Life Healthcare
NURSING COLLEGE
Life Healthcare Group (Pty) Ltd
EDUCATION FOR SERVICE EXCELLENCE

READER - APPLIED SOCIAL SCIENCE

HIGHER CERTIFICATE IN NURSING

Life Healthcare

Making life better

Content

1. Introduction

The Applied Psychosocial Science (APS) curriculum offers a foundation in key psychosocial concepts, focusing on how they can be applied in practice to enhance patient care and outcomes. By examining topics such as communication, cultural competency, mental health, behavioural dynamics, and coping mechanisms, nurses gain the ability to deliver holistic care that addresses not only physical ailments but also the deeper challenges their patients face. In the complex world we live in it is of utmost importance to train nurses in applied psychosocial science. They become advocates, caregivers, and collaborators, creating a compassionate and empathetic approach to healing that recognizes the humanity in every patient.

This reader serves as a guide, offering insights, evidence-based strategies, and real-world applications to prepare nurses for the interpersonal and psychosocial challenges of their profession. By engaging with this material, nursing students will be able to reach the outcomes set in the curriculum but will also be better equipped to provide comprehensive care that is as empathetic as it is effective.

In the Module guide you will find the references to each topic.

In the contents page of this reader, each topic is embedded with a hyperlink for easy navigation. To access the specific topic resources, hover with the mouse over the topic and click to be redirected. Under each topic are the references of textbooks included in the section.

Good luck with your studies.

Naomi Hattingh

Subject Coordinator

2. Communication

The upcoming pages will help you locate information on the Specific Learning Outcomes outlined in the learner guide. This material is designed to enhance your communication skills, enabling you to interact effectively with patients, colleagues, and members of the multidisciplinary team. Additionally, it is essential to understand communication methods for engaging with patients who have special needs and disabilities.

References:

Berman, A; Snyder, S and Frandsen, G. 2022. Kozier & Erb's *Fundamentals of Nursing Concepts. Process and Practice*. 11th Edition, Global edition. PEARSON.

Booysen L, Erasmus, I, Van Zyl, M. *The Auxiliary Nurse.* Fourth edition. JUTA.

Brooker, C., Waugh, A., Van Rooyen, D & Jordan, PJ. 2016. *African Edition Foundations of Nursing Practice: Fundamentals of Holistic care*. 2nd Edition. ELSEVIER

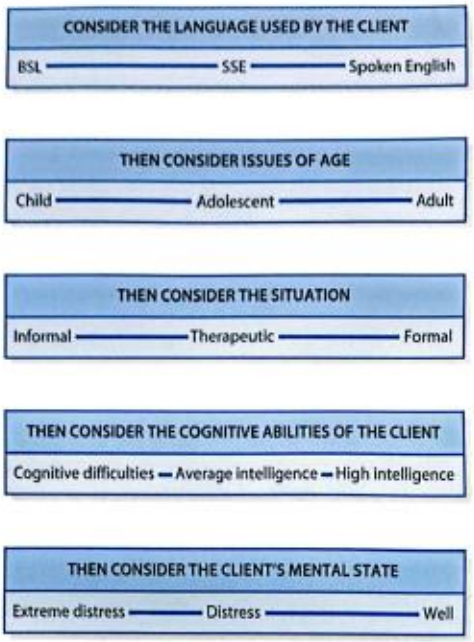

Fig. 9.3 • Communication model derived from Shannon and Weaver's model.

professionals in understanding their (the patient's) language. This puts the patient in an empowered position, thus giving respect to and acknowledgement of their language skills.

In addition to the considerations on the cline, nurses consider issues of gender, social background, education experience, family connections, spirituality and culture. This creates a very complex communication situation where skilled communicators are essential.

Accommodating and diverging in communication

People usually accommodate other people's communication style quite naturally (Fromkin et al. 2013). When travelling abroad with little or no knowledge of the language, people reduce conversation to more simple sentences, use clear pronunciation, and increase the use of gesture to assist the message. As already discussed, when talking to small children, people adjust language to suit their needs, speaking in simpler terms, using fewer key ideas per sentence, and breaking down sentences into chunks that the child can more readily access. When speaking to a person they relate well to, people 'converge' – they use similar vocabulary, pronunciation, conversation tempo and may change their accent or dialect to accommodate the other person.

Nurses accommodate the needs of patients/carers when they explain complex therapies. They speak in non-technical terms using less jargon to enable the other party to understand. Where the nurse speaks Zulu and English and the patient speaks Afrikaans and English, the patient and the nurse will accommodate each other by using English, even though it may not be either person's first language.

Occasionally, people do not accommodate the listener's needs – they 'diverge'; this occurs when the:

- Speaker is not skilled at understanding the needs of others
- Other person has upset them
- Person is making a political statement by distancing the listener
- Person aspires to a higher social class or intellectual status
- Person wants to show a difference in backgrounds (Holmes 2001).

There are numerous examples of speech divergence in healthcare. For instance, a healthcare professional provides technical information to the patient very quickly, without eye contact, disempowering the patient. It requires confidence to challenge the speaker, something that people in hospital may lack due to their illness and anxiety or because they may feel in a subordinate position (see Ch. 7).

It is clear that converging often creates effective communication, whereas diverging creates difference and less effective communication. However, people can use divergence to assist people to change their level of formality or informality to help them to adjust to the needs of the situation. When people converge too much it can sound patronizing. Where a patient is relying on the nurse to make them feel confident in the therapeutic process, it is useful to use technical terms and to support the patient with an explanation of the meaning of each term.

Interpersonal communication skills

Interpersonal communication can be divided into verbal/signed, non-verbal and listening skills. In addition, we consider how, for nurses, courtesy is crucial to interpersonal communication.

People represent their world in different ways and have different preferences in the way they access information about their world. People tend to use a visual system, an auditory system or a kinaesthetic system. Some people like to 'see' what people are saying, some like to 'hear' a good idea and some like to 'feel' a sense of what is happening.

Table 9.2 Representational word systems

Representational system	Examples of words used	Possible responses
Visual	'I see the idea'	'Does that give you a clearer view of things?'
Auditory	'That rings a bell'	'I heard that you wanted to sound out the options'
Kinaesthetic	'I have a bad feeling about this drug'	'How would you feel about taking a similar drug?'

When communicating with patients it is useful to be able to use their preferred representational system because this will enable them to access the information with less effort and develop rapport quickly. Initially, this may seem rather complicated, but by looking at the words that may suit people it will be easier to understand and practise.

In order to recognize someone's representational system, it is necessary to listen to the words they use to describe their world, perhaps by asking them to talk about something that they have enjoyed, e.g. their favourite place. Listening for the 'describing' words the patient uses will provide clues about their preference for one or two systems or all three (Table 9.2).

Courtesy

Most patients and carers rightly expect nurses to be civil, courteous and polite. People are more likely to complain when they feel others are being rude to them. The number of such complaints is increasing. The signs of courtesy include:

- Paying attention to people when the nurse is with them or when they request the nurse's attention
- Being civil to a person, treating them with respect, behaving towards them as a valued person.
- Being polite, which is essential to developing rapport, e.g. saying please and thank you, not rushing people, smiling and using the person's preferred name, all help to ensure the person feels they are important and valued.

Consideration for others also depicts courtesy. Considering the other person in all dealings with them sounds obvious, but unfortunately people feel that nurses do not always show consideration. This could be not listening to requests, rushing care or not considering individual preferences, e.g. in food, cosmetics, clothing, etc. This all shows a lack of consideration for the person.

The signs of courtesy are clear, although it may feel they are sometimes difficult to achieve due to resource (time, people, and money) allocation, the emotional context in which nurses work and the barriers to communication that must be overcome (see p. 202). Developing sensitive skills in courtesy and customer care allows nurses to meet the needs of all stakeholders in the healthcare system.

Verbal communication

Spoken words are arbitrary representations of ideas that have been agreed over time by those using a language. In other words, they are an agreed sound or group of sounds that we know represent a thing or an action. Without such agreement on meaning, words would be nonsensical or idiosyncratic – understood only by the person who produced them. Verbal communication usually has written equivalents to the words produced, although some languages do not.

Nurses employ various verbal communication strategies to develop relationships, seek and understand information, provide feedback to others and to demonstrate professional compassion and self-awareness. Some strategies are outlined below. It is useful for nurses to recognize when they use these strategies naturally, before developing their skills further.

Strategies – questioning with good intentions

People use positive intentions when questioning others. This helps them to show courtesy and respect and this develops trust; therefore they get the correct information in a short space of time with 'ecology', i.e. without damaging the relationship environment.

Open questions/exploring

Open questions are used to gain information about people, their feelings, their beliefs and values, their perceptions and wishes. Open questions usually begin with a 'What ...? Who ...? How ...? When ...? Where ...?'. To help people accept these questions, nurses can also use a 'softener' such as 'It would be good to know how ...'. Open questions 'open up' the listener's mind to answers that they can give; information that they hold. Softeners, however, may be so gentle that it becomes a closed question, e.g. 'Please could you tell me when ...'. It is so easy to respond 'no' to this very polite request.

Closed questions

Closed questions are used when specific information is needed quickly or if there are other limitations causing barriers, e.g. the patient is distressed. Closed questions are those to which a person can answer 'yes' or 'no', e.g. 'Do you like soap on your face?'; 'Are you unhappy?'. It may be the nurse's intention to gather more information than purely a 'yes' or 'no'. It can be very frustrating trying to get beyond the yes/no responses. Closed questions can be opened by leaving the end of the sentence unfinished, e.g. 'Are you unhappy ... or ...?'. This is a useful strategy when the patient/child/carer really does not want a lengthy conversation but the nurse needs to open a way for further discussion.

Funnelling

Funnelling is a strategy used first to obtain general information and then to narrow the information down to an agreement, specific point or clear conclusion.

Summarizing

A summary is a strategy whereby the listener summarizes information given by the speaker, in the speaker's own words. The purpose of summarizing is to check the listener's understanding at the same time as acknowledging what has been said.

Paraphrasing

This strategy is similar to summarizing but with more use of the listener's own words. This often helps listeners get the information straight in their own mind.

Clarifying

This enables the listener to present the information back tc the speaker, then to question if this is what they heard. It is also useful for speakers to identify with their own thought: coming from another source; sometimes it sounds or feel:

Nursing skills Box 9.8

Verbal communication strategies

Occupational therapist (OT) – 'Ghedi has been out with the students to the sports centre. He relaxed once he knew that he could choose a time that was set aside for people new to the gym. He said that he was happy to attend twice a week, so he bought a 6-month off-peak pass. It was really reasonable; I have one, they really are worth the money. Anyway, he went to his first session, Tai Chi, then back for lunch. He says he feels confident and relaxed and he really does look it too.'

Summarizing

Keyworker – 'Oh, thanks for that information, so [in summary], he's got his membership, will be attending at off-peak times, he had his first session of Tai Chi and he is feeling confident and relaxed. Great.'

Paraphrasing

Keyworker – 'OK, so Ghedi has been out, joined the sports centre, paid for 6 months off-peak and has already started to use the facilities. He's fine with this and feeling confident.'

Clarifying

Keyworker – 'OK [let me get this clear], Ghedi has been out this morning to the sports centre, got an off-peak membership, he is feeling better because he knows this is a quieter time and he has already been to his first Tai Chi class and feels fine about the arrangements?'

Feedback

Keyworker – 'That's great news. I hope the student will be going with Ghedi again soon as this is so important to him.'

different, thus providing another perspective. In this case it is effective to use a closed ended question after the information was given back to the speaker in order to clarify if the listener has the correct interpretation or not.

Feedback

Feedback provides the listener with acknowledgement of their performance. It can reinforce the behaviour so that it is more likely to happen again and it helps to motivate people through the knowledge that their behaviour was appropriate.

Box 9.8 provides an example of some of these strategies.

Assertive communication

The skill of assertiveness is important to nurses. Assertiveness enables people to be honest with themselves and in their relationships with others. Assertiveness helps to enhance relationships, avoid power games and is a vehicle for clear outcomes. Hargie (2006) details four elements of assertive communication:

- Content – where the rights of the people involved are embedded gently in the statement. This could be done using an explanation, empathy for the listener, praise for the listener, an apology for the consequence for the listener or a compromise that is favourable to both people
- Covert elements – where the speaker is able to recognize their rights and the rights of the listener in the communication process. These include respect, expressing feelings, having your own priorities, being able to say 'no', being able to make mistakes and choosing to say nothing (see Further reading, e.g. Holland and Ward 1997)
- Process – concerned with how people express themselves assertively. Is their body language (see Non-verbal communication, below), intonation (see p. 204) and choice of language reflective of a confident assertive person? Are the processes that make up communication congruent, in keeping with what is being said? The process also involves managing the setting so that people are not embarrassed, or the 'noise' levels are kept to a minimum (see pp. 202–203). Increasing the likelihood of assertive communication happening again involves feedback to the listener to show that their accomplishment is appreciated
- The non-verbal cues – gesture, touch, proxemics and posture – also need to reflect confidence, regard and respect for self and others (see below and pp. 191–192).

Negotiation and delegation

These are areas that depend on assertive communication. Negotiation is the process where people come together with their own ideas, discuss their ideas and agree on an outcome that is acceptable to both parties. It could be as simple as negotiating an off duty change, e.g.

Nurse A asks Nurse B to change a duty on Wednesday because she needs the morning off. Nurse B agrees if Nurse A will do the same for her next Sunday. They agree and the plan is negotiated.

Delegation is another way of getting things done. Delegation often occurs between people of different authority, e.g.:

Staff Nurse A: 'Andrew, Ms Wilkinson's medicines are ready to be picked up and her lift home will be here soon. Please could you go over for them?'

Staff Nurse A has delegated the task of collecting the prescription from pharmacy to Andrew, a first year student nurse. When delegating to another person it is imperative to be polite, assertive and clear. Offering information to support the request allows the other person to understand why they are being asked to perform a task. Delegation is reliant on a number of issues:

- Can the person accept the delegated task? Do they have the right level of knowledge, experience, skills, responsibility or status?
- Is it the right time to delegate this task to this individual?
- Are you delegating because you have left something too late? If so, how will the timeframe for completion affect this person?
- Does the situation allow for the task to be delegated?

Non-verbal communication

Non-verbal communication is that part of communication that is not reliant on words. As approximately 60% of communication is non-verbal, non-verbal skills are essential for effective communication. It is clear that people determine a great deal of meaning from aspects of communication other than words. People who are blind or partially sighted generally

place more emphasis on the intonation of a person's voice to pick up the non-verbal messages (see Ch. 16). Argyle (1994) suggested that non-verbal communication was made up of:

- Accent
- Bodily contact
- Direction of gaze
- Emotive tone in speech
- Facial and gestural movements
- Physical appearance
- Posture
- Proximity
- Speech errors
- Timing of speech.

This section focuses on gesture, touch, proxemics and posture. Paralinguistic issues, i.e. the voiced aspects of non-verbal behaviour, for instance 'guggles', are discussed later.

Gesture

Gesture is a crucial aspect of non-verbal communication. Some psychologists and linguists suggest that early humans used gesture before they used spoken or signed language (Armstrong et al. 1995). Gestures can be classified into categories of increasing complexity.

Universal gestures that are understood by most people include opening arms and eyes wide to suggest large size; furrowed brows, pursed lips, drawing body inwards and moving index fingers together would suggest small size. Subtler gestures include a cupped hand to the mouth to indicate a drink, or a single upwards gesture of the hand with palm facing upwards suggests that someone stand up.

Certain gestures are recognized as specific to a language community, such as the 'OK' gesture with thumb and index finger touching to make a circle with the other fingers raised. However, it is important to be aware that some gestures that are acceptable in one community are possibly offensive in another.

Touch

This is a complex communication subject and often difficult to tackle. Children tend to be touched more than adults. Interestingly, babies and young children who do not experience touch do not thrive as well as those who do (Hargie 2006).

Touch for many people is an essential aspect of their working lives. Nurses in particular must learn how to touch people in a professional context without causing embarrassment or concern to the patient. In addition, nurses must ensure their own safety. Nurses use two clear types of touch: first and often the most intimate type is the necessary touch nurses use when attending to people's physical needs and during other nursing interventions. The second type is the touch that communicates a feeling or a meaning, such as, 'I am here for you'. Everyone has a personal view about touch, when it is appropriate and when not. People from different cultures will touch each other according to their accepted norms.

Reflective practice Box 9.9

Appropriate touch – learning from others

Nurses who are consciously competent in respecting a patient's dignity will more readily engage their trust, and therefore be more likely to be able to work therapeutically and less likely to cause offence. Think about occasions when you worked with registered nurses who perform the most intimate of procedures while maintaining the dignity of the patient.

Student activities

- How did the nurse behave in relation to touch?
- What did they say to the patient?
- Reflect on how the patient may have felt.

Reflective practice Box 9.10

Feelings about touch

Think about your feelings about being touched and touching others.

Student activities

- What is your norm?
- How does that fit in with the clinical environment?
- Could you leave yourself or others open to the risk of inappropriate touch or at risk of feeling alone and isolated when in distress?

It is suggested that a well-timed touch on the shoulder or hand can help a person in distress to feel comforted, which in turn creates a sense of trust. Touch in this scenario is thought to encourage the person's cathartic release by communicating that you are with them in the moment, supporting them and sharing their feelings. This affirms their sense of self, respects their distress and shows the nurse's commitment to their needs.

Touch is more appropriate in some clinical settings than in others. Understanding what is acceptable in each area is important and nurses can learn much from each other (Box 9.9). As a student new to a patient group, it is useful to know how people deal with patients' emotions. Also crucial is an understanding of common courtesy (see pp. 188–189) and the social norms of the patients and carers who are most likely to attend the clinical setting. Nurses should attend to their developing professional boundaries at all times and question the actions of others that are discourteous or abusive.

It is vital that nurses also recognize their own feelings around touch (Box 9.10). This aspect is very important, as this will have an impact on the nursing practitioner's way to communicate through touch as well as his/her interpretation of a patient's touch.

Proxemics

Proxemics is a fascinating area of communication – people have very different views about their own personal space – how close people like to be to others and how close they

Appropriate eye contact

Appropriate eye contact is where the listener looks at the speaker. They blink just after the speaker blinks or when they are ending a sentence. The listener's blink rate matches that of the speaker and corresponds with their head nods of encouragement. The eye gaze is generally soft, as opposed to staring and hard (eyes slightly wider than usual denotes some muscular tension). However, the listener's gaze also mirrors the verbal and non-verbal expressions of the speaker. This aspect is influenced by certain cultural differences between ethnic groups in South Africa. In certain cultures it is defined as disrespectful if a younger person makes eye contact with an older person. In this case it is very important that a nursing practitioner utilize his/her cultural sensitive skills in order to ensure effective communication.

Mirroring

When engaged in listening, people naturally find themselves 'mirroring' the speaker's posture. This does not mean copying their every movement as if playing a game; instead the listener may be leaning slightly in the same direction, tapping their pen at the same time the speaker is tapping their foot, folding one arm across the body as the speaker folds both arms (Box 9.12).

Critical thinking Box 9.12

Mirroring

Watch an experienced nurse and patient or a couple who are getting on well.

Student activity

Observe their posture, their mannerisms, their tempo or timing of their movements. See if you can notice how much the listener is mirroring the speaker. For example, do they have similar facial expressions, gestures, posture and movements?

This behaviour is a natural sign for the speaker to show that the listener is with them, acknowledging their mood, recognizing their feelings and trying to understand them. This behaviour increases rapport between them and encourages the process to continue.

Nurses and other healthcare professionals often need to develop trust and rapport quickly in order to work effectively with people. Being aware of their skills in mirroring another person is vital in enhancing the therapeutic or professional relationship (see pp. 193–198).

Guggles

Guggles are the sounds (non-words) uttered when listening, e.g. 'mmmms', 'ahs', 'hmm'. These affirm the speaker's point, agree with them and confirm their view or idea. To do this, guggles rely heavily on intonation and tunes (see p. 204). The use of guggles by the listener encourages the speaker to continue by providing evidence that the listener is listening (Box 9.13). It is also known as minimal verbal response and it is viewed as more effective when used within a conversation, if not used too many times. A balance is needed.

Reflective practice Box 9.13

Skills that encourage and discourage conversation

Next time you are listening to a friend telling you a story (one that is not too sensitive), listen to your own guggles.

Student activities

- Gently increase the number of guggles you use. What difference does it make to your friend's storytelling?
- If you gently reduce the number of guggles so that you hardly express any, how does this affect the storytelling?
- If you increase them a little more, does this make any difference?
- How many guggles become too many and stop your friend telling the story because they feel uncomfortable?
- Tell your friend what you having been doing, apologize and ask them how it made them feel.
- Reflect on the experience with your friend and consider how you will use it to improve your listening skills.

Active listening

Nurses and others often highlight active listening as an essential skill; as the term implies there is a need for energy and concentration on the part of the nurse when they actively listen. The aim is to enhance the quality of the therapeutic relationship and to facilitate problem-solving by being with the speaker on a social, psychological and emotional level (Egan 2013). In active listening, the listener:

- Listens to the speaker, bearing in mind the context of the speaker's message with regard to their background, life experience and current situation, i.e. their 'blueprint of behaviour'
- Attends to the speaker's non-verbal behaviours
- Listens and understands the speaker's message
- Listens for inconsistencies in the message and incongruence between what is being said and the speaker's non-verbal behaviour.

Active listening requires the practitioner to understand:

- How and why people communicate the way they do
- What language they are likely to use
- How a person's non-verbal communication provides information about the message.

Nursing relationships

So far, this chapter has provided the knowledge and encouragement needed to develop skills in a variety of ways to create a good communicator. This section draws upon this learning for enhancing communication in a range of relationships with different outcomes.

The types of relationship that people connect with on a day-to-day basis are intimate, social, professional and therapeutic. The focus here is on the therapeutic and professional relationships that nurses' experience and how these relate to care and health outcomes.

like others to be to them, can be very complex and bound by personal rules. Every person's background has an influence on this aspect of communication. For example, if a person was not exposed to touch through loved ones as a child (whether it was because of the absence of loved ones or because of the absence of emotional connection between the loved ones) it will be very challenging for that person to allow people to enter their personal space and vice versa.

Boundaries enable people to feel comfortable in their environment. Some boundaries are fixed, such as walls and rooms within buildings. Others are semi-fixed, such as the seating in the clinic or seating arrangements in a dining room and the location of the television. These arrangements are an indication of where to sit, where to eat and which way to face. Fixed and semi-fixed boundaries can help or hinder communication.

Another boundary is the informal space between people. This space is fluid and utilized in different ways for different messages and in different settings.

The person listening will be aware of the distance between themselves and the speaker and vice versa. There are clear cultural differences in the distance people accept between each other.

Knowingly intruding into someone's personal space can be very intimidating for the listener. This approach is used to interrogate or bully people, resulting in their disempowerment. It may be necessary to gently remind colleagues or children or patients that their comfort zone may be smaller than that of other people.

Reflective practice Box 9.11

Personal space

Choose a person in the class with whom to do this exercise. Move into the person's personal space without warning (it is important that you choose a person that you are comfortable with). Reflect on the person's reaction. Talk to the person about his/her experience (thoughts and feelings) related to the situation. Reflect on your own experience (thoughts and feelings).

Posture

How a person holds their body in relation to other people and in relation to the fixed and semi-fixed boundaries communicates a great deal about what they are feeling and thinking. Posture sends a very clear message, e.g. leaning forward indicates interest and respect for the other person. On the other hand, despite looking at the other person, a lack of interest is portrayed if the listener's body is orientated towards the door, or sitting back in the chair arms folded and head down.

How a person filters the information provided by the external event will affect their thoughts, feelings and behaviours; therefore their posture is a mirror of their inner beliefs (see below).

When a nurse wants to create a sense of confidence, they walk into the situation with their head held high, at a moderate pace. People will look at the nurse's posture and decide very quickly whether they like them or not and whether they can be trusted or not. Once people have made a judgement, it is difficult to convince them otherwise. This may seem a little harsh but it is a survival technique that has helped people to function socially for thousands of years.

Listening skills

How do people know that they are really listening to someone, or that someone is really listening to them? Many nurses claim to be good listeners, because in the clinical environment to suggest otherwise is as bad as saying they are poor nurses.

People often know when someone is not listening to them – they feel ignored, undervalued, frustrated and disempowered. Not listening to the other person can seriously affect the relationship. In a nurse–patient relationship the outcome of not listening to a patient can result in their choices being reduced, e.g. not eating their choice of food, the nurse not understanding their fears/anxieties, the potential for misdiagnosis and ultimately ineffective or even harmful treatment. If nurses fail to listen to colleagues, not only is vital information missed but it can also affect the colleagues' motivation, trust, self-esteem and skills.

There are a number of reasons for listening and different types of listening skills are needed. Wolvin and Coakley (1996) identified four types of listening:

- *To comprehend in order to understand information*: When listening for understanding the focus is on main topics, ideas and data. In the clinical setting it is used during admissions, ward rounds and handovers, for receiving information from patients, etc.
- *To appreciate sound, to feel relaxed or at ease*: This includes listening to music on headphones or in a Snoezelen (stimulation room – Mental Health settings) room (see Ch. 11); listening to a meditation tape or to recordings of 'sounds of nature' in order to relax – all for pleasure, meditation or wellbeing.
- *To evaluate information, when the speaker wants to persuade or to influence behaviour*: This may include evaluating information from a drug company representative, wound care advisors and continence nurses, and to weigh up points in team meetings
- *To empathize where the focus is on the speaker rather than the listener*: In this situation, the aim is to listen to patients, etc. who need to talk/express themselves in order to alleviate stress, to problem-solve or to release tensions. This type of listening is a therapeutic skill that practitioners must acquire.

Characteristics of good listening

Good listening skills are vital to rapport and empathy (see pp. 195–196). The following characteristics of good listening are based on English-speaking Western cultural norms. People from different linguistic and cultural groups have different norms of communicative behaviour (see pp. 204–205).

Appropriate eye contact

Appropriate eye contact is where the listener looks at the speaker. They blink just after the speaker blinks or when they are ending a sentence. The listener's blink rate matches that of the speaker and corresponds with their head nods of encouragement. The eye gaze is generally soft, as opposed to staring and hard (eyes slightly wider than usual denotes some muscular tension). However, the listener's gaze also mirrors the verbal and non-verbal expressions of the speaker. This aspect is influenced by certain cultural differences between ethnic groups in South Africa. In certain cultures it is defined as disrespectful if a younger person makes eye contact with an older person. In this case it is very important that a nursing practitioner utilize his/her cultural sensitive skills in order to ensure effective communication.

Mirroring

When engaged in listening, people naturally find themselves 'mirroring' the speaker's posture. This does not mean copying their every movement as if playing a game; instead the listener may be leaning slightly in the same direction, tapping their pen at the same time the speaker is tapping their foot, folding one arm across the body as the speaker folds both arms (Box 9.12).

Critical thinking — Box 9.12

Mirroring

Watch an experienced nurse and patient or a couple who are getting on well.

Student activity

Observe their posture, their mannerisms, their tempo or timing of their movements. See if you can notice how much the listener is mirroring the speaker. For example, do they have similar facial expressions, gestures, posture and movements?

This behaviour is a natural sign for the speaker to show that the listener is with them, acknowledging their mood, recognizing their feelings and trying to understand them. This behaviour increases rapport between them and encourages the process to continue.

Nurses and other healthcare professionals often need to develop trust and rapport quickly in order to work effectively with people. Being aware of their skills in mirroring another person is vital in enhancing the therapeutic or professional relationship (see pp. 193–198).

Guggles

Guggles are the sounds (non-words) uttered when listening, e.g. 'mmmms', 'ahs', 'hmm'. These affirm the speaker's point, agree with them and confirm their view or idea. To do this, guggles rely heavily on intonation and tunes (see p. 204). The use of guggles by the listener encourages the speaker to continue by providing evidence that the listener is listening (Box 9.13). It is also known as minimal verbal response and it is viewed as more effective when used within a conversation, if not used too many times. A balance is needed.

Reflective practice — Box 9.13

Skills that encourage and discourage conversation

Next time you are listening to a friend telling you a story (one that is not too sensitive), listen to your own guggles.

Student activities

- Gently increase the number of guggles you use. What difference does it make to your friend's storytelling?
- If you gently reduce the number of guggles so that you hardly express any, how does this affect the storytelling?
- If you increase them a little more, does this make any difference?
- How many guggles become too many and stop your friend telling the story because they feel uncomfortable?
- Tell your friend what you having been doing, apologize and ask them how it made them feel.
- Reflect on the experience with your friend and consider how you will use it to improve your listening skills.

Active listening

Nurses and others often highlight active listening as an essential skill; as the term implies there is a need for energy and concentration on the part of the nurse when they actively listen. The aim is to enhance the quality of the therapeutic relationship and to facilitate problem-solving by being with the speaker on a social, psychological and emotional level (Egan 2013). In active listening, the listener:

- Listens to the speaker, bearing in mind the context of the speaker's message with regard to their background, life experience and current situation, i.e. their 'blueprint of behaviour'
- Attends to the speaker's non-verbal behaviours
- Listens and understands the speaker's message
- Listens for inconsistencies in the message and incongruence between what is being said and the speaker's non-verbal behaviour.

Active listening requires the practitioner to understand:

- How and why people communicate the way they do
- What language they are likely to use
- How a person's non-verbal communication provides information about the message.

Nursing relationships

So far, this chapter has provided the knowledge and encouragement needed to develop skills in a variety of ways to create a good communicator. This section draws upon this learning for enhancing communication in a range of relationships with different outcomes.

The types of relationship that people connect with on a day-to-day basis are intimate, social, professional and therapeutic. The focus here is on the therapeutic and professional relationships that nurses' experience and how these relate to care and health outcomes.

Communicating 16

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe the components of the communication process.
2. Discuss the various aspects that nurses need to consider when using the different forms of communication.
3. Describe factors influencing the communication process.
4. Compare therapeutic communication techniques that facilitate communication and focus on client concerns.
5. Recognize barriers to communication.
6. Describe the four phases of the helping relationship.
7. Discuss how nurses use communication skills in each phase of the nursing process.
8. State why effective communication is imperative among health professionals.
9. Describe the following disruptive behaviors and how they affect the healthcare environment and client safety: incivility, bullying, and workplace violence.
10. Discuss the differences between nurse and physician communication and how to address these differences.
11. Differentiate the major characteristics of assertive and nonassertive communication.

KEY TERMS

attentive listening, *304*
boundaries, *304*
bullying, *314*
communication, *295*
congruent communication, *302*
decode, *297*
elderspeak, *304*
electronic communication, *298*
email, *300*
emotional intelligence (EI), *316*
empathy, *309*
encoding, *296*
feedback, *297*
helping relationships, *306*
incivility, *314*
nonverbal communication, *297*
personal space, *301*
process recording, *313*
proxemics, *301*
territoriality, *302*
therapeutic communication, *304*
verbal communication, *297*

Introduction

Communication is a critical skill for nursing. It is the process by which humans meet their survival needs, build relationships, and experience emotions. In nursing, communication is a dynamic process used to gather assessment data, to teach and persuade, and to express caring and comfort. It is an integral part of the helping relationship.

Communicating

The term *communication* has various meanings, depending on the context in which it is used. To some, communication is the interchange of information between two or more people; in other words, the exchange of ideas or thoughts. This kind of communication uses methods such as talking and listening or writing and reading. However, painting, dancing, and storytelling are also methods of communication. In addition, thoughts are expressed to others not only by spoken or written words but also by gestures or body actions.

Communication may have a more personal meaning than the interchange of ideas or thoughts. It can be a transmission of feelings or a more personal and social interaction between individuals. Frequently, one member of a couple comments that the other is not communicating. Some teenagers complain about a generation gap—being unable to communicate with understanding or feeling to a parent or authority figure. Sometimes a client may say that a nurse is efficient but lacking in something called *bedside manner*. In this text, **communication** is any means of exchanging information or feelings between two or more individuals. It is a basic component of human relationships, including nursing.

The intent of any communication is to obtain a response. Thus, communication is a process. It has two main purposes: to influence others and to gain information. Communication can be described as helpful or unhelpful. The former encourages a sharing of information, thoughts, or feelings between two or more individuals. The latter hinders or blocks the transfer of information and feelings.

Nurses who communicate effectively are better able to collect assessment data, initiate interventions, evaluate outcomes of interventions, initiate change that promotes health, and prevent the safety and legal problems associated with nursing practice. The communication process is built on a trusting relationship with a client and the client's support people. Effective communication is essential for the establishment of a nurse–client relationship.

Communication can occur on an intrapersonal level within a single individual as well as on interpersonal and group levels. Intrapersonal communication is the communication that you have with yourself; another name is *self-talk*. Both the sender and the receiver of a message usually engage in self-talk. It involves thinking about the message before it is sent, while it is being sent, and after it is sent, and it occurs constantly. Consequently, intrapersonal communication can interfere with an individual's ability to hear a message as the sender intended (Figure 16.1 ■).

The Communication Process

Face-to-face communication involves a sender, a message, a receiver, and a response, or feedback (Figure 16.2 ■). In its simplest form, communication is a two-way process involving the sending and the receiving of a message. Because the intent of communication is to elicit a response, the process is ongoing; the receiver of the message then becomes the sender of a response, and the original sender then becomes the receiver.

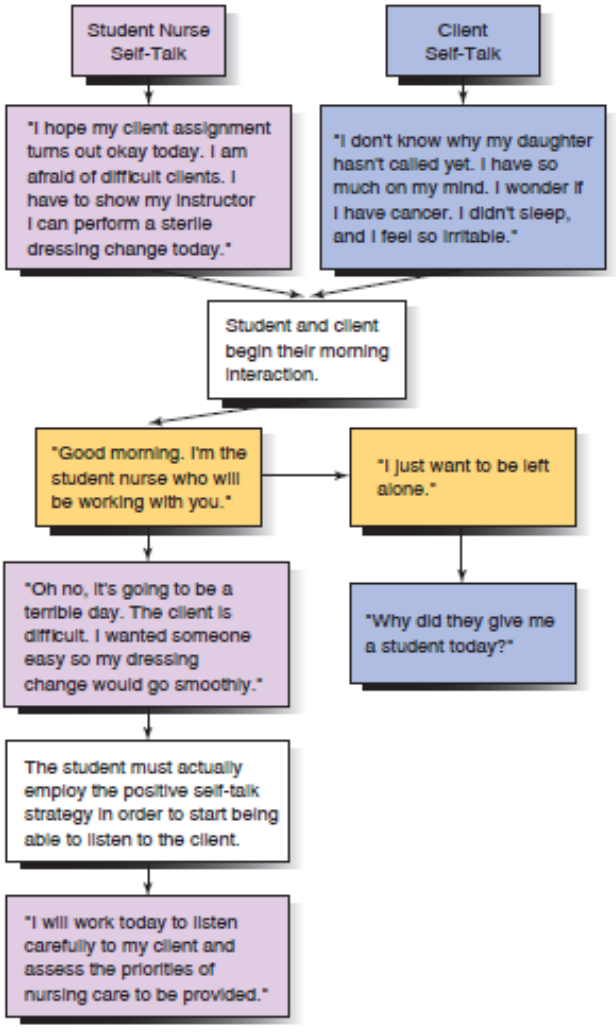

Figure 16.1 ■ Student nurse self-talk.

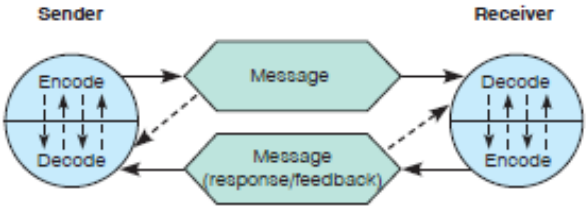

Figure 16.2 ■ The communication process. The dashed arrows indicate intrapersonal communication (self-talk). The solid lines indicate interpersonal communication.

