, neighbors, playmates, and other outside forces made us do things. Many adults continue to believe this. However, a person who accepts the responsibility for herself as a person has learned that she is the one who decides how people and circumstances affect her life. It is the driver and not the light that stops the car.

There are three mistaken ideas concerning feelings and responsibility that affect our relationship with others. The first idea is that other people can make us feel a certain way. We make such comments as: she makes me feel stupid, or she makes me feel like a fool, or she makes me angry, or she makes me feel guilty. Certainly other people's behavior can have a great influence on the feelings we experience. However, another person does not make us feel stupid,

foolish, or angry; but rather we respond to the behavior of another by feeling stupid, foolish, or angry. We are responsible for our feelings of stupidity, anger, or foolishness.

The second idea is that we can make others feel a certain feeling. We make comments such as: I said that to make her feel good, I made her angry, or I made her feel like a fool. Certainly our behavior does influence the feelings other people experience, and how we behave in relation to others is our responsibility. But we are deceiving ourselves if we believe that we are so powerful that we can make others experience certain feelings. We are responsible for how we behave toward others, but how others respond to our behavior, and the feelings they experience in response to our behavior, is their responsibility. Some of us may have learned this when we tried to make someone feel a certain way only to find that they responded to our behavior with an entirely different and unexpected feeling.

The third idea is that we can feel for someone else. We make such comments as I felt embarrassed for her or I felt anxious for him. For example, a nurse was talking with a patient who stuttered. Every time the patient had difficulty with a word the nurse would immediately interrupt him with the word that he was trying to say. According to the nurse, she did this because she felt embarrassed for the patient. Actually the nurse's feelings of embarrassment was her response to the patient's behavior. When he behaved in this way, she was embarrassed. Her behavior of interrupting the patient was her response to her feelings of embarrassment. The stuttering was the patient's problem and responsibility but the nurse's feelings and behavior in response to the patient's behavior was her responsibility.

I mentioned that we are responsible for ourselves as persons and by the same token others are responsible for themselves as persons. Often the question is raised as to how we can make others accept and carry their responsibility for themselves. The simple answer is that we can't. We delude ourselves when we think that we can make others be responsible. People will only carry the amount of responsibility that they can personally place on their own shoulders. We can delegate and assign responsibility to others, we can tell others that they are responsible for themselves, but this is no assurance that they will carry this responsibility. The person needs to accept this responsibility and place it on his own shoulders before he will carry the responsibility that we have given to him. If he does not accept this, he will use one of the many methods available of evading responsibility.

Even though we cannot force or make others carry responsibility,

we can encourage or discourage them from being responsible. What are some of the ways that we can encourage others to be responsible? Of utmost importance is that of accepting, owning, and carrying one's own responsibility. By carrying one's own responsibility, we may encourage others by example. Furthermore, if we carry our own responsibility rather than place it on the shoulders of another, we are not dependent on them; therefore, we are in a position to refuse to carry their responsibility. Refusing to carry another's responsibility is the second step in encouraging others to take responsibility for themselves. Thirdly, responsibility can be encouraged by allowing others as much freedom in living their lives and carrying out their work as possible. Too many rules and regulations make it difficult for people to be responsible. Finally, we can encourage others to accept and carry their own responsibility by being honest and open about what can be expected from us.

There are several ways in which we can discourage others from accepting responsibility for themselves. It is helpful to know them if we wish to avoid doing it. We have already mentioned rules and regulations. Making many rules and regulations which restrict a person's movement or the use of his own judgement is an effective way of discouraging him from carrying responsibility. Another method is to be overly involved in placing blame when things go wrong rather than looking at the situation and deciding what needs to be done. If much emphasis is placed on who is to blame when things go wrong, workers tend to use their energy in trying to remain blameless. They avoid taking risks and risks are a necessary part of using one's own judgement and being responsible. If mistakes are unacceptable, people tend to become irresponsible. A third method is to consistently do things for others that they could well do for themselves. This is especially true if it is one-sided and there's no room for an exchange of favors or work. A fourth method is to believe that we know what is right and best for others and therefore direct others in how to conduct their lives. Closely related to this is doing things which are for the "good of others" whether they like it or not. An extremely self-sacrificing person, one who will do for others what he will not allow others to do for him, can discourage others from carrying their responsibility. A final method is assuming that others are incapable of handling situations, so that we do work or do work over without the knowledge and consent of the person whose responsibility these things should really be.