Sender

The *sender*, an individual or group wishing to communicate a message to another, can be considered the *source-encoder*. This term suggests that the individual or group sending the message must have an idea or reason for communicating (source) and must put the idea or feeling into a form that can be transmitted. **Encoding** involves the selection of specific signs or symbols (codes) to transmit the message, such as which language and words to use, how to arrange the words, and what tone of voice and gestures to use. For example, if the receiver speaks English, the sender usually selects English words. If the message is "Mr. Johnson, you have to wait another hour for your pain medication," the tone of voice selected and a shake of the head can reinforce it. The nurse must not only deal with dialects and foreign languages but also cope with two language levels—the layperson's and the health professional's.

Message

The second component of the communication process is the *message* itself—what is actually said or written, the body language that accompanies the words, and how the message is transmitted. The method used to convey the message can target any of the receiver's senses. It is important for the method to be appropriate for the message, and it should help make the intent of the message clearer. For example, talking face to face with an individual may be more effective in some instances than telephoning, emailing, or texting a message. Written communication is often appropriate for long explanations or for a communication that needs to be preserved.

Another form of communication has evolved with technology—**electronic communication**. Common forms of electronic communication are email and texting, in which an individual can send a message, by computer or smartphone, to another individual or group of people. The use of email and texting has become prevalent as a primary form of *personal* communication. It is important to know the rules of etiquette for each. For example, emails should be short and to the point, and punctuation matters. Acronyms should be used sparingly, and do not write in all caps because it implies you are shouting. Texting is even more concise, and if the information is complex, consider

using email or telephone or speaking with the individual in person. Communicating by email and text does not provide the sender relevant information, such as if the receiver is confused, upset, or needs clarification. Therefore, it is important to reread what you email or text before pressing the send button. Nurses need to know when it is and when it is not appropriate to use email for communicating with clients, which is discussed later in the chapter.

The nonverbal channel of touch is often highly effective (Figure 16.3 ■). Nurses use touch in two key circumstances. For example, touch is used frequently when completing a physical task while providing nursing care of a client (e.g., taking blood pressure, administering medications, changing a dressing). The other circumstance is driven by an emotional response to a client's distress (e.g., holding a hand, stroking a shoulder, providing a comforting embrace).

Receiver

The *receiver*, the third component of the communication process, is the listener, who must listen, observe, and attend. This individual is the *decoder*, who must perceive what the sender intended (interpretation). Perception uses all the senses to receive verbal and nonverbal messages. To **decode** means to translate the message sent via the receiver's knowledge and experiences to sort out the meaning of the message. Whether the message is decoded accurately by the receiver, according to the sender's intent, depends largely on their similarities in knowledge and experience and sociocultural background.

Figure 16.3 ■ Appropriate forms of touch can communicate caring.
Katarzyna Bialasiewicz/123RF.

If the meaning of the decoded message matches the intent of the sender, then the communication has been effective. Ineffective communication occurs when the receiver misinterprets the sent message. For example, Mr. Johnson may perceive the message accurately—"No pain medication for another hour." However, if experience has taught him that he can receive the pain medication early if a certain nurse is on duty, he will interpret the intent of the message differently.

Response

The fourth component of the communication process, the *response*, is the message that the receiver returns to the sender. It is also called **feedback**. Feedback can be either verbal, nonverbal, or both. Nonverbal examples are a nod of the head or a yawn. Either way, feedback allows the sender to correct or reword a message. In the case of Mr. Johnson, the receiver may appear irritated or say, "Well, the nurse on the other shift gives me my pain medication early if I need it." The sender then knows the message was interpreted accurately. However, now the original sender becomes the receiver, who is required to decode and respond.

Modes of Communication

Communication is generally carried out in two different modes: verbal and nonverbal. **Verbal communication** uses the spoken or written word; **nonverbal communication** uses other forms, such as gestures, facial expressions, and touch. Although both kinds of communication occur concurrently, most communication is nonverbal. Learning about nonverbal communication is important for nurses in developing effective communication patterns and relationships with clients.

Verbal Communication

Verbal communication is largely conscious because people choose the words they use. The words used vary among individuals according to culture, socioeconomic background, age, and education. As a result, countless possibilities exist for the way ideas are exchanged. An abundance of words can be used to form messages. In addition, a wide variety of feelings can be transmitted when people talk.

Nurses need to consider the following when choosing words to say or write: pace and intonation, simplicity, clarity and brevity, timing and relevance, adaptability, credibility, and humor.

PACE AND INTONATION

The manner of speech, as in the rate or rhythm and tone, will modify the feeling and impact of a message. The tone of words can express enthusiasm, sadness, anger, or amusement. The rate of speech may indicate interest, anxiety, boredom, or fear. For example, speaking slowly and softly to an excited client may help calm the client.

SIMPLICITY

Simplicity includes the use of commonly understood words, brevity, and completeness. The use of complex technical terms becomes natural to nurses. However, clients often misunderstand these terms. Words such as *vasoconstriction* or *cholecystectomy* are meaningful to the nurse and easy to use but not advised when communicating with clients. Nurses need to select appropriate, understandable, and simple terms based on the client's age, knowledge, culture, and education. For example, instead of saying to a client, "I will be catheterizing you for a urine analysis," it may be more appropriate and understandable to say, "I need to get a sample of your urine, so I will collect it by putting a small tube into your bladder." The latter statement is more likely to elicit a response from the client asking why it is needed and whether it will be uncomfortable because the client understands the message being conveyed by the nurse.

CLARITY AND BREVITY

A message that is direct and simple will be effective. Clarity is saying precisely what is meant, and brevity is using the fewest words necessary. The result is a message that is simple and clear. An aspect of this is congruence, or consistency, where the nurse's behavior or nonverbal communication matches the words spoken. When the nurse tells the client, "I am interested in hearing what you have to say," the nonverbal behavior would include the nurse facing the client, making eye contact, and leaning forward. The goal is to communicate clearly so that all aspects of a situation or circumstance are understood. To ensure clarity in communication, nurses also need to enunciate (pronounce) words carefully.

TIMING AND RELEVANCE

Nurses need to be aware of both relevance and timing when communicating with clients. No matter how clearly or simply words are stated or written, the timing needs to be appropriate to ensure that words are heard. Furthermore, the messages need to relate to the client or to the client's interests and concerns.

This involves sensitivity to the client's needs and concerns. For example, a client who is fearful of the possibility of cancer may not hear the nurse's explanations about the expected procedures before and after gallbladder surgery. In this situation, it is better for the nurse first to encourage the client to express concerns and then to deal with those concerns. The necessary explanations can be provided at another time when the client is better able to listen.

Another problem in timing is asking several questions at once. For example, a nurse enters a client's room and says in one breath, "Good morning, Mrs. Brody. How are you this morning? Did you sleep well last night? Your husband is coming to see you before your surgery, isn't he?" The client no doubt wonders which question to answer first, if any. A related pattern of poor timing is to ask a question and then not wait for an answer before making another comment. Conversely, by allowing the client to respond to the social talk or chat, the nurse develops a rapport with the client that can help facilitate effective therapeutic communication.

ADAPTABILITY

The nurse needs to alter spoken messages in accordance with behavioral cues from the client. This adjustment is referred to as *adaptability*. What the nurse says and how it is said must be individualized and carefully considered. This requires smart assessment and sensitivity on the part of the nurse. For example, a nurse who usually smiles, appears cheerful, and greets the client with an enthusiastic "Hi, Mrs. Brown!" notices that the client is not smiling and appears distressed. It is important for the nurse to then modify his or her tone of speech and express concern by facial expression while moving toward the client.

CREDIBILITY

Credibility means worthiness of belief, trustworthiness, and reliability. Credibility may be the most important criterion for effective communication. Nurses foster credibility by being consistent, dependable, and honest. The nurse needs to be knowledgeable about what is being discussed and to have accurate information. Nurses should convey confidence and certainty in what they are saying while being able to acknowledge their limitations (e.g., "I don't know the answer to that, but I will find someone who does").

HUMOR

The use of humor can be a positive and powerful tool in the nurse–client relationship, but it must be used with care. Humor can be used to help clients adjust to difficult and painful situations. The physical act of laughter can be an emotional and physical release, reducing tension by providing a different perspective and promoting a sense of well-being.

When using humor, it is important to consider the client's perception of what is considered humorous. Timing is also important to consider. Although humor and laughter can help reduce stress and anxiety, the feelings of the client need to be considered.

Nonverbal Communication

Nonverbal communication, sometimes called *body language*, includes gestures, body movements, use of touch, and physical appearance, including adornment. Nonverbal communication often tells others more about what an individual is feeling than what is being said because nonverbal behavior is controlled less consciously than verbal behavior (Figure 16.4 ■). Nonverbal communication either reinforces or contradicts what is said verbally. For example, if a nurse says to a client, "I'd be happy to sit here and talk to you for a while," yet glances nervously at a watch every few seconds, the actions contradict the verbal message. The client is more likely to believe the nonverbal behavior, which conveys "I am very busy and need to leave."

Observing and interpreting the client's nonverbal behavior is an essential skill for nurses to develop. To observe nonverbal behavior efficiently requires a systematic assessment of the client's overall physical appearance, posture, gait, facial expressions, and gestures. The nurse, however, needs to exercise caution in interpretation, always clarifying any observation with the client.

Clients who have altered thought processes, such as in schizophrenia or dementia, may experience times when expressing themselves verbally is difficult or impossible. During these times, the nurse needs to be able to interpret the feeling or emotion that the client is expressing nonverbally. An attentive nurse who clarifies observations very often portrays caring and acceptance to the client. This can be a beginning for establishing a trusting relationship between the nurse and the client, even in clients who have difficulty communicating appropriately.

A

B

Figure 16.4 ■ Nonverbal communication sometimes conveys meaning more effectively than words. *A*, The postures of these individuals indicate openness to communication. *B*, The listener's posture and nonverbal demeanor suggest resistance to communication.
A, Westend61/Getty Images; *B*, SDI Productions/E+/Getty Images.

Transculturally, nonverbal communication varies widely (Seiler, Beall, & Mazer, 2017). Even for behaviors such as smiling and handshaking, cultures differ. For example, to some individuals, smiling and handshaking are an integral part of an interaction and essential to establishing trust. The same behavior might be perceived by others as insolent and frivolous.

The nurse cannot always be sure of the correct interpretation of feelings that are expressed nonverbally. The same feeling can be expressed nonverbally in more than one way, even within the same cultural group. For example, anger may be communicated by aggressive or excessive body motion, or it may be communicated by frozen stillness. In some cultures, a smile may be used to conceal anger. Therefore, the interpretation of such observations requires validation with the client. For example, the nurse might say, "You look like you have been crying. Is something upsetting you?"

PERSONAL APPEARANCE

Clothing and adornments can be sources of information about an individual. Although the choice of apparel is highly personal, it may convey social and financial status, culture, religion, group association, and self-concept. Charms and amulets may be worn for decorative or for health protection purposes. When the symbolic meaning of an object is unfamiliar, the nurse can inquire about its significance, which may foster rapport with the client.

How an individual dresses is often an indicator of how the individual feels. People who are tired or ill may not have the energy or the desire to maintain their normal grooming. When a client known for immaculate grooming becomes careless about appearance, the nurse may suspect a loss of self-esteem or a physical illness. The nurse must validate these observed nonverbal data by asking the client. For acutely ill clients in hospital or home care settings, a change in grooming habits may signal that the client is feeling better. For example, a man may request a shave, or a woman may request shampoo and some makeup.

POSTURE AND GAIT

The ways people walk and carry themselves are often reliable indicators of self-concept, current mood, and health. Erect posture and an active, purposeful stride suggest a feeling of well-being. Slouched posture and a slow, shuffling gait suggest depression or physical discomfort. Tense posture and a rapid, determined gait suggest anxiety or anger. The posture of people when they are sitting or lying down can also indicate feelings or mood. Again, the nurse clarifies the meaning of the observed behavior by describing to the client what the nurse sees and then asking what it means or whether the nurse's interpretation is correct. For example, "You look like it really hurts you to move.

I'm wondering how your pain is and if you might need something to make you more comfortable?"

FACIAL EXPRESSION

No part of the body is as expressive as the face (Figure 16.5 ■). Feelings of surprise, fear, anger, disgust, happiness, and sadness can be conveyed by facial expressions. Although the face may express the individual's genuine emotions, it is also possible to control these muscles so that the emotion expressed does not reflect what the individual is feeling. When the message is not clear, it is important to get feedback to be sure of the intent of the expression. Many facial expressions convey a universal meaning. The smile expresses happiness. Disapproval is conveyed by the mouth turned down, the head tilted back, and the eyes directed down the nose. No single expression can be interpreted accurately, however, without considering other reinforcing physical cues, the setting in which it occurs, the expression of others in the same setting, and the background of the client.

Nurses need to be aware of their own expressions and what they are communicating to others. Clients are quick to notice the nurse's facial expression, particularly when they feel unsure or uncomfortable. The client who questions the nurse about a feared diagnostic result will watch whether the nurse maintains eye contact or looks away when answering. The client who has had disfiguring surgery will examine the nurse's face for signs of disgust. It is impossible to control all facial expression, but the nurse must learn to control expressions of feelings such as fear or disgust in some circumstances.

Eye contact is another essential element of facial communication. In many cultures, mutual eye contact acknowledges recognition of the other individual and a willingness to maintain communication. Often, an individual initiates contact with another individual with a glance, capturing the individual's attention prior to communicating. An individual who feels weak or defenseless often averts the eyes or avoids eye contact; the communication received may be too embarrassing or too dominating.

Figure 16.5 ■ The nurse's facial expression communicates warmth and caring.
ayotoayo/PIXVE+/Getty Images.

GESTURES

Hand and body gestures may emphasize and clarify the spoken word, or they may occur without words to indicate a feeling or to give a sign. A father awaiting information about his daughter in surgery may wring his hands, tap his foot, pick at his nails, or pace back and forth. A gesture may more clearly indicate the size or shape of an object. A wave goodbye and the motioning of a visitor toward a chair are gestures that have relatively universal meanings. Some gestures, however, are culture specific. The gesture meaning "shoo" or "go away" in some cultures means "come here" or "come back" in other cultures.

For individuals with special communication challenges, such as those with hearing impairments, the hands are invaluable in communication. Many people who are deaf learn sign language. Ill individuals who are unable to reply verbally can similarly devise a communication system using the hands. The client may be able to raise an index finger once for "yes" and twice for "no." Other signals can often be devised by the client and the nurse to denote other meanings.

Electronic Communication

Computers play an increasing role in nursing practice. Many healthcare agencies are moving toward electronic medical records where nurses document their assessments and nursing care. Email can be used in healthcare facilities for many purposes: to schedule and confirm appointments, to report normal laboratory results, to conduct client education, and for follow-up with discharged clients.

EMAIL

Email is the most common form of electronic communication. It is important for the nurse to know the advantages and disadvantages of email and other guidelines to ensure client confidentiality.

Advantages Email has many positive advantages. It is a fast, efficient way to communicate, and it is legible. It provides a record of the date and time of the message that was sent or received. Some health facilities provide their clients with a portal to schedule appointments, refill prescriptions, and send secure email messages to their healthcare providers. This improves communication and continuity of client care. Email promises better access, and evidence has shown that clients who communicated with their healthcare providers were found to have improved healthcare measures (Industry Watch, 2016).

Disadvantages One disadvantage or negative aspect of email is concern by both clients and primary care providers regarding privacy, confidentiality, and potential misuse

of information, such as cyberattacks and hacking aimed at healthcare organizations (Biddle & Milstead, 2016). Protection of client privacy remains an issue when transferring information electronically. The healthcare agency needs to have an email encryption system to ensure security. An agency may have its own system or outsource it to an encryption service.

Another disadvantage is one of socioeconomics. Not everyone has a computer, and even if people have access to computers at, say, a public library, not everyone has the necessary computer skills. Email may enhance communication with some clients but not all clients. Other forms of communication will be needed for clients who have limited abilities with speaking English, reading, writing, or using a computer.

Other Guidelines Agencies usually develop standards and guidelines for the use of email in healthcare. Nurses need to know their agency's guidelines about what can be sent to clients by email. The client usually signs an email consent form. This form provides information about the risks of email and authorizes the health agency to communicate with the client at a specified email address.

Information sent to a client via email is considered part of the client's medical record. Therefore, a copy of the email needs to be put in the client's chart. Emails, like other documentation in the client's record, may be used as evidence during litigation.

The use of email can enhance effective relationships with clients. It is not, however, a substitute for effective verbal and nonverbal communication. Nurses need to use their professional judgment about what form of communication(s) will best meet their clients' health needs.

Factors Influencing the Communication Process

Many factors influence the communication process. Some of these are development, gender, values and perceptions, personal space, territoriality, roles and relationships, environment, congruence, interpersonal attitudes, and boundaries.

Development

Language, psychosocial, and intellectual development move through stages across the lifespan. Knowledge of a client's developmental stage will allow the nurse to modify the message accordingly. The use of dolls and games coupled with simple language may help explain a procedure to an 8-year-old. With adolescents who have developed more abstract thinking skills, a more detailed explanation can be given, whereas a well-educated, middle-aged business executive may wish to have detailed technical information provided. Older clients are apt to have had a wider range of experiences with the healthcare system, which may influence their response or understanding. With aging also come changes in vision and hearing acuity that can affect nurse–client interactions.

Gender

From an early age, females and males communicate differently. Girls tend to use language to seek confirmation, minimize differences, and establish intimacy. Boys use language to establish independence and negotiate status within a group. These differences can continue into adulthood, so a man and a woman may interpret the same communication differently.

Values and Perceptions

Values are the standards that influence behavior, and *perceptions* are the personal view of an event. Because each individual has unique personality traits, values, and life experiences, each will perceive and interpret messages and experiences differently. For example, if the nurse draws the curtains around a crying woman and leaves her alone, the woman may interpret this as "The nurse thinks that I will upset others and that I shouldn't cry" or "The nurse respects my need to be alone." It is important for the nurse to be aware of a client's values and to validate or correct perceptions to avoid creating barriers in the nurse–client relationship.

Personal Space

Personal space is the distance people prefer in interactions with others. **Proxemics** is the study of distances that people allow between themselves and objects or other people. Communication thus varies in accordance with four distances, each with a close and a far phase. Beebe, Beebe, and Ivy (2019, pp. 83–84) list the following examples:

1. ***Intimate:*** 0 to $1\frac{1}{2}$ feet
2. ***Personal:*** $1\frac{1}{2}$ to 4 feet
3. ***Social:*** 4 to 12 feet
4. ***Public:*** 12 feet and beyond.

Intimate distance communication is characterized by body contact, heightened sensations of body heat and smell, and vocalizations that are low. Vision is intense, is restricted to a small body part, and may be distorted. Nurses frequently use intimate distance. Examples include cuddling a baby, touching a client who is blind, positioning clients, assessing an incision, and restraining a toddler for an injection.

It is a natural protective instinct for people to maintain a certain amount of space immediately around them, and the amount varies with individuals and cultures. When someone who wants to communicate steps into another individual's personal space, the receiver unconsciously responds by stepping back a pace or two. In their therapeutic roles, nurses often are required to violate this personal space. However, it is important for them to be aware of when this will occur and to alert the client. In many instances, the nurse can respect (not come as close as) a client's intimate

distance. In other instances, the nurse may come within intimate distance to communicate warmth and caring.

Personal distance is less overwhelming than intimate distance. Voice tones are moderate, and body heat and smell are noticed less. Physical contact such as a handshake or touching a shoulder is possible. More of the individual is perceived at a personal distance, so nonverbal behaviors such as body stance or full facial expressions are seen with less distortion. Much communication between nurses and clients occurs at this distance. Examples occur when nurses are sitting with a client, giving medications, or establishing an intravenous infusion. Communication at a close personal distance can convey involvement by facilitating the sharing of thoughts and feelings. On the other hand, it can also create tension if the distance encroaches on the other individual's personal space (Figure 16.6 ■). At the outer extreme of 4 feet, however, less involvement is expressed. Bantering and some social conversations usually take place at this distance.

Social distance is characterized by a clear visual perception of the whole individual. Body heat and odor are imperceptible, eye contact is increased, and vocalizations are loud enough to be overheard by others. Communication is therefore more formal and is limited to seeing and hearing. The individual may feel protected and out of reach for touch or personal sharing of thoughts or feelings. Social distance allows more activity and movement back and forth. It is expedient for communicating with several people at the same time or within a short time. Examples occur when nurses make rounds or wave a greeting to someone. Social distance is important in accomplishing the business of the day. However, it is frequently misused. For example, the nurse who stands in the doorway and asks a client "How are you today?" will receive a more noncommittal reply than the nurse who moves to a personal distance to make the same inquiry.

Figure 16.6 ■ Personal space influences communication in social and professional interactions. Encroachment into another individual's personal space creates tension.

Public distance requires loud, clear vocalizations with careful enunciation. Although the faces and forms of people are seen at a public distance, individuality is lost. Instead, the perception is of the group of people or the community.

Territoriality

Territoriality is a concept of the space and things that an individual considers as belonging to the self. Territories marked off by people may be visible to others. For example, clients in a hospital often consider their territory as bounded by the curtains around the bed unit or by the walls of a private room. Healthcare workers must recognize this human tendency to claim territory. Clients often feel the need to defend their territory when others invade it; for example, when a visitor or nurse removes a chair to use at another bed, the visitor has inadvertently violated the territoriality of the client whose chair was removed. Nurses need to obtain permission from clients to remove, rearrange, or borrow objects in their hospital area.

Roles and Relationships

The roles and the relationships between the sender and receiver affect the communication process. Roles such as nursing student and instructor, client and primary care provider, or parent and child affect the content and responses in the communication process. Choice of words, sentence structure, and tone of voice vary considerably from role to role. In addition, the specific relationship between the communicators is significant. The nurse who meets with a client for the first time communicates differently from the nurse who has previously developed a relationship with that client.

Environment

People usually communicate most effectively in a comfortable environment. Temperature extremes, excessive noise, and a poorly ventilated environment can all interfere with communication. Also, lack of privacy may interfere with a client's communication about matters the client considers private. For example, a client who is worried about the ability of his wife to care for him after discharge from the hospital may not wish to discuss this concern with a nurse within the hearing range of other clients in the room. Environmental distraction can impair and distort communication.

Congruence

In **congruent communication**, the verbal and nonverbal aspects of the message match. Clients more readily trust the nurse when they perceive the nurse's communication

LIFESPAN CONSIDERATIONS **Communication with Children**

The ability to communicate is directly related to the development of thought processes, the presence of intact sensory and motor systems, and the extent and nature of an individual's opportunities to practice communication skills. As children grow, their communication abilities change markedly.

INFANTS

- Infants communicate nonverbally, often in response to body feelings rather than in a conscious effort to be expressive.
- Infants' perceptions are related to sensory stimuli, so a gentle voice is soothing, for example, while tension and anger around them create distress.

TODDLERS AND PRESCHOOLERS

- Toddlers and young children gain skills in both expressive (i.e., telling others what they feel, think, want, care about) and receptive (hearing and understanding what others are communicating to them) language.
- Allow time for them to complete verbalizing their thoughts without interruption.
- Provide a simple response to questions because they have short attention spans.
- Drawing a picture can provide another way for the child to communicate.

SCHOOL-AGE CHILDREN

- Talk to the child at his or her eye level to help decrease intimidation.
- Include the child in the conversation when communicating with the parents.

ADOLESCENTS

- Take time to build rapport with the adolescent.
- Use active listening skills.
- Project a nonjudgmental attitude and nonreactive behaviors, even when the adolescent makes disturbing remarks.

Nurses can use the following communication techniques to work effectively with children and their families:

- Play, the universal language, allows children to use other symbols, not just words, to express themselves.
- Nonverbal children may be able to use drawing, painting, and other art forms to communicate.
- Storytelling, in which the nurse and child take turns adding to a story or putting words to pictures, can help the child feel safer in expressing emotions and feelings.
- Word games that pose hypothetical situations or put the child in control, such as "What if . . . ?" "If you could . . . ," "If a genie came and gave you a wish . . . ," can help a child feel more powerful or explore ideas about how to manage the illness.
- Read books with a theme similar to the child's condition or problem, and then discuss the meaning, characters, and feelings generated by the book. Movies or videos can also be used in this way.
- Writing can be used by older children to reflect on their situation, develop meaning, and gain a sense of control.

In all interactions with children, it is important to give them opportunities to be expressive, listen openly, and respond honestly, using words and concepts they understand.

as congruent. This will also help to prevent miscommunication. Both nurse and client can easily determine if there is congruence between verbal expression and nonverbal expression. Nurses are taught to assess clients, but clients are often just as adept at reading a nurse's expression or body language. If there is incongruence between verbal and nonverbal expression, the body language or nonverbal communication is usually the one with the true meaning. For example, when teaching a client how to care for a colostomy, the nurse might say, "You won't have any problem with this." However, if the nurse looks worried while saying this, the client is less likely to trust the nurse's words.

Interpersonal Attitudes

Attitudes convey beliefs, thoughts, and feelings about people and events. Attitudes are communicated convincingly and rapidly to others. Attitudes such as caring, warmth, respect, and acceptance facilitate communication, whereas condescension, lack of interest, and coldness inhibit communication.

Caring and *warmth* convey a feeling of emotional closeness, in contrast to an impersonal approach. Caring is more enduring and intense than warmth. It conveys deep and genuine concern for the individual, whereas warmth conveys friendliness and consideration, shown by acts of smiling and attention to physical comforts. Caring involves giving feelings, thoughts, skill, and knowledge. It requires psychologic energy and poses the risk of gaining little in return; yet by caring, people usually reap the benefits of greater communication and understanding.

Respect is an attitude that emphasizes the other individual's worth and individuality. It conveys that the individual's hopes and feelings are special and unique even though they are like others in many ways. People have a need to be different from—and at the same time similar to—others. Being too different can be isolating and threatening. A nurse conveys respect by listening with an open mind to what the other individual is saying, even if the nurse disagrees. Nurses can learn new ways of approaching situations when they conscientiously listen to another individual's perspective.

Healthcare providers may unknowingly use speech that they believe shows caring but the client perceives

as demeaning or patronizing. This frequently happens in settings that provide healthcare to older adults and individuals with obvious physical or mental disabilities. **Elderspeak** is a speech style similar to baby talk that gives the message of dependence and incompetence and is viewed as patronizing by older adults. It does not communicate respect. Many healthcare providers are not aware that they use elderspeak or that it can have negative meanings to the client. The characteristics of elderspeak include inappropriate terms of endearment (e.g., "honey," "grandma"); inappropriate plural pronoun use (e.g., "Are *we* ready for *our* bath?"); tag questions (e.g., "You want to wear this dress, don't you?"); and slow, loud speech. Although elderspeak is often used by well-intentioned care providers, the literature suggests that elderspeak can negatively affect the overall social and psychologic health of older adults (Corwin, 2018; Williams et al., 2017).

Acceptance emphasizes neither approval nor disapproval. The nurse willingly receives the client's honest feelings. An accepting attitude allows clients to express personal feelings freely and to be themselves. The nurse may need to restrict acceptance in situations where clients' behaviors are harmful to themselves or to others. Helping the client to find appropriate behaviors for feelings is often part of client teaching.

Boundaries

Boundaries are the "defining limits of individuals, objects, or relationships" (Boyd, 2017, "Boundaries and Body Space Zones" section, para 1). For nurses, professional boundaries are crucial in the context of the nurse–client relationship. To maintain clear boundaries, the nurse keeps the focus on the client and avoids sharing personal information or meeting his or her own needs through the nurse–client relationship. If the client seeks friendship with the nurse or a relationship outside the work environment, the nurse affirms his or her professional role and declines the invitation. Some indicators that boundary issues need to be addressed include gift-giving by the nurse or client, spending more time than necessary with a client, or the nurse believing only he or she understands the client (Boyd, 2017).

Web-based social networks such as Facebook, Myspace, and Twitter are experiencing increased usage. Unfortunately, online sites such as these have brought new hazards to nursing professionalism. Unprofessional uses of social networking tools are common; thus, the nurse needs to be diligent about not crossing nurse–client boundaries in an online setting. The American Nurses Association (ANA) Code of Ethics for Nurses (2015a) states that the nurse is responsible for maintaining professional boundaries in all communications and actions (p. 7). It is important to remember that the need for nurses to behave professionally is constant, even when off duty, including social media or any other means of communication (p. 9).

Therapeutic Communication

Therapeutic communication promotes understanding and can help establish a constructive relationship between the nurse and the client. Unlike a social relationship, where there may not be a specific purpose or direction, the therapeutic helping relationship is client and goal directed.

Nurses need to respond not only to the content of a client's verbal message but also to the feelings expressed. It is important to understand how the client views the situation and feels about it before responding. The content of the client's communication is the words or thoughts, as distinct from the feelings. Sometimes people can convey a thought in words while their emotions contradict the words; that is, words and feelings are incongruent. For example, a client says, "I am glad he has left me; he was very cruel." However, the nurse observes that the client has tears in her eyes as she says this. To respond to the client's *words*, the nurse might simply rephrase, saying, "You are pleased that he has left you." To respond to the client's *feelings*, the nurse would need to acknowledge the tears in the client's eyes, saying, for example, "You seem saddened by all this." Such a response helps the client to focus on her feelings. In some instances, the nurse may need to know more about the client and her resources for coping with these feelings.

Sometimes clients need time to deal with their feelings. Strong emotions are often draining. People usually need to deal with feelings before they can cope with other matters, such as learning new skills or planning for the future. This is most evident in hospitals when clients learn that they have a terminal illness. Some require hours, days, or even weeks before they are ready to start other tasks. Some need only time to themselves, others need someone to listen, others need assistance identifying and verbalizing feelings, and others need assistance making decisions about future courses of action.

Attentive Listening

Attentive listening is listening actively and with mindfulness, using all the senses, and paying attention to what the client says, does, and feels as opposed to listening passively with just the ear. It is probably the most important technique in nursing and is basic to all other techniques. Attentive listening is an active process that requires energy and concentration. It involves paying attention to the total message, both verbal and nonverbal, and noting whether these communications are congruent. Attentive listening means absorbing both the content and the feeling the client is conveying while putting aside your own judgments and ideas to really hear and focus on the client's needs. Attentive listening conveys an attitude of caring and interest, thereby encouraging the client to trust you, open up, and talk (Figure 16.7 ■).

Attentive listening also involves listening for key themes in the communication. The nurse must be careful

Figure 16.7 ■ The nurse conveys attentive listening through a posture of involvement.
Thomas M Jackson/Radiants/Getty Images.

not to react quickly to the message. The nurse should not interrupt the speaker, and the nurse (the responder) should take time to think about the message before responding. As a listener, the nurse also should ask questions either to obtain additional information or to clarify. The message sender (i.e., the client) should decide when to close a conversation. When the nurse closes the conversation, the client may assume that the nurse considers the message unimportant. It is also important for nurses to be aware of their own biases. A message from a client that reflects different values or beliefs should not be discredited for that reason.

In summary, attentive listening is a highly developed skill, and it can be learned with practice. A nurse can communicate attentive listening to clients in various ways. Common responses are nodding the head, uttering "Uh huh" or "Mmm," repeating the words that the client has used, or saying "I see what you mean." Each nurse has characteristic ways of responding, and the nurse must take care not to sound insincere or phony.

Visibly Tuning In

At times, your nonverbal behavior may be as important, or more important, than your words. Active learners are engaged physically and mentally in the listening process. They have good eye contact with the client and communicate their interest with an intent facial expression, a natural forward lean, and appropriate head nods (Beebe et al., 2019).

Therapeutic communication techniques facilitate communication and focus on the client's concerns (Table 16.1).

Barriers to Communication

Nurses need to recognize barriers or nontherapeutic responses to effective communication (Table 16.2). Failing to listen, improperly decoding the client's intended message, and placing the nurse's needs above the client's needs are major barriers to communication.

TABLE 16.1 Therapeutic Communication Techniques

Technique	Description	Examples
Using silence	Accepting pauses or silences that may extend for several seconds or minutes without interjecting any verbal response	Sitting quietly (or walking with the client) and waiting attentively until the client is able to put thoughts and feelings into words
Providing general leads	Using statements or questions that (a) encourage the client to verbalize, (b) choose a topic of conversation, and (c) facilitate continued verbalization	"Can you tell me how it is for you?" "Perhaps you would like to talk about . . . " "Would it help to discuss your feelings?" "Where would you like to begin?" "And then what?"
Being specific and tentative	Making statements that are specific rather than general and tentative rather than absolute	"Rate your pain on a scale of 0 to 10." (specific statement) "Are you in pain?" (general statement) "You seem unconcerned about your diabetes." (tentative statement)
Using open-ended questions	Asking broad questions that lead or invite the client to explore (elaborate, clarify, describe, compare, or illustrate) thoughts or feelings. Open-ended questions specify only the topic to be discussed and invite answers that are longer than one or two words.	"I'd like to hear more about that." "Tell me more . . . " "How have you been feeling lately?" "What brought you to the hospital?" "What is your opinion?" "You said you were frightened yesterday. How do you feel now?"

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TABLE 16.1 Therapeutic Communication Techniques—*continued*

Technique	Description	Examples
Using touch	Providing appropriate forms of touch to reinforce caring feelings. Because tactile contacts vary considerably among individuals, families, and cultures, the nurse must be sensitive to the differences in attitudes and practices of clients and self.	Putting an arm over the client's shoulder. Placing your hand over the client's hand.
Restating or paraphrasing	Actively listening for the client's basic message and then repeating those thoughts or feelings in similar words. This conveys that the nurse has listened and understood the client's basic message and also offers clients a clearer idea of what they have said.	*Client:* "I couldn't manage to eat any dinner last night—not even the dessert." *Nurse:* "You had difficulty eating yesterday." *Client:* "Yes, I was very upset after my family left."
Seeking clarification	A method of making the client's broad overall meaning of the message more understandable. It is used when paraphrasing is difficult or when the communication is rambling or garbled. To clarify the message, the nurse can restate the basic message or confess confusion and ask the client to repeat or restate the message. Nurses can also clarify their own message with statements.	"I'm puzzled." "I'm not sure I understand that." "Would you please say that again?" "Would you tell me more?" "I meant this rather than that." "I'm sorry that wasn't very clear. Let me try to explain another way."
Perception checking or seeking consensual validation	A method similar to clarifying that verifies the meaning of specific words rather than the overall meaning of a message	*Client:* "My husband never gives me any presents." *Nurse:* "You mean he has never given you a present for your birthday or Christmas?" *Client:* "Well—not never. He does get me something for my birthday and Christmas, but he never thinks of giving me anything at any other time."
Offering self	Suggesting one's presence, interest, or wish to understand the client without making any demands or attaching conditions that the client must comply with to receive the nurse's attention	"I'll stay with you until your daughter arrives." "We can sit here quietly for a while; we don't need to talk unless you would like to." "I'll help you to dress to go home, if you like."
Giving information	Providing, in a simple and direct manner, specific factual information the client may or may not request. When information is not known, the nurse states this and indicates who has it or when the nurse will obtain it.	"Your surgery is scheduled for 11 a.m. tomorrow." "You will feel a pulling sensation when the tube is removed from your abdomen." "I do not know the answer to that, but I will find out from Mrs. King, the nurse in charge."
Acknowledging	Giving recognition, in a nonjudgmental way, of a change in behavior, an effort the client has made, or a contribution to a communication. Acknowledgment may be with or without understanding, verbal or nonverbal.	"You trimmed your beard and mustache and washed your hair." "I notice you keep squinting your eyes. Are you having difficulty seeing?" "You walked twice as far today with your walker."
Clarifying time or sequence	Helping the client clarify an event, situation, or happening in relation to time	*Client:* "I vomited this morning." *Nurse:* "Was that after breakfast?" *Client:* "I feel that I have been asleep for weeks." *Nurse:* "You had your operation Monday, and today is Tuesday."
Presenting reality	Helping the client to differentiate the real from the unreal	"That telephone ring came from the program on television." "Your magazine is here in the drawer. It has not been stolen."

TABLE 16.1 Therapeutic Communication Techniques—*continued*

Technique	Description	Examples
Focusing	Helping the client expand on and develop a topic of importance. It is important for the nurse to wait until the client finishes stating the main concerns before attempting to focus. The focus may be an idea or a feeling; however, the nurse often emphasizes a feeling to help the client recognize an emotion disguised behind words.	*Client:* "My wife says she will look after me, but I don't think she can, what with the children to take care of, and they're always after her about something—clothes, homework, what's for dinner that night." *Nurse:* "Sounds like you are worried about how well she can manage."
Reflecting	Directing ideas, feelings, questions, or content back to clients to enable them to explore their own ideas and feelings about a situation	*Client:* "What can I do?" *Nurse:* "What do you think would be helpful?" *Client:* "Do you think I should tell my husband?" *Nurse:* "You seem unsure about telling your husband."
Summarizing and planning	Stating the main points of a discussion to clarify the relevant points discussed. This technique is useful at the end of an interview or to review a health teaching session. It often acts as an introduction to future care planning.	"During the past half hour, we have talked about . . . " "Tomorrow afternoon, we may explore this further." "In a few days, I'll review what you have learned about the actions and effects of your insulin." "Tomorrow, I will look at your feeling journal."

TABLE 16.2 Barriers to Communication

Technique	Description	Examples
Stereotyping	Offering generalized and oversimplified beliefs about groups of people that are based on experiences too limited to be valid. These responses categorize clients and negate their uniqueness as individuals.	"Two-year-olds are brats." "Women are complainers." "Men don't cry." "Most people don't have any pain after this type of surgery."
Agreeing and disagreeing	Similar to judgmental responses, agreeing and disagreeing imply that the client is either right or wrong and that the nurse is in a position to judge this. These responses deter clients from thinking through their position and may cause a client to become defensive.	*Client:* "I don't think Dr. Broad is a very good doctor. He doesn't seem interested in his clients." *Nurse:* "Dr. Broad is head of the department of surgery and is an excellent surgeon."
Being defensive	Attempting to protect an individual or healthcare services from negative comments. These responses prevent the client from expressing true concerns. The nurse is saying, "You have no right to complain." Defensive responses protect the nurse from admitting weaknesses in healthcare services, including personal weaknesses.	*Client:* "Those night nurses must just sit around and talk all night. They didn't answer my light for over an hour." *Nurse:* "I'll have you know we literally run around on nights. You're not the only client, you know."
Challenging	Giving a response that makes clients prove their statement or point of view. These responses indicate that the nurse is failing to consider the client's feelings, making the client feel it is necessary to defend a position.	*Client:* "I felt nauseated after that red pill." *Nurse:* "Surely you don't think I gave you the wrong pill?" *Client:* "I feel as if I am dying." *Nurse:* "How can you feel that way when your pulse is 60?" *Client:* "I believe my husband doesn't love me." *Nurse:* "You can't say that; why, he visits you every day."
Probing	Asking for information chiefly out of curiosity rather than with the intent to assist the client. These responses are considered prying and violate the client's privacy. Asking "why" is often probing and places the client in a defensive position.	*Client:* "I was speeding along the street and didn't see the stop sign." *Nurse:* "Why were you speeding?" *Client:* "I didn't ask the doctor when he was here." *Nurse:* "Why didn't you?"

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TABLE 16.2 Barriers to Communication—*continued*

Technique	Description	Examples
Testing	Asking questions that make the client admit to something. These responses permit the client only limited answers and often meet the nurse's need rather than the client's.	"Who do you think you are?" (forces people to admit their status is only that of client) "Do you think I am not busy?" (forces the client to admit that the nurse really is busy)
Rejecting	Refusing to discuss certain topics with the client. These responses often make clients feel that the nurse is rejecting not only their communication but also the clients themselves.	"I don't want to discuss that. Let's talk about . . . " "Let's discuss other areas of interest to you rather than the two problems you keep mentioning."
Changing topics and subjects	Directing the communication into areas of self-interest rather than considering the client's concerns is often a self-protective response to a topic that causes anxiety. These responses imply that what the nurse considers important will be discussed and that clients should not discuss certain topics.	"I can't talk now. I'm on my way for a coffee break." *Client:* "I'm separated from my wife. Do you think I should have sexual relations with another woman?" *Nurse:* "I see that you're 36 and that you like gardening. This sunshine is good for my roses. I have a beautiful rose garden."
Unwarranted reassurance	Using clichés or comforting statements of advice as a means to reassure the client. These responses block the fears, feelings, and other thoughts of the client.	"You'll feel better soon." "I'm sure everything will turn out all right." "Don't worry."
Passing judgment	Giving opinions and approving or disapproving responses, moralizing, or implying one's own values. These responses imply that the client must think as the nurse thinks, fostering client dependence.	"That's good (bad)." "You shouldn't do that." "That's not good enough." "What you did was wrong (right)."
Giving common advice	Telling the client what to do. These responses deny the client's right to be an equal partner. Note that giving expert rather than common advice is therapeutic.	*Client:* "Should I move from my home to a nursing home?" *Nurse:* "If I were you, I'd go to a nursing home, where you'll get your meals cooked for you."

The Helping Relationship

Nurse–client relationships are referred to by some as *interpersonal relationships*, by others as *therapeutic relationships*, and by still others as **helping relationships**. Helping is a growth-facilitating process that strives to achieve three basic goals (Egan & Reese, 2019, pp. 14–17):

1. Help clients manage their problems in living more effectively and develop unused or underused opportunities more fully.
2. Help clients become better at helping themselves in their everyday lives.
3. Help clients develop an action-oriented prevention mentality in their lives.

A helping relationship may develop over weeks of working with a client, or within minutes. The keys to the helping relationship are (a) the development of trust and acceptance between the nurse and the client and (b) an underlying belief that the nurse cares about and wants to help the client.

The personal and professional characteristics of the nurse and the client influence the helping relationship. Age, gender, appearance, diagnosis, education, values, ethnic and cultural background, personality, expectations, and setting can all affect the development of the nurse–client relationship. Consideration of all these factors, combined with good communication skills and sincere interest in the client's welfare, will enable the nurse to create a helping relationship. Characteristics of helping relationships are listed in Box 16.1.

Phases of the Helping Relationship

The helping relationship process can be described in terms of four sequential phases, each characterized by

BOX 16.1 Characteristics of a Helping Relationship

A helping relationship:

- Is an intellectual and emotional bond between the nurse and the client and is focused on the client.
- Respects the client as an individual, including
  - Maximizing the client's abilities to participate in decision-making and treatments
  - Considering ethnic and cultural aspects
  - Considering family relationships and values.
- Respects client confidentiality.
- Focuses on the client's well-being.
- Is based on mutual trust, respect, and acceptance.

Benefits of effective communication

Effective communication results in:

- harmony among employees because there is less opportunity for disputes, as information is shared effectively
- greater opportunity for learning, as new information is communicated effectively by both patients and nursing staff
- understanding of when a message needs to be clarified or repeated, eg if the colleague or patient is not listening properly
- ensuring increased recovery rates because the patient and family have a greater sense of trust and satisfaction about the quality of nursing care they are receiving
- greater adherence and commitment to treatment plans.

Consequences of poor communication

Poor communication:

- leads to a lack of clarity and uncertainty, which portrays a poor image to both patients and co-workers
- affects productivity because staff are unsure of duties to be carried out
- leads to poor coordination of tasks
- results in a high degree of conflict, as ineffective communication leads to distrust
- causes unnecessary stress because staff are uncertain about the outcomes of discussions
- results in demotivation of employees, as feedback, either good or bad, is communicated poorly.

Learner activity
Write a report on the characteristics of an auxiliary nurse. Remember to include your own opinions and characteristics.

Barriers to effective communication

Table 6.2 Catergories of communication barriers

Language barriers	People speaking different languages, dialects or even speaking in an unfamiliar accent
Psychological barriers	When one or both people are stressed, anxious, nervous or angry, the psychological emotions can make communicating very difficult
Physiological barriers	These include barriers of a physiological nature, eg impaired hearing or vision, or if the patient is experiencing pain
Physical barriers	Physical barriers include distracting noise, distance between the sender and receiver, malfunctioning or non-existent electronic equipment ➲

Systematic barriers	May exist in organisations where the channels of communication and information systems are ineffective, resulting in employees not knowing what is excepted of them, and what their role in the communication process is
Attitudinal barriers	This may result from personality conflicts, poor management and resistance to change or a lack of motivation

Practical examples of communication barriers in nursing

- The patient is confused or speaks a different language. An interpreter might be needed.
- The patient is hearing-impaired. This patient may not be able to understand your words. You may need to use sign messages or written messages.
- The patient is blind. This patient will not be able to see your facial expressions. Your words and tone of voice will be even more important than usual.
- The patient has aphasia (inability to speak) and therefore is not able to communicate thoughts and ideas effectively.
- The patient is unconscious and cannot respond.
- The patient is disorientated and may need special communication methods as he or she is not orientated to time, date and place.
- The patient is depressed and may interpret messages in a very negative manner, which will require the nurse to be very tactful and patient.
- The patient does not understand the medical jargon. Avoid using over-complicated, unfamiliar and technical terms such as 'nil per os' instead of nothing to eat or drink.
- There may be emotional barriers or taboos. Some people may find it difficult to express their emotions and some topics may be completely 'off-limits' or taboo. For example, taboos may include a young unmarried female nurse discussing the topic of contraception with a married man.
- The patient or colleague is not paying attention, is not interested or is distracted.
- There may be differences in perception and viewpoint.
- There may be cultural differences such as making eye contact (or not) when speaking to an elder.

Learner activity
Discuss the communication barriers you have experienced in the wards where you have worked, and select the best possible ways in which to overcome them.

Improving communication with patients

Communication impairments or disorders may be a result of many factors, but are usually related to language, speech or hearing processing. Disorders may range from slight stuttering to misarticulation of words, or the complete inability to speak (aphasia). Sometimes the communication impairment is due to sensory loss such as visual or hearing loss.

General guidelines on how to improve communication

There are several points to keep in mind when communicating. The first point is that you are there to provide care and support to a patient. Be open, respectful and gracious in all your interactions and keep their cultural preferences in mind. Answer call bells promptly.

Some ways of improving communication are as follows:

- Make sure you have the patient's attention.
- Use words that are non-threatening – explain what you would like to do and do not give orders to the patient.
- Use simple, understandable phrases, not medical terms, as most patients do not understand these terms.
- Speak clearly and courteously and show respect and empathy.
- Be alert to the patient's needs. Allow time for answers to your requests and to answer the patient's questions.
- Improve your verbal communication skills; if the language that is used in the organisation is not your first language, familiarise yourself with it.
- Develop and become more aware of effective non-verbal language cues, eg when a patient covers his/her head with a sheet or folds his/her arms tightly across the chest, he/she may not be open to discussion at that time. This could be due to pain or discomfort from their illness.
- Pronounce words correctly to ensure safe nursing practice.
- Be aware of cultural differences and be sensitive to how your words may be interpreted, for example, when giving health education on sexually transmitted diseases. In many cultures, for example, young girls may not interact with older men, especially not to discuss matters of sexuality.
- Listen without interrupting the person who is talking.
- Try to stay focused on the conversation. Do not, however, force the patient to continue if he/she becomes anxious or seems to want to change the subject.
- Use body language that indicates your interest and concern. Touch the patient lightly on the arm if it seems appropriate, to show concern. Lean forward, listen intently and maintain eye contact.
- Offer factual information. This relieves anxiety. Do not offer your personal opinion. Assure the patient that you will maintain confidentiality.
- To encourage the patient to continue the discussions, reflect and rephrase the feelings and thoughts the patient is expressing, eg if the patient says she is very sad, you could rephrase it: 'You seem sad, can you tell me why?'
- Keep your sentences short. Ask the patient/receiver to repeat what you have told them so that you know they understand.
- Do not ask multiple questions – ask one question at a time and wait for an answer before asking the next question.
- Give your co-workers your full attention when communicating with them, try to make eye contact most of the time, and show if you understand or not.
- Ask questions to clarify unclear messages.
- Provide a quiet environment without distractions.
- Be convincing when communicating.

Communicating with a patient with a visual impairment

Keep the following points in mind:

- Always assess a patient's needs in terms of how severe the loss of sight is and adapt your communication style to their needs.
- Identify a patient by naming them; don't just speak because the patient will not know that you are directing the conversation at them.
- Identify who you are and what the purpose of the conversation will be.
- Speak normally, pronounce words correctly, clearly and in a loud enough tone, but do not shout, and remember that the patient has loss of sight not loss of hearing or intellectual ability.
- Pay attention to your body language and avoid only nodding your head when wanting to say 'yes' or acknowledge something. Remember that the person can't see you. Continue smiling, as this is conveyed through your voice.
- When speaking to a group of patients, introduce everyone to ensure that you have the attention of all the members.
- In a group discussion if somebody wants to say something, introduce who is speaking to facilitate understanding and participation in discussion.
- It is important to speak and use body language as you would normally do, as this affects your tone of voice. People with visual impairments are very attentive to tone of voice and they gain valuable information in this manner.
- Continue using everyday terms such as 'see' and 'look' because by trying to omit these words it would affect your confidence and create uncertainty for the patient.
- If a patient jokes about not being able to 'see' accept this as a joke and continue, as 'see' in this context would also mean 'understanding'.
- When describing something to a visually impaired patient be specific with directions, such as saying that 'the bed locker is on your left', or when describing a plate of food, 'meat is at 12 o'clock, rice at 3 o'clock and pumpkin at 6 o'clock'.
- Be descriptive when assisting the patient, explaining what you see, eg 'we are now going down the corridor to the nurse's station' or 'we are turning left and going down three steps', so the patient can anticipate what is happening.
- When giving health education, adapt your method or medium of communication to a patient's needs, eg you cannot use pamphlets or pictures, but you could use equipment and allow the patient to touch and feel the equipment.
- During procedures it is even more important to explain the procedure to the patient as she/he cannot see and anticipate what you are going to do, eg when giving a bedpan explain 'I am now closing the curtains' and then 'the curtains are now closed, so now I am going to pull down the blankets'. This way the patient understands that you have provided privacy before offering the bedpan.
- Always ask a patient if he/she requires assistance. Don't just 'take over', because often the person will be able to help themselves.
- Be conscious of communication barriers such as noise interference or speaking too softly, as the patient relies heavily on verbal communication to understand what is going on around them.
- When leaving a conversation with a visually-impaired person, always announce your intentions, so that the patient will not still be talking to you after you have already left.

Communicating with a patient with hearing loss

Assess a patient's needs in terms of how severe the loss of hearing is and adapt your communication style to their needs. Consider the following points:

- Avoid 'talking down' to a hearing-impaired person; he/she is probably fully alert mentally, and treat him/her with respect and dignity.
- Greet the person by their name, to ensure their full attention before you start the conversation.
- Position yourself as close as possible to the person, preferably on the side with the best hearing if possible.
- Face the person directly, make sure there is good lighting and that no light is shining in the patient's eyes, as this would make it difficult for them to see your face and speech read.
- Speak normally, and pronounce your words as clearly as possible. Exaggerated mouth movements may make it difficult for the patient to understand you.
- Speak a little slower, for clarity, and speak as loudly as required for the patient to hear you.
- Do not shout, as shouting distorts sounds and makes speech reading very difficult.
- Avoid speaking too fast. Do not make sentences too long and pause between phrases to ensure that the patient has a good understanding of what has been said.
- When speaking, pay attention to the patient's non-verbal language; a frown may indicate that the person does not understand you, or leaning towards you may indicate that the person does not hear you clearly.
- Refrain from chewing gum, smoking or putting your hands over your mouth or near your face, as this makes speech reading difficult.
- Do not talk to a person with hearing impairment from another room, or when you are not facing them as they will not hear you.
- Pay attention to communication barriers such as noise interference or activities taking place in the same room, as this may distract the patient. Provide a quiet, calm environment for conversation.
- Take turns to talk and do not interrupt the hearing-impaired patient when speaking; a situation where both persons are speaking simultaneously makes hearing and listening impossible.
- Sometimes a hearing-impaired person will not hear/understand a certain phrase or word. In this case, try to use a different word, as different sounds are sometimes easier to hear.
- Make use of sign language or point to objects that you are talking about if difficulties arise.
- Keep a notepad nearby to write down a word or phrase, if necessary.
- Familiarise yourself with basic sign language and encourage the patient to learn sign language as well.
- If the person is using a hearing aid, ensure that the ear pieces are fitted correctly and in good working order.
- Include the hearing-impaired patient in conversations, to prevent him/her from feeling isolated and ignored.

Using sign language when communication with a deaf patient

When communicating with a deaf or hearing-impaired patient you can make use of signs or pictures to get your message across, some of which have been discussed in the guidelines on the previous page.

It is important to note that different versions of sign language are used throughout the world, eg in South Africa we use 'SASL' (South African Sign Language) as the official sign language. It is the sign language used on SABC news broadcasts to interpret the spoken word to those who are deaf. Sign language also makes use of common signs, eg 'hello' is interpreted by a wave of the hand and a 'thumbs up' for when you agree with something.

In the nursing context we often make use of signing, not only if the patient is deaf, but also if there are language barriers, eg when you point to a body part, or make the sign of 'eating' or 'drinking'. However, it would be to your benefit to study sign language if you are working in an environment where you continuously work with deaf patients.

Examples of sign language are given in Figure 6.2.

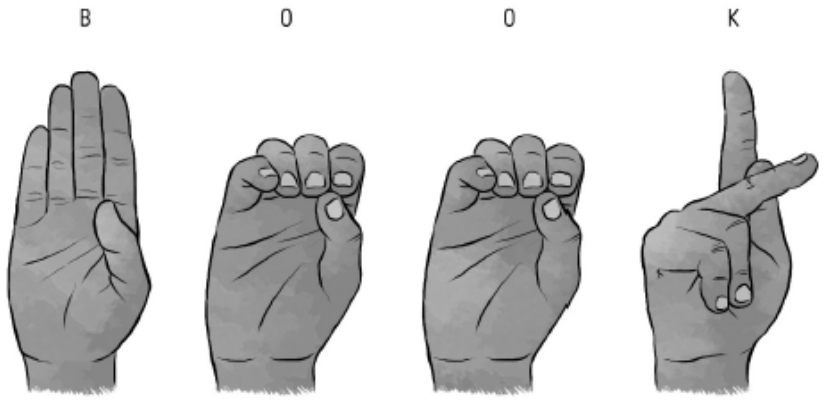

Figure 6.2 SASL one-hand finger spelling/spelled alphabet

Communicating with a confused or disorientated patient

Confusion or disorientation may be the result of memory loss. However, conditions such as infection, dehydration or certain medications can cause confusion and disorientation. Keep the following points in mind when communicating with a confused or disorientated patient:

- When communicating with a patient who is confused it is important to remember that they may not remember that they have already asked you a certain question and do not remember your answer, so try not to become impatient if the patient repeats a question.
- Be very patient and tolerant and assess a patient's needs in terms of how severe the confusion or cognitive impairment is.
- Gain a patient's attention by calling them by name, making direct eye contact and even touching their arm or hand; sit or stand directly in front of the person.

- Speak naturally and as clearly as possible, assess if a patient has any other impairments, which may increase the state of confusion such as blurred vision or hearing difficulty, and adapt your communication to their needs.
- Orientate a patient if necessary, explaining who you are and what you are doing.
- Use simple, direct wording, asking one question at a time or explaining one phrase at a time.
- If a patient hears you but shows no understanding, rephrase your sentence, as this often helps with comprehension.
- Communicate at the specific time of the event, eg 'It's time to take your medicine' then administer the medication immediately; don't tell a patient in advance, 'Remember to take your medicine at 2 o'clock'.
- When asking a question, make it direct, eg 'What would you like to drink, tea or coffee?' not just 'What would you like to drink?' Specific questions help a patient to distinguish what is required of them.
- Acknowledge a patient when they have given appropriate responses.
- If a patient has difficulty in finding correct words, gently provide assistance, especially in remembering names of people or items.
- If a patient can read, provide a notice board with written instructions or information about what to do, or the patient's physical location.
- Provide clocks and calendars that display the correct dates and times, to minimise confusion.
- Provide familiar surroundings if possible, or allow a familiar person to assist with communication.
- A confused patient often displays behavioural problems, therefore adapt communication to rectify the behavioural problems.
- Do not affirm the patient's confusion by allowing them to think that what they see, hear or experience is correct in order to gain their cooperation. For example, if they see imaginary little men walking around the room, don't confirm this by saying, 'Don't worry they will go away just now'.

Communicating with a patient with impaired speech

Vocal cord damage, stroke or brain damage can all cause speech impairments, which makes the communication process cumbersome, as it is difficult to decipher what the patient is trying to say. Other forms of speech impairment include stuttering or articulation difficulty in pronouncing or selecting the words to be said.

People who have had their voice box removed are often well prepared for their loss of speech, and they may be on a rehabilitation programme where an electronic device could be used to regain speech/sound formation capabilities.

A person with brain damage may be able to speak, but unable to find the correct words, which could lead to immense frustration on the part of the patient and the caregiver.

Loss of speech often implies that the person may be able to re-learn how to speak. If this is the case, allow the patient time to pronounce words and don't show impatience if the process is slow and cumbersome.

To ease the communication process, consider the following points:

- Utilise more than the spoken word, eg make use of a pen/pencil and writing pad so that the person can write instead of talk.
- Use computers or photographs so that the person can point to items or needs.
- It remains debatable whether one should help a person when he/she is trying to find a word – some patients may get angry when help is given in this manner, whereas others may appreciate it. It is important, therefore, to assess a patient's needs and personality when establishing a communication relationship.
- Present a calm and relaxed body posture; do not rush the person as this would increase anxiety and make speech more difficult.
- If a person uses obscene language or a specific swear word, do not get angry as they often formulate a specific word or phrase to use when they are unable to recollect the correct word.
- Get to know your patient and their speech patterns, eg sometimes they will point to an item they are referring to but use the incorrect word for it.

Communication with an unconscious patient

Unconsciousness is described as being unaware of the surrounding environment, being incapable of responding to sensory stimuli, and being insensible. The person is beyond awareness and unable to respond.

Unconsciousness is determined by evaluating the person's clinical state using the Glasgow Coma Scale, determining the level of consciousness, which could be from a slightly confused state to a deep 'sleep' and unable to react to any stimuli.

According to research, hearing is the last sense to diminish when a patient becomes unconscious, therefore, although the person may still be able to hear, they will be unable to respond.

It has been reported by many patients after regaining consciousness that they could hear the nurses talking and remembered the conversations and recognised their voices. Therefore, it is imperative always to assume that a patient can hear you and understand you, but is just unable to respond. For this reason we have to communicate with a patient as if they can hear and understand us.

Keep the following points in mind when nursing an unconscious patient:

- When providing nursing care for an unconscious patient, introduce yourself, and explain the procedure to them, touching them in an appropriate manner, as this could reduce anxiety and fear.
- Although communication is a two-way process, it is imperative to continue communicating with the unconscious patient as if they can understand and comprehend, even if they do not respond.
- Continuous communication may reduce fear and anxiety in a patient, especially if they are aware of monitoring equipment and sounds and nursing procedures. Communication reassures the patient and may reduce psychological stress and provide emotional stimulation.
- An important aspect to consider when nursing an unconscious patient is not to become too involved in technological care and not pay sufficient attention to the patient. but to keep communicating verbally with the patient and providing reassuring touch.
- When addressing the patient it is necessary to personalise the communication by calling them by name.

- Allow visitors to communicate with the patient and encourage them to relate personal experiences. If the patient appreciates personal contact, encourage touch as a means of communication.
- Close monitoring of the patient's condition is required during communication processes, as an increase of intracranial pressure, heart rate or blood pressure could indicate anxiety and stress.
- Be a role model to family and friends when communicating with the patient, by providing guidance and support.

Communication with a depressed or anxious patient

When communicating with a depressed or anxious patient it is often not only about what and how you say something, but also about what *not to say*. It is very important to understand that depression and anxiety is an illness just like having high blood pressure or pneumonia, and you wouldn't tell a person with these conditions to 'get over it' would you?

Everyone becomes depressed or experiences anxiety at some point in their life. The most important aspects of communicating with a depressed patient are the following:

- Listen to what the patient is telling you, and try to understand their experiences from their perspective not yours.
- Allow the patient to talk, which often gives them the opportunity to verbalise their own feelings and understand their own emotions, getting them to the point where they realise that they need help to treat the depression or anxiety.
- Show empathy – you are not trying to solve the problem, you are trying to get insight into the patients feelings.
- Use silence as a communication technique. If the patient says something that you may find unrealistic, keep quiet and allow the patient to continue with the explanation.
- Acknowledge what the patient is saying, either by using appropriate body language or by saying, 'Yes, I follow you'.
- Give recognition to the patient, such as, 'I've noticed that you have brushed your hair today', praising positive behaviour.
- Offer personal time to the patient, say that you will sit with them and talk to them.
- Build a trusting relationship with the patient. Ethically you must maintain patient confidentiality and not divulge personal information. However, as an auxiliary nurse you are obliged to report behaviour that could indicate that the patient may want to harm themselves; inform the patient that you are going to report such instances.
- If you think a patient requires more advanced counselling, tell the patient that you are going to get a more experienced person to counsel them.
- If a patient says things like, 'I'm useless', remind them of a time when they did something well; this will direct their thoughts to a more normal interaction without depression or anxiety.

What *not* to say to a depressed or anxious patient

- Never tell a depressed or anxious patient to 'get over it' or 'snap out of it'; it is like telling a diabetic patient to get over it.

- Don't compare a patient's hardships to yours or to those of other people.
- Don't say, 'I understand'. It is not truthful because you can't experience what the patient is experiencing; he/she is an individual experiencing his/her own unique suffering. Rather say something like, 'I hear what you are saying' or 'Okay, can you tell me more'.
- Don't tell a patient 'there's nothing to be afraid of'. This can make them feel as if their fear and anxiety is unrealistic and that there's something wrong with them.
- Don't say 'Don't worry, everything will be fine'. This may be an empty promise.
- Don't tell an anxious patient to 'relax' because they can't, this is part of their disease process. Rather help them to regulate their breathing and to focus on visualising and obtaining a calm state of mind.
- When you say, 'You look worried, is something wrong?' to a depressed or anxious patient, you are telling them something they already know, and you are stating the obvious. This makes the patient angry, because they see that you don't understand their problem.
- When you say 'You are such a sissy' to an anxious patient, you are creating the belief that they should be anxious because they are a 'sissy'. Rather focus on the reality and help them to overcome their fear and depression.

Learner activities

Form small groups. Discuss communication skills in general. Then form pairs and role play communicating with the following categories of patients:

- blind patients
- deaf patients
- patients who have trouble with speech
- a patient who is depressed
- a disorientated patient
- a patient suffering from hallucinations
- an unconscious patient
- a small child.

Swap roles, so that each partner has a turn as a patient and a nurse.

Communication by phone

Nurses are often required to communicate over the phone and this could lead to misunderstandings. The way in which you answer a phone and interpret a message requires special skills, because the body language of the person at the other end of the phone line cannot be seen.

When answering the phone, remember these points:

- Answer the phone as quickly as possible, preferably after the first ring or two.
- Always speak loudly and clearly into the mouthpiece of the phone.
- Offer a greeting (for example, good morning, or good afternoon).
- Identify the unit or place of work.
- Identify yourself and your title.

- Identify the person you are speaking to, eg 'Good morning, ward 6, auxiliary nurse Blue speaking. How may I help you?' Remember to identify the person you are speaking to.
- Politely listen to the message, and make notes if you think you may not remember all the information.
- If you are asked to call another person, ask the caller please to wait while you locate that person.
- If you take a message, jot down the date, time, caller's name and telephone number, together with the message. Sign the message.

When making a phone call, remember these points:

- Always speak loudly and clearly into the mouthpiece of the phone.
- Offer a greeting (eg good morning or good afternoon).
- Identify yourself by indicating who you are and where you are phoning from (not everyone has a caller identification system).

Learning unit 6.2 Interpersonal skills and the communication process

The purpose of learning

This unit will outline the principles of good interpersonal skills and the development thereof.

Specific outcomes
After working through this unit, you should be able to: - List five interpersonal skills - Discuss ways to improve interpersonal skills - Describe strategies to deal with conflict.

Introduction

We use interpersonal skills daily to communicate and interact with people around us, individually and in groups. These skills have been developing since childhood, often subconsciously, and have been influenced by our upbringing and the different exposures in our life.

People with strong interpersonal skills find communication and interaction with colleagues and clients easier, and are often successful in their professional and personal lives.

Good interpersonal skills enhance employment opportunities and are conducive to positive relationships in the workplace. Employers often evaluate a potential candidate's interpersonal skills to see if they would work well in a team and be able to communicate effectively.

To improve your interpersonal skills it is necessary to know what skills are required, and then to follow the process of life-long development in perfecting these skills.

List of interpersonal skills

- Verbal communication – what we say, our choice of words, and how we say it.
- Non-verbal communication – what and how we communicate without using words, our body language and appearance are some examples.
- Listening skills – how we interpret messages from others.
- Negotiation skills – how we work with others and find agreeable solutions when differences arise.
- Problem solving – working with people to identify, define and solve problems.
- Decision-making – the ability to explore and examine different choices and make good decisions.
- Assertiveness – communicating our values, ideas and opinions, not hesitating and believing in them, without fear of reprisal.

How to develop interpersonal skills

Interpersonal skills are known as a 'soft' skill, and may easily be developed by observing others whom you perceive to have good interpersonal skills, learning from them and practising in order to improve. Here are some guidelines:

- Learn to listen – ie not only hearing what someone says, but carefully observing and listening for verbal and non-verbal clues. Don't be in a hurry to make a comment or to reply.
- Choose your words wisely – words should be chosen to be clear, not create misunderstanding, and ask questions to ensure that you have been understood correctly.
- Understand why communication is sometimes ineffective – know the barriers to effective communication and when you identify them, reduce or eliminate them.
- Relax – try to be calm, make eye contact, smile and show your confidence, as nervousness makes us talk too quickly, resulting in an unclear message. If you feel nervous, take a moment, take a deep breath and only then start to speak.
- Clarify – take a real interest in people when you talk to them, ask questions and ensure that you have a full understanding of what they are trying to say to you.
- Be positive – remain in control of the situation, show a positive attitude towards the people you're communicating with; if you allow negative feelings about the situation or person to develop, it will show in your body language.
- Show empathy – accept that other people may have different opinions and ideas, try to see things from their perspective, listen carefully to what they say and you may learn something from their ideas. Trust and respect the person you're communicating with.
- Identify stress – recognise, manage and reduce stress in yourself and others. Don't just tell them to 'relax'; instead, read the signs of stress in people you're dealing with, and communicate in a way that would reduce the stress.
- Learn to be assertive – ie being neither passive nor aggressive. To be assertive you need good self-esteem and must be able to express your feelings and beliefs with confidence so that others respect and understand your point of view.

- Evaluate – reflect on and try to improve your conversations, learn from your mistakes, look at your strong and not so strong points during conversations and try to improve on them each time you interact with someone.
- Negotiate – effective negotiation requires you to be assertive, but respectful towards the person or persons with whom you are negotiating.
- Working in groups – learn to work in groups, be involved and supportive of your group members, whether it is professionally or socially. A 'team player' is an asset in society and popular in the work environment.

Dealing with conflict

In every family and workplace there will at times be conflict. In the healthcare setting, such conflicts might occur with your colleagues, supervisor and possibly even your patients. The successful handling of such situations can have a huge impact on your effectiveness at work and your overall happiness.

Before offering advice on conflict resolution, there are a few golden rules:

- Never have an argument with a colleague or supervisor in public – take the conversation to a private place and try to remain calm.
- Never shout at or be rude to your patients; remember he/she is in your care and in a vulnerable position – do not abuse your position of power or trust.

The strategies offered below can only be accomplished when both parties see the conflict as a problem and have a desire to solve it mutually. Each person must participate actively in the resolution and make an effort and commitment to find answers that are as fair as possible to both parties.

- **Identify the problem**. Have a discussion to understand both sides of the problem. Listen carefully and do not form opinions or interrupt before the speaker has completed what he/she is saying.
- **Suggest a number of alternative solutions**. Both parties should put forward suggestions without analysing these too deeply at this stage. Write the suggestions down if necessary.
- **Evaluate the solutions**. Both parties must give input and each of you must be honest about what will work and what will not work.
- **Decide on the best solution**. Decide on the solution that is the most agreeable to both of you. Accept that there may have to be compromises.
- **Implement the solution**. Before implementation, be sure that both of you understand what has to be done to rectify the situation.
- **Continuously evaluate the solution**. After implementation, discuss whether the solution is working for both of you.

Resolving conflict with a patient might take a slightly different route. Some suggestions are offered here:

- **Defuse the situation** – if a patient is upset or angry, the most important thing you have to achieve is to calm them down – the very last thing that should happen is for a shouting match to ensue. Your patient may argue that you are to blame for his/her unhappiness. At this point, your goal is to address the patient's anger – and you do this by simply agreeing. When you find some truth in the other point of view, it is difficult for the other person to remain angry, eg 'I know that I said I would bring you water an hour ago. You are absolutely

right'. There is probably a very good reason why you didn't deliver the water as promised, but your first objective is to defuse the situation rather than defend yourself – that can come later once the patient is calm. This may be hard to do when you have been wrongly accused but should eventually show results.

- **Empathise** – try to put yourself in the patient's shoes to understand how he/she feels. Listen carefully and acknowledge their anger, eg 'I can understand that you feel upset about that'.

Learning unit 6.3 Health education

The purpose of learning

This unit outlines the basic principles of preparing a health education intervention.

Specific outcomes
After working through this unit, you should be able to: ○ Discuss the basic principles for preparing a health education presentation. ○ Discuss the principles of a health education presentation. ○ List various health education presentation techniques.

As an auxiliary nurse working in the hospital and community, one of your functions will be to educate patients about health issues, eg you may have to give a presentation on the benefits of not smoking. To be effective in the community, you will therefore have to develop good communication skills.

Preparing a health education talk

Giving a presentation to a group of people requires good preparation and planning:

- Prepare a written guideline for your presentation, as this will provide you with a point of reference for future use. It should include:
  - The topic, an outline and the main points (lesson plan).
  - Make sure you know your target audience, how many will be present and their specific needs, eg if you're talking to patients, you should not use medical terminology but rather lay-man's terms to ensure that they understand the topic.
  - Consider the audience's culture, eg in certain cultures people don't eat pork, so do not use pork meat as an example in a talk on nutrition.
  - Use the same language as the target audience, otherwise they may have difficulty understanding you, or make use of an interpreter.
  - Relate information to people's everyday experiences – provide examples where possible, eg if the patient uses a pit latrine at home don't explain about flushing as they will not be able to relate to this.
  - Plan the time frame, ie how long your presentation is going to be. Health education sessions should not be longer than 30 minutes in total; your audience may have other activities to attend to and patients may not be able to take in too much information at a time.
  - Write down the contents of your presentation, so that you can refer to your notes if necessary. For example, write down the definition and key

- **Communication** – the right to communicate freely, and measures designed to ensure the enjoyment of this right shall include the provision of Braille and audio-recorded material for the blind, recognition and use of sign language for people with hearing and or speech disabilities. Mentors for mentally disabled people.
- **Participation in social life** – persons with disabilities have the right to make their own decisions in all areas of social life and this shall include the freedom to engage in sexual relationships and to have a family.
- **Prevention** – to take effective and appropriate steps to prevent disability.
- **Positive action** – to address existing discriminatory practices and disadvantaging conditions facing disabled people, giving special attention to the situation of underrepresented groups such as disabled women and children, deaf people, mentally disabled people, people with albinism and disabled people living in underdeveloped areas.
- **Enforcement** – appropriate and effective policies and legislation as well as accountable services to be developed and enforced to provide all disabled people with opportunities for the full enjoyment of all of these rights.