If, as I mentioned earlier, a person will only accept as much responsibility as he is willing to carry, what happens to the rest of it?

This responsibility is avoided or evaded in some way. There are several ways in which this is done. One, which seems to be very common among nurses, is by carrying the responsibility for others. In this way, the others are placed in one's debt and it is quite simple to point out to them that the least they can do under the circumstances is to carry our responsibility. We may not be able to convince others to stop carrying our responsibility if this is what they choose to do. However, to avoid getting caught in this trap one needs to carry one's own responsibility as much as possible and not expect others to carry it for us. Then we need to recognize that if the other person, of his own free choice, decided to carry our responsibility, we are not obligated to them in any way.

Another way of avoiding responsibility is to develop a complete lack of awareness that a particular situation exists or that one has any responsibility in that situation. This is rather like an ostrich putting his head in the sand. We indicate by our behavior that what one isn't aware of isn't one's responsibility. A third way is to become defensive immediately when even as much as a suggestion of a negative comment is made about oneself. For example, someone may ask, "Did you give Mrs. Holmes her tray?" The nurse immediately replies, "Well, I have been so busy, where could I have found the time," or a similar reply which justifies herself even though she hasn't been accused of anything. In the example, there was no indication why the question was asked. There was no implication that the nurse had failed to do her job. Yet her reply indicated that she thought that someone was dissatisfied with her work. This type of response to ordinary questions can sometimes discourage people from discussing situations with you in which you have failed to carry your responsibility.

Another way to evade responsibility is to verbally attack another person when they are somewhat critical of your behavior. For example, the supervisor asked the staff to try not to waste supplies. One of the staff members replied, "All you ever worry about is cost." The supervisor then came back with, "I do not." Now the conversation has moved from not wasting supplies to whether or not the supervisor is concerned about anything besides costs. Meanwhile, the staff nurse has nicely evaded her responsibility.

Finally, constantly excusing or justifying one's behavior is a means of evading responsibility. If we compare our behavior or work with others and decide that our behavior is just as good if not better than that of others and then give this as a justification for our poor work or undesirable behavior, we are evading our responsi-

bility. Holding someone else responsible for our behavior is another example of excusing ourselves. If a person says that she doesn't do her work well because the supervisor doesn't like her anyway, that person is holding the supervisor responsible for her work.

The following situation depicts a person who used several methods to evade her responsibility.

> Miss Nightowl had difficulty awaking in the morning. When her alarm rang, she would turn it off and go back to sleep. She was frequently one or two hours late for work. She left her telephone number with a note at the nursing station, asking the night nurse to call her every morning at 6 a.m. The night nurse did this faithfully for three weeks and Miss Nightowl arrived on duty on time. One morning after a very busy night, the night nurse completely forgot to call Miss Nightowl. Miss Nightowl's absence wasn't noticed until she, very irate, walked on the unit at 8:30. Due to her lateness, several eight o'clock medications and treatments weren't given and the patients assigned to her hadn't received any care.

I invite the reader to look at this situation in the light of some of the comments made earlier. Can you pick out the methods Miss Nightowl used to evade her responsibility? If you were working with her, how would you encourage her to accept her responsibility? How much responsibility would you carry for her? Is Miss Nightowl the only one in this situation who is not accepting her responsibility?

I would like to discuss three areas of responsibility that we have as nurses. First, responsibility toward self; secondly, responsibility toward patients; finally, responsibility toward co-workers.