Social grants and assistance for the disabled person

A person with a disability has the right to access the social grant system, if the requirements set out by the grant regulations are met. Refer to the section on social grants in Learning unit 11.5.

Communication with the person with disabilities

During the care of people with disabilities effective communication is one of the most important aspects to ensure holistic, quality care. To ensure understanding of communication with persons with disabilities refer to Chapter 6: Communication in a nursing context, which elaborates on communication with persons with the following disabilities:

- hearing impairments
- visual impairments
- confusion or disorientation
- impaired speech
- unconsciousness
- depression or anxiety.

General etiquette when communicating with a disabled patient

- Show the same respect and dignity to the person as you would to any other person.
- Respect the person's privacy and personal space.
- Don't impose on the person's property by, eg leaning on their wheelchair or resting on a crutch.
- Do not pat the head of a person in a wheelchair or who is lower than you due to their disability.
- Communicate courteously by addressing adults as 'Mr' or 'Mrs' and not as 'Darling' or 'Honey', etc.

- Speak directly to the person, address them directly, not their caregiver or companion.
- Try to make eye contact by lowering yourself to the disabled person's eye level.
- First ask the disabled person's permission before helping or assisting, and clarify how they would like you to help.
- If help is refused, respect that and allow the person to function independently.
- Take into distance, weather conditions, stairs and general obstacles or difficulties into consideration when giving directions to a person in a wheelchair.
- Allow the disabled person extra time to do or say things, and take into consideration the effect their disability has on their ability to complete a task.

Behavioural problems in people with disabilities

Sometimes when a person becomes ill, has an injury or disability they go through a process of accepting the inevitable and adjusting their lifestyle. However, some people may not accept or adjust well to their new situation, and may display certain behavioural problems.

The process of accepting and living with a long-term illness, injury or disability is a life-long process. The person's personality will determine how behavioural patterns will be affected.

When we look at Learning unit 11.6 Palliative care, as described by Elizabeth Kübler-Ross, we understand that being diagnosed with an illness, injury or disability brings about a sense of loss and grief and the process that follows is acceptable, as this gives a person an opportunity to adjust to their new situation.

Chronic behavioural issues relating to the above are also acceptable. However, behavioural problems may make it very difficult to care for the disabled person. Understanding some of the behavioural problems you may be faced with, will allow for greater empathy and reduce the related stress and guilt experienced by the nursing auxiliary.

Defence and coping mechanisms

Defence and coping mechanism are those behaviours displayed by an individual to defend themselves against uncomfortable experiences and ways to cope with the associated problems.

We have learnt early on in psychology that our 'fight' or 'flight' reaction is crucial to our survival. This means that in a situation of danger or fright, the response would often be to 'fight' and this could be a literal interpretation where one would attack the object of danger, eg a wild animal or person threatening your life. However, it is also possible to regard the danger as overwhelming and then 'flight', or literally run away, as the better option.

When a person is confronted with a disability, 'fight' and 'flight' reactions may present in various ways.

3. Self-concept

The upcoming pages will help you grasp the concept of self: its definition, development, and the factors that influence self-concept. Various components of self-concept will be explored. Understanding self-concept in relation to patients is crucial for assessing any alterations, as it affects their behaviour and their ability to cope with illness.

References:

Berman, A; Snyder, S and Frandsen, G. 2022. Kozier & Erb's *Fundamentals of Nursing Concepts. Process and Practice*. 11th Edition, Global edition. PEARSON

Mogotlane, S. (Editor). 2022. *Juta's Complete Textbook of Medical Surgical nursing*. 2nd Edition. Cape Town. JUTA.

interactive dynamics of growth and development. Temperament may persist throughout the lifespan, although caution must be taken not to irrevocably label or categorize infants and children.

Family

The purpose of a family is to provide support and safety for the child. The family is the major constant in a child's life. Families are involved in their children's physical and psychologic well-being and development. Children are socialized through family dynamics. The parents set expected behaviors and model appropriate behavior.

Nutrition

Adequate nutrition is an essential component of growth and development. For example, poorly nourished children are more likely to have infections than are well-nourished children. In addition, poorly nourished children may not attain their full height potential.

Environment

A few environmental factors that can influence growth and development include the living conditions of the child (e.g., homelessness), socioeconomic status (e.g., impoverished versus financially stable), climate, and community (e.g., provides developmental support versus exposes the child to hazards).

Health

Illness, injury, or congenital conditions (e.g., congenital cardiac conditions) can affect growth and development. Being hospitalized is stressful for a child and can affect the coping mechanisms of the child and family. Prolonged or chronic illness may affect normal developmental processes.

Culture

Cultural customs can influence a child's growth and development. Nutritional practices may influence the rate of growth for infants. Childrearing practices may influence development.

Stages of Growth and Development

The rate of a person's growth and development is highly individual; however, the sequence of growth and development is predictable. Stages of growth usually correspond to certain developmental changes (Table 23.1).

Growth and development theories commonly include the following major components: biophysical, psychosocial, cognitive, moral, and spiritual. A discussion follows of some of the major theories relating to these components, as well as other well-known growth and development theories.

Growth and Development Theories

Researchers have advanced several theories about the various stages and aspects of growth and development, particularly with regard to infant and child development.

Biophysical Theory

Biophysical development theories describe the development of the physical body—how it grows and changes. These changes are compared against established norms. Arnold Gesell (1880–1961) is often identified as the "father of child development" in the United States. His theory states that development is directed by genetics. He conducted extensive research at Yale University in the 1920s and 1930s, asserting that child development is a process of **maturation**, or differentiation and refining of abilities and skills, based on an in-born "timetable." Although children benefit from experience, they will achieve maturational milestones such as rolling over, sitting, and walking at specific times. Gesell's (1934) most important work is found in *An Atlas of Infant Behavior*. His research documented a fixed sequence of developmental milestones of children from infancy through adolescence (Ball, 1977). Gesell observed children through a one-way mirror to determine their developmental milestones. As he collected data through observation, he also utilized photography to obtain an objective image of a child's developmental milestones. His goal was to produce a complete understanding of a child's development. The photographs were inspected, and 10 stages of development were identified. Each stage identified was assigned a percentage frequency for which the developmental milestone occurred (Varga, 2011).

Gesell's theory continues to play a significant role in determining causes and processes within neurologic developmental science and psychopathology, according to Green (2016). Gesell's information on embryology provides data for studies conducted today. In a study conducted in China by Liu et al. (2016), the adverse effects of prenatal and postnatal exposure to organophosphate pesticides were investigated. Gesell's theory was revised by the Beijing Mental Development Cooperative in 1985. The researchers utilized this information to assess neurologic development in children who had been exposed to organophosphate pesticides.

Psychosocial Theories

Psychosocial development refers to the development of personality. **Personality**, a complex concept that is difficult to define, can be considered as the outward (interpersonal)

TABLE 23.1 Stages of Growth and Development

Stage	Age	Significant Characteristics	Nursing Implications
Neonatal	Birth–28 days	Behavior is largely reflexive and develops toward more purposeful behavior.	Assist parents to identify and meet unmet needs.
Infancy	1 month–1 year	Physical growth is rapid.	Control the infant's environment so that physical and psychologic needs are met.
Toddlerhood	1–3 years	Motor development permits increased physical autonomy. Psychosocial skills increase.	Safety and risk-taking strategies must be balanced to permit growth.
Preschool	3–6 years	The preschooler's world is expanding. New experiences and the preschooler's social role are tried during play. Physical growth is slower.	Provide opportunities for play and social activity.
School age	6–12 years	Stage includes the preadolescent period (10–12 years). Peer group increasingly influences behavior. Physical, cognitive, and social development increase, and communication skills improve.	Allow time and energy for the school-age child to pursue hobbies and school activities. Recognize and support the child's achievements.
Adolescence	12–20 years	Self-concept changes with biological development. Values are tested. Physical growth accelerates. Stress increases, especially in the face of conflicts.	Assist adolescents to develop coping behaviors. Help adolescents develop strategies for resolving conflicts.
Young adulthood	20–40 years	A personal lifestyle develops. The individual establishes a relationship with a significant other and a commitment to something.	Accept the adult's chosen lifestyle and assist with necessary adjustments relating to health. Recognize the individual's commitments. Support change as necessary for health.
Middle adulthood	40–65 years	Lifestyle changes are due to other changes; for example, children leave home or occupational goals change.	Assist clients to plan for anticipated changes in life, to recognize the risk factors related to health, and to focus on strengths rather than weaknesses.
OLDER ADULTHOOD			
Young-old	65–74 years	Adaptation to retirement and changing physical abilities is often necessary. Chronic illness may develop.	Assist clients to keep physically and socially active and to maintain peer-group interactions.
Middle-old	75–84 years	Adaptation to decline in speed of movement, reaction time, and increasing dependence on others may be necessary.	Assist clients to cope with loss (e.g., hearing, sensory abilities and eyesight, death of loved one). Provide necessary safety measures.
Old-old	85 and over	Increasing physical problems may develop.	Assist clients with self-care as required, with maintenance of as much independence as possible.

expression of the inner (intrapersonal) self. It encompasses an individual's temperament, feelings, character traits, independence, self-esteem, self-concept, behavior, ability to interact with others, and ability to adapt to life changes.

Many theorists attempt to account for psychosocial development in humans, specifically the development of an individual's personality and the causes of behavior.

Freud (1856–1939)

Sigmund Freud introduced a number of concepts about development that are still used today. The concepts of the unconscious mind; defense mechanisms; and the id, ego, and superego are Freud's. The **unconscious mind** is the part of an individual's mental life of which the individual is unaware. This concept of the unconscious is one of Freud's major contributions to the field of psychiatry. The **id** resides in the unconscious and, operating on the pleasure principle, seeks immediate pleasure and gratification. The **ego**, the realistic part of the individual, balances the gratification demands of the id with the limitations of social and physical circumstances. The methods the ego uses to fulfill the needs of the id in a socially acceptable manner are called defense mechanisms. **Defense mechanisms**, or **adaptive mechanisms** as they are more commonly called today, are the result of conflicts between the id's impulses and the anxiety created by the conflicts due to social and environmental restrictions. The third aspect of the personality, according to Freud, is the superego. The **superego** contains the conscience and the ego ideal. The conscience consists of society's "do not's," usually as a result of parental and cultural expectations. The ego ideal comprises the standards of perfection toward which the individual strives. Freud proposed that the underlying motivation for human development is a dynamic, psychic energy, which he called **libido**.

According to Freud's theory of psychosexual development, the personality develops in five overlapping stages from birth to adulthood. The libido changes its location of

TABLE 23.2 Freud's Five Stages of Development

Stage	Age	Characteristics	Task to Be Attained
Oral	Birth–1½ years	Pleasure is accomplished by exploring the mouth and by sucking.	Weaning
Anal	1½–3 years	Pleasure is accomplished by exploring the organs of elimination.	Bowel and bladder control Toilet training
Phallic	4–6 years	Pleasure is accomplished by exploring the genitals. The child is attracted to the parent of the opposite sex.	Resolution of the Oedipus or Electra complex
Latency	6 years–puberty	Pleasure is directed by focusing on relationships with same-sex peers and the parent of the same sex.	Engagement in activities, such as sports, schoolwork, and socialization with same-sex peers
Genital	Puberty and after	Pleasure is directed in the development of sexual relationships.	Engagement in activities to promote independence

Adapted from *The Ego and the Mechanism of Defense*, by S. Freud, copyright 1946. New York, NY: International Universities Press.

emphasis within the individual from one stage to another. Therefore, a particular body area has special significance to a client at a particular stage. The first three stages (oral, anal, and phallic) are called *pregenital stages*. The culminating stage is the *genital stage*. Table 23.2 indicates characteristics for each stage. Freudian theory asserts that the individual must meet the needs of each stage in order to move successfully to the next developmental stage. For example, during an infant's oral stage, nurses can assist an infant's development by making feeding a pleasurable experience. This provides comfort and security for the infant. Freud also emphasized the importance of infant–parent interaction. Therefore, the nurse as a caregiver should provide a warm, caring atmosphere for an infant and assist parents to do so when the infant returns to their care.

If the individual does not achieve satisfactory progression at one stage, the personality becomes fixated at that stage. **Fixation** is immobilization or the inability of the personality to proceed to the next stage because of anxiety. For example, making toilet training a positive experience during the anal stage enhances the child's feeling of self-control. If, however, the toilet training was a negative experience, the resulting conflict or stress can delay or prolong progression through a stage or cause an individual to regress to a previous stage. Ideally, an individual progresses through each stage with a balance between the id, ego, and superego.

Erikson (1902–1994)

Erik H. Erikson (1963, 1964) adapted and expanded Freud's theory of development to include the entire lifespan, believing that individuals continue to develop throughout life. He described eight stages of development.

Erikson's theory proposes that life is a sequence of **developmental stages** or levels of achievement. Each stage signals a task that must be accomplished. The resolution of the task can be complete, partial, or unsuccessful. Erikson believed that the more success an individual has at each developmental stage, the healthier the personality of the individual. Failure to complete any developmental stage influences the individual's ability to progress to the next level. These developmental stages can be viewed as a series of crises or conflicts. Successful resolution of these crises supports healthy ego development. Failure to resolve the crises damages the ego.

Erikson's eight stages reflect both positive and negative aspects of the critical life periods. The resolution of the conflicts at each stage enables the individual to function effectively in society. Each phase has its own developmental task, and the individual must find a balance between, for example, trust versus mistrust (stage 1) or integrity versus despair (stage 8).

Stage 1 is trust versus mistrust, which is from birth to 18 months of age. The infant learns to trust the primary caregiver to meet the infant's needs for food, shelter, and personal care. In early childhood, age 18 months to 3 years, the development task is autonomy versus shame and doubt. The child begins to identify with the development of control of bodily functions (Erikson, 1963).

Initiative versus guilt is the developmental task of late childhood, between the ages of 3 and 5 years. At this stage, the child becomes assertive and is aware of her own behavior. If this task is not successfully achieved, the child will have decreased self-confidence, and feelings of fear will result (Erikson, 1963).

From age 6 to 12 years the developmental task is industry versus inferiority. Successful attainment indicates the child's ability to create. A negative response is withdrawal and a sense of hopelessness (Erikson, 1963).

The fifth stage of Erikson's theory is identity versus role confusion. This stage occurs from about 12 to 18 years. The individual searches for self and personal identity. A negative response would involve role confusion and inability to identify their place in society. From age 18 to 24 years, the central task is intimacy versus isolation. The individual is exploring relationships with other individuals while also exploring work experiences. A negative resolution would be the avoidance of a career or relationships.

The developmental task of adulthood is generativity versus stagnation. The adult age 25–65 years is creative and develops new interests. From age 65 years to death, the individual's central task is integrity versus despair.

The individual accepts his life and ultimate death (Erikson, 1963). See Figures 23.2 ■ and 23.3 ■.

When using Erikson's developmental framework, nurses should be aware of indicators of positive and negative resolution of each developmental stage. According to Erikson, the environment is highly influential in development. Nurses can enhance a client's development by being aware of the individual's developmental stage and assisting with the development of coping skills related to the stressors experienced at that specific level. Nurses can strengthen a client's positive resolution of a developmental task by providing appropriate opportunities and encouragement. For example, a 10-year-old child (industry versus inferiority) can be encouraged to be creative, to finish schoolwork, and to learn how to accomplish these tasks within the limitations imposed by health status.

Figure 23.2 ■ Trust is established when the infant's basic needs are met.
Tyler Olson/123RF.

Figure 23.3 ■ Assistive devices help maintain independence and self-esteem, which also helps older adults maintain ego integrity and adapt to and cope with the realities of aging.
tidfy/123RF.

Erikson emphasized that individuals must change and adapt their behavior to maintain control over their lives. In his view, no stage in personality development can be bypassed, but individuals can become fixated at one stage or regress to a previous stage under anxious or stressful conditions. For example, a middle-aged woman who has never satisfactorily accomplished the task of resolving identity versus role confusion might regress to an earlier stage when stressed by an illness with which she cannot cope.

Havighurst (1900–1991)

Robert Havighurst believed that learning is basic to life and that individuals continue to learn throughout life. He described growth and development as occurring during six stages, each associated with 6 to 10 tasks to be learned (Box 23.2).

Havighurst promoted the concept of developmental tasks in the 1950s. A **developmental task** is "a task which arises at or about a certain period in the life of an individual, successful achievement of which leads to his [*sic*] happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks" (Havighurst, 1972, p. 2).

Havighurst's developmental tasks provide a framework that the nurse can use to evaluate the client's general accomplishments. However, these tasks are presented as very broad categories and some nurses find them of limited use when assessing specific accomplishments, particularly those of infancy and childhood. Also, in a multicultural society, the definition of successful resolution of tasks may vary with values and belief systems (e.g., not all individuals may wish to marry or bear children), making these tasks less relevant for some.

Peck

Theories and models about adult development are relatively recent compared with theories of infant and child development. Research into adult development has been stimulated by a number of factors, including increased longevity and healthier old age. In the past, development was viewed as complete by the time of physical maturity, and aging was considered a decline following maturity. The emphasis was on the negative aspects rather than the positive aspects of aging. However, Robert Peck (1968) believes that although physical capabilities and functions decrease with old age, mental and social capacities tend to increase in the latter part of life.

Peck proposes three developmental tasks during old age, in contrast to Erikson's one (integrity versus despair):

1. ***Ego differentiation versus work-role preoccupation.*** Adults' identity and feelings of worth are highly dependent on their work roles. On retirement, individuals may experience feelings of worthlessness unless they derive their sense of identity from a number of roles so that one such role can replace the work role

39 Self-Concept

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Summarize the development of self-concept and self-esteem, including the framework described by Erikson.
2. Describe the dimensions and components of self-concept.
3. Identify common stressors affecting self-concept and coping strategies.
4. Describe the essential aspects of assessing role relationships.
5. Identify nursing diagnoses related to altered self-concept.
6. Describe nursing interventions designed to achieve identified outcomes for clients with altered self-concept.
7. Describe ways to enhance client self-esteem.

KEY TERMS

body image, *1014*
core self-concept, *1014*
global self, *1013*
global self-esteem, *1016*
ideal self, *1014*
role, *1016*
role ambiguity, *1016*
role conflicts, *1016*
role development, *1016*
role mastery, *1016*
role performance, *1016*
role strain, *1016*
self-awareness, *1012*
self-concept, *1012*
self-esteem, *1016*
specific self-esteem, *1016*

Introduction

Self-concept is one's mental image of oneself. A positive self-concept promotes an individual's mental and physical health. Individuals with a positive self-concept are better able to develop and maintain interpersonal relationships and resist psychologic and physical illness. An individual possessing a strong self-concept can better accept or adapt to changes that may occur over the lifespan. How one views oneself affects one's interaction with others.

Nurses have a responsibility to assess clients' self-concept and to identify ways to help them develop a more positive view of themselves. Individuals who have a poor self-concept may express feelings of worthlessness, self-dislike, or even self-hatred. They may feel sad or hopeless, and may state they lack energy to perform even the simplest of tasks.

Self-Concept

Self-concept involves all of the self-perceptions—appearance, values, and beliefs—that influence behavior and are referred to when using the words *I* or *me*. Self-concept influences the following:

- How one thinks, talks, and acts
- How one sees and treats another individual
- Choices one makes
- Ability to give and receive love
- Ability to take action and to change things.

There are four dimensions of self-concept:

- ***Self-knowledge:*** insight into one's own abilities, nature, and limitations
- ***Self-expectation:*** what one expects of oneself; may be realistic or unrealistic expectations
- ***Social self:*** how one is perceived by others and society
- ***Social evaluation:*** the appraisal of oneself in relationship to others, events, or situations.

Individuals who value "how I perceive me" above "how others perceive me" can be termed *me-centered*. They try hard to live up to their own expectations and compete only with themselves, not others. In contrast, strongly *other-centered* individuals have a high need for approval from others and try hard to live up to the expectations of others, comparing, competing, and evaluating themselves in relation to others. They tend to have difficulty asserting themselves, and fear disapproval. The positive self-concept, therefore, is me-centered and is formed with limited reference to others' opinions.

In addition to assessing and promoting a positive self-concept with clients, a nurse's own self-concept is important. Nurses who understand the different dimensions of themselves are better able to understand the needs, desires, feelings, and conflicts of their clients. Nurses who feel positive about themselves are more likely to help clients meet their needs.

Self-awareness refers to the relationship between an individual's own and others' perception of self. Thus, a nurse who is very self-aware has perceptions that are very congruent. Becoming more self-aware is a process that requires time and energy and is never complete. One important component of the process is introspection, which involves the nurse reflecting on personal beliefs, attitudes, motivations, strengths, and limitations. The nurse also gains insight into the self through working with other nurses who serve as mentors and by taking feedback

obtained during regular performance reviews seriously and acting on it.

The nurse who has developed a clear understanding and awareness of self can respect others' beliefs and avoid projecting personal beliefs onto others. While in the caregiver role, the self-aware nurse is able to suspend judgment and focus on the needs of the client, even if they differ from those of the nurse. When conflicts arise, the nurse can analyze their own reactions through introspection and by asking these questions:

- "Why do I react this way (fear, anger, anxiety, annoyance, worry)?"
- "Can I change the way I respond to this situation to affect the client's reaction in a helpful way?"

Formation of Self-Concept

An individual is not born with a self-concept; rather, it develops as a result of social interactions with others. Chapter 23 discusses various theories of growth and development, including Erikson's stages of development, Piaget's cognitive developmental phases, and Havighurst's developmental tasks.

According to Erikson (1963), throughout life individuals face developmental tasks associated with eight psychosocial stages that provide a theoretical framework. The success with which an individual copes with these developmental tasks largely determines the development of self-concept. Difficulty coping can result in self-concept problems at the time and, often, later in life. Table 39.1 lists examples of behaviors indicating successful and unsuccessful resolution of these developmental tasks.

The development of one's self-concept consists of three broad steps:

- The infant learns that the physical self is separate and different from the environment.
- The child internalizes others' attitudes toward self.
- The child and adult internalize the standards of society.

The term **global self** refers to the collective beliefs and images one holds about oneself. It is the most complete

TABLE 39.1 Examples of Behaviors Associated with Erikson's Stages of Psychosocial Development

Stage: Developmental Tasks	Behaviors Indicating Positive Resolution	Behaviors Indicating Negative Resolution
Infancy: trust vs. mistrust	Requesting assistance and expecting to receive it Expressing belief of another individual Sharing time, opinions, and experiences	Restricting conversation to superficialities Refusing to provide an individual with personal information Being unable to accept assistance
Toddlerhood: autonomy vs. shame and doubt	Accepting the rules of a group but also expressing disagreement when it is felt Expressing one's own opinion Easily accepting deferment of a wish fulfillment	Failing to express needs Not expressing one's own opinion when opposed Overly concerned about being clean
Early childhood: initiative vs. guilt	Starting projects eagerly Expressing curiosity about many things Demonstrating original thought	Imitating others rather than developing independent ideas Apologizing and being very embarrassed over small mistakes Verbalizing fear about starting a new project
Early school years: industry vs. inferiority	Completing a task once it has been started Working well with others Using time effectively	Not completing tasks started Not assisting with the work of others Not organizing work
Adolescence: identity vs. role confusion	Asserting independence Planning realistically for future roles Establishing close interpersonal relationships	Failing to assume responsibility for directing one's own behavior Accepting the values of others without question Failing to set goals in life
Early adulthood: intimacy vs. isolation	Establishing a close, intimate relationship with another individual Making a commitment to that relationship, even in times of stress and sacrifice Accepting sexual behavior as desirable	Remaining alone Avoiding close interpersonal relationships
Middle-aged adults: generativity vs. stagnation	Being willing to share with another individual Guiding others Establishing a priority of needs, recognizing both self and others	Talking about oneself instead of listening to others Showing concern for oneself in spite of the needs of others Being unable to accept interdependence
Older adults: integrity vs. despair	Using past experience to assist others Maintaining productivity in some areas Accepting limitations	Crying and being apathetic Not accepting changes Demanding unnecessary assistance and attention from others

description that individuals can give of themselves at any one time. It is also an individual's frame of reference for experiencing and viewing the world. Some of these beliefs and images represent statements of fact, for example, "I am a woman," "I am a father," or "I am short." Others refer to less tangible aspects of self, for instance, "I am competent" or "I am shy."

Each separate image and belief one holds about oneself has a bearing on self-concept. However, self-concept is not simply a sum of its parts. The various images and beliefs individuals hold about themselves are not given equal weight and prominence. Each individual's self-concept is like a piece of art. At the center of the art are the beliefs and images that are most vital to the individual's identity. They constitute **core self-concept**. For example, "I am very smart/of average intelligence" or "I am male/female." Images and beliefs that are less important to the individual are on the periphery. For example, "I am left-/right-handed" or "I am athletic/unathletic."

Individuals are thought to base their self-concept on how they perceive and evaluate themselves in these areas:

- Vocational performance
- Intellectual functioning
- Personal appearance and physical attractiveness
- Sexual attractiveness and performance
- Being liked by others
- Ability to cope with and resolve problems
- Independence
- Particular talents.

Self-concept in these areas also extends to the choices individuals make and perceptions they have about their health. Individuals with strong positive self-concept about appearance are likely to value healthy behaviors and take action to maintain the health of their skin, hair, and body tone, for example. Individuals with negative self-concepts may be less proactive about health promotion and illness prevention activities.

Maintaining and evaluating one's self-concept is an ongoing process. Events or situations may change the level of self-concept over time. Having a basic self-concept includes how we see ourselves and how we are seen by others. There is also the **ideal self**, which is how we should be or would prefer to be. The ideal self is the individual's perception of how one should behave based on certain personal standards, aspirations, goals, and values. Sometimes this ideal self is realistic; sometimes it is not. When the perceived self is close to the ideal self, individuals do not wish to be much different from what they believe they already are. A discrepancy between the ideal self and perceived self can be an incentive to self-improvement. However, when the discrepancy is great, low self-esteem can result.

Nurses, like other adults, view themselves based on both internal and external inputs acquired over many years. The ability to appraise one's own strengths, the desire to follow in the steps of role models, and the feedback received from colleagues and clients are some of the influences on the nurse's self-concept.

Components of Self-Concept

The four components of self-concept are personal identity, body image, role performance, and self-esteem.

Personal Identity

Personal identity is the conscious sense of individuality and uniqueness that is continually evolving throughout life. Individuals often view their identity in terms of name, gender, age, race, ethnic origin or culture, occupation or roles, talents, and other situational characteristics (e.g., marital status and education).

Personal identity also includes beliefs and values, personality, and character. For instance, is the individual outgoing, friendly, reserved, generous, selfish? Personal identity thus encompasses both the tangible and factual, such as name and citizenship, and the intangible, such as values and beliefs. Identity is what distinguishes self from others.

In most Western cultures, individuals have a sexual identity, whether heterosexual, gay, lesbian, bisexual, or some other. Sexual identity is not a component of self-concept in some parts of the world where relationships and contextual behavior have a stronger role than the individual's characteristics (Hyde & DeLamater, 2017). See Chapter 40 ∞.

An individual with a strong sense of identity has integrated body image, role performance, and self-esteem into a complete self-concept. This sense of identity provides an individual with a feeling of continuity and a unity of personality. Furthermore, the individual views self as a unique individual.

Body Image

The image of physical self, or **body image**, is how an individual perceives the size, appearance, and functioning of the body and its parts. Body image has both cognitive and affective aspects. The cognitive is the knowledge of the material body; the affective includes the sensations of the body, such as pain, pleasure, fatigue, and physical movement. Body image is the sum of these attitudes, conscious and unconscious, that an individual has toward their body.

Body image includes clothing, makeup, hairstyle, jewelry, and other things intimately connected to the individual (Figure 39.1 ■). It also includes body prostheses, such as artificial limbs, dentures, and hairpieces, as well as devices required for functioning, such as wheelchairs, canes, and eyeglasses. Past as well as present perceptions and how the body has evolved over time are part of one's body image.

An individual's body image develops partly from others' attitudes and responses to that individual's body and partly from the individual's own exploration of the body. For example, body image develops in infancy as the parents or caregivers respond to the child with smiles, holding, and touching, and as the child explores their own body sensations during breastfeeding, thumb sucking, and the bath. Cultural and societal values also influence an individual's body image.

The various information and entertainment media have played a part over the years in how individuals

Figure 39.1 Body image is the sum of an individual's conscious and unconscious attitudes about their body.
JGI/Jamie Grill/Getty Images.

view themselves and others. During adolescence, concerns related to body image are of paramount concern. The "ideal" individual portrayed by the media is really an unrealistic goal for many.

If an individual's body image closely resembles their body ideal, the individual is more likely to think positively about the physical and nonphysical components of the self. The body ideal is greatly influenced by cultural standards. For example, currently in North America the fit, well-toned body is admired.

Another aspect of body image is the understanding that different parts of the body have different values for different individuals. For example, large breasts may be highly important to one woman and unimportant to another, or the occurrence of gray hair may be traumatic to one individual and barely noticed by another.

An individual with a healthy body image will normally show concern for both health and appearance. This individual will seek help if ill and will include health-promoting practices in daily activities. An individual who has an unhealthy body image is likely to be overly concerned about minor illness and to neglect important activities like sleep and a healthy diet.

The individual who has a body image disturbance may hide or not look at or touch a body part that is significantly changed in structure by illness or trauma. Some individuals may also express feelings of helplessness, hopelessness, powerlessness, and vulnerability, and may exhibit self-destructive behavior such as over- or undereating or suicide attempts.

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

Body Image in Childhood

Body image is the way in which individuals view their physical self. It can include emotions, feelings, thoughts, and perspectives on body shape, size, and weight. While several studies have examined the concept of body image in various population groups, little attention has been given to body image during childhood. Neves et al. (2017) performed an integrative review of the current body of scientific evidence relating to body image during childhood to gauge how children understand the concept of body image.

The integrative review of literature examined those studies published between January 2013 and January 2016 that evaluated the concept regarding body image in children aged 0 to 12 years. Three electronic databases including Scopus, Medline, and Virtual Health Library – BVS were searched. Studies that did not include an empirical methodology, did not evaluate a component of body image, included children with underlying diseases or conditions (e.g., cancer, burns, etc.), and included children not belonging to the age range being studied were not taken into account. After screening 7,681 studies, a total of 33 studies were included in the final analysis.

Results showed that girls had higher rates of body dissatisfaction than boys, a trend that is reflected even in older population groups such as adolescents and adults. This finding may be related to cultural influences that present a lean body as the ideal physique for females. Body mass index was shown to affect body image regardless of sex as both boys and girls who had higher body mass indices had higher body dissatisfaction. In addition, sociocultural factors such as the media, parents, and friends were found to impact health behaviors that children felt would allow them to achieve their ideal body image. For example, boys were found to admire male athletes, while girls were found to admire famous actresses and singers. Parental restrictions on eating habits and food choices were also found to contribute to how children viewed their physical selves. On the other hand, the integrative review of literature found few differences in body image perceptions based on race or ethnicity.

For all studies included in the research, it was found that there were varying concepts regarding body image in the number of children belonging to different age groups. This was found to be problematic because body image is a concept that evolves in line with distinct developmental stages that children undergo. Lastly, instruments used to measure body dissatisfaction and perception were not validated for use in the age group of interest, which may raise questions as to the validity of study results.

Implications

Understanding body image in childhood is significant because body image disturbances in childhood may contribute to psychological problems later in life. Nurses can contribute to the early identification of body image issues in children and can help parents and families in implementing early interventions that modify risk factors such as food restrictions, media usage, and eating habits.

Role Performance

Throughout life, individuals undergo numerous role changes. A **role** is a set of expectations about how the individual occupying a particular position behaves. **Role performance** is how an individual in a particular role behaves in comparison to the behaviors expected of that role. **Role mastery** means that the individual's behaviors meet role expectations. Expectations, or standards of behavior of a role, are set by society, a cultural group, or a smaller group to which an individual belongs. Each individual usually has several roles, such as husband, parent, brother, son, employee, friend, nurse, and church member. Some roles are assumed for only limited periods, such as client, student, and ill individual. **Role development** involves socialization into a particular role. For example, nursing students are socialized into nursing through exposure to their instructors, clinical experience, classes, laboratory simulations, and seminars.

Individuals need to know who they are in relation to others and what society expects for the positions they hold. **Role ambiguity** occurs when expectations are unclear, and individuals do not know what to do or how to do it and are unable to predict the reactions of others to their behavior. Failure to master a role creates frustration and feelings of inadequacy, often with consequent lowered self-esteem.

Self-concept is also affected by role strain and role conflicts. People undergoing **role strain** are frustrated because they feel or are made to feel inadequate or unsuited to a role. Role strain is often associated with sex role stereotypes. For example, women in occupations traditionally held by men might be treated as having less knowledge and competence than men in the same roles. The significance of this concept for nurses and clients is also apparent in nursing diagnoses related to the role strain experienced by caregivers.

Role conflicts arise from opposing or incompatible expectations. In an interpersonal conflict, individuals have different expectations about a particular role. For example, grandparents may have different expectations than the parents about how to care for the children. One individual's or group's role expectations may differ from the expectations of another individual or group. For example, an individual who has little flexibility in a full-time job schedule has a role conflict if the individual's spouse expects him or her to handle all the childcare problems. Sometimes role expectations violate the beliefs or values of the role occupant. For example, a nurse in a family planning clinic may be expected to advise couples about birth control methods that are not consistent with the nurse's belief system regarding prevention or management of unwanted pregnancy. Role conflict can lead to tension, a decrease in self-esteem, and embarrassment.

Self-Esteem

Self-esteem is one's judgment of one's own worth, that is, how that individual's standards and performances compare to others' standards and to one's ideal self. If an individual's self-esteem does not match the ideal self, then low self-concept results.

The two types of self-esteem are global and specific. **Global self-esteem** is how much one likes oneself as a whole. **Specific self-esteem** is how much one approves of a certain part of oneself. Global self-esteem is influenced by specific self-esteem. For example, if a man values his looks, then how he looks will strongly affect his global self-esteem. By contrast, if a man places little value on his cooking skills, then how well or badly he cooks will have little influence on his global self-esteem.

Self-esteem is derived from self and others. In infancy, self-esteem is related to the caregiver's evaluations and acceptances. Later the child's self-esteem is affected by competition with others. As an adult, an individual who has high self-esteem has feelings of significance, of competence, of the ability to cope with life, and of control over one's destiny.

The foundation for self-esteem is established during early life experiences, usually within the family structure. However, an adult's level of overall self-esteem may change markedly from day to day and moment to moment. Severe stress—for example, stress related to prolonged illness or unemployment—can substantially lower an individual's self-esteem. In healthcare, clients who believe that their condition is viewed negatively by society may have low self-esteem. Individuals frequently focus on their negative aspects and spend less time on their positive aspects. It is important for both strengths and weaknesses to be identified.

If Maslow's level of love and belonging needs are met, the needs for self-esteem are next higher on the hierarchy. When the need for self-esteem is satisfied, the individual strives for self-actualization (see Chapter 19 ∞).

Factors That Affect Self-Concept

Many factors affect an individual's self-concept. Major factors are stage of development, family and culture, stressors, resources, history of success and failure, and illness.

Stage of Development

As an individual develops, the conditions that affect the self-concept change. For example, an infant requires a supportive, caring environment, whereas a child requires freedom to explore and learn. Older adults' self-concept is based on their experiences in progressing through life's stages.

Family and Culture

A young child's values are largely influenced by the family and culture. Later on, peers influence the child and thereby affect the sense of self. When the child is confronted by differing expectations from family, culture, and peers, the child's sense of self is often confused (Figure 39.2 ■). For example, a child may realize that his parents expect he will

Figure 39.2 ■ A child is often pulled in opposite directions by family and peer expectations.
Scott Griessel/123RF.

not drink alcohol and that he will attend religious services each Saturday. At the same time, his peers drink beer and encourage him to spend Saturday with them.

Stressors

Stressors can strengthen the self-concept as an individual copes successfully with problems. On the other hand, overwhelming stressors can cause maladaptive responses including substance abuse, withdrawal, and anxiety. The ability of an individual to handle stressors will largely depend on personal resources. It is important for the nurse to identify any stressors that may affect aspects of the self-concept. See Box 39.1 for examples of stressors that may place a client at risk for problems with self-concept.

Resources

An individual's resources are internal and external. Examples of internal resources include confidence and values, whereas external resources include support network, sufficient finances, and organizations. Generally, the greater the number of resources an individual has and uses, the more positive the effect on the self-concept.

History of Success and Failure

Individuals who have a history of inability to overcome barriers come to see themselves as failures, whereas individuals with a history of successes will have a more positive self-concept. Likewise, individuals with a positive self-concept tend to find contentment in their level of success, whereas a negative self-concept can lead to viewing one's life situation as negative.

Illness

Illness and trauma can also affect an individual's self-concept. A woman who has had a mastectomy may see herself as less attractive, and the loss may affect how she acts and values herself. Individuals respond to stressors such as illness and alterations in function related to aging in a variety of ways. Acceptance, denial, withdrawal, and depression are common reactions.

BOX 39.1 Stressors Affecting Self-Concept

IDENTITY STRESSORS
- Change in physical appearance (e.g., facial wrinkles)
- Declining physical, mental, or sensory abilities
- Inability to achieve goals
- Relationship concerns
- Sexuality concerns
- Unrealistic ideal self

BODY IMAGE STRESSORS
- Loss of body parts (e.g., amputation, mastectomy, hysterectomy)
- Loss of body functions (e.g., from stroke, spinal cord injury, neuromuscular disease, arthritis, declining mental or sensory abilities)
- Disfigurement (e.g., through pregnancy, severe burns, facial blemishes, colostomy, tracheostomy)
- Unrealistic body ideal (e.g., a muscular configuration that cannot be achieved)

ROLE STRESSORS
- Loss of parent, spouse, child, or close friend
- Change or loss of job or other significant role
- Divorce
- Illness of self or others that affects role performance
- Ambiguous or conflicting role expectations
- Inability to meet role expectations

SELF-ESTEEM STRESSORS
- Lack of positive feedback from significant others
- Repeated failures
- Unrealistic expectations
- Abusive relationship
- Loss of financial security

●○● NURSING MANAGEMENT

Assessing

A thorough assessment includes a psychosocial assessment of the client and the family or support person because this provides clues to actual or potential problems. The nurse assessing self-concept focuses on its four components: (1) personal identity, (2) body image, (3) role performance, and (4) self-esteem.

Before conducting a psychosocial assessment, the nurse must establish trust and a working relationship with the client. Guidelines for conducting a psychosocial assessment include the following:

- Create a quiet, private environment.
- Minimize interruptions if possible.
- Maintain appropriate eye contact.
- Sit at eye level with the client.
- Demonstrate an interest in the client's concerns.

- Indicate acceptance of the client by not criticizing, frowning, or demonstrating shock.
- Ask open-ended questions to encourage the client to talk rather than close-ended questions that tend to block free sharing.
- Avoid asking more personal questions than are actually needed.
- Minimize writing detailed notes during the interview because this can create client concern that confidential material is being "recorded" as well as interfere with your ability to focus on what the client is saying.
- Determine whether the family can provide additional information.
- Maintain confidentiality.
- Be aware of your own biases and discomforts that could influence the assessment.
- Consider how the client's behavior is influenced by culture.

QSEN Patient-Centered Care: Assessing Self-Concept

It is the nurse's responsibility to use therapeutic communication and to remain sensitive to the effect that cultural influences will have on a client's behaviors and needs. Cultural background is not only assessed directly but is also considered as a factor in the areas of self-perception, role relationships, major stressors, and coping strategies. In the area of behaviors that may suggest low self-esteem, nurses need to ask themselves the following question: Is this really a behavior that would suggest low self-esteem or is it part of the cultural behavior(s) of the client? In addition, might the client be experiencing cultural dissonance, a situation in which there are conflicting beliefs and attitudes between the client's culture and the one in which the client is living?

When stressors are identified, the nurse needs to determine how the client perceives the stressor. A positive, growth-oriented perception of stressful events reinforces self-worth; a negative, hopeless, defeatist perception leads to decreased self-esteem. The nurse should also identify the client's coping style and determine whether this style is effective by asking the client such questions as these:

- When you have a problem or face a stressful situation, how do you usually deal with it?
- How effective are these methods?

Clinical Alert!

The degree to which a stressor is perceived to affect self-concept varies among individuals. For example, some individuals may respond to repeated failures by trying harder, whereas others may give up.

Personal Identity

When assessing self-concept, the information the nurse first needs is about the client's personal identity. This involves who the client believes he or she is. See the accompanying Assessment Interview for examples of questions to ask.

ASSESSMENT INTERVIEW Personal Identity

- How would you describe your personal characteristics? How do you see yourself as an individual?
- How do others describe you as an individual?
- What do you like about yourself?
- What do you do well?
- What are your personal strengths, talents, and abilities?
- What would you change about yourself if you could?
- How do you feel if you think someone does not like you?

Body Image

If there are indications of a body image disturbance (Figure 39.3 ■), the nurse should assess the client carefully for possible functional or physical problems. The disturbance may be a result of a present deformity or malfunction or an anticipated one. In addition to the stated responses about the problem, it is important to assess related behavior. See the accompanying Assessment Interview for examples of questions to ask about body image.

Figure 39.3 ■ Individuals do not always appear to themselves as they appear to others.
romakoma/Shutterstock.

Role Performance

The nurse assesses the client's satisfactions and dissatisfactions associated with role responsibilities and relationships: family roles, work roles, student roles, and social roles. Family roles are especially important because family relationships are particularly close. Relationships can be supportive and growth producing or, at the opposite extreme, highly stressful if there is violence or abuse. Assessment of family role relationships may begin with structural aspects such as the number in the family group, ages, and residence location. To obtain data related to the

ASSESSMENT INTERVIEW **Body Image**

- Is there any part of your body you would like to change?
- Do you feel different from others?
- How do you feel about your appearance?
- What changes in your body do you expect following your surgery, treatment, or illness?
- How have significant others in your life reacted to changes in your body?

client's family relationships and satisfaction or dissatisfaction with work roles and social roles, the nurse might ask some of the questions shown in the accompanying Assessment Interview. Keep in mind, however, that questions need to be tailored to the individuals and their culture, age, and situation.

Self-Esteem

A nurse can ask the following questions to determine a client's self-esteem:

- Are you satisfied with your life?
- How do you feel about yourself?
- Are you accomplishing what you want?
- What goals in life are important to you?

It is important for the nurse to determine the client's backgroundin order to not misinterpret specific behaviors. The following behaviors might reflect low self-esteem or may be misinterpreted due to the client's background:

- Avoids eye contact.
- Stoops in posture and moves slowly.
- Has an unkempt appearance.
- Is hesitant or halting in speech.
- Is overly critical of self (e.g., "I'm no good," or "People don't like me.").
- May be overly critical of others.
- Is unable to accept positive remarks about self.
- Apologizes frequently.
- Verbalizes feelings of hopelessness, helplessness, and powerlessness, such as "I really don't care what happens," "I'll do whatever anyone wants," or "Whatever is destined will happen."

Diagnosing

A positive self-concept can serve as a resource to a client when facing health challenges. Sometimes, as supported by data, the client has a problem in the area of self-perception, self-concept, self-esteem, or body image. Examples of nursing diagnoses that are appropriate for clients who have alterations in their self-concept can include impaired body image, modified role performance, and low self-esteem. Additional nursing diagnoses that may apply indirectly to clients with problems of self-concept are altered personal identity, anxiety related to changed physical appearance (e.g., amputation, mastectomy), grieving related to change in physical appearance, and challenges in parenting.

Planning

The nurse develops plans in collaboration with the client and support people when possible, according to the client's state of health, level of anxiety, resources, coping mechanisms, and sociocultural and religious affiliation. The nurse who has little experience in caring for clients with altered self-concept may wish to consult with a more experienced nurse to develop effective plans. The nurse and client set goals to enhance the client's self-concept.

The goals or desired outcomes established will vary according to the diagnoses and defining characteristics related to each individual. Specific nursing interventions can be selected to meet the individual needs of the client.

Implementing

Nursing interventions to promote or enhance a positive self-concept include helping a client to identify areas of strength. In addition, for clients who have an altered self-concept, nurses should establish a therapeutic relationship and assist clients to evaluate themselves and make behavioral changes.

ASSESSMENT INTERVIEW **Role Performance**

FAMILY RELATIONSHIPS

- Tell me about your family.
- What is home like?
- How is your relationship with your spouse, partner, or significant other (if appropriate)?
- What are your relationships like with your other relatives?
- Do you feel safe with your family members?
- How are important decisions made in your family?
- What are your responsibilities in the family?
- How well do you feel you accomplish what is expected of you?
- What about your role or responsibilities would you like to change?
- Are you proud of your family members?
- Do you feel your family members are proud of you?

WORK ROLES AND SOCIAL ROLES

- Do you like your work?
- How do you get along at work?
- What about your work would you like to change if you could?
- How do you spend your free time?
- Are you involved in any community groups?
- Are you most comfortable alone, with one other individual, or in a group?
- Who is most important to you?
- Whom do you seek out for help?

Identifying Areas of Strength

Individuals often perceive their problems and weaknesses more easily than their assets and strengths. Individuals with low self-esteem tend to focus even more on their limitations and to be aware of fewer strengths and many more problems. When a client has difficulty identifying personality strengths and assets, the nurse provides the client with a set of guidelines or a framework for identifying personality strengths (Box 39.2).

BOX 39.2 Framework for Identifying Personality Strengths

Note past, present, and anticipated future participation in:

- Hobbies and crafts
- Expressive arts such as writing, painting, dance, or music
- Sports and outdoor activities, including spectator sports
- Education, training, reading, technology, and related areas
- Work, vocation, job, or position

In addition, determine:

- Sense of humor and the ability to laugh at oneself and take kidding
- Health status including healthy aspects of body function and good health maintenance practices
- Special aptitudes such as sales or mechanical ability; a "green thumb"; ability to recognize and enjoy beauty; ability to solve problems; a liking for adventure or pioneering; having perseverance and the drive needed to get things done
- Relationship strengths including the ability to make people feel comfortable, the capacity to enjoy being with people, being aware of people's needs and feelings, and being able to listen
- Emotional strengths including the capacity to give and receive warmth, affection, and love; the ability to "take" anger and to feel and express a wide range of emotions; and the capacity for empathy
- Spiritual strengths such as religious faith or love of God, and membership and participation in church and related activities.

Nurses can employ the following specific strategies to reinforce strengths:

- Stress positive thinking rather than self-negation.
- Notice and verbally reinforce client strengths.
- Encourage the setting of attainable goals.
- Acknowledge goals that have been attained.
- Provide honest, positive feedback.

Enhancing Self-Esteem

Nurses assisting clients who have an altered self-concept or self-esteem must establish a therapeutic relationship. To do this the nurse must have self-awareness and effective communication skills. The following nursing techniques may help clients analyze the problem and make positive changes in their self-esteem:

- Encourage clients to appraise the situation and express their feelings.
- Encourage clients to ask questions.
- Provide accurate information.
- Become aware of distortions, inappropriate or unrealistic standards, and faulty labels in clients' speech.
- Explore clients' positive qualities and strengths.
- Encourage clients to express positive self-evaluation more than negative self-evaluation.
- Avoid criticism.
- Teach clients to substitute negative self-talk ("I can't walk to the store anymore") with positive self-talk ("I can walk half a block each morning"). Negative self-talk reinforces a negative self-concept.

Certain strategies vary depending on the age of the client (see Lifespan Considerations).

Evaluating

To determine whether client goals or desired outcomes have been achieved, the nurse uses data collected during interactions with the client and significant others. If outcomes are not achieved, the nurse should explore the reasons, considering questions such as the following:

- Have old situations recurred, triggering feelings or behaviors associated with low self-esteem?
- Have new stressful situations occurred with which the client feels unable to cope, resulting in continuing or recurrent low self-esteem (see Chapter 42)?
- Are new or additional roles causing increased stress in adapting?
- Are significant others supporting the client adequately in attempts to improve self-esteem?
- Did the client follow through on referrals to appropriate agencies? Did the agencies provide the expected services?
- Were the client's expectations too high in relation to the time needed for successful resolution of self-esteem problems?

Weaving the Tapestry of Life

The mainstays of the tapestry of life are the powers in one's life—self-esteem, love of life and humanity, and closeness to and recognition of the Godlife in oneself and others.

The weavings that form the patterns in one's life are experiences, knowledge, and dreams. Beauty can be seen throughout, but the strength of the fabric increases with age as the tapestry displays interweavings and integration of these special qualities.

As time goes on, aging is often accompanied by a fragileness of the physical body and an increased number of inevitable losses—emotional and social, as well as physical. This is when the integration of those special fibers—strengthening qualities—becomes so crucial to the overall quality of life of the individual.

When these strengths are displayed in the tapestry of life, the individual is not only given a feeling of self-worth and self-love, but the tapestry is a beautiful gift for all who behold it and are somehow touched by it.

Grace Miller

LIFESPAN CONSIDERATIONS Enhancing Self-Esteem

CHILDREN

- Children build strong self-esteem if they develop five basic attitudes: (1) security and trust, (2) identity, (3) belonging, (4) purpose, and (5) personal competence.
  - Security and trust are developed early in life; infants should learn that they can rely on their parents to meet their needs promptly and consistently. With older children, trust and security are strengthened when adults spend time with them: listening, playing, reading, or just being there. Both emotional and physical contact, such as a smile or a hug, convey warmth and caring.
  - Identity is developed when children are allowed to explore and experiment with the world around them and to express themselves as unique individuals in that world. They should be given opportunities to "practice" who they are. Preschoolers, for example, love to dress themselves and should be allowed to wear outlandish outfits (within limits of weather and safety) if they choose. Teenagers who try new hair colors and styles, some of which may "offend" their parents, are engaging in a crucial developmental step (Figure 39.4 ■).
  - Belonging is essential for all individuals, and having a sense that others in your social network care about you, want you there, and benefit by your contribution is important to healthy self-esteem. Children gain this sense of belonging by being included in activities, by being praised for their efforts and achievements, and by being valued by parents, siblings, caregivers, and other adults. Parents should make an effort to "catch their children doing well" and praise them for it (e.g., "I like the way you share with your brother."). Children should also hear that they are valued just for being themselves (e.g., "I like doing things with you. Remember when we went to the park? Wasn't that fun?").
  - Purpose and belonging are closely related. Children need opportunities to participate in the family and their community in order to discover what they can best contribute based on their strengths and skills. One mother, for example, stated "Leo (age 4) is our actor. He is wonderful with costumes and can make any of us smile when he starts his routine." Leo may never become an actor, but he knows he makes a significant contribution to his family's well-being. He brings them joy.
  - Personal competence grows as children identify and refine their skill sets. Children develop competence as they confront and solve problems, face challenges, expand their thinking, and are asked to do more than they think they can do. Adults must, however, provide children with support, guidance, appropriate assistance, and constructive feedback (including praise) in order to prevent the child from being overwhelmed. Too much frustration or uncertainty can lead to giving up, avoidance, lying, bullying, and other antisocial behaviors. If adults help children to accomplish goals that are important to them, children are more likely to develop a sense of personal competence and independence.
- Key ingredients for helping children develop high self-esteem are love, acceptance, firmness, consistency, and the establishment of expectations. Such qualities provide children with a safe, loving, supportive, and predictable world in which to live.

ADOLESCENTS

- Provide increasing levels of responsibility. Adolescents need to experience successes and failures and the consequences of their own behavior.
- Encourage discussion about issues including problems and mistakes.
- Show appreciation for effort and contributions. Emphasize the process, not just the result.
- Ask for their opinions and suggestions.
- Encourage participation in decision-making in areas that affect the adolescent. Show confidence in the teen's judgments.
- Avoid comparison with or ridicule or punishment in front of others.
- Assist in the creation of realistic goals and standards.
- Adolescents often engage in volunteer activities in their schools or communities, helping them to identify their strengths and find meaning in their activities. Knowing that they have a purpose and make a difference gives children strong self-esteem (Figure 39.5 ■).

Figure 39.4 ■ Exploring different styles is a healthy and normal step in developing one's identity.
Evgeniya Litovchenko/123RF.

Figure 39.5 ■ Community service enhances self-esteem.
Cathy Yeulet/123RF.

Continued on page 1022

LIFESPAN CONSIDERATIONS **Enhancing Self-Esteem**—*continued*

ADULTS

- Explore the meaning of self-esteem and how the client's self-esteem has influenced past behaviors and actions (and can influence present and future plans and decisions).
- Assist the client in assessing the internal and external forces contributing to or detracting from their self-esteem.
- Act in ways that demonstrate belief that the client can cope with the realities and demands of life and is worthy of experiencing joy and happiness.
- Avoid comparisons with other individuals.
- Discourage statements about the self that are negative.
- Encourage the use of affirmations to enhance self-esteem, including statements such as "I like myself" or "I am a valuable individual."
- Encourage associations with positive, supportive individuals.
- Make positive statements about the client's past successes (major or minor).
- Assist the client to make a list of their positive qualities and to review this list often.
- Suggest the client do things for others. Making a contribution enhances positive feelings of self-worth.

OLDER ADULTS

Older adults who become increasingly dependent can develop low self-esteem. Old age is frequently accompanied by changes such as reduced income, decline in physical health, loss of friends and family, and retirement. In addition to those actions listed above for use with adults, nurses can use the following techniques to help older adults enhance their self-esteem:

- Encourage clients to participate in planning their own care.
- Listen carefully to their concerns.
- Assist clients to identify and use their own strengths.
- Encourage them to participate in activities in which they can be successful.
- Communicate that the client is valued. Use the client's name and ask for input.
- Encourage older adults to stay connected with their memories (Figure 39.6 ■). Reminiscing by writing or recording an autobiography or storytelling are excellent ways to do this.
- For older adults who are in hospitals or nursing homes, make sure that they are always shown respect and dignity and are provided privacy.
- Encourage creative activities to tap their resources. Examples are music, art, storytelling, quilting, and photography.
- Work with clients to establish goals in small steps that are achievable—this, in itself, can bolster self-esteem.

Figure 39.6 ■ Sharing memories with others can enhance seniors' self-esteem and general feelings of well-being.

The nurse, client, and significant others need to understand that to change beliefs, feelings, and behaviors affecting self-esteem requires time and ongoing effort. Unlike many physical problems (e.g., wounds) where healing can be quickly observed, improving one's self-concept can be a continuing concern and is not so easily evaluated. New crises can cause clients to doubt themselves and revert to former feelings of inadequacy. Individuals can learn from each new situation and gain new strategies for feeling satisfied with themselves.

Critical Thinking Checkpoint

Craig is a 20-year-old male college student who was involved in an automobile crash 3 days ago, suffering a traumatic amputation of his left lower leg. Craig's mother has remained with him since the crash and is very supportive. His father is grief stricken and having difficulty dealing with Craig's condition because Craig was captain of his college basketball team and had aspirations of becoming a professional athlete. Craig's condition is stable and he is being placed into a rehabilitation program immediately. Soon, he will be fitted for a leg prosthesis. Usually an outgoing individual, Craig is somber and quiet. He does not look at his leg when dressings are being changed and he refuses to discuss his rehabilitation program.

1. Given Craig's age, speculate about whether Craig's self-concept is at risk for being adversely affected by his disability.
2. What data suggest that Craig's self-esteem is, or is at risk for being, negatively affected by his amputation?
3. What factors are likely to affect Craig's adaptation to his amputation and rehabilitation?
4. How would your interventions differ for a client with the same condition who was 70 years old?
5. What other groups of clients, in addition to those with amputations, are at risk for the development of altered self-esteem or body image?

Answers to Critical Thinking Checkpoint questions are available on the faculty resources site. Please consult with your instructor.

Environmental hygiene also influences health, and many diseases, such as asthma and other upper respiratory problems, can be directly related to pollution and to less-than-ideal environmental conditions. The need to maintain optimal environmental hygiene can also be considered a human need.

Need for comfort and rest

The word 'comfort' refers to a sense of ease and well-being. Physical comfort means not only the absence of pain, but also includes:

- the position of the body
- the temperature of the environment
- the absence of hunger or thirst
- the absence of annoying distractions and stressful happenings.

Rest is closely tied to comfort and refers to a state of physical inactivity, repose and relaxation. Sleeping and waking, as well as factors that might induce restlessness, must be taken into account. Physical and emotional stress may interfere with an individual's ability to rest. Rest and sleep are essential for normal physical and psychological functioning in order to replenish energy and repair tissues.

Need for safety

The need for safety is multidimensional and includes the following:

- **Physical safety.** In this instance, the need for safety means the avoidance of physical injury and damage to the body. The individual's level of consciousness and awareness, as well as their level of physical fitness and agility, are relevant to this need.
- **Psychological safety.** This pertains to the feeling of being secure and of knowing what to expect from the people around you, as well as being able to cope with events. It means that individuals understand what is happening and trust that their best interests will be safeguarded.

Need for security

Security is based on physical safety, which means adequate food and shelter, as well as freedom from physical harm. Security is all-encompassing and it is a broader concept than physical safety. It relates to:

- a state of comfort within one's environment, and it means that individuals are assured of the means with which to support themselves in society. It implies that an individual is comfortable with their role and satisfied with their position in society.
- protection under the law and from violation of one's fundamental human rights. There is obedience to the law and respect for the worth of human dignity in the society and in healthcare facilities in particular.
- free access to health facilities and services.

Need for sensation and perception

Normal human functioning includes the ability to perceive the environment and respond appropriately to it. Sensation and perception require the ability to see, hear, feel, smell and taste, as well as cognitive abilities that enable an individual to interpret information and to respond appropriately.

Need for sexuality

In the physical context, sexual or reproductive needs refer to those actions or processes that are necessary for the reproduction of the species. These include copulation, conception, gestation and parturition. Sexuality needs are assessed throughout the lifespan, from infancy to older adulthood, as these needs relate to a stage in life. Sexuality is influenced by a variety of factors, such as age, sociocultural background, ethics, self-concept and physical fitness.

Sexuality is more than a physical need because of the psychological and cultural dimensions which must be taken into account when dealing with patients. The socio-cultural aspects of sexuality for females include:

- menstruation
- pregnancy
- abortion
- contraception.

Assessment regarding sexuality needs should take cognisance of the fact that sexual dysfunction (challenges regarding the desire or actual performance of sexual activity) may be as a result of illness, disability, drugs, stress, or other physiological changes like menopause. Nurses must also be aware of patients' need for information about sexual activity and ways in which sexual activity is altered according to the health status of the patient. Comprehensive history taking on the first visit to a health facility regarding sexuality should include:

- a history of sexually transmitted diseases (STD)
- sexual activity or practice
- sexual orientation
- sexual dysfunction.

Psychosocial needs

Psychosocial needs refer to a variety of cognitive, emotional and interpersonal factors that enable individuals to adapt to the environment, form relationships with others, and function successfully within a community.

Need for cognition

The word cognition comes from Latin *cognoscere*, to know. In order for an individual to function adequately in relation to the environment, other individuals and the community, effective thought processes must be developed. Effective thought processes include orientation to the environment and the people in the environment, as well as problem-solving skills and the ability to form concepts and organise thoughts in a logical manner. Memory and the ability to understand and learn are also necessary for adequate cognition.

Need for adaptation

In order to be able to deal with stress and life events effectively, individuals must develop a variety of conscious coping skills. Coping behaviours involve the use of problem-solving techniques and relaxation, as well as the avoidance of stressful situations. Healthy coping implies adaptability and the capacity to deal with change rationally and appropriately. Less healthy coping mechanisms include aggression, withdrawal and substance abuse.

Unconscious coping behaviours include defence mechanisms such as denial, projection, repression and regression. Coping skills are more difficult to assess in children, but children who are able to make their needs known and who are confident of having these needs met are coping effectively. Severe stress in a child may bring out primitive defence mechanisms such as temper tantrums, withdrawal and regression.

Need for self-esteem and self-concept

Self-esteem implies that one has confidence in one's abilities. Adequate self-esteem requires acceptance of the self and feeling good about the self. This includes acceptance of bodily appearance and characteristics. Good bonding in an infant is a prerequisite for the development of self-esteem. A child with good self-esteem will show confidence and be outgoing. Adequate role performance is related to self-esteem needs, as every individual has a need to fulfil their various life roles effectively.

Self-concept relates to how one feels or thinks about oneself. The components of self-concept include identification, body image, role performance and self-esteem. A healthy self-concept requires acceptance of one's personality traits, as well as a realistic perception and acknowledgement of one's faults.

Self-confidence is based on a healthy self-concept and self-esteem which are the basis of sound interpersonal relationships and mental health.

Need for autonomy

Autonomy implies independence, control and the competent management of the cognitive, perceptual and behavioural processes of an individual, within societal definitions of 'normality' or 'mental health', and conforming to accepted social norms.

Autonomy also includes the facility of choice, or the ability to make an informed decision between several alternatives, based on personal beliefs and preferences. The ability to exercise choice also implies the right to have those choices respected.

Need for relatedness

Humans are social beings and need the esteem and cooperation of their fellow human beings. We also have a need to form close associations with others, as the fullest expression of the personality is attained within reciprocal human relationships. Different types of relationships are characterised by different degrees of self-disclosure. Close, intimate relationships demonstrate mutual trust and support, as well as mutual esteem building. These relationships include the following:

- **The nurse–patient relationship.** This is a special type of relationship in that it is intimate and caring without being too close. The nurse knows and cares for their patients, but does not become emotionally involved with them. Nurse–patient relationships are also characterised by empathy and a 'disinterested' concern for the patient's best interests.
- **Family relationships.** Usually influenced by one's role in the family, eg father, mother, daughter, son, etc. The presence or lack of family support is also crucial for dealing with illness.
- **Significant other relationships.** Characterised by emotional ties with one another or other factors.

Need for stimulation

Curiosity is one of the most striking features of human nature. People have an innate need to explore, to develop their potential, to respond to challenges and to achieve. Stimulation is essential for the development of human potential. The environment, education and interaction with other people are all crucial for development. Stimulation also includes the need for leisure time activities, during which individuals express themselves in an informal and pleasurable way. Meaningful work, on the other hand, is an important source of stimulation as it enhances self-esteem.

Need for communication

Communication with others is a natural human activity that is essential for survival and for the formation of

meaningful relationships. Communication is the process of giving and receiving information, and of attaching meaning to information and making use of that meaning. It is a major factor in determining the relationships that people have with others and what happens to them in the world.

Table 3.1 Summary of bio-psychosocial needs

Physical needs	Psychosocial needs	Spiritual needs
Oxygen	Cognition	Meaning-fulness
Circulation	Adaptation	Religious expression
Fluids and electrolytes	Self-esteem and self-concept	
Nutrition	Autonomy	
Elimination	Relatedness	
Temperature regulation	Stimulation	
Skin integrity	Communication	
Mobility and exercise		
Hygiene		
Comfort and rest		
Safety		
Security		
Sensation and perception		
Sexuality		

Need for meaningfulness (existentialism)

Meaningfulness implies the need for meaning and purpose in an individual's life in order to cope with life's challenges, for example illness or even death. Finding meaning in life requires the development of a personal philosophy and ideology to facilitate the process of finding meaning.

Grieving is an essential part of finding meaning in pain, suffering and death. Both patient and family may need to grieve in order to accept and work through the diagnosis of illness or the death of a loved one.

Meaning in life is frequently connected to self-esteem and relatedness, as many people find meaning and self-expression in their relationships with others, and with a higher or divine power.

Spiritual needs

Human nature has a spiritual dimension, which encompasses the need to find meaning in life and a relationship with a higher or divine power. Human spirituality also means defining life values and belief systems, and relating to the self and to others within the framework of those life values and belief systems or philosophies.

Spiritual needs are dynamic as they change with time and circumstances, for example life events such as the illness or death of a loved one.

The terms spirituality and religion are often used synonymously, although the two are not necessarily the same. Spirituality is a broader concept than religion. However, most religious people are spiritual as well. The spiritual needs of the patient include the need for meaningfulness (existentialism) and the need for the expression of religion.

Holistic care in nursing includes giving spiritual care, which includes reason, reflection, religion, relationships and restoration. Assessments of patients on admission should include a comprehensive history taking regarding the patient's religious beliefs with regard to health and illness. This is to ensure that these beliefs and practices are taken into consideration when planning nursing care, as well as their impact on medical treatment and procedures.

Very often, nurses will only ask about religious affiliation and not delve into the specific health beliefs or practices that may impact on healthcare.

Meeting the spiritual needs of the patient

Principles of spiritual care

Some principles include:

- recognition and acceptance of the spiritual dimension of human beings (self-awareness)
- comprehensive assessment to determine the patient's spiritual and religious needs
- good communication; the need to listen in an authentic manner
- empathy and the ability to accept what the patient says
- sympathy to enhance a trusting relationship to allow the patient to feel safe
- use of judicious self-disclosure
- referral to professionals more qualified in spiritual care, eg a hospital chaplain or the religious leader of the patient.

4. Culturally sensitive nursing

Cultural sensitivity is essential for nurses as it fosters effective communication and builds trust with patients from diverse backgrounds. By understanding and respecting different cultural beliefs, values, and practices, nurses can provide more personalized and compassionate care. In the following pages you will find the Specific Learning Outcomes on culturally sensitive nursing.

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- In the case of a patient who does not want to sign the form, the person who has warned the patient signs a statement that the patient has been warned, and any witnesses to the warning should also sign the statement.

In the following cases the patient may be prevented from leaving, but the relevant responsible person has to be informed that he/she tried to leave:

- mentally retarded or mentally ill people who are being kept with the necessary authority
- under-age patients who act without permission of their parents or guardian
- a patient who is being detained by the police, not the health authorities.

Learning unit 2.3 Cultural diversity and the auxiliary nurse

The purpose of learning

This unit will familiarise the learner with cultural diversity in the South African context.

Specific outcomes
After working through this unit, you should be able to: - Discuss the importance of culture for nurses. - Identify and discuss the different cultural issues in health. - Identify cultural issues the auxiliary nurse must be aware of when communicating with patients and their families. - Describe the importance of alternative and traditional practitioners in the South African context. - Identify why an understanding of different cultures is important for optimal health and better nursing care.

Defining culture

Culture can be defined as the characteristics of a particular group, race or community. These characteristics include such things as language, norms and values, perceptions, social conventions, food and clothing.

Culture enables people to function and live together. It might also be considered as a framework that influences individual behaviour.

Learning activity
As an example of culture, discuss how your fellow learners celebrate marriage. Is an African wedding very different from a Muslim wedding? Is a Christian wedding very different from a Hindu or Jewish wedding?

The importance of cultural knowledge for nurses

Former President Nelson Mandela called South Africa the 'rainbow nation' and this is indeed a good way to describe South Africa with its many different cultures and 11 official languages. To be a good nurse in South Africa, it is important to be

able to work with people whose beliefs and cultures differ from their own without discriminating or judging.

Remember always that it is the patient's right to receive culturally appropriate nursing care. It is also the auxiliary nurse's ethical responsibility to provide this care and to avoid discrimination.

The topic of cultural issues is a vast one and you should continuously try to enlarge your knowledge on this topic. However, the points discussed below highlight some of the reasons why it is so important for the nurse to be aware of cultural differences.

- If the nurse disregards a patient's cultural preferences, this may be seen as discrimination. The patient may take legal action in such a case.
- If the nurse is not up to date with the different cultural beliefs, he/she will not be able to give the right information according to the patient's cultural beliefs so that the patient can make an informed decision regarding his/her health. This may be seen as negligence.

The auxiliary nurse and cultural issues in health

Women

Be aware that in certain societies women are not allowed to make decisions about their health without consulting their husbands or other close male relatives. This is because in some societies, women are regarded as minors and are always under the supervision of a male relative. Some African groups follow this pattern, as do some Muslim communities.

Sexuality

In many cultures sexuality is not discussed in mixed company. Women generally discuss such issues with other women, and men discuss them with other men. With this in mind, the nurse should approach some topics with caution, eg contraception. In such cases the nurse will first have to approach the head of the family.

In these cultures, it is also not appropriate to discuss intimate matters with an unmarried female and using graphic descriptions may give offence.

Diet

It is the nurses' responsibility to find out during assessment what cultural beliefs will influence food or fluid intake. If the patient's dietary requirements cannot be met by the hospital, a suggestion would be to advise the family of this and ask them to bring the food for the patient.

Remember also to take note of the patient's cultural dietary requirements when giving health education (see Chapter 8, Table 8.4 for examples).

Death and dying

At this difficult time, the nurse needs to be aware of differing religious requirements: the family will want to ensure that everything is done according to the patient's wishes.

Note that it is the nurse's responsibility to find out if a specific family member wants to be present at the bedside of the dying patient, or if the family wishes to carry out a specific ritual, such as in the following cases:

- Roman Catholic patients may want a priest to be called.
- The family of a Jewish patient will want to watch at the bedside of the dying patient. Orthodox Jews will also need a person from the Jewish community to lay out the body after death.
- Muslim men may only be nursed by their own family members or persons of the same gender wearing gloves if not from the Muslim faith themselves.
- Jewish and Muslim patients who have died must be kept in a separate section in the mortuary and will want to use their own burial organisations.
- The family of Orthodox Jews and Muslims must be consulted, before any tubes, such as a drip or tracheostomy, are removed by the nurse, as this may be seen as a desicration of the body after death.

Disposal of body parts

It is the responsibility of the nurse to find out if special measures need to be taken where an organ has been removed or a limb amputated. In some cultures, the body part must not be sent to the incinerator because a proper burial is required, eg in the Muslim faith.

Note that not all cultures agree with blood or organ donation – some societies believe the body must be buried with all organs and body parts intact. This also applies to post-mortem examinations, which some cultures will refuse (unless the post-mortem is required by law).

Communication lines

In order to facilitate good communication, the nurse must be aware of hierarchical structures within that family. For instance, in some African groups, the elders or even the ancestors have to be consulted before consent can be given for an operation.

When consent for a child is needed, at times the mother may not be allowed to give this consent and must consult the father or a male relative.

Hygiene

Hygiene practices differ between cultures. Some differences are:

- Muslims wash their hands, genitals and anal area after using the toilet.
- Some cultural groups only shower. They regard using the bath as unhygienic.
- During menstruation some cultural groups take specific hygiene measures, eg avoiding preparing meals for the family.
- In the Hindu culture, the newborn's head is shaved by the mother-in-law for hygienic reasons.
- In some cultures the female genital area may be shaved for hygienic reasons.

Charms and amulets

In some cultures it is believed that charms and amulets protect the patient from harm. The nurse must know not to remove these. If it is necessary to remove the charm or amulet before a surgical procedure, the family must be notified.