First of all, responsibility toward oneself. We have a responsibility to accept ourselves as we are at any given moment. It is so easy to compare ourselves with others and find ourselves inadequate. Perhaps some expert in nursing could have done much better than we in a particular situation or maybe she couldn't! But that's beside the point. The point is that we did the best we were capable of at the moment. We are who we are. We are constantly changing and at another time in a similar situation we may act much differently and more effectively. However, if we do the best we can and what is right for us, that is all we can expect. If we aren't happy with the way we responded in a certain situation, we can change providing we accept the responsibility for ourselves. Once we stop putting the responsibility for our feelings and behavior on others and take it upon

ourselves we can do something about them. How we can change our feelings and behavior has been discussed in the chapter on acceptance of feelings. Often I have seen nurses accept responsibility for others' being and/or behavior but not their own. They excuse, justify, smooth over others' behavior, especially when there are complaints from patients or personnel. Yet their own behavior is projected onto someone else. Accepting one's responsibility toward oneself includes recognizing and accepting one's ability to be mistaken and make errors.

It is important that we recognize how and when we evade our responsibilities. By remembering the various ways that one can evade responsibilities, we can look for these in ourselves. Once we recognize the ways we evade responsibility, we can attempt to eradicate them.

We have a responsibility to recognize and accept when we have done a good job. This is an area where many of us fall down. It seems to be very difficult for us to recognize the things we have done well and accept the credit for them. So often we belittle what we have done with a remark such as, "Anyone could have done that." Yet, accepting credit for what we have done is a part of being responsible.

Secondly, a few words about our responsibility toward our patients. Patients as people are responsible for themselves. They are responsible for their disease in the sense that it belongs to them and is part of what they are as a person at the present time. Certainly, while they are in the hospital, we relieve them of much responsibility which they would be carrying if they were at home. It is important to allow the patient to carry as much of his own responsibility as he is comfortable doing at the time. For a patient to be able to carry the responsibility of their illness it is necessary to give him certain information. For example, how he can co-operate and work together with the nurses and doctors to hasten his recovery and make his hospital stay as pleasant as possible. We need to guard against allowing the patient to carry either too little or too much responsibility.

The third area of responsibility is toward co-workers. As I mentioned before, people carry only the amount of responsibility that they place on their own shoulders. Assigning responsibility does not mean that it will be carried. This frequently causes conflicts and problems in the nursing situation and in staff relationships. What is our responsibility in relation to our co-workers and their responsibility which they do not carry? It is helpful to recognize evading of responsibility in others as well as in ourselves and to develop skills in

encouraging others to be responsible. If someone doesn't carry their responsibility then we, as an individual, need to decide how we wish to react to this. How about carrying the responsibility for them? In making a decision about this I think there are two areas we need to look at. First, whether or not it is affecting patient care. Are patients suffering on account of it? Secondly, by carrying the other person's responsibility, will this enable the other person to carry it eventually or discourage her from ever carrying it?

In the situation involving Miss Nightowl, the patients were suffering. Their medications and treatments were delayed. Someone needs to carry this responsibility. If the person who had been assigned this responsibility isn't carrying it then someone else needs to do so. When we make a decision to carry another's responsibility, then we need also to make a decision about the irresponsible person. A responsible person does not carry another's responsibility forever. Although Miss Nightowl had been called for three weeks, she was no nearer to carrying her own responsibility than before. It is easy to get into a situation like this and then have great difficulty in getting out of it. Before committing oneself to this type of arrangement, we might ask ourselves whether we are prepared to do this for an indefinite period of time. We may as a favor agree to call someone in the morning, but if six months later we are still expected to do this, it may become a burden. Problems can be avoided if it is clearly understood by both people how long one is prepared to carry a certain responsibility for the other. There are probably times when we carry some of the responsibilities of our co-workers and they may carry ours. But if most of the time, we carry our own responsibilities and encourage others to carry theirs we will be able to decrease the number of problems that arise in a work situation.

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Chapter XIV

Minor Problem Areas

In the previous chapters, I have discussed some major problems that we can encounter in our relationships with our co-workers. There are also certain areas where we often encounter minor problems. Problems can arise in these areas, which aren't extremely upsetting or disrupting yet are upsetting enough that they take their toll in unhappiness and detract from job satisfaction. I wish to discuss five of the more common areas; namely, the desire to make a difference or have an influence, giving and receiving criticism, mistakes and errors, patients' response to nursing care, and gossip.

It is important to most of us to make a contribution or have an influence on our work situation. But many of us aren't aware of how this can be done. Often I hear a nurse say, "What can I do? I'm just one person." I think every person, regardless of the position they hold, can have either a positive or negative influence on the work situation and usually does. It is possible that one's influence is so subtle that it is difficult to recognize either by oneself or others. Nevertheless, it is there. Sometimes it is not recognized until the person leaves, but at that time it becomes obvious how much of an influence that person actually had on the work situation. I want to discuss three things which we might want to influence; namely, the quality of nursing care, improved interpersonal relationships of the staff, and policy changes. One way that anyone can exert a positive influence on the quality of nursing care given is to give the best care that one is capable of giving to the patients for whom one is directly responsible. We can continue to improve our care by periodically evaluating what we are doing, by staying abreast of knowledge gained in the nursing field, and by applying this knowledge to our patient care. Giving good nursing care to one's own patient need not be directly aimed at improving the care that others give, yet often it

has a positive effect on the nursing care given by others. In fact, it may be more effective than pointing out to others where their nursing care could be improved. There are some people who have much difficulty in following directions, instructions, or suggestions given by others, yet they are able to follow examples. They may even be totally unaware that they are being influenced by the example of another. The reverse is also true; that is, if we give poor nursing care, our example can negatively influence the care that others give. Another way that we may help others to improve their nursing care is by sharing what we have read or learned at workshops. I think that sharing this knowledge and these experiences can be just as effective, if not more so, when they are shared as something of interest rather than something we should do or something "you should do." By discussing this information as items of interest, we allow people to think about them at their leisure. They may be more receptive to the ideas since there is less pressure to put them into practice immediately or at all. Another way we may promote changes is by expressing concerns about care given to patients. If concerns are expressed and suggestions are made at times when the staff is relatively relaxed and receptive, the staff may be less threatened by suggested changes. However, if these suggestions are made when the staff is rushed and overworked, it may actually have a negative effect on care. A staff that is rushed and overworked tends to feel discouraged and inadequate. If at that time, new methods of care and changes are suggested, it may do nothing more than increase these feelings of discouragement and inadequacy. This in turn may result in poorer rather than improved nursing care; therefore, timing is very important. Furthermore, suggestions for improved nursing care tend to be more acceptable from a person who recognizes and comments on good nursing care. So if we wish to have a positive influence on the quality of nursing care given, we need to let people know that we are aware of the good care they give as well as commenting on the care which needs improvement.

Secondly, one may wish to exert an influence in improving interpersonal relationships. Again, we may hear someone say, "I know we don't get along well together, but what can I do? No one will listen to me." Such comments indicate that the person isn't aware of the effect they are having on others. Possibly since their efforts don't result in drastic and obvious changes, they can't see that they are having any influence at all on the interpersonal relationships of the staff. But here, as well, I think a person can have either a negative or positive influence. There are certain measures that we

can take if we wish to have a positive influence on the interpersonal relations of our co-workers. One is to assume that our co-workers like and approve of us unless it is definitely proven otherwise. Some people who don't make this assumption spend much time looking for problems in interpersonal relationships until eventually they either find or create them. We are looking for problems by worrying about whether others accept or like us. In one's effort to determine this one can see slights where no slights were intended and interpret everything in a negative way. If we are overly concerned about how others feel about us it is easy to conclude that one isn't being accepted or liked by others. Once convinced that we aren't liked or accepted, we may change our own attitude and behavior toward others. This change in attitude and behavior may cause problems in interpersonal relationships. By assuming that one is liked and accepted, many potential problems die before they are born. Therefore, it is a waste of time and energy to constantly worry about how others feel about us.

Self understanding can also be helpful in improving staff interpersonal relationships. Knowing what effect we have on others, knowing how we are able to affect other people's behavior in a positive way, and knowing what types of situations we can and cannot handle are all a part of self understanding. Everyone is different in this respect and to be effective we need to take our own strengths and weaknesses into consideration. An error that many people make in an attempt to improve the interpersonal relationships of others is to get involved unwisely and unnecessarily in their interpersonal relationship problems. If two staff members are having problems relating with each other then sometimes the most effective thing we can do is not to get involved and allow them either to keep the problem or work it out by themselves. It is very easy to make a problem between two people the problem of the entire staff and in this way create a larger problem rather than solve one. I will use an example to emphasize some of the points that I am trying to make.