Other cultural issues the auxiliary nurse must be aware of

- **When to speak**: Junior people must wait for more senior people to speak.
- **Eye contact**: In Western societies if a person makes eye contact, it is regarded as honesty. In some African societies if a person makes eye contact, it is regarded as not being polite.
- **Greeting**: In African society it is not polite to start a discussion without greeting first, and the senior person will greet first. In Western society it is polite if the junior person greets first. In some cultures the greeting consists of kissing both cheeks of the other person.
- **Touching**: In most societies, it is acceptable to touch only the hands, arms and shoulder during communication.
- **Expressing emotion**: In most societies the physical expression of anger is not acceptable. However, in some cultures excessive crying, screaming and tearing of clothes after the death of a person is a sign of caring and love.

Traditional healers

In South Africa, traditional healers, herbalists and *sangomas* are still commonly consulted. It is therefore important for the nurse to have a basic knowledge of how traditional healers operate.

The traditional healer consults the ancestors regarding the patient's health. This is done by the traditional healer going into a trance or by throwing bones. Herbal remedies may be given to the patient, and these remedies usually cause purging to cleanse the body. In some cases these remedies can be toxic because of the imprecise dosage. Sometimes an amulet is given, as some cultures believe that charms and amulets protect the patient from harm.

Traditional healers are an important link in illnesses such as:

- Tuberculosis (TB) – advise the patient to keep on taking his/her medication, whether or not traditional medication is taken.
- HIV/AIDS – advise the patient to keep on taking his/her medication, whether or not traditional medication is taken.

Traditional medicine presents some problems because most of these medicines have not been analysed scientifically. This means that their interaction with Western medicine is not always known, and dosages are not exact. Therefore, should the patient be hospitalised, it is important that the patient tells the prescribing doctor about any traditional medicine he/she may be taking. Usually the prescribing doctor will ask the patient to stop taking this, at least for the period of hospitalisation.

Learner activities
○ The nurse must be aware of different cultural beliefs in order to give the best possible nursing care and facilitate understanding. Make notes on the key points you should take into account. ○ The auxiliary nurse must respect the different cultures and not judge other groups by their own values and norms. In a group, discuss words and actions that should be avoided. ○ Can you think of any pitfalls that may be associated with taking traditional medicines?

Culture and healthcare (see Ch. 1)

A profound interconnection exists between these. People from different cultures may conceptualize health and illness differently, e.g. diagnostic criteria for mental health problems such as schizophrenia are dissimilar between Western and Eastern perspectives, while studies show wide cultural variations regarding pain tolerance (see Ch. 23), recreational drug use (e.g. of cannabis by Rastafarians), and sexual behaviours (e.g. involving the spread of the human immunodeficiency virus (HIV) in sub-Saharan Africa).

To deliver holistic care, nurses must be sensitive to the cultural expectations of individual patients and families, without making stereotypical assumptions (Box 8.12). This may involve aspects including:

- *Health beliefs* (see Ch. 1)
- *Naming systems*: e.g. Sikh names comprise a personal name, a gender designation (Singh for males and Kaur for females) and a last/family name. Preferable terms are 'first name' rather than 'Christian name' and 'last/family name' instead of 'surname'
- *Assessment interview* (see Ch. 14): In patriarchal cultures, a man may expect to answer questions and make decisions, or be present at interviews, concerning his wife or children. Nursing practitioners in South Africa must be guided by the South African Nursing Council (SANC) - The Scope of Practice related to each specific category of nursing practitioners in South Africa, which covers consent to treatment or care (see Ch. 7).
- *Dietary considerations* (see Ch. 19): Proscriptions include avoidance of pork by Jews and Muslims, and beef by Sikhs and Hindus; many sects are vegetarian; vegans eat no animal derivatives, including eggs and dairy products; Mormons avoid caffeine and alcohol. Foods may be prescribed, e.g. Muslims require Halaal meat from animals slaughtered in accordance with Islamic law; Jews require Kosher food prepared according to Judaism. Religious fasting may be observed, e.g. by Muslims during Ramadan. However, extremes of age or illness may be exempt from fasting restrictions and not all followers adhere to orthodox practices.
- *Dignity*: Members of several cultural/religious groups prize modesty and would be unhappy wearing revealing hospital gowns, or sharing sleeping, bathing and lavatory facilities with/being nursed by the opposite sex.
- *Personal hygiene/elimination* (see Chs 16, 20, 21): Hindus and Muslims prefer to wash using running water, and do this after elimination rather than use toilet tissue. Strict Muslims must wash before prayers. The left hand is used for 'dirtier' areas and the right hand for handling food. Women may wash their whole bodies at each personal hygiene intervention during menstruation.
- *Medical interventions*: Blood transfusions and tissue transplants are not permitted by Jehovah's Witnesses; Christian Scientists may refuse any treatment beyond prayer, even for sick children; Hindu women may refuse vaginal examinations; Chinese patients may prefer traditional options, e.g. herbal remedies and acupuncture (see Ch. 10) to those of Western medicine.

Critical thinking Box 8.13

Cultural awareness in nursing practice

You are helping the registered nurse (RN) to admit an obviously tense patient. The RN asks the patient for his Christian name and is surprised when he challenges her, saying that he is Muslim.

Student activities

- Find out about Muslim naming systems.
- Ascertain the policy for name enquiries on your next placement.
- Choose a religion/culture that you are unfamiliar with and identify its usual practices related to activities described in this section.

Resource

BBC (Religion and Ethics) – www.bbc.co.uk/religion/religions September 2012.

- *Family planning*: Many religions, including Buddhism and Roman Catholicism, disapprove of artificial birth control and termination of pregnancy. Many cultures such as Chinese and Indian prefer male babies.
- *Palliative care* (see Ch. 12).

Socialization

A society transmits its culture (or a group its subculture) to future members by this process. Thus, individuals acquire the knowledge and skills that allow them to function socially, leading to personal and communal success. Two phases of socialization are usually distinguished: primary and secondary (Box 8.14).

Primary socialization

This occurs in early childhood, its main 'agents' usually close family members. The pre-school child acquires fundamental social skills including speech, gesture and appropriate behaviour, and self-care, e.g. continence, dressing, feeding. Additionally, attitudes including moral and religious beliefs are transmitted. Sometimes teaching can be formal, or deliberate, e.g. tying shoelaces, but may be unconscious, or informal,

Reflective practice Box 8.14

Personal experience of socialization

Think back to when you learned something from a parent or person close to you, from the mass media and from an RN while on placement.

Student activities

- Reflect on the agents of socialization in each case, your relationship with them and any feelings experienced.
- Did your feelings differ between the three examples and did this affect your learning? Discuss your feelings with your mentor

Note: You may find that emotions colour such recollections. As socialization is an interpersonal process, it often imparts learning in a profound and affective (emotional) manner.

Culturally Responsive Nursing Care 21

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe concepts related to culture, such as race, ethnicity, and acculturation.
2. Examine factors that contribute to health disparities among racial and ethnic groups.
3. Describe the role of federal agencies and initiatives regarding the provision of culturally responsive healthcare.
4. Describe cultural models of care, such as cultural competency.
5. Describe health views from culturally diverse perspectives.
6. Differentiate culturally influenced approaches to healing and treatment.
7. Describe ways culture influences communication patterns and how to provide linguistically appropriate care.
8. Create self-awareness of your own culture, beliefs, biases, and assumptions.
9. Identify methods of cultural assessment.
10. Create a culturally responsive nursing care plan.

KEY TERMS

acculturation, *401*
assimilation, *402*
biomedical health belief, *404*
cultural broker, *407*
cultural competence, *403*
culturally responsive care, *397*
culture, *398*
discrimination, *399*
diversity, *398*
ethnicity, *398*
ethnocentrism, *399*
folk medicine, *405*
generalizations, *399*
health disparities, *399*
health equity, *400*
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heritage consistent, *411*
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holistic health belief, *404*
interpreter, *407*
magico-religious health belief, *404*
multicultural, *398*
nationality, *399*
prejudice, *399*
race, *398*
racism, *399*
religion, *399*
scientific health belief, *404*
stereotyping, *399*
subculture, *398*
traditional, *403*
transcultural nursing, *402*
translator, *407*

Introduction

Nursing care is holistic and encompasses the client's perspectives on health, which are greatly influenced by the client's culture. Each individual is born into a culture influenced by place of birth and family of origin. A child learns the family's customs and beliefs, which shape his or her worldview. An individual's culture is dynamic and shifts over the course of a lifetime, influenced by many other factors, such as communities, schools, migration patterns, career choices, and religion. Similarly, a nurse's worldview is influenced by the culture of the nursing profession and the culture of the organization that he or she represents. Therefore, every nurse–client interaction is a cultural encounter. A nurse cannot assume sameness of values, even if the client appears to resemble the nurse in outward appearance. It is the nurse's responsibility to recognize the client's cultural perspectives.

Culturally responsive care is care that is centered on the client's cultural point of view and integrates the client's values and beliefs into the plan of care. To deliver such care, the nurse must first develop self-awareness of personal culture, attitudes, and beliefs and examine the biases and assumptions about different cultures. Next, the nurse needs to gain the necessary knowledge and skills to create an environment where trust can be developed with the client. This knowledge must include an understanding of health disparities as well as the historical and current portrayals of racial and ethnic groups in society. Additionally, cultural knowledge can help the nurse to better understand different perspectives while recognizing that cultural generalizations may not hold true at the individual level. Cultural assessment skills are essential in understanding the client's viewpoint more fully and learning what the client values as important. The nurse must partner with the client in a caring and respectful relationship that honors the client's differences and perspectives. In culturally responsive care, the nurse must respond to the client's needs, not vice versa. Only through self-awareness, deliberate cultural assessment, and incorporation of the client's culture into the plan of care can a nurse optimally care for a client.

Cultural Concepts

Culture is complex, with multiple definitions, and the term *culture* may be used interchangeably with other terms such as *race*, *ethnicity*, and *nationality* depending on the circumstances.

- **Culture** has many definitions, but concepts common to most include the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. It has been described as the learned and shared patterns of information that a group uses to generate meaning among its members. These patterns include nonverbal language and material goods. Within macro-cultures (national, ethnic, or racial groups) are micro-cultures (gender, age, or religious beliefs) in which members share a belief in certain rules, roles, behaviors, and values. Macro- and micro-cultures combine to shape the individual's worldview and influence interaction with others.
- A **subculture** is usually composed of individuals who have a distinct identity and yet are related to a larger cultural group. A subcultural group generally shares ethnic origin or physical characteristics with the larger cultural group. Examples of cultural subgroups include occupational groups (e.g., nurses), societal groups (e.g., feminists), and ethnic groups – (e.g., Sudanese, who migrate to European countries like Malta and Italy and settle there, either temporarily or permanently).
- **Multicultural** is used to describe an individual who has multiple patterns of identification or crosses several cultures, lifestyles, and sets of values. For example, a man whose father is Maltese and whose mother is Filipino may honor his Filipino **heritage** (things passed down from previous generations) while also being influenced by his father's cultural values. Another example exists in Australia where many Europeans migrated after the second world war, thereby strongly influencing the overall Australian culture. The term *multicultural* is often used interchangeably with *bicultural*, *biracial*, *multiracial*, and *multiethnic*.
- **Diversity** refers to the fact or state of being different. Many factors account for diversity: sex, age, culture, ethnicity, socioeconomic status, educational attainment, religious affiliation, and so on. Diversity, therefore, occurs not only *between* cultural groups but also *within* a cultural group.
- **Race** is a term with many definitions, often used interchangeably with the terms *ethnicity* and *culture*. The Office of Management and Budget (OMB, 1997), which determines U.S. federal standards for reporting race, stated that racial categories "should not be interpreted as being primarily biological or genetic in reference. Race and ethnicity may be thought of in terms of social and cultural characteristics as well as ancestry" (p. 36, 881).

The American Anthropological Association (1998) statement on race defines it as an idea created by Western Europeans following exploration across the world to account for differences among individuals and justify colonization, conquest, enslavement, and social hierarchy among humans. It has been used to refer to groupings of individuals according to common origin or background and associated with perceived biological markers. Ideas about race are culturally and socially transmitted and form the basis of racism, racial classification, and often complex racial identities.

The Human Genome Project has discovered that humans are 99.9% genetically alike and that the genetic variations related to geographic ancestry do not correlate with the socially constructed racial classifications; that is, there are no genetically discrete races. In fact, there is greater genetic variability within the racial categories than among them (Figure 21.1 ■). The official U.S. classification of race has varied throughout history. The 2010 U.S. Census racial classifications were White, Black/African American/Negro, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, and Some Other Race. It does not classify Hispanic as a race. In addition to the question about race, respondents were asked if they were of Hispanic, Latino, or Spanish origin. For example, of the 50 million respondents to the 2010 U.S. Census who indicated they were Hispanic or Latino, 53% indicated their race as White; less than 3% as Black, Asian, Native Hawaiian/Pacific Islander, or American Indian or Alaska Native; 36.7% as Some Other Race; and 6% as Two or More Races (Humes, Jones, & Ramirez, 2011). As a result of the large number of respondents choosing "Some Other Race," the Census Bureau piloted modified categories for use in the 2020 census survey, including options to indicate a specific country of origin within each race or ethnicity (Matthews et al., 2017).

Although there are plans to reconsider some categories as related to research, the categories currently used by the National Institutes of Health (NIH, 2015) are American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White.

Although it is now recognized that there is no scientific merit to the concept of race, race remains an important social construct, whereby social meanings are attached to perceived physical differences, resulting in inequality among racial groups.

- **Ethnicity** is a term often used interchangeably used with *race*. Ethnicity may be viewed as a relationship among individuals who believe that they have distinctive

Figure 21.1 ■ Although differing in outward appearance, humans are biologically more similar to each other than they are different.
Plume Creative/DigitalVision/Getty Images.

characteristics that make them a group. Ethnicity is not a fixed concept. Much like culture, ethnicity may shift over time. Migration, intermarriage, and intermating patterns show that individuals move into another ethnic group and become participants in that ethnicity, sharing the language, religion, values, beliefs, and customs. Latino people, for instance, represent multiple geographic areas and multiple races and often share a common language. Ethnic groups may be self-defined, and labeling can become problematic.

- **Nationality** is sometimes used interchangeably with *ethnicity* or *citizenship*. It generally refers to the sovereign state or country where an individual has membership, which may be through birth, through inheritance (parents), or through naturalization. It is also possible to be a member of a nation where no such country is officially recognized, for instance, Native Americans. An individual may also be multinational, holding citizenship in two or more countries. Ethnic groups may have territories to which they have national affiliation. This was particularly evident in Eastern Europe, where group tensions led to divisions of multiethnic states along territorial lines. For instance, Czechoslovakia became two countries: the Czech Republic and Slovakia. Yugoslavia became six countries: Bosnia and Herzegovina, Croatia, Macedonia, Montenegro, Serbia, and Slovenia.
- **Religion** may be considered a system of beliefs, practices, and ethical values about divine or superhuman power(s) worshipped as the creator(s) and ruler(s) of the universe. The practice of religion is revealed in numerous denominations, organizations, sects, and cults. Ethnicity and religion are related, and one's religion is often determined by one's ethnic group. Religion gives an individual a frame of reference and a perspective with which to organize information. Religious teachings about health help to present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. Illness is sometimes seen as punishment for the violation of religious codes and morals. See Chapter 41 ∞ for more information on spirituality.
- **Ethnocentrism** is the belief in the superiority of one's own culture and lifestyle. Other viewpoints are not only considered different but also wrong or of lesser importance. A related concept is *xenophobia*—the fear or dislike of individuals different from oneself.
- **Prejudice** is a preconceived notion or judgment that is not based on sufficient knowledge; it may be favorable or unfavorable. Unfavorable prejudice may lead to stereotyping and discriminatory behavior toward groups of individuals. There are many types of prejudice, including racial prejudice.
- **Racism** refers to assumptions held about racial groups. Assumptions include the belief that races are biologically discrete and exclusive groups that are inherently unequal and ranked hierarchically. Cultural behaviors are viewed as inherited and exclusive to each group and form the basis of judging individuals based on their racial classification. *Institutional racism* or *institutional discrimination* is the denial of opportunities and equal rights based on race. Examples include standards for assessing credit risks that disadvantage African American and Hispanic individuals who may lack conventional credit references, higher insurance costs in low income areas, school testing that favors White middle-class children because of the types of questions included, and hiring practices that require experience at jobs not historically open to members of subordinate groups (Schaefer, 2019). In a system that advantages White people over other races, the advantages are often referred to as "White privilege."
- **Discrimination** refers to the negative treatment of individuals or groups on the basis of their race, ethnicity, gender, or other group membership. It occurs when rights and opportunities are denied for arbitrary or prejudicial reasons.
- **Generalizations** are statements about common cultural patterns. Generalizations may not hold true at the individual level and should serve only as openings for individuals to better understand each other. Unfortunately, generalizations are often interpreted as statements describing every individual in a group, which leads to stereotyping.
- **Stereotyping** refers to making the assumption that an individual reflects all characteristics associated with being a member of a group. For instance, a nurse may assume that a Latino client speaks limited English and comes from a large family. Rather than asking the client, the nurse immediately calls for an interpreter, speaks loudly and very slowly to the client, and tells the client that the visitor policy allows for only two visitors at a time and that the client's entire family cannot visit at the same time. Stereotyping serves as a barrier to communication and understanding and propagates discriminatory behavior. One type of stereotyping is racial profiling, in which police-initiated action is based on race, ethnicity, or national origin rather than the individual's behavior.

Health Disparities

Health disparities are the differences in care experienced by one population compared with another population. Dimensions of health disparities include health insurance coverage, access to healthcare, quality of care provided, inability of providers to recognize and address disparities, levels of health, data collection, and resources allocated to address disparities, such as research into the causes of disparities and solutions to differences in health outcomes (Orgera & Artiga, 2018). Just like the *National Healthcare Disparities Report* (2017) that shows how in the US some individuals receive inferior healthcare compared with others, the European Commission published a report about inequalities in the ability to access healthcare both within and across European member states (Baeten, Spasova, Vanhercke, & Coster, 2018).

This report concludes that there is a huge difference in the amount of money spent on healthcare by each EU member state. In some countries, healthcare

To assess the lungs with a stethoscope, for example, the nurse needs to move into the client's intimate space. The nurse should first explain the procedure and, when possible, await permission to continue.

Clients who reside in long-term care facilities or who are hospitalized for an extended time may want to personalize their space. They may want to arrange the room differently or control the placement of objects on the bedside cabinet. The nurse should be responsive to clients' needs to have some control over their space. When there are no medical contraindications, clients should be permitted and encouraged to have objects of personal significance. Having personal and cultural items in one's environment can increase self-esteem by promoting not only one's individuality but also one's cultural identity. Of course, the nurse should caution the client about the risk for loss or damage of personal items in the healthcare setting.

Time Orientation

Time orientation refers to an individual's focus on the past, the present, or the future. Most cultures include all three time orientations, but one orientation is more likely to dominate. The European American focus on time tends to be directed to the future, emphasizing time and schedules. European Americans often plan for next week, their vacation, or their retirement. Other cultures may have a different concept of time. For example, the Navajo Indians are present and past oriented and do not have a word for "late." A Navajo mother may view her child's development differently from European Americans and might not measure her child's milestones, such as toileting and walking, by the same targeted schedule as other cultures. African Americans are often generalized as present oriented as well, with a focus on current health status rather than the anticipation of what may happen in the future. Socioeconomic status may also influence time orientation. The middle class is generally future oriented; however, lower socioeconomic classes are generally present oriented because of the focus on daily survival, which may not allow for the luxury of being able to plan for the future.

The culture of nursing and healthcare values punctuality and is future oriented. Appointments are scheduled, and treatments are prescribed with time parameters (e.g., changing a dressing once a day). Medication orders include how often a medicine is to be taken and when (e.g., digoxin 0.25 mg, once a day, in the morning). Nurses need to be aware of the meaning of time for clients. When caring for clients who are "present oriented," it is important to avoid fixed schedules. The nurse can offer a time range for activities and treatments. For example, instead of telling the client to take digoxin every day at 10:00 A.M., the nurse might tell the client to take it every day in the morning or every day after getting out of bed.

Nutritional Patterns

Most cultures have staple foods that are plentiful or readily accessible in the environment. For example, the staple food of Asians is usually rice, and for Europeans, it may be bread or pasta. Even clients who have been in the United States for several generations often continue to eat the foods of their cultural homeland.

The way food is prepared and served is also related to cultural practices. For example, in the United States, a traditional food served for the Thanksgiving holiday is stuffed turkey; however, in different regions of the country, the contents of the stuffing may vary. In Southern states, the stuffing may be made of cornbread; in New England, it may be made of seasoned bread and chestnuts.

The way in which staple foods are prepared also varies. For example, some Asian cultures prefer steamed rice; others prefer boiled rice. Southern Asians from India prepare unleavened bread from wheat flour rather than the leavened bread of European Americans.

Food-related cultural behaviors can include whether to breastfeed or bottle-feed infants and when to introduce solid foods to infants. Food can also be considered either the cause or part of the remedy for illness. In some cultures, nutrients such as calcium, iron, potassium, or zinc, which are lacking in the usual diet, are supplemented by eating clay or dirt (Giger, 2017).

The religious practices associated with specific cultures also affect diet. Some Roman Catholics avoid meat on certain days, such as Ash Wednesday and Good Friday, and some Protestant faiths prohibit meat, tea, coffee, or alcohol. Both Orthodox Judaism and Islam prohibit the ingestion of pork or pork products. Orthodox Jews observe kosher customs, eating certain foods only if they have been inspected by a rabbi and prepared according to certain dietary laws. For example, the eating of milk products and meat products at the same meal is prohibited. Some Buddhists, Hindus, and Sikhs are strict vegetarians. The nurse must be sensitive to such religious dietary practices.

●○● NURSING MANAGEMENT

All phases of the nursing process are affected by the client's and the nurse's cultural values, beliefs, and behaviors. As the client's culture and the nurse's culture come together in the nurse–client relationship, a unique cultural environment is created that can improve or impair the client's outcome. Self-awareness of personal biases can enable nurses to develop modifying behaviors or (if they are unable to do so) to remove themselves from situations where care may be compromised. Nurses can become more aware of their own culture through values clarification (see Chapter 4 ∞). The nurse must also consider the cultural values dominant in the healthcare setting because those, too, may influence the client's outcome.

Developing Self-Awareness

In learning how to provide culturally responsive care, the nurse must first understand his or her own culture, beliefs, and assumptions. Many models have been documented in the literature to deepen this self-exploration (Albougami,

Pounds, & Alotaibi, 2016). Campinha-Bacote (2007) offers the ASKED mnemonic model to develop cultural consciousness: Awareness, Skill, Knowledge, Encounters, Desire. Using this model, nurses reflect on questions that focus on how well prepared they are to acknowledge their own biases, their openness to embracing differences in individuals, and their willingness to learn appropriate means of communicating and caring for diverse populations.

Other self-identity questions may include the following (Tochluk, 2016):

- When did you first realize you were a member of your culture/race/ethnicity? What did it mean to you at that time?
- How did your culture/race/ethnicity play a role in your childhood and adolescence?
- What important events changed your relationship to culture/race/ethnicity? What happened?
- What significant individuals and relationships shaped the way you experience being a member of your culture/race/ethnicity?
- How do you understand what it means to be a member of your culture/race/ethnicity at this time in your life?

Health-related questions may include:

- How does your ethnic/racial group view health and illness?
- What are the common healing practices in your cultural/ethnic/racial group?
- What are examples of your family's traditional health and illness beliefs and practices?
- Do they value stoic behavior in relation to pain, or is it permissible to state that you are in pain? Are the rights of the individual valued over and above the rights of the family?
- What is your view on health? How does it compare to your family's view of health?
- What beliefs do you hold about healthcare providers?

Conveying Cultural Sensitivity

Box 21.1 lists texts authored by nurses that may be helpful in developing cultural knowledge. The process of cultural assessment is important. How and when questions are asked requires sensitivity and clinical judgment. The timing and phrasing of questions need to be adapted to the individual. Timing is important in introducing questions. Sensitivity is needed in phrasing questions. Trust must be established before clients can be expected to volunteer and share sensitive information. The nurse therefore needs to spend time with clients and convey a genuine desire to understand their values and beliefs.

Before conducting a cultural assessment, determine what language the client speaks and the client's degree of fluency in the English language. It is also important to learn about the client's communication patterns and space orientation. This is accomplished by observing both verbal and nonverbal communication. For example, does the client do the speaking or defer to another? What nonverbal communication behaviors does the client exhibit (e.g., touching, eye contact)? What significance do these behaviors have for the nurse–client interaction? What is the client's proximity to other individuals and objects within the environment? How does the client react to the nurse's movement toward the client? What cultural objects within the environment have importance for health promotion or health maintenance?

It is vital for nurses to be culturally sensitive and to convey this sensitivity to clients, support people, and other healthcare personnel. Some ways to do so follow:

- Always address clients, support people, and other healthcare personnel by their last names (e.g., Mrs. Aylia, Dr. Rush) until they give you permission to use other names. In some cultures, the more formal style of address is a sign of respect, whereas the informal use of first names may be considered disrespectful. It is important to ask individuals how they wish to be addressed.
- When meeting an individual for the first time, introduce yourself by your full name, and then explain your role (e.g., "My name is Alicia Bernett, and I am a nursing student at Nightingale School of Nursing"). This helps establish a relationship and provides an opportunity for clients, others, and nurses to learn the pronunciation of one another's names and their roles.
- Be authentic with individuals, and be honest about your knowledge about their culture. When you do not understand an individual's actions, politely and respectfully seek information.
- Use language that is culturally sensitive; for example, say "gay," "lesbian," or "bisexual" rather than "homosexual"; do not use "man" or "mankind" when referring to a woman.

BOX 21.1 Selected Nurse-Authored Texts

Andrews, J. D., & Boyle, J. S. (2016). *Transcultural concepts in nursing care* (7th ed.). Philadelphia, PA: Wolters Kluwer.

Giger, J. N. (2017). *Transcultural nursing: Assessment and intervention* (7th ed.). St. Louis, MO: Mosby.

Holland, K. (2018). *Cultural awareness in nursing and health care: An introductory text* (3rd ed.). New York, NY: Routledge.

Jeffreys, M. R. (2016). *Teaching cultural competence in nursing and health care: Inquiry, action, and innovation* (3rd ed.). New York, NY: Springer.

McFarland, M. R., & Wehbe-Alamah, H. B. (2018). *Leininger's culture care diversity and universality: A worldwide nursing theory* (4th ed.). New York, NY: McGraw Hill.

Papadopoulos, I. (2018). *Culturally competent compassion: A guide for healthcare students and practitioners*. New York, NY: Routledge.

Ray, M. (2016). *Transcultural caring dynamics in nursing and health care* (2nd ed.). Philadelphia, PA: F. A. Davis.

Skemp, L. E. &. Dreher, M. C., Lehman, S. P. (2016). *Healthy places, healthy people* (3rd ed.). Indianapolis, IN: Sigma Theta Tau International.

Spector, R. E. (2017). *Cultural diversity in health and illness* (9th ed.). New York, NY: Pearson.

- Ask how the client self-identifies his or her race/ethnicity. The client may have a preferred term, such as Latino rather than Hispanic. Make note of the client's preferences, and use the language preferred by the client.
- Find out what the client thinks about his or her health problems, illness, and treatments. Assess whether this information is congruent with the dominant healthcare culture. If the beliefs and practices are incongruent, determine the impact on the client's health.
- Always ask about anything you do not understand to avoid making assumptions about the client.
- Show respect for the client's values, beliefs, and practices, even if they differ from your own or from those of the dominant culture. If you do not agree with them, it is important to respect the client's right to hold these beliefs.
- Show respect for the client's support people. In some cultures, males in the family make decisions affecting the client, whereas in other cultures, females make the decisions.
- Make a concerted effort to obtain the client's trust, but do not be surprised if it develops slowly or not at all. A cultural assessment may take time and may need to extend over several meetings.
- Should you inadvertently do something to offend the client, be humble, admit that you made a mistake, and excuse yourself. Learn from experience.

Assessing

In creating a plan of care that is culturally responsive, many assessment tools are available. The tools are a way of interviewing and facilitating communication with clients and their families and may be used in any setting. The LEARN model and the 4 C's are quick assessment tools to better understand the client's perspective. LEARN is a commonly used tool (Berlin & Fowkes, 1983):

Listen actively with empathy to the client's perception of the problem.
Explain what you think you heard or ask for clarification.
Acknowledge the importance of what is said and what it means.
Recommend inclusive strategies.
Negotiate the plan of care by collaborating with the client and others.

The 4 C's of Culture were developed by Slavin, Galanti, and Kuo (Developed by Stuart Slavin, MD, Geri-Ann Galanti, PhD, and Alice Kuo, MD. www.ggalanti.org).

1. What do you *call* your problem? (Remember to ask "What do you think is wrong?" or "What is concerning or worrying you?" to get at the client's perception of the problem. You should not literally ask, "What do you call your problem?")
2. What do you think *caused* your problem? (This gets at the client's beliefs regarding the source of the problem.)
3. How do you *cope* with your condition? (You may want to phrase this as "What have you done to try to make it better? Who else have you been to for treatment?")
4. What are your *concerns* regarding the condition and/or recommended treatment? (This should address questions such as "How serious do you think this is?" "What potential complications do you fear?" "How does it interfere with your life, or your ability to function?" "Do you know anyone else who has tried the treatment I've recommended? What was their experience with it?")

The Heritage Assessment Interview (Spector, 2017) depicts the questions to ask when conducting a heritage assessment. It is designed to enhance the process in order to determine if clients are identifying with their traditional cultural heritage (**heritage consistent**) or if they have acculturated into the local culture in which they reside (**heritage inconsistent**). The tool may be used in any setting and is used to facilitate conversation and help in the planning of cultural care. When using the tool, the nurse may need to ask additional questions to allow the client to expand

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

What Literature Is Available for Nurses About Older Amish Adults' Culture and Healthcare Experiences?

Older Amish adults are a growing population in the United States and have unique risks for healthcare disparities. Limited information is available about the caregiving needs of Amish older adults or their interactions with Western healthcare systems. This information is needed for nurses to develop interventions to reduce health disparity risks and promote culturally congruent care. Famar, Kulig, and Sullivan-Wilson (2018) performed an integrative review of the literature between 1985 and 2016 about Amish older adult caregivers and their healthcare experiences. Twenty-seven publications were included in the final analysis, which addressed the characteristics of Amish caregivers of older adults, locations of caregiving, descriptive information about Amish older adult health and illness, and how decisions are made in Amish communities to access Western healthcare.

Implications

Nurses commonly care for clients whose culture and background are markedly different from their own. Research and descriptive publications, especially regarding smaller, unique groups of clients such as older Amish adults, can be essential to inform the nurse. This research provides specific material about the Amish but also highlights the importance of research and publications about underrepresented groups. In addition, the authors suggest that what is learned from studies of the Amish may have broader implications for other cultural groups in the United States.

on the yes or no answers. If appropriate, the nurse should modify the tool to add or eliminate items based on the nurse's cultural sensitivity. Once a conversation begins and the client describes aspects of cultural heritage, it becomes possible to develop an understanding of the client's unique health and illness beliefs, practices, and cultural needs. For example, you may discover that the individual participates in ethnic cultural events and social groups, such as religious festivals or national holidays, sometimes with singing, dancing, and costumes (Figure 21.4 ■).

Figure 21.4 ■ Celebrations of the passage to adulthood are often based on culture or religion; for example, the Jewish bar mitzvah at age 13 and the Latin American quinceañera or fifteenth birthday celebration. (Top) Gordon Swanson/Shutterstock; (Bottom) Erin Patrice O'Brien/Taxi/Getty Images.

Or you may learn that the client's childhood development occurred in the client's country of origin or in an immigrant community in the United States. For example, the client was raised in a specific ethnic neighborhood, such as an Italian, African American, Hispanic, or Jewish one, in a given part of a city and was exposed only to the culture, language, foods, and customs of that particular group. There are infinite examples of cultural influences on the client's health.

Diagnosing

The nursing diagnoses in the United States are focused on nursing care provided in that country and are based on European-centric cultural beliefs. It is essential to expand the understanding of nursing practice to include beliefs of other cultures when naming nursing diagnoses or problem statements. Nurses must provide appropriate care to clients of any culture. This is accomplished through developing cultural sensitivity and considering how a client's culture influences his or her responses to health conditions, much as the nurse considers how a client's age or gender influences a nursing diagnosis, the nursing plan, and the delivery of nursing care.

Planning

Providing culturally responsive care is an ongoing process that requires an individual or organization to develop along a continuum until diversity is accepted as a norm and the nurse has acquired greater understanding and capacity in a diverse environment. The knowledge and skills necessary to incorporate cultural care as a fundamental component of nursing require the acquisition of a broad base of knowledge about different cultures and social structures (Box 21.2). As one's knowledge and skills grow, the ability to convey cultural sensitivity also grows.

The following are examples of the necessary steps:

1. Become aware of one's own cultural heritage.
2. Become aware of the client's heritage and health traditions as described by the client.
3. Become aware of adaptations the client made to live in another culture. During this part of the interview, a nurse can also identify the client's preferences in health practices, diet, hygiene, and so on.
4. Form a nursing plan with the client that incorporates cultural beliefs regarding the maintenance, protection, and restoration of health. In this way, the client's cultural values, practices, and beliefs can be incorporated with the necessary nursing care.

Implementing

The implementation of culturally responsive nursing care includes (a) cultural preservation and maintenance and (b) cultural accommodation and negotiation. Cultural preservation may involve the use of cultural healthcare

ASSESSMENT INTERVIEW **Heritage Assessment Tool**

This set of questions is used to describe an individual's (or your own) ethnic, cultural, and religious background. The *heritage assessment* is helpful to determine how deeply a given individual identifies with his or her *traditional* heritage. This assessment is very useful in setting the stage for understanding an individual's traditional health and illness beliefs and practices and in helping to determine the family and community resources that will be appropriate for support when necessary. The greater the number of positive responses, the greater the degree to which the individual may identify with his or her traditional heritage. The one exception to positive answers is the question about whether an individual's name was changed.

1. Where was your mother born? _____
2. Where was your father born? _____
3. Where were your grandparents born?
   a. Your mother's mother? _____
   b. Your mother's father? _____
   c. Your father's mother? _____
   d. Your father's father? _____
4. How many brothers ____ and sisters ____ do you have?
5. What setting did you grow up in? Urban ____ Suburban ____ Rural ____
6. What country did your parents grow up in?
   Father _____
   Mother _____
7. How old were you when you came to the United States?
   _____
8. How old were your parents when they came to the United States?
   Mother _____
   Father _____
9. When you were growing up, who lived with you?
   _____
10. Have you maintained contact with
    1. Aunts, uncles, cousins? (1) Yes ____ (2) No ____
    2. Brothers and sisters? (1) Yes ____ (2) No ____
    3. Parents? (1) Yes ____ (2) No ____
    4. Your own children? (1) Yes ____ (2) No ____
11. Did most of your aunts, uncles, cousins live near your home?
    1. Yes ____
    2. No ____
12. Approximately how often did you visit family members who lived outside of your home?
    1. Daily ____
    2. Weekly ____
    3. Monthly ____
    4. Once a year or less ____
    5. Never ____
13. Was your original family name changed?
    1. Yes ____
    2. No ____
14. What is your religious preference?
    1. Catholic ____
    2. Jewish ____
    3. Protestant _____ Denomination ____
    4. Islam ____
    5. Buddhist ____
    6. Hindu ___
    7. Other ____
    8. None ____
15. Is your spouse/partner the same religion as you?
    1. Yes ____
    2. No ____
16. Is your spouse/partner from the same ethnic background as you?
    1. Yes ____
    2. No ____
17. What kind of school did you go to?
    1. Public ____
    2. Private ____
    3. Parochial ____
18. As an adult, do you live in a neighborhood where the neighbors are the same religion and ethnic background as you?
    1. Yes ____
    2. No ____
19. Do you belong to a religious institution?
    1. Yes ____
    2. No ____
20. Would you describe yourself as an active member?
    1. Yes ____
    2. No ____
21. How often do you attend your religious institution?
    1. More than once a week
    2. Weekly ____
    3. Monthly ____
    4. Special holidays only ____
    5. Never ____
22. Do you practice your religion in your home?
    1. Yes ____ (if yes, please specify by checking activities below)
       Praying ____
       Bible reading ____
       Diet ____
       Celebrating religious holidays ____
    2. No ____
23. Do you prepare foods special to your ethnic or religious background?
    1. Yes ____
    2. No ____
24. Do you participate in ethnic activities?
    1. Yes ____ (if yes, please specify) ____
       Singing ____
       Holiday celebrations ____
       Dancing ____
       Festivals ____
       Costumes ____
    2. No ____
25. Are your friends from the same religious background as you?
    1. Yes ____
    2. No ____
26. Are your friends from the same ethnic background as you?
    1. Yes ____
    2. No ____
27. What is your native language other than English? ____
28. Do you speak this language?
    1. Yes ____
    2. Occasionally ____
    3. No ____
29. Do you read your native (other than English) language?
    1. Yes
    2. No

From *Cultural Diversity in Health & Illness*, 9th ed. (pp. 276–278), by R. E. Spector, 2017, New York, NY: Pearson Education.