> Two nurses were standing in the corridor during visiting hours. In loud voices they were saying some very uncomplimentary things about each other. This wasn't the first time this had happened, in fact, this was rather a common occurrence. These two nurses seemed to find many things to fight about and it didn't seem to matter to them where they were or who heard them. Miss James, another nurse who worked on this unit, was very embarrassed and upset by this behavior. In the past, she

had thought that she should be able to put a stop to it. In an attempt to do this, she would join them and try to reason with them, but in order to be heard it was necessary for her to speak quite loudly. The result was that instead of two people shouting at each other, there were three. When she realized that her behavior was ineffective in reaching the goal she had hoped to achieve, Miss James decided to change her behavior. She decided that this problem belonged to the other two nurses and she wasn't going to add to it. Therefore, instead of getting involved, she calmly walked away and busied herself at the other end of the unit.

In this example, after repeated attempts to stop these two nurses from shouting at each other, Miss James recognized her inability to solve the problem. She also realized that she could add to the problem and had done so in the past. Therefore, she decided that the best she could do about the situation at this time was to ignore it and remove herself from the area. Perhaps with more thought and experience she would be able to do more about it at another time. But for now this was the best she could do. There are times that the best we can do about the problems between other staff members is to be quiet and do nothing. This is by no means a small or easy thing to do.

Thirdly, we might wish to influence policy changes. One of the most ineffective methods to promote a change in policy is to constantly complain. If policies are changed because of our complaints, we may find that we aren't satisfied with the change that is made. So to influence changes in policies, we need to go through various steps. First of all, we need to have clearly in our mind which policies we want changed. Secondly, we need to know how we want the policies changed. To determine this, it is necessary to gather information and facts which indicate that the policy change is desirable and that a particular change will be more satisfactory. Having done this ground work and having information and facts at our fingertips, we are in a position to suggest change because we are equipped to talk about the change in a rational and sensible manner. The person who calmly presents her ideas and has facts to back up her statements tends to be heard more readily than the constant complainer.

The second potential problem area I want to discuss is that of giving and receiving criticism. At some time or other, we find ourselves in a position in which it is necessary to give criticism.

Before we criticize others, our motives for criticizing need to be clear. Why are we criticizing this person or people? Is it to clarify what we expect of them? Is it to express our authority? Is it to rid ourselves of our hostility or frustrations? Once we have established the reasons as to why we plan to criticize others then we can reassess whether or not it is necessary to do so. In giving criticism, we need to be specific and state clearly what it is that we are dissatisfied with and what we would like changed. Secondly, we need to speak directly to the person or persons involved. We may occasionally hear a person in a position of authority make an announcement something to this effect, "Some of you are doing such and such and I want it stopped." I tend to turn a deaf ear to these kinds of remarks and I think many other people react in the same way. If it is important enough that the behavior be changed then it is important enough for the person in the position of authority to find out who is doing it and to speak to them directly. If it isn't that important, why bring it up at all? In giving criticism, the work or behavior is what needs to be criticized and not the person as a human being. There's a difference between saying, "After you have used some equipment, I want you to clean it and put it away," and "You are messy, irresponsible, or lazy because you never clean up after yourself." If we are unhappy with the quality of work this needs to be clearly pointed out, but labelling people is not constructive criticism.

Since receiving criticism is not easy, tact is important when criticizing. However, we don't want to be so tactful that the message doesn't get across. This can happen when either the criticism is slipped in with many other things that are said or it is so vague that the message can't be understood. Sometimes criticism is given in a somewhat underhanded way by hinting at certain desirable changes but never criticizing outright. I see this as cowardly behavior. Criticism needs to be given in a straightforward, clear, and kind manner. Furthermore, criticism is much more helpful if it is accompanied with suggestions as to how changes can be made. To inform a person that their work or behavior is unsatisfactory without giving specific and concrete suggestions on how it can be improved is of very little value to the person being criticized. If we follow the rule of always giving suggestions for improvement with criticism, this may help us avoid criticizing for the sake of criticizing.

On the other side of the ledger is the problem of receiving criticism. It is natural to want others to think well of our quality work and be satisfied with it. However, this isn't always the case. No one's work is perfect and we can always improve in certain areas. We

can't expect everyone always to be satisfied with our work. Occasionally other people will point out to us the areas where we can improve. As I mentioned, the method by which criticism is given often affects how it is received. However, there is not much we can do about changing the way others criticize us unless they wish to change. But, we can change the way we receive criticism. Some people seem to be able to take and profit from criticism, regardless how it is given, while others are crushed and deeply hurt by criticism, even when it is given in a kind and tactful way. If you are one of those people who is very easily hurt by criticism, you might benefit by examining your self concept. Are your standards for yourself set so high that imperfection isn't tolerated? Is imperfection in yourself so threatening to you that you cannot entertain the idea that there may be room for improvement? Are you relying too heavily on others for the evaluation of you and your work and not heavily enough on your own evaluation? If your answers to these questions are yes, then that may explain why you are easily hurt by criticism. A person with a low self esteem, who relies heavily on others for evaluation of their work, tends to be hurt by criticism. When a person is easily hurt by criticism, it is rather difficult for that person to profit from it. Therefore, I suggest that you examine your self concept and attempt to raise it. To raise one's self concept it may be helpful to examine your feelings about your work. What is your attitude toward your work? Are you trying to do the best you can by giving the best nursing care under the circumstances and trying to improve and develop your nursing skills to the best of your ability? Or, are you only doing what is necessary and nursing is merely a job to help you make it from one payday to the next? If you can honestly say that you are trying to do good work, then I think you can trust your judgement as to what constitutes or does not constitute good nursing care. Therefore, by taking more responsibility for your own performance and its evaluation, you may be able to decrease your sensitivity to criticism.

Whether or not criticism is given in a kind and tactful way or in a cruel and hurtful way does not determine whether or not one can profit from it. Therefore, I am suggesting some steps to follow in receiving criticism. First of all, listen to what is said and accept it as the opinion and viewpoint of the other person; it is not necessarily a fact but rather an opinion. Secondly, accept criticism objectively and not defensively. For many of us, defensiveness seems to be a natural response to criticism. It is not necessary to defend ourselves when we receive criticism, but if we are accustomed to responding

this way, it requires a conscious effort to change this behavior. Although this isn't easy, it can be done. In an effort to break the habit of defensiveness, it is helpful to give yourself several seconds before verbally responding to the criticism. This will give you time to decide in which way you wish to respond. Often a "Thank you" or "I'll think about your statements" will be all the response that is necessary. The next step is to look at the criticism as objectively as possible to determine its validity. What can you learn from this criticism and how can you profit from it? Once you have established this then you are in the position to decide how you wish to act on it. Regardless of the source of the criticism, or the content of the criticism, it is your right and responsibility to decide whether or not you are going to change.

Unfortunately all criticism given to us does not arise out of other's concern for us and their interest in our growth and development. Some people give criticism to hurt and put down other people or in an effort to raise their own self esteem or obtain a feeling of superiority. Some people criticize others to draw the attention away from their own work or behavior. In general, criticism thus motivated is better ignored. I am not suggesting that the criticism or our own feelings in response to the criticism be repressed, but rather that we let it flow past us. We need not hold it in our mind or dwell on it. A person who criticizes to hurt very seldom has any sound suggestions to give for change or improvement. They are very ready to say that our work or behavior isn't acceptable but when questioned as to how it can be improved or how they would like it to be, they are at a loss for an answer or their suggestions are very vague and of little help. A person who constantly criticizes but has no suggestions for improvement more than likely is criticizing for the sake of criticizing rather than out of a desire for change or to help another person grow and develop their skills. The final step in receiving criticism is to decide for yourself what you wish to do with the criticism. You are responsible for your own life and behavior, and ultimately your own evaluation of your work is the most important. Whether or not you will act on the criticism is your decision to make.