BOX 21.2 Selected Cultural Health-Related Practices

Note that these practices may or may not be applicable to the client you are caring for; they are generalizations of practices common among members of certain cultural groups. Caution must be exercised to not convert a generalization into a stereotype.

- Coining and cupping are traditional medical practices. They should not be misinterpreted as abuse.
- Fevers may be treated by wrapping the ill individual in warm blankets and having him or her drink warm liquids.
- Hot liquids, such as tea, may be preferred over ice water.
- Adherence to traditional treatment may be very different from the expected adherence to modern medicine. Care must be taken to fully explain instructions, such as taking antibiotics for the entire course, even after symptoms have disappeared.
- Menstruation may be viewed as the body's way of clearing dirty and excess blood. Too little flow may be viewed as "bad blood" staying in the body; too much flow may be viewed as weakening the body. May influence views of birth control.
- May avoid dairy products due to lactose intolerance. Check for family history.
- The focus on present time may interfere with the use of preventive medicine and follow-up care.
- Postpartum rest is valued.
- Sponge baths may be preferred to showers or tub baths after giving birth.
- Strong beliefs in fate and external control over events may lead to less adherence to medical regimens.

practices, such as giving herbal tea, chicken soup, or "hot" foods to the ill client. The tasks of accommodating a client's viewpoint and negotiating appropriate care require expert communication skills, such as responding empathetically, validating information, and effectively summarizing content. Negotiation is a collaborative process. It acknowledges that the nurse–client relationship is reciprocal and that different views exist of health, illness, and treatment. The nurse attempts to bridge the gap between the nurse's scientific and the client's cultural perspectives. During the negotiation process, the client's views are explored and acknowledged. Relevant scientific information is then provided. If the client's views reveal that certain behaviors would not affect the client's condition adversely, then they are incorporated into the care plan. If the client's views can lead to harmful behavior or outcomes, then an attempt is made to educate the client on the scientific view.

Nurses should determine precisely how a client is managing an illness, what practices could be harmful, and which practices can be safely combined. For example, reducing dosages of an antihypertensive medication or replacing insulin therapy with herbal measures may be detrimental. Some herbal remedies are synergistic with modern medicines, and others are antagonistic; therefore, it is necessary to fully inform the client about the possible outcomes. Consider these examples of potential conflicts between cultural beliefs or practices and the American healthcare system. The nurse does not assume that all members of a group make the same healthcare decisions and must always determine the particular client or family beliefs.

- Some women may value large body size and may be resistant to weight control.
- The decision to circumcise male infants, often made based on cultural and family beliefs, can occasionally conflict with medical advice.
- Some Hispanic/Latino or Asian clients may be unable to obtain hospice care if family members do not permit the client to be informed of the diagnosis or prognosis.
- Most members of the Jehovah's Witness faith do not accept blood transfusions even in life-threatening situations.
- Traditional Orthodox Sikhs do not cut their hair. This can conflict with the need to shave the hair for medical procedures.

When a client chooses to follow only cultural practices and declines all prescribed medical or nursing interventions, the nurse and client must adjust the client goals. Monitoring the client's condition to identify changes in health and to recognize impending crises before they become irreversible may be all that is realistically achievable. At a time of crisis, the opportunity may arise to renegotiate care.

Providing culturally responsive care can be challenging. It requires the discovery of the meaning of the client's behavior, flexibility, creativity, and knowledge to adapt nursing interventions. An effort must be made to learn from each experience. This knowledge will improve the delivery of culture-specific care to future clients.

Evaluating

In evaluating nursing care that incorporates the client's cultural perspectives, the actual client outcomes are compared with the goals and expected outcomes established following a comprehensive assessment that includes cultural sensitivity. However, if the outcomes are not achieved, the nurse should be especially careful to consider whether the client's belief system has been adequately included as an influencing factor.

Critical Thinking Checkpoint

Rachel was born to a Jewish couple and lists her religion as Jewish. Her father died when she was 10 years old, and her mother remarried 3 years later. Rachel was legally adopted by her Italian stepfather, who was a devout Catholic. Although the family participated in Catholic and Italian traditions, Rachel's mother taught her many Jewish traditions as well so that her heritage would be preserved. Rachel is now 58 years old, practices traditions from both her Jewish and Italian upbringing, and is dying of cancer. You are the nurse caring for Rachel during her final days.

1. Differentiate between Rachel's culture and ethnicity.
2. How might Rachel's multicultural background affect you as her nurse or in working with her family?
3. How might Rachel's culture affect her approach to death and the care of her body following her death?
4. Of what benefit would a cultural assessment be to Rachel or her family given that she is dying?
5. How could nurses' culture or religion influence their care of clients who are racially or culturally different?

Answers to Critical Thinking Checkpoint questions are available on the faculty resources site. Please consult with your instructor.

Chapter 21 Review

CHAPTER HIGHLIGHTS

- Culturally responsive care requires the nurse to develop self-awareness and gain the attitudes, knowledge, and skills to incorporate each client's cultural perspectives into the plan of care.
- Individuals may live within their traditional heritage, or they may embrace both their original ethnocultural traditional heritage(s) and the culture of the country they are living in.
- Nurses should understand the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS) and apply them to their professional practice.
- *Healthy People 2020* calls for nursing to contribute to eliminating health disparities by gender, race or ethnicity, education, income, disability, geographic location, and sexual orientation.
- Racial and Ethnic Approaches to Community Health Across the United States (REACH U.S.) is an initiative that strives to eliminate racial and ethnic disparities in infant mortality, deficits in breast and cervical cancer screening/management, cardiovascular diseases, diabetes, HIV infections, AIDS, and child and adult immunizations.
- Acculturation is a two-way process. The minority groups accept the culture of their host country, and the host country is also influenced by the culture of the minority groups.
- Personal characteristics also modify an individual's cultural values, beliefs, and practices.
- Health beliefs and practices, family patterns, communication style, space and time orientation, and nutritional patterns may influence the relationship between the nurse and the client who have different cultural backgrounds.
- When assessing a client, the nurse considers the client's cultural values, beliefs, and practices related to health and healthcare.

TEST YOUR KNOWLEDGE

1. A community health nurse is learning about the REACH initiative and has decided to implement community education. Which of the following topics relate to this approach? Select those that apply.
   1. Child and adult immunizations
   2. Cardiovascular disease
   3. Chronic lower respiratory disease
   4. Stroke
   5. Infant mortality
2. A home health client participates in cultural health practices that the nurse feels may be detrimental to his health. In order to remain attentive to cultural sensitivity and provide appropriate cultural nursing care, what should the nurse do?
   1. Explain the right and wrong of the client's treatment and try to persuade him to follow the scientific perspective.
   2. Have the client's physician explain the care to the client in a firm but gentle manner.
   3. Validate the client's practices and understand that for this client it may be beneficial to continue with his preferences.
   4. Try to negotiate with the client by exploring his views and then provide relevant scientific information.
3. In initiating care for a client from a different culture than the nurse, which of the following would be an appropriate statement?
   1. "Because in your culture, individuals don't drink ice water, I will bring you hot tea."
   2. "Do you have any books I could read about individuals of your culture?"
   3. "Please let me know if I do anything that is not acceptable in your culture."
   4. "You will need to set aside your usual customs and practices while you are in the hospital."
4. Which of the following statements shows a nurse's understanding of the term *culture*? Select all that apply.
   1. "Culture involves groups who share biological markers."
   2. "Cultures seldom have diversity within them."
   3. "Male nurses are an example of a culture."
   4. "A culture is primarily exhibited through shared thoughts, actions, and beliefs."
   5. "A culture shapes its members' view of the world."

2 Practising nursing within a culturally diverse society

LEARNING OBJECTIVES

On completion of this Chapter, the learner should be able to:

- describe how a nurse can provide culturally competent nursing care
- discuss the development of effective relationships with patients, their families and significant others through culturally appropriate care and communication
- plan healthcare taking into account the cultural requirements of patients
- explain the principles of patients' advocacy in respect of cultural needs
- discuss the interface between Western medicine and alternative/traditional practitioners
- give health information and/or health education that is culturally appropriate and acceptable to patients and their families.

KEY CONCEPTS AND TERMINOLOGY	
acculturation	The paradigm shift that patients must undergo in order to change their culture and adopt the culture of the healthcare provider.
amulet	An object that protects a person from trouble such as ornaments or jewellery worn to chase evil spirits away.
charms	Objects that have power or a spell over evil.
culture	A way of life, which encompasses the ideas, customs, and social behaviour of a particular people or society.
cultural diversity	The variety of human cultures in a specific region.
cultural knowledge	The knowledge the healthcare professional has about specific or diverse groups' fundamental norms, customs, belief and values.
paradigm	System of understanding and organising knowledge.
supernatural	Something that has a force beyond scientific understanding or the laws of nature.
traditional practitioners	People who practice traditional medicine.

PREREQUISITE KNOWLEDGE

- Batho-Pele principles
- Patients' rights
- Human rights.

MEDICO-LEGAL CONSIDERATIONS

- The fulfilment of cultural requirements is a patient's right, and failure on the part of a nurse to meet this need can be interpreted as negligence.

- Failure to give accurate and adequate information to a patient may also be construed as negligence, particularly if the patient must make major decisions relating to their healthcare, or if the patient is expected to manage their medical condition at home. In order for health information to be acceptable and understood by a patient, the information must be put across in a manner that takes cultural factors into account. Failure to do this is likely to cause a patient to be non-compliant.
- Disregard of cultural requirements is an instance of discrimination and may involve the healthcare institution, and the individual nurse, in legal action.

ETHICAL CONSIDERATIONS

- Nurses have an ethical obligation to
  - respect the culture and preserve the dignity of patients at all times
  - apply cultural knowledge and sensitivity in order to avoid offending or discriminating against patients based on their cultural backgrounds.
- Every patient has a right
  - to participate in their own healthcare, including having their cultural needs met
  - to health information and health education that is accessible, understandable, acceptable, appropriate and congruent with their cultural requirements
  - not to be discriminated against because they wish to consult an alternative or traditional practitioner.

Practice alert!

In situations where patients strongly wish to consult alternative or traditional practitioners, it is imperative that they are made to understand the full implications of their choice.

ESSENTIAL HEALTH LITERACY

Holistic nursing care includes cultural nursing as culture impacts on the patient's health behaviour. It is essential for the nurse to have a brief background of the patient's culture and information that will assist to comply with the patient's wish for alternative treatment. Patients must be encouraged to communicate their wishes and also be given a chance to exercise them if need be. However, possible effects of the alternative medicine on their health and illness must be explained to the patient for them to make informed decisions.

Introduction

Nursing is an interpersonal activity, with the goal of restoring or maintaining the health of patients. Interpersonal activities such as nursing care are, by definition, built on relationships and communication. To be effective in facilitating the healthcare of patients, nurses should develop a good nurse–patient relationship and should be able to communicate effectively with patients. It is essential for nurses to develop insight into the culture of their patients, as well as an understanding of how the individual patient's culture impacts on health behaviour. Acquiring cultural knowledge assists with the integration of health-related beliefs, practices and cultural values (Campinha-Bacote, 2010). Nurses must be able to gain knowledge about the culture of a patient by asking the right questions and by demonstrating sensitivity towards the patient's beliefs and culture. Health and illness behaviour must be understood in the light of a patient's cultural context if a nurse is to fulfil their role in helping the patient to achieve or maintain optimum health.

In the light of current policy directions in South Africa, a nurse may need to work with indigenous or alternative health practitioners. To do this harmoniously and effectively, nurses must develop an elementary understanding of the basic principles and philosophical outlook of these practitioners. Therefore, the nurse must develop cultural competence in the delivery of healthcare. Cultural competence is a set of congruent behaviours, practices, attitudes and policies that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations. The process of developing cultural competence includes desire, awareness, skill and knowledge (Campinha-Bacote, 2010). The aim of this Chapter is to assist you to develop sensitivity towards the traditions and respect for the culture of patients and the community.

The concept of culture

Culture is a shared set of norms, values, perceptions and social conventions that give cohesion to a group, race or

community, enabling them to live together and function effectively and harmoniously. It is a key influence on the way in which an individual perceives and responds to the world. Culture, however, is simply one set of factors among many that mould the individual and their response to the world and to society. Individual behaviour is heavily influenced by culture, but culture is a framework and not a stereotype.

Culture consists of the following aspects:

- Observable phenomena, such as manner of dress, diet, architecture, language, writing and the arts.
- Norms and values, including ideas about how people should behave, about right and wrong, and good and bad. These norms and values are usually taken for granted within a culture; they are universally accepted within that culture, having been absorbed by people at a very early age. Each individual learns about their own culture from an early age, and also learns how to function within that particular worldview.

Culture is not inherited; it is acquired during the process of socialisation in childhood. Subgroups or subcultures exist within every society. Organisations, occupations and professions also have their own micro-cultures that individuals accept and adapt to when they join the group. Culture is therefore an integrated pattern of human knowledge, belief, and behaviour that is a result of, and integral to, the human capacity for learning and transmitting knowledge to succeeding generations. It is learned and shared, dynamic and changing. Cultural awareness is thus a deliberate and cognitive process through which sensitivity to a person's values, beliefs and practices develop.

The importance of culture

Culture consists of language, ideas, beliefs, customs, taboos, codes, institutions, tools, techniques, and works of art, rituals, ceremonies, and symbols. It has played an important role in human evolution, allowing human beings to adapt the environment to their own purposes.

In a diverse society such as South Africa, cultural differences are very evident; and to be effective in their profession, nurses must be able to work with people whose culture and traditions are different from their own. However, without sufficient knowledge of other people's culture, it will be difficult to work with or understand people whose culture is different from their own. It is vitally important for the nurse to acquire sufficient knowledge of the cultures they work with in order to avoid offensive stereotyping.

Cultural insight and knowledge are also essential for nurses given the interpersonal nature of their work. Much of the effectiveness of nursing care is due to interpersonal interactions with patients and the nature of the nurse–patient relationship. There are several nursing theories and models of care that highlight the centrality of culture and trans-cultural nursing, such as: the cultural safety model; Leininger's theory of Culture Care Diversity and Universality and the Sunrise model; the Giger and Davidhizar Trans-cultural Assessment Model; and Campinha-Bacote's cultural competence in healthcare model.

2.1 The acquisition of cultural knowledge and understanding

Some suggestions on how to acquire cultural knowledge and understanding:

- Nurses should develop an awareness of their own cultural assumptions and prejudices.
- Written or visual material on other cultures can be useful to build general knowledge, provided that such material is not biased or prejudiced.
- Once a nurse has developed a good relationship with a patient, the nurse can ask questions. If the right questions are asked in a respectful manner and the response is received respectfully, much can be learned.
- A nurse should not automatically assume that they know best and that their way of doing things is the only way. Nurses must allow space for the preferences of their patients, which includes cultural and religious preferences.

Cultural issues in healthcare

Every human society has its own particular culture. Variation among cultures is attributable to such factors as differing physical habitats and resources, the range of possibilities inherent in areas such as language, ritual, social organisation and historical phenomena such as the development of links with other cultures. An individual's attitudes, values, ideas and beliefs are greatly influenced by the culture (or cultures) in which they live. Culture change takes place as a result of ecological, socioeconomic, political, religious, or other fundamental factors affecting a society or an individual such as health and illness.

There are several cultural factors that act as barriers to effective healthcare. Because South Africa is a diverse society, nurses need to develop an understanding of the cultural dimensions of a number of health-related issues. Many of these issues may be closely allied to religious practices, but all need to be taken into account when

dealing with patients and the community. Because nursing care is interpersonal and because nursing involves meeting the needs of patients, cultural factors such as modesty, hygiene practices, attitudes to pain and illness, diet and food, as well as death and dying must be understood and taken into account when planning nursing care. These and other issues are discussed below.

Diet

Diet is an important cultural characteristic, and it is an area that nurses must find out about during the assessment of their patients. Information should be obtained about, for example, which foods may or may not be eaten, or if there is any special method of preparation. This is important as certain food taboos are based on cultural and religious beliefs. For example, pork is the well-known food taboo of some religions in African and Muslim people.

In a hospital setting, efforts should be made to supply the appropriate diet for each patient. If the dietary requirements of the hospital in-patient cannot be met, it may be necessary to approach the family with a view to having them bring in food for the patient, if the condition of the patient allows. A thorough knowledge of the diet of the patient, including the ways in which food is prepared, is essential when giving health education to the patient. Health education should be contextualised according to the patient's individual lifestyle, and this means taking careful note of specific characteristics, whether cultural or individual. In instances where health education and advice are not appropriate to a patient's lifestyle and culture, the advice may not be followed and this will be to the detriment of the patient.

Hygiene practices

Hygiene practices often differ from culture to culture. Muslim people, for example, always wash their hands as well as the urethral and/or anal area after using the toilet. For some cultural groups, a bath is not regarded as hygienic, and only a shower will suffice. For other groups, specific hygiene measures are taken during menstruation. Nurses should take note of these and any other hygiene requirements that they encounter and try to meet the needs of their patients in the best way possible.

Family hierarchy and lines of communication

Culture is instrumental in communication. Language is a powerful instrument that can be used to get to know the other person's culture. Family hierarchy and lines of communication are sometimes significant when consent has to be obtained for treatment or for a surgical procedure.

In South Africa, the current legislation allows people 18 years and older to give consent to medical treatment autonomously. However, in many African groups, consent to an operation or other form of treatment is a major decision. Sometimes a patient will ask to go home and consult the elders of the clan, and in some instances the ancestors are consulted. Many African groups require that consent for an operation on a child must be obtained from the child's family or from the senior male relative, and the mother will feel unable to give consent without consulting the father or a male relative. This can create difficulties where the child is acutely ill and is in need of emergency treatment or surgery and the father is not available. In such a case, it may be necessary for the Medical Superintendent to give consent. In many groups, health matters relating to reproductive health or to sexual matters, such as contraception, must often be discussed with the husband first, before talking to both husband and wife, as it is the husband who takes decisions in the home and nothing will happen if only the wife has received the advice.

It is important for the nurse to find out about lines of communication in the various cultural groups because nursing care is based on good communication, and it is essential at all times to make sure that the lines of communication with all stakeholders are appropriate and effective.

Disposal of body parts

If an organ has to be removed or a limb amputated, it is essential to find out from the patient or from the relatives whether any special measures are needed for the disposal of the tissue or limb. In many cultural groups, the body parts must be given burial and not simply sent to the incinerator. This requirement is particularly important in the case of amputation. The requirement is often not so stringent in the case of organs and parts of organs or tissues.

In South Africa, matters relating to human tissues are legislated in the National Health Act 61 of 2003, which repealed the Human Tissue Act 65 of 1983.

Organ donation pratices also vary between different cultures; some groups will not consent because of the belief that the deceased must be buried with all their body parts intact. Organ donation is not universally accepted among African cultures, although there is no specific prohibition in traditional African belief and it may vary depending on the particular group or set of religious beliefs. Orthodox Jewish people and many Muslim people are also likely to refuse organ donation, out of a cultural belief that the body must be buried intact and not necessarily out of any specific religious prohibition. Some groups may refuse permission for post-mortem examination, for example Orthodox Jewish people and Muslim people.

Death, dying and the disposal of the body

As this is the last thing that the family will do for the patient, most families have a strong desire to ensure that things are done in accordance with what the patient would have wanted. It is important to find out, for example, whether the family would like a priest to be called, as would be the case with a Roman Catholic patient. Also important would be to find out whether the family expect to be allowed to stay with the dying person and, if so, which specific family members. In the case of Jewish patients, it is customary for the family to watch at the bedside of a dying relative, but this function is also provided by Jewish community organisations that may be contacted to perform this function if the family is unable to do so.

In some cultures, specific rituals are carried out at the bedside of a dying patient. The care of the body after death is also an important cultural aspect. In some African cultures, after the death of a person in hospital, the family may come to collect the spirit of the dead person from the bed where the patient passed on. Nurses should find out whether it is acceptable for the staff to remove tubes and lines and lay the body out, or if there is any specific procedure to be followed before doing the last offices. For example, an individual known as the *Wagter*, who is sent by the relevant Jewish community organisation, lays out a Jewish patient who has died, although it is usually expected that the nursing staff will remove the tubes and lines. Jewish and Muslim patients are accommodated in their own separate sections of the mortuary and have their own burial organisations.

Amulets and charms

Beliefs in charms and amulets are a widespread phenomenon, and are found in many cultures. Amulets and charms are believed to facilitate healing and to protect the patient from harm. The use of charms is not only found among so-called primitive groups but is found in many Western groups. Among Mediterranean groups, for example, belief in the 'evil eye' is common and charms are worn to ward off the evil eye. Some amulets are religious in nature, such as holy pictures and holy medals, but their purpose remains the same: to promote healing by supernatural means and to protect the individual from harm.

Generally, amulets and charms should not be removed unless it is clearly necessary, eg if the patient is going for operation in the theatre. It may also be necessary to remove amulets in order to facilitate treatment. If it is indeed necessary to remove an amulet, the patient and family should be informed of the need and of the reason for it. Sometimes amulets can be moved to other places on the body, or they can be placed at the bedside, or sent home with the family, but usually the hospitalised patient prefers to keep such items with them. Amulets should never simply be discarded, as this can cause great offence to the patient and/or family.

The role of women

The role and social position of women varies between societies, and often depends on whether the society is matriarchal or patriarchal. In many cultures, a woman is a perpetual minor, always under the guardianship and supervision of a male relative. Women in such a position usually need to consult with their husbands or senior male relatives before taking decisions, even those relating to health. Among many African groups, it is the male head of the household who must decide if a member of the household can be taken to a hospital or clinic for treatment. This often means that women must wait for absent heads of households to return before a decision can be taken. A great deal of education and empowerment is needed to change these patterns.

Sexuality

Sexuality is a universal human trait, but the social regulation and expression of sexuality varies from culture to culture. The area of sexuality covers relations between the sexes, modesty, rituals and practices related to the female menstrual cycle, and, very importantly for nurses, the manner in which intimate matters may be discussed.

In many cultures, the frank discussion of sexual matters is regarded as uncouth. It is common to find that it is unacceptable for sexual matters to be discussed between the sexes; women talk to women about sexuality and men talk to men. It follows, therefore, that any discussion on matters related to sexuality, such as contraception or safe sexual practices, must be approached correctly and very carefully. For some, it is necessary to discuss such matters with the head of the household; if they accept, then the family will follow their lead. Depending on the group, it is often prudent to have a male nurse talk to male patients or male family members, and female nurses to talk to female patients or female family members. A young unmarried female is frequently not seen as an appropriate person with whom to discuss intimate matters.

The way in which intimate topics and those of a sexual nature are discussed is also important. Frank graphic descriptions are often not acceptable and may cause offence, and the nurse must find ways to get the message across by using terminology that is acceptable to the patients and their families.

Other cultural issues related to areas of cultural diversity are family organisation, language, personal space, touching, eye contact, gestures, healthcare beliefs, and spirituality and religion.

Cultural perspectives on health and illness

Beliefs on healthcare systems vary among cultures, thus patients regard healthcare differently. Every culture has a system for healthcare based on the values and beliefs that have existed for generations. Nurses have an increased responsibility to meet the needs of an increasingly diverse society in order to reduce health disparities and improve healthcare quality. Beliefs about health and illness are an important cultural factor in healthcare. The challenge for nurses rendering healthcare in a Western-oriented healthcare system, such as the one in South Africa, is to bring the health/illness paradigm of patients into alignment with the system. Health and illness beliefs fall into three major groups, described in the sections that follow.

The magico-religious paradigm

In this paradigm, illness has a supernatural cause, as opposed to injury, which has a specific and obvious cause. Consequently, the cure for illness lies in the supernatural or spiritual dimension. It is widely believed among African cultures that illness may be brought on by a malicious spell or by the neglect of or a transgression against the ancestors. The cure for illness, while it may involve medication, is spiritual and involves rituals, prayer and possibly some form of sacrifice. Health may be seen as a sign of supernatural favour, and illness as a curse or punishment. In this paradigm, it is also commonly believed that the actions of one individual may affect the health of the community.

People who adhere to this belief system do not necessarily reject Western scientific approaches to therapy, but scientific treatment methods are not seen as being the sole agent in effecting a cure. For many African cultures, the two systems exist in parallel, and both are regarded as being effective. For treatment within a modern scientific framework to be successful, however, patients must be allowed expression of the spiritual dimension and access to practitioners who practise within the magico-religious framework.

Patient education is an important factor in bringing the two systems into alignment for a patient, and the nurse is a key agent in this process. Accurate health education that takes into account and shows respect for the patient's health or illness beliefs and behaviours must be offered.

The biomedical paradigm

This is the dominant belief system among Western cultures, but not necessarily the only one. According to this paradigm, there is a demonstrable cause–effect relationship for all types of illness. These causes may be due to environmental factors, trauma, pathogens, fluid and chemical imbalances or structural changes. All forms of ill health thus have a specific cause and can be cured or alleviated by eliminating or neutralising the identified cause.

This belief system underpins the practice of modern medicine, but the wholeness of the individual and the relationship with the spiritual dimension are frequently lost sight of. Healthcare within a biomedical paradigm can often be experienced as dehumanising and harsh. Within this system it is the nurse who preserves a holistic approach to the patient. Nurses always strive to meet their patients' needs and to ensure that all aspects of the patients' humanity are taken into account. It is easy to become a mere technician in this model and it is important for nurses to guard against this.

The holistic paradigm

In this paradigm, human beings are seen as a part of nature and as having a need to maintain balance and harmony with the laws that govern the cosmos. Disturbing the cosmic balance causes disharmony, chaos and disease. Explanations for ill health and disease are based on disharmony between the human organism and the forces of the universe.

The holistic paradigm is widely held among many cultures, including Western cultures. Many forms of alternative healing in both the East and the West are based on the holistic paradigm, and it is the dominant paradigm among Asian cultures. Florence Nightingale's philosophy that the role of the nurse and the nursing profession is to provide an environment in which the patient can recover naturally reflects this holistic paradigm. This philosophy forms one of the foundations of the practice of nursing.

Integrative and complementary healthcare

Integrative therapy includes a more collaborative approach to patient care and encompasses the treatment of patients with both traditional and alternative therapies concurrently. Complementary therapies include a range of philosophies, approaches and therapies that Western medicine does not commonly use, accept, study or understand. The concept of wellness means more than being healthy or without a disease. However, no illness is purely physical. The effects of illness manifest themselves physically, mentally, socially, spiritually and otherwise. Humans are complex beings. The interactions between mind, body, emotions and spirit connect individuals to their environment and other people. Patients from different cultures may have used alternative therapies as their primary approach to health and illness care, and may want to continue the therapies while in hospital. Nurses need to be knowledgeable about the different cultural beliefs and alternative practices. Integrative and

complementary therapies are holistic and treat the person as a whole. They can be grouped into the therapies as discussed below.

Alternative medical systems. These are practices such as homeopathic or naturopathic medicine, and traditional medicine which includes herbal medicine, acupuncture and massage. These therapies are practised by many cultures throughout the world. In South Africa, culture and the law play a pivotal role in herbal medicine, which is regulated under the Traditional Health Practitioners Act 22 of 2007. An example of alternative practice in the South African context is circumcision, which can be done by either traditional groups or dedicated healthcare practitioners, at different cultural circumcision schools or at medical healthcare facilities, respectively.

Mind–body interventions. This includes meditation, hypnosis, dance, music and art therapy, and prayer. The therapies enhance the mind's ability to affect bodily functions.

Biologically based treatments. These treatments include products such as herbal medicines, special diets and biological therapies.

Manipulative and body-based methods. The therapies include chiropractic and massage therapy. Massage therapy in hospital may also be used in conjunction with physiotherapy.

Energy therapies. These therapies include focusing on energy originating from within the body, or from other sources such as therapeutic touch or magnetic fields, and includes reiki, physio acoustics and bio-electromagnetics.

Collaborative, comprehensive and/or alternative healthcare provision

Alternative healthcare includes health therapies that are used in place of traditional medicine.

Patients are increasingly using alternative therapies from alternative practitioners, and among African cultures the practice of consulting a herbalist, traditional healer or *sangoma* when ill is common. These kinds of practitioners play a pivotal role in the African community. The importance of indigenous practitioners and the esteem in which they are held in the community are the basis for the frequent calls that are made for these traditional practitioners to be integrated into the health system.

Traditional practitioners consult the ancestors regarding the patient's health by throwing bones or by going into a trance. Following the diagnosis, a remedy will be prescribed, again in consultation with the ancestors. These remedies are invariably herbal and are often designed to cleanse, usually by causing purging. Other remedies include tonics and vitamin preparations. Dosage and strength are imprecise and extremely variable, and some concoctions may be highly toxic if too large a dose is taken. The prescription of medication is usually accompanied by some form of ritual and/or prayer designed to enhance the treatment. Sometimes an amulet is given to the patient to complement the treatment and should be worn until the course of treatment has been completed.

Both Western and Eastern holistic practitioners may also prescribe medication, again mostly herbal based. Dosages tend to be far more precise, but some herbal preparations can be toxic if taken in too high a dose. In holistic practice, medication is designed to help restore the patient to a state of harmony or balance. Some alternative practitioners such as osteopaths use physical manipulation to achieve a cure by restoring the vertebral column to correct alignment.

Traditional, alternative and holistic practitioners enjoy wide respect and are frequently consulted by patients in addition to Western scientific practitioners. The problem is one of identifying a set of principles for a relationship between Western scientific medicine and the various forms of indigenous and alternative medicine. Often this is not a dilemma that the patient will discuss with their Western scientific doctor, because the said doctor is quite likely to disapprove of the patient consulting an alternative practitioner. Nurses are, however, quite often asked to give advice regarding the use of alternative practitioners. It is therefore important for nurses to have a sound knowledge of what treatments the various types of practitioners offer and to be able to identify those that would be harmless and those that might cause the patient harm. Openness should be encouraged, and nurses should find out whether a patient has consulted a traditional or alternative practitioner and, if so, whether any form of medication is being taken.

Recent dialogue with African traditional herbalists has led to the establishment of some guidelines. If the patient has consulted a traditional healer and then consulted a Western scientific practitioner, they should return to the herbalist to discuss this. Sometimes traditional medication can be continued, but more often it is advisable to discontinue the traditional medication until the Western medication has been completed. In many areas of South Africa, outreach programmes and training programmes are in place to educate herbalists and *sangomas* regarding the interaction between traditional medicine and Western medicine. Included in such outreach programmes are principles of referral, particularly in relation to the

nature of conditions that should be referred to a Western practitioner and when to refer.

In the area of health education, traditional practitioners play an invaluable role. In the case of conditions such as tuberculosis, it is of paramount importance that the patient continue with the treatment, whether or not traditional medication is taken in addition. Traditional practitioners are also an important link in the campaign against HIV/Aids. It is important to convince a patient not to discontinue Western treatment simply because they are consulting a traditional practitioner. This principle applies particularly where regular forms of treatment such as dialysis are concerned, and where stopping the Western treatment could be life threatening.

In the case of a hospitalised patient who is acutely or even critically ill, the use of traditional medication is definitely dubious, if not actually dangerous, and should be discontinued. The problem with the vast majority of traditional herbal remedies is that they have never been scientifically analysed, and they often contain unknown ingredients that may be potentially harmful to an acutely ill patient.

2.2 Practices to be encouraged in cultural exchanges

- Being aware of diversity and respecting it, even celebrating it
- Recognising that cultural factors are important in the health and illness of patients
- Being knowledgeable and respectful about the cultural groups one encounters
- Recognising one's own biases, prejudices and blind spots, and working to overcome these when dealing with patients
- Finding ways to care for patients in culturally appropriate and acceptable ways
- Striving to give holistic care in all situations.

A nurse's interface with different cultures

A nurse is the patient's advocate as well as the coordinator of care. It is the nurse who meets the basic needs of the patient, and many of these needs must be met in a culturally appropriate manner, or at least in a way that shows respect for the patient's culture, norms and values and does not give offence. An example of cultural advocacy could be a patient who refuses hospital treatment due to observation of cultural practices. In South Africa, refusal of hospital treatment and the right to a second opinion or health provider of own choice are included in the Patients' Rights Charter, which is enshrined in the Constitution of the Republic of South Africa, 1996. The nurse should therefore consider the patient's rights in conjunction with their culture and wishes.

Nurses also frequently carry the major responsibility of giving health education and ensuring that patients and their families have understood the information given to them. Nurses are thus the primary caregivers and healthcare practitioners, and they interact with many cultures. Nurses need to develop a broad store of cultural knowledge, and they also need to develop a high degree of cultural sensitivity. Cultural sensitivity embodies the principle of respect and awareness of one's own norms and values, as well as those of the patient. Culturally sensitive nursing involves caring for a patient in a way that matches the patient's perceptions of their health problems with their treatment goals.

A nurse's role within the multidisciplinary team from a cultural perspective

It is not possible for the average nurse to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare

2.3 Pitfalls to be avoided in cultural exchanges

- Ignorance and lack of understanding of other cultural groups
- Stereotyping, such as assuming that all individuals belonging to a particular cultural group conform to a general pattern or behave in a certain way; it should be considered that all patients are individuals and that their behaviour and reactions are also determined by other factors, such as family, education, and environment
- Judging other groups by one's own norms and values – certain basic principles, such as the concern for hygiene, are practically universal, but may be expressed in different ways
- Assigning negative attributes or characteristics to people from another cultural group
- Seeing the worldview and experience of other groups as inferior – this leads to prejudice, discrimination and racism
- Taking a paternalistic attitude of 'I know what is good for you'
- Being culturally blind and proceeding as though cultural differences do not exist. The practice of giving dietary advice that is based exclusively on a typical Western diet is such an example.

and these should be assessed as part of a routine nursing assessment. These key aspects are:

- Diet and food habits
- Rituals and taboos relating to key events in the lifecycle such as sexuality, birth and death
- Health and illness beliefs
- Types of practitioner consulted
- Health/illness behaviours and decision-making, including family or clan involvement
- Relationship with health professionals, as in many cultures the medical practitioner is expected to tell the patient what is wrong, not the other way around
- Genetically based biological variations, such as blood values, bone structure and bone density
- Practices related to modesty
- The discussion of sensitive issues.

Culture and communication

The importance of culture in communication cannot be overemphasised. It is essential for nurses to develop a basic insight into the culture of all the patients that they deal with. Failure to develop this insight will hamper health communication and nurses may be seen as being insensitive or even rude as a result of their lack of understanding of the patient's culture. Where language is a problem, translators may be useful. It is also important for nurses to use the correct channels of communication, such as a senior male relative when necessary.

Communication in a cultural context

Cultural context is the care, beliefs, values and practices of a culture that shape a person's environment.

Culture profoundly influences interpersonal communication, and it is essential for nurses to have a basic understanding of the norms and values of the cultural groups with whom they will be working in order to communicate effectively with these groups. Culture determines several key aspects of communication, such as:

- **How to greet.** For example, in African cultures it is not polite to get straight to the matter under discussion without first greeting the other participants and enquiring after their health. Among African cultures it is the older or more senior person who is greeted, and indicates when to speak and when not to speak. In many cultures, a junior person waits to be invited to speak, or waits until the more senior people have had their say and only then may they speak.
- **Expressing anger and other strong emotions.** In most societies, direct physical expressions of anger are not acceptable, as this can be dangerous and lead to injury and even death. Showing grief is another matter. In some cultures, it is a mark of love and esteem for a departed relative if those left behind cry and give way to strong overt signs of grief like screaming or tearing at clothes. In other societies, control is expected on the death of a loved one. A controlled reaction does not necessarily mean that the relatives did not care for the person who has died. In other cultures, a man is not supposed to cry, or should cry privately.
- **Eye contact.** In Western societies, looking the other person directly in the eye is taken as a mark of openness and honesty. In other cultures, like African cultures for example, sustained direct eye contact is not polite, particularly from a junior to a senior person, or even female to male.
- **Gesturing and touching.** Generally, areas that may be touched during communication depend on the degree of intimacy of the communicators and the context of the communication. During sexual intercourse, the partners are very intimate and all parts of the body may be touched. In everyday social interaction between work colleagues there is not a high degree of intimacy, and thus only the hands, arms and shoulders may be touched during communication, especially when greeting or congratulating a person. In some cultures, it is the norm to kiss the cheeks of the other person when greeting, irrespective of gender.

Cultures can be categorised according to whether they are individualistic or collectivistic, as well as by their communication style. Cultures may have high-context communication styles or low-context communication styles.

- Individualistic cultures, such as most Western European cultures, stress individual goals and achievements. These cultures tend to promote competition, and they place great value on achievement.
- Collectivistic cultures, such as are found in Africa, stress group activities and group achievements. These place great value on cooperation and group cohesion.
- Cultures characterised by a high-context communication style tend to be indirect or overly polite in communication, having a great concern for perceptions and leaving much to be gleaned from the context and circumstances of the communication, which means that the other person in the communication needs to have a degree of insight into the context and circumstances of the communication in order to be able to fully understand the communication. Many Eastern as well as African cultures have a high-context communication style, and it can be difficult for an individual from a different cultural background to work out the full meaning of the communication unless time has been spent in developing the necessary insight to

be able to communicate effectively. In African cultures, much communication is implied and the listener must pick this up from the context. Much is left unsaid or is conveyed through nonverbal means, or by riddles and euphemisms, which the listener must understand in order to grasp the full drift of the communication. For example, in the African context the expression *'izindaba zocansi'* is a term used to cover a multitude of issues related to sex and sexuality.

- In contrast, low-context cultures, such as most Western European cultures, have a direct communication style and are much more explicit verbally. The listener will know exactly what is meant, but the style is not always comfortable and can be perceived as rude, especially by someone from a high-context culture.

Essential health information

It is especially important to consider the patient's heritage, education level and language skills when planning patient education. The assistance of an interpreter may be appropriate. The unfamiliar hospital environment may be threatening when language barriers make it difficult to ask questions. Nurses should:

- provide information on indications, contraindications, potential benefits and adverse effects of alternative therapies in relation to the present diagnosis
- advise the patient about herb–drug interactions
- advise the patient to seek help regarding exploration of therapies that are suitable to them
- advise the patient to keep a log of any adverse reactions and report these to the healthcare practitioner
- when using oils on the patient, advise the family to be cautious of the risk for toxicity or skin irritation
- enquire into allergies when using biologically based therapies
- advise the patient to consult safe and competent practitioners.

Conclusion

The Nursing and Midwifery Council (NMC) in the United Kingdom states that 'nurses must practise in a fair and an anti-discriminatory way, acknowledging the differences in beliefs and practices of individuals or groups' (NMC, 2002). The culture of the patient must be taken into consideration when planning nursing care. Alternative and complementary therapies that will be beneficial for the care of the patient should be assessed. It is not possible for nurses to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare, and these should be assessed as part of a routine nursing assessment.

Suggested activities for learners

Activity 2.1

A male patient is admitted in your unit and the family request to massage him with a body lotion of mixed medicinal herbs which they obtained from a traditional healer. They believe that the lotion will heal the patient of the condition he is suffering from.

They have been instructed to put the lotion all over the body and that the patient should not have a bath for 3 days in order for the medicine to work effectively. The family asks you to allow them to put the lotion on the patient and follow the instructions. Debate the following issues:

1. How would you proceed?
2. How does this enhance or inhibit the achievement of the specific outcomes outlined in this Chapter?

Activity 2.2

A patient in your unit is confused and refuses oxygen therapy, saying it is disturbing him as he would like to communicate with his ancestors. He is desaturating and becomes violent when you try to put the face mask on him. He then requests you to give him space to discuss the treatment (oxygen therapy) you want to give him with his great-grandmother, who is already dead. Debate how you would proceed in this situation.

Activity 2.3

A female patient admitted in your unit with chronic back pain has been scheduled for a spinal operation. Following a visit from relatives she requests to be discharged from the hospital because she is considering acupuncture, and the family has organised an intercessory prayer for her. Explain how you would proceed to deal with this patient.

5. Spirituality

Considering spirituality in nursing is vital for holistic patient care, as it acknowledges the emotional and existential aspects of health that can significantly impact a patient's well-being. By understanding and respecting patients' spiritual beliefs and practices, nurses can create a supportive environment that fosters healing and comfort. This consideration also benefits nurses themselves, promoting their own resilience and emotional health.

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2 Practising nursing within a culturally diverse society

LEARNING OBJECTIVES

On completion of this Chapter, the learner should be able to:

- describe how a nurse can provide culturally competent nursing care
- discuss the development of effective relationships with patients, their families and significant others through culturally appropriate care and communication
- plan healthcare taking into account the cultural requirements of patients
- explain the principles of patients' advocacy in respect of cultural needs
- discuss the interface between Western medicine and alternative/traditional practitioners
- give health information and/or health education that is culturally appropriate and acceptable to patients and their families.

KEY CONCEPTS AND TERMINOLOGY

acculturation	The paradigm shift that patients must undergo in order to change their culture and adopt the culture of the healthcare provider.
amulet	An object that protects a person from trouble such as ornaments or jewellery worn to chase evil spirits away.
charms	Objects that have power or a spell over evil.
culture	A way of life, which encompasses the ideas, customs, and social behaviour of a particular people or society.
cultural diversity	The variety of human cultures in a specific region.
cultural knowledge	The knowledge the healthcare professional has about specific or diverse groups' fundamental norms, customs, belief and values.
paradigm	System of understanding and organising knowledge.
supernatural	Something that has a force beyond scientific understanding or the laws of nature.
traditional practitioners	People who practice traditional medicine.

PREREQUISITE KNOWLEDGE

- Batho-Pele principles
- Patients' rights
- Human rights.

MEDICO-LEGAL CONSIDERATIONS

- The fulfilment of cultural requirements is a patient's right, and failure on the part of a nurse to meet this need can be interpreted as negligence.

- Failure to give accurate and adequate information to a patient may also be construed as negligence, particularly if the patient must make major decisions relating to their healthcare, or if the patient is expected to manage their medical condition at home. In order for health information to be acceptable and understood by a patient, the information must be put across in a manner that takes cultural factors into account. Failure to do this is likely to cause a patient to be non-compliant.
- Disregard of cultural requirements is an instance of discrimination and may involve the healthcare institution, and the individual nurse, in legal action.

ETHICAL CONSIDERATIONS

- Nurses have an ethical obligation to
  - respect the culture and preserve the dignity of patients at all times
  - apply cultural knowledge and sensitivity in order to avoid offending or discriminating against patients based on their cultural backgrounds.
- Every patient has a right
  - to participate in their own healthcare, including having their cultural needs met
  - to health information and health education that is accessible, understandable, acceptable, appropriate and congruent with their cultural requirements
  - not to be discriminated against because they wish to consult an alternative or traditional practitioner.

Practice alert!

In situations where patients strongly wish to consult alternative or traditional practitioners, it is imperative that they are made to understand the full implications of their choice.

ESSENTIAL HEALTH LITERACY

Holistic nursing care includes cultural nursing as culture impacts on the patient's health behaviour. It is essential for the nurse to have a brief background of the patient's culture and information that will assist to comply with the patient's wish for alternative treatment. Patients must be encouraged to communicate their wishes and also be given a chance to exercise them if need be. However, possible effects of the alternative medicine on their health and illness must be explained to the patient for them to make informed decisions.

Introduction

Nursing is an interpersonal activity, with the goal of restoring or maintaining the health of patients. Interpersonal activities such as nursing care are, by definition, built on relationships and communication. To be effective in facilitating the healthcare of patients, nurses should develop a good nurse–patient relationship and should be able to communicate effectively with patients. It is essential for nurses to develop insight into the culture of their patients, as well as an understanding of how the individual patient's culture impacts on health behaviour. Acquiring cultural knowledge assists with the integration of health-related beliefs, practices and cultural values (Campinha-Bacote, 2010). Nurses must be able to gain knowledge about the culture of a patient by asking the right questions and by demonstrating sensitivity towards the patient's beliefs and culture. Health and illness behaviour must be understood in the light of a patient's cultural context if a nurse is to fulfil their role in helping the patient to achieve or maintain optimum health.

In the light of current policy directions in South Africa, a nurse may need to work with indigenous or alternative health practitioners. To do this harmoniously and effectively, nurses must develop an elementary understanding of the basic principles and philosophical outlook of these practitioners. Therefore, the nurse must develop cultural competence in the delivery of healthcare. Cultural competence is a set of congruent behaviours, practices, attitudes and policies that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations. The process of developing cultural competence includes desire, awareness, skill and knowledge (Campinha-Bacote, 2010). The aim of this Chapter is to assist you to develop sensitivity towards the traditions and respect for the culture of patients and the community.

The concept of culture

Culture is a shared set of norms, values, perceptions and social conventions that give cohesion to a group, race or

community, enabling them to live together and function effectively and harmoniously. It is a key influence on the way in which an individual perceives and responds to the world. Culture, however, is simply one set of factors among many that mould the individual and their response to the world and to society. Individual behaviour is heavily influenced by culture, but culture is a framework and not a stereotype.

Culture consists of the following aspects:

- Observable phenomena, such as manner of dress, diet, architecture, language, writing and the arts.
- Norms and values, including ideas about how people should behave, about right and wrong, and good and bad. These norms and values are usually taken for granted within a culture; they are universally accepted within that culture, having been absorbed by people at a very early age. Each individual learns about their own culture from an early age, and also learns how to function within that particular worldview.

Culture is not inherited; it is acquired during the process of socialisation in childhood. Subgroups or subcultures exist within every society. Organisations, occupations and professions also have their own micro-cultures that individuals accept and adapt to when they join the group. Culture is therefore an integrated pattern of human knowledge, belief, and behaviour that is a result of, and integral to, the human capacity for learning and transmitting knowledge to succeeding generations. It is learned and shared, dynamic and changing. Cultural awareness is thus a deliberate and cognitive process through which sensitivity to a person's values, beliefs and practices develop.

The importance of culture

Culture consists of language, ideas, beliefs, customs, taboos, codes, institutions, tools, techniques, and works of art, rituals, ceremonies, and symbols. It has played an important role in human evolution, allowing human beings to adapt the environment to their own purposes.

In a diverse society such as South Africa, cultural differences are very evident; and to be effective in their profession, nurses must be able to work with people whose culture and traditions are different from their own. However, without sufficient knowledge of other people's culture, it will be difficult to work with or understand people whose culture is different from their own. It is vitally important for the nurse to acquire sufficient knowledge of the cultures they work with in order to avoid offensive stereotyping.

Cultural insight and knowledge are also essential for nurses given the interpersonal nature of their work. Much of the effectiveness of nursing care is due to interpersonal interactions with patients and the nature of the nurse–patient relationship. There are several nursing theories and models of care that highlight the centrality of culture and trans-cultural nursing, such as: the cultural safety model; Leininger's theory of Culture Care Diversity and Universality and the Sunrise model; the Giger and Davidhizar Trans-cultural Assessment Model; and Campinha-Bacote's cultural competence in healthcare model.

2.1 The acquisition of cultural knowledge and understanding

Some suggestions on how to acquire cultural knowledge and understanding:

- Nurses should develop an awareness of their own cultural assumptions and prejudices.
- Written or visual material on other cultures can be useful to build general knowledge, provided that such material is not biased or prejudiced.
- Once a nurse has developed a good relationship with a patient, the nurse can ask questions. If the right questions are asked in a respectful manner and the response is received respectfully, much can be learned.
- A nurse should not automatically assume that they know best and that their way of doing things is the only way. Nurses must allow space for the preferences of their patients, which includes cultural and religious preferences.

Cultural issues in healthcare

Every human society has its own particular culture. Variation among cultures is attributable to such factors as differing physical habitats and resources, the range of possibilities inherent in areas such as language, ritual, social organisation and historical phenomena such as the development of links with other cultures. An individual's attitudes, values, ideas and beliefs are greatly influenced by the culture (or cultures) in which they live. Culture change takes place as a result of ecological, socioeconomic, political, religious, or other fundamental factors affecting a society or an individual such as health and illness.

There are several cultural factors that act as barriers to effective healthcare. Because South Africa is a diverse society, nurses need to develop an understanding of the cultural dimensions of a number of health-related issues. Many of these issues may be closely allied to religious practices, but all need to be taken into account when

dealing with patients and the community. Because nursing care is interpersonal and because nursing involves meeting the needs of patients, cultural factors such as modesty, hygiene practices, attitudes to pain and illness, diet and food, as well as death and dying must be understood and taken into account when planning nursing care. These and other issues are discussed below.

Diet

Diet is an important cultural characteristic, and it is an area that nurses must find out about during the assessment of their patients. Information should be obtained about, for example, which foods may or may not be eaten, or if there is any special method of preparation. This is important as certain food taboos are based on cultural and religious beliefs. For example, pork is the well-known food taboo of some religions in African and Muslim people.

In a hospital setting, efforts should be made to supply the appropriate diet for each patient. If the dietary requirements of the hospital in-patient cannot be met, it may be necessary to approach the family with a view to having them bring in food for the patient, if the condition of the patient allows. A thorough knowledge of the diet of the patient, including the ways in which food is prepared, is essential when giving health education to the patient. Health education should be contextualised according to the patient's individual lifestyle, and this means taking careful note of specific characteristics, whether cultural or individual. In instances where health education and advice are not appropriate to a patient's lifestyle and culture, the advice may not be followed and this will be to the detriment of the patient.

Hygiene practices

Hygiene practices often differ from culture to culture. Muslim people, for example, always wash their hands as well as the urethral and/or anal area after using the toilet. For some cultural groups, a bath is not regarded as hygienic, and only a shower will suffice. For other groups, specific hygiene measures are taken during menstruation. Nurses should take note of these and any other hygiene requirements that they encounter and try to meet the needs of their patients in the best way possible.

Family hierarchy and lines of communication

Culture is instrumental in communication. Language is a powerful instrument that can be used to get to know the other person's culture. Family hierarchy and lines of communication are sometimes significant when consent has to be obtained for treatment or for a surgical procedure.

In South Africa, the current legislation allows people 18 years and older to give consent to medical treatment autonomously. However, in many African groups, consent to an operation or other form of treatment is a major decision. Sometimes a patient will ask to go home and consult the elders of the clan, and in some instances the ancestors are consulted. Many African groups require that consent for an operation on a child must be obtained from the child's family or from the senior male relative, and the mother will feel unable to give consent without consulting the father or a male relative. This can create difficulties where the child is acutely ill and is in need of emergency treatment or surgery and the father is not available. In such a case, it may be necessary for the Medical Superintendent to give consent. In many groups, health matters relating to reproductive health or to sexual matters, such as contraception, must often be discussed with the husband first, before talking to both husband and wife, as it is the husband who takes decisions in the home and nothing will happen if only the wife has received the advice.

It is important for the nurse to find out about lines of communication in the various cultural groups because nursing care is based on good communication, and it is essential at all times to make sure that the lines of communication with all stakeholders are appropriate and effective.

Disposal of body parts

If an organ has to be removed or a limb amputated, it is essential to find out from the patient or from the relatives whether any special measures are needed for the disposal of the tissue or limb. In many cultural groups, the body parts must be given burial and not simply sent to the incinerator. This requirement is particularly important in the case of amputation. The requirement is often not so stringent in the case of organs and parts of organs or tissues.

In South Africa, matters relating to human tissues are legislated in the National Health Act 61 of 2003, which repealed the Human Tissue Act 65 of 1983.

Organ donation pratices also vary between different cultures; some groups will not consent because of the belief that the deceased must be buried with all their body parts intact. Organ donation is not universally accepted among African cultures, although there is no specific prohibition in traditional African belief and it may vary depending on the particular group or set of religious beliefs. Orthodox Jewish people and many Muslim people are also likely to refuse organ donation, out of a cultural belief that the body must be buried intact and not necessarily out of any specific religious prohibition. Some groups may refuse permission for post-mortem examination, for example Orthodox Jewish people and Muslim people.

Death, dying and the disposal of the body

As this is the last thing that the family will do for the patient, most families have a strong desire to ensure that things are done in accordance with what the patient would have wanted. It is important to find out, for example, whether the family would like a priest to be called, as would be the case with a Roman Catholic patient. Also important would be to find out whether the family expect to be allowed to stay with the dying person and, if so, which specific family members. In the case of Jewish patients, it is customary for the family to watch at the bedside of a dying relative, but this function is also provided by Jewish community organisations that may be contacted to perform this function if the family is unable to do so.

In some cultures, specific rituals are carried out at the bedside of a dying patient. The care of the body after death is also an important cultural aspect. In some African cultures, after the death of a person in hospital, the family may come to collect the spirit of the dead person from the bed where the patient passed on. Nurses should find out whether it is acceptable for the staff to remove tubes and lines and lay the body out, or if there is any specific procedure to be followed before doing the last offices. For example, an individual known as the *Wagter*, who is sent by the relevant Jewish community organisation, lays out a Jewish patient who has died, although it is usually expected that the nursing staff will remove the tubes and lines. Jewish and Muslim patients are accommodated in their own separate sections of the mortuary and have their own burial organisations.

Amulets and charms

Beliefs in charms and amulets are a widespread phenomenon, and are found in many cultures. Amulets and charms are believed to facilitate healing and to protect the patient from harm. The use of charms is not only found among so-called primitive groups but is found in many Western groups. Among Mediterranean groups, for example, belief in the 'evil eye' is common and charms are worn to ward off the evil eye. Some amulets are religious in nature, such as holy pictures and holy medals, but their purpose remains the same: to promote healing by supernatural means and to protect the individual from harm.

Generally, amulets and charms should not be removed unless it is clearly necessary, eg if the patient is going for operation in the theatre. It may also be necessary to remove amulets in order to facilitate treatment. If it is indeed necessary to remove an amulet, the patient and family should be informed of the need and of the reason for it. Sometimes amulets can be moved to other places on the body, or they can be placed at the bedside, or sent home with the family, but usually the hospitalised patient prefers to keep such items with them. Amulets should never simply be discarded, as this can cause great offence to the patient and/or family.

The role of women

The role and social position of women varies between societies, and often depends on whether the society is matriarchal or patriarchal. In many cultures, a woman is a perpetual minor, always under the guardianship and supervision of a male relative. Women in such a position usually need to consult with their husbands or senior male relatives before taking decisions, even those relating to health. Among many African groups, it is the male head of the household who must decide if a member of the household can be taken to a hospital or clinic for treatment. This often means that women must wait for absent heads of households to return before a decision can be taken. A great deal of education and empowerment is needed to change these patterns.

Sexuality

Sexuality is a universal human trait, but the social regulation and expression of sexuality varies from culture to culture. The area of sexuality covers relations between the sexes, modesty, rituals and practices related to the female menstrual cycle, and, very importantly for nurses, the manner in which intimate matters may be discussed.

In many cultures, the frank discussion of sexual matters is regarded as uncouth. It is common to find that it is unacceptable for sexual matters to be discussed between the sexes; women talk to women about sexuality and men talk to men. It follows, therefore, that any discussion on matters related to sexuality, such as contraception or safe sexual practices, must be approached correctly and very carefully. For some, it is necessary to discuss such matters with the head of the household; if they accept, then the family will follow their lead. Depending on the group, it is often prudent to have a male nurse talk to male patients or male family members, and female nurses to talk to female patients or female family members. A young unmarried female is frequently not seen as an appropriate person with whom to discuss intimate matters.

The way in which intimate topics and those of a sexual nature are discussed is also important. Frank graphic descriptions are often not acceptable and may cause offence, and the nurse must find ways to get the message across by using terminology that is acceptable to the patients and their families.

Other cultural issues related to areas of cultural diversity are family organisation, language, personal space, touching, eye contact, gestures, healthcare beliefs, and spirituality and religion.

Cultural perspectives on health and illness

Beliefs on healthcare systems vary among cultures, thus patients regard healthcare differently. Every culture has a system for healthcare based on the values and beliefs that have existed for generations. Nurses have an increased responsibility to meet the needs of an increasingly diverse society in order to reduce health disparities and improve healthcare quality. Beliefs about health and illness are an important cultural factor in healthcare. The challenge for nurses rendering healthcare in a Western-oriented healthcare system, such as the one in South Africa, is to bring the health/illness paradigm of patients into alignment with the system. Health and illness beliefs fall into three major groups, described in the sections that follow.

The magico-religious paradigm

In this paradigm, illness has a supernatural cause, as opposed to injury, which has a specific and obvious cause. Consequently, the cure for illness lies in the supernatural or spiritual dimension. It is widely believed among African cultures that illness may be brought on by a malicious spell or by the neglect of or a transgression against the ancestors. The cure for illness, while it may involve medication, is spiritual and involves rituals, prayer and possibly some form of sacrifice. Health may be seen as a sign of supernatural favour, and illness as a curse or punishment. In this paradigm, it is also commonly believed that the actions of one individual may affect the health of the community.

People who adhere to this belief system do not necessarily reject Western scientific approaches to therapy, but scientific treatment methods are not seen as being the sole agent in effecting a cure. For many African cultures, the two systems exist in parallel, and both are regarded as being effective. For treatment within a modern scientific framework to be successful, however, patients must be allowed expression of the spiritual dimension and access to practitioners who practise within the magico-religious framework.

Patient education is an important factor in bringing the two systems into alignment for a patient, and the nurse is a key agent in this process. Accurate health education that takes into account and shows respect for the patient's health or illness beliefs and behaviours must be offered.

The biomedical paradigm

This is the dominant belief system among Western cultures, but not necessarily the only one. According to this paradigm, there is a demonstrable cause–effect relationship for all types of illness. These causes may be due to environmental factors, trauma, pathogens, fluid and chemical imbalances or structural changes. All forms of ill health thus have a specific cause and can be cured or alleviated by eliminating or neutralising the identified cause.

This belief system underpins the practice of modern medicine, but the wholeness of the individual and the relationship with the spiritual dimension are frequently lost sight of. Healthcare within a biomedical paradigm can often be experienced as dehumanising and harsh. Within this system it is the nurse who preserves a holistic approach to the patient. Nurses always strive to meet their patients' needs and to ensure that all aspects of the patients' humanity are taken into account. It is easy to become a mere technician in this model and it is important for nurses to guard against this.

The holistic paradigm

In this paradigm, human beings are seen as a part of nature and as having a need to maintain balance and harmony with the laws that govern the cosmos. Disturbing the cosmic balance causes disharmony, chaos and disease. Explanations for ill health and disease are based on disharmony between the human organism and the forces of the universe.

The holistic paradigm is widely held among many cultures, including Western cultures. Many forms of alternative healing in both the East and the West are based on the holistic paradigm, and it is the dominant paradigm among Asian cultures. Florence Nightingale's philosophy that the role of the nurse and the nursing profession is to provide an environment in which the patient can recover naturally reflects this holistic paradigm. This philosophy forms one of the foundations of the practice of nursing.

Integrative and complementary healthcare

Integrative therapy includes a more collaborative approach to patient care and encompasses the treatment of patients with both traditional and alternative therapies concurrently. Complementary therapies include a range of philosophies, approaches and therapies that Western medicine does not commonly use, accept, study or understand. The concept of wellness means more than being healthy or without a disease. However, no illness is purely physical. The effects of illness manifest themselves physically, mentally, socially, spiritually and otherwise. Humans are complex beings. The interactions between mind, body, emotions and spirit connect individuals to their environment and other people. Patients from different cultures may have used alternative therapies as their primary approach to health and illness care, and may want to continue the therapies while in hospital. Nurses need to be knowledgeable about the different cultural beliefs and alternative practices. Integrative and

complementary therapies are holistic and treat the person as a whole. They can be grouped into the therapies as discussed below.

Alternative medical systems. These are practices such as homeopathic or naturopathic medicine, and traditional medicine which includes herbal medicine, acupuncture and massage. These therapies are practised by many cultures throughout the world. In South Africa, culture and the law play a pivotal role in herbal medicine, which is regulated under the Traditional Health Practitioners Act 22 of 2007. An example of alternative practice in the South African context is circumcision, which can be done by either traditional groups or dedicated healthcare practitioners, at different cultural circumcision schools or at medical healthcare facilities, respectively.

Mind–body interventions. This includes meditation, hypnosis, dance, music and art therapy, and prayer. The therapies enhance the mind's ability to affect bodily functions.

Biologically based treatments. These treatments include products such as herbal medicines, special diets and biological therapies.

Manipulative and body-based methods. The therapies include chiropractic and massage therapy. Massage therapy in hospital may also be used in conjunction with physiotherapy.

Energy therapies. These therapies include focusing on energy originating from within the body, or from other sources such as therapeutic touch or magnetic fields, and includes reiki, physio acoustics and bio-electromagnetics.

Collaborative, comprehensive and/or alternative healthcare provision

Alternative healthcare includes health therapies that are used in place of traditional medicine.

Patients are increasingly using alternative therapies from alternative practitioners, and among African cultures the practice of consulting a herbalist, traditional healer or *sangoma* when ill is common. These kinds of practitioners play a pivotal role in the African community. The importance of indigenous practitioners and the esteem in which they are held in the community are the basis for the frequent calls that are made for these traditional practitioners to be integrated into the health system.

Traditional practitioners consult the ancestors regarding the patient's health by throwing bones or by going into a trance. Following the diagnosis, a remedy will be prescribed, again in consultation with the ancestors. These remedies are invariably herbal and are often designed to cleanse, usually by causing purging. Other remedies include tonics and vitamin preparations. Dosage and strength are imprecise and extremely variable, and some concoctions may be highly toxic if too large a dose is taken. The prescription of medication is usually accompanied by some form of ritual and/or prayer designed to enhance the treatment. Sometimes an amulet is given to the patient to complement the treatment and should be worn until the course of treatment has been completed.

Both Western and Eastern holistic practitioners may also prescribe medication, again mostly herbal based. Dosages tend to be far more precise, but some herbal preparations can be toxic if taken in too high a dose. In holistic practice, medication is designed to help restore the patient to a state of harmony or balance. Some alternative practitioners such as osteopaths use physical manipulation to achieve a cure by restoring the vertebral column to correct alignment.

Traditional, alternative and holistic practitioners enjoy wide respect and are frequently consulted by patients in addition to Western scientific practitioners. The problem is one of identifying a set of principles for a relationship between Western scientific medicine and the various forms of indigenous and alternative medicine. Often this is not a dilemma that the patient will discuss with their Western scientific doctor, because the said doctor is quite likely to disapprove of the patient consulting an alternative practitioner. Nurses are, however, quite often asked to give advice regarding the use of alternative practitioners. It is therefore important for nurses to have a sound knowledge of what treatments the various types of practitioners offer and to be able to identify those that would be harmless and those that might cause the patient harm. Openness should be encouraged, and nurses should find out whether a patient has consulted a traditional or alternative practitioner and, if so, whether any form of medication is being taken.

Recent dialogue with African traditional herbalists has led to the establishment of some guidelines. If the patient has consulted a traditional healer and then consulted a Western scientific practitioner, they should return to the herbalist to discuss this. Sometimes traditional medication can be continued, but more often it is advisable to discontinue the traditional medication until the Western medication has been completed. In many areas of South Africa, outreach programmes and training programmes are in place to educate herbalists and *sangomas* regarding the interaction between traditional medicine and Western medicine. Included in such outreach programmes are principles of referral, particularly in relation to the

nature of conditions that should be referred to a Western practitioner and when to refer.

In the area of health education, traditional practitioners play an invaluable role. In the case of conditions such as tuberculosis, it is of paramount importance that the patient continue with the treatment, whether or not traditional medication is taken in addition. Traditional practitioners are also an important link in the campaign against HIV/Aids. It is important to convince a patient not to discontinue Western treatment simply because they are consulting a traditional practitioner. This principle applies particularly where regular forms of treatment such as dialysis are concerned, and where stopping the Western treatment could be life threatening.

In the case of a hospitalised patient who is acutely or even critically ill, the use of traditional medication is definitely dubious, if not actually dangerous, and should be discontinued. The problem with the vast majority of traditional herbal remedies is that they have never been scientifically analysed, and they often contain unknown ingredients that may be potentially harmful to an acutely ill patient.

2.2 Practices to be encouraged in cultural exchanges

- Being aware of diversity and respecting it, even celebrating it
- Recognising that cultural factors are important in the health and illness of patients
- Being knowledgeable and respectful about the cultural groups one encounters
- Recognising one's own biases, prejudices and blind spots, and working to overcome these when dealing with patients
- Finding ways to care for patients in culturally appropriate and acceptable ways
- Striving to give holistic care in all situations.

A nurse's interface with different cultures

A nurse is the patient's advocate as well as the coordinator of care. It is the nurse who meets the basic needs of the patient, and many of these needs must be met in a culturally appropriate manner, or at least in a way that shows respect for the patient's culture, norms and values and does not give offence. An example of cultural advocacy could be a patient who refuses hospital treatment due to observation of cultural practices. In South Africa, refusal of hospital treatment and the right to a second opinion or health provider of own choice are included in the Patients' Rights Charter, which is enshrined in the Constitution of the Republic of South Africa, 1996. The nurse should therefore consider the patient's rights in conjunction with their culture and wishes.

Nurses also frequently carry the major responsibility of giving health education and ensuring that patients and their families have understood the information given to them. Nurses are thus the primary caregivers and healthcare practitioners, and they interact with many cultures. Nurses need to develop a broad store of cultural knowledge, and they also need to develop a high degree of cultural sensitivity. Cultural sensitivity embodies the principle of respect and awareness of one's own norms and values, as well as those of the patient. Culturally sensitive nursing involves caring for a patient in a way that matches the patient's perceptions of their health problems with their treatment goals.

A nurse's role within the multidisciplinary team from a cultural perspective

It is not possible for the average nurse to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare

2.3 Pitfalls to be avoided in cultural exchanges

- Ignorance and lack of understanding of other cultural groups
- Stereotyping, such as assuming that all individuals belonging to a particular cultural group conform to a general pattern or behave in a certain way; it should be considered that all patients are individuals and that their behaviour and reactions are also determined by other factors, such as family, education, and environment
- Judging other groups by one's own norms and values – certain basic principles, such as the concern for hygiene, are practically universal, but may be expressed in different ways
- Assigning negative attributes or characteristics to people from another cultural group
- Seeing the worldview and experience of other groups as inferior – this leads to prejudice, discrimination and racism
- Taking a paternalistic attitude of 'I know what is good for you'
- Being culturally blind and proceeding as though cultural differences do not exist. The practice of giving dietary advice that is based exclusively on a typical Western diet is such an example.

and these should be assessed as part of a routine nursing assessment. These key aspects are:

- Diet and food habits
- Rituals and taboos relating to key events in the lifecycle such as sexuality, birth and death
- Health and illness beliefs
- Types of practitioner consulted
- Health/illness behaviours and decision-making, including family or clan involvement
- Relationship with health professionals, as in many cultures the medical practitioner is expected to tell the patient what is wrong, not the other way around
- Genetically based biological variations, such as blood values, bone structure and bone density
- Practices related to modesty
- The discussion of sensitive issues.

Culture and communication

The importance of culture in communication cannot be overemphasised. It is essential for nurses to develop a basic insight into the culture of all the patients that they deal with. Failure to develop this insight will hamper health communication and nurses may be seen as being insensitive or even rude as a result of their lack of understanding of the patient's culture. Where language is a problem, translators may be useful. It is also important for nurses to use the correct channels of communication, such as a senior male relative when necessary.

Communication in a cultural context

Cultural context is the care, beliefs, values and practices of a culture that shape a person's environment.

Culture profoundly influences interpersonal communication, and it is essential for nurses to have a basic understanding of the norms and values of the cultural groups with whom they will be working in order to communicate effectively with these groups. Culture determines several key aspects of communication, such as:

- **How to greet.** For example, in African cultures it is not polite to get straight to the matter under discussion without first greeting the other participants and enquiring after their health. Among African cultures it is the older or more senior person who is greeted, and indicates when to speak and when not to speak. In many cultures, a junior person waits to be invited to speak, or waits until the more senior people have had their say and only then may they speak.
- **Expressing anger and other strong emotions.** In most societies, direct physical expressions of anger are not acceptable, as this can be dangerous and lead to injury and even death. Showing grief is another matter. In some cultures, it is a mark of love and esteem for a departed relative if those left behind cry and give way to strong overt signs of grief like screaming or tearing at clothes. In other societies, control is expected on the death of a loved one. A controlled reaction does not necessarily mean that the relatives did not care for the person who has died. In other cultures, a man is not supposed to cry, or should cry privately.
- **Eye contact.** In Western societies, looking the other person directly in the eye is taken as a mark of openness and honesty. In other cultures, like African cultures for example, sustained direct eye contact is not polite, particularly from a junior to a senior person, or even female to male.
- **Gesturing and touching.** Generally, areas that may be touched during communication depend on the degree of intimacy of the communicators and the context of the communication. During sexual intercourse, the partners are very intimate and all parts of the body may be touched. In everyday social interaction between work colleagues there is not a high degree of intimacy, and thus only the hands, arms and shoulders may be touched during communication, especially when greeting or congratulating a person. In some cultures, it is the norm to kiss the cheeks of the other person when greeting, irrespective of gender.

Cultures can be categorised according to whether they are individualistic or collectivistic, as well as by their communication style. Cultures may have high-context communication styles or low-context communication styles.

- Individualistic cultures, such as most Western European cultures, stress individual goals and achievements. These cultures tend to promote competition, and they place great value on achievement.
- Collectivistic cultures, such as are found in Africa, stress group activities and group achievements. These place great value on cooperation and group cohesion.
- Cultures characterised by a high-context communication style tend to be indirect or overly polite in communication, having a great concern for perceptions and leaving much to be gleaned from the context and circumstances of the communication, which means that the other person in the communication needs to have a degree of insight into the context and circumstances of the communication in order to be able to fully understand the communication. Many Eastern as well as African cultures have a high-context communication style, and it can be difficult for an individual from a different cultural background to work out the full meaning of the communication unless time has been spent in developing the necessary insight to

be able to communicate effectively. In African cultures, much communication is implied and the listener must pick this up from the context. Much is left unsaid or is conveyed through nonverbal means, or by riddles and euphemisms, which the listener must understand in order to grasp the full drift of the communication. For example, in the African context the expression