Closely related to criticism is the third potential problem area, that of mistakes and errors made either by ourselves or others. We would like to believe that nurses do not make mistakes. In fact, in many work areas, there is an unwritten rule that nurses are not to make mistakes. This is one of those rules that cannot be obeyed. Sometimes small mistakes and sometimes big mistakes are made, but we all make mistakes. Certainly the work of a nurse carries with it a great deal of responsibility and if mistakes are made, they may

have serious consequences. A life may even be lost. I am all for impressing on nurses the importance of carefully and conscientiously carrying out their responsibilities. However, outlawing mistakes will not prevent them. What it may do is raise the anxiety level of the nurse so that she cannot work as carefully as she might otherwise, thereby increasing the possibility of mistakes rather than preventing them. Or it may encourage or almost force a nurse to hide her mistakes, resulting in serious consequences which might have been prevented if the mistake had been reported.

Since nurses do and will make mistakes, we need to ask ourselves how we can best deal with them. As soon as a mistake is made and recognized, our first responsibility is to determine the effect the mistake could have on a patient or patients and to do whatever is necessary to minimize the negative effect it might have on them. When we are assured that the patient or patients are out of danger, then it is important to identify how and why the mistake was made and what we can do to prevent the same mistake from being made again. Any further action taken regarding the mistake needs to be geared toward learning from the mistake and preventing it from reoccurring rather than toward disciplining and punishing the nurse who made the mistake. If a nurse consistently makes mistakes, it may be necessary to take some action such as removing the nurse from the area or require her to take certain steps to improve her performance. However, the action taken needs to be geared to the growth and development of that nurse rather than discipline. Once the error has been studied, and necessary steps have been taken to prevent its reoccurrence, then the person who made the mistake needs to be forgiven and the entire incident forgotten.

The principles that apply to mistakes made by others also apply to mistakes made by oneself. Often we are more lenient toward and understanding of others than we are of ourselves. We will make mistakes and when we do it is important to do what we can to undo any damage our mistakes have caused. Rather than belittling or condemning ourselves, we need to forgive ourselves for the mistake we made. Then when we have done what we can to prevent the mistake from reoccurring, we need to forget the incident.

The fourth potential problem area that I want to discuss is that of the patient's response to nursing care. Often patients will compare nursing care; for example, they may compare the care given by one nurse with the care given by another nurse. The patient who has been in the hospital many times and in different areas of the hospital may compare the care given on one unit with the care given on another

unit. The patient who has been in many hospitals in the city may compare one hospital with another. In general, we don't have too much difficulty in handling this if the comparison is in our favor. Although, occasionally we may feel uncomfortable if we are compared favorably to another nurse on the unit, and possibly more so if we aren't too impressed with the other nurse's work. We may feel somewhat guilty if we verbally either agree or disagree with the patient. However, it isn't necessary either to agree or disagree with the patient. This isn't the time or place for us to work through our negative feelings about our co-worker and merely accepting what the patient says rather than agreeing or disagreeing is all that is required of us.

Situations which are difficult to handle are those in which the patients compare us with others and they view us and our work as inferior. We need not defend our work, our co-workers, our unit, or our hospital when a patient is making comparisons. If we are satisfied with our own work or are sincerely trying to do our best, that is all we can ask of ourselves. If we want to improve our care, we can ask the patient what it was about the care she has received from others that in her opinion was superior. In this way, we might receive some helpful suggestions that we could use in improving our care. However, the approach many of us tend to use in these situations is that we try to convince the patient that our care, our work, our unit, and our hospital are superior to those with whom we are being compared. We often succeed in merely reinforcing the patient's point of view that someone else's care was superior. If it is unacceptable to us that in the patient's opinion other nurses are giving better care than we are, it is time that we looked at our own work and our evaluation of it. This may be an indication that we aren't very happy with our own performance. If so, we can take the steps necessary to improve the care we are giving to our patients.

The last area that I want to discuss is that of gossip. People love to gossip and nurses are no exception. However, being the target of gossip can be very unpleasant and gossiping in general can cause much harm. If we wish, we can lessen the amount and effects of gossip. We can refrain from gossiping, and if we are in the habit of gossiping, it will take a certain amount of self discipline to break that habit. The change in our behavior could make a difference in the amount and the effect of gossip in our work situation. Secondly, we can take a stand against gossiping when we find ourselves in a situation where gossiping is going on. We can do this in a variety of ways. One way is merely by not joining in and another way is that we

attempt to change the subject. It may be rather difficult to change the subject when the group is gossiping since one needs to find a topic which is more interesting to the group than the one being discussed. Another way we can take a stand is by stating that we are against gossip and are trying not to indulge in it. Letting others know our decision takes courage and could result in much negative feedback. Before taking such a stand, it helps to prepare ourselves for the negative feedback so that we would be better able to handle it. Still another way that we can take a stand against gossip is to appear dull and bored whenever gossip is going on. This may dampen the spirits of the gossipers enough to stop them. However, if the gossip is very interesting to others, one disinterested person isn't going to stop it. Finally, we can lessen the amount and effect of gossip by refusing to pass on any gossip which reaches our ears and thus effectively killing it.

But there can be times when we are the subject of gossip. How can we most effectively handle gossip about ourselves? In general, I think a wise policy to follow is to try not to respond. However, at times it may be necessary to defend oneself or deny the gossip. Be sure that it is necessary and wise before doing so since less damage is usually done if we let gossip about ourselves flow past us. A fairly common situation is one in which someone would like you to know how they feel about you or your behavior. They are not open enough or bold enough to tell you directly and, therefore, they will tell another person, who they think will bring it to your attention. This happens at times regarding one's work performance. A person may be dissatisfied with someone's work but for one reason or other decides not to tell them directly. I think that the wisest way to handle this is by refusing to listen to secondhand comments about oneself. If someone wishes to tell you what another person has said about you, you could interrupt them and inform them that you aren't interested in hearing it. You can go on to tell them that if anyone has anything to say, you expect them to say it directly to you and you will not listen to people's comments if they come to you secondhand. It is better that we try to avoid hearing these types of comments, rather than listening to them and then ignoring them. The reason being that it is very difficult to feel and react the same way toward a person when it has been brought to our attention that she has said some very unpleasant and hurtful things about us. Often these comments that one receives secondhand are harsher than those that people would tell a person directly. Even if we try to ignore what has been said, it may be hard not to react negatively toward that person

the next time we see them or have some problems with them. Furthermore, what can we do with the information? If we discuss the statement with the person who supposedly made it, we indicate that we listen to and encourage gossip. If we do discuss it with her, she may flatly deny ever saying it and one is left in an embarrassing position. If we don't discuss it with her, then of what value is the knowledge to us? I think it is of little value and it would be to our advantage not to know what has been said. Therefore, it is wise not to listen to gossip about ourself. This is a situation where "what I don't know won't hurt me," at least, it won't hurt me as much as knowing would hurt me.

A nurse in a position of authority was involved in just such a situation. The secondhand information she was getting indicated that her staff were very dissatisfied with her work. Yet no one approached her directly. She came to me for help in solving this problem. I suggested that when anyone volunteered to tell her what someone had said about her that she respond with, "If that person wants me to know, I suggest that she tell me directly. I do not want to hear it from you." I predicted that if she took this stand that the staff would soon stop trying to give her this information. She seemed to understand my suggestion and the value of this type of reaction; however, her response to it was, "But I'm so curious to know what people are saying about me." My reply was, "Well, have fun." If this is the situation we find ourselves in, namely, that we are curious to know what people are saying about us and, therefore, are reluctant to put a stop to this type of gossip, then we better be prepared for all kinds of problems because we're bound to have them.

I have mentioned several minor problem areas found in the work situation and I have suggested three guidelines in dealing with these problems: namely, accept the responsibility for one's own behavior, attempt to look at the situation realistically, and decide for yourself how you wish to react in each situation. Using these guidelines, we can minimize the anxiety and stress caused by minor problems in our work situation.

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Epilogue

I have touched on several topics. The reader will probably agree with me in certain areas and strongly disagree in others. I hope that some ideas are new to the reader and that she is motivated to think through her own ideas in these areas. I have included a list of suggested reading which I have found helpful as I attempted to clarify my thinking in various areas of nursing and interpersonal relationships. As I increase my experience and knowledge, I will adjust my thinking to accommodate these experiences and knowledge. Therefore in the future, I may disagree with some of the ideas I have expressed or at least view them in a different light. But for the present, this is the way I see it.

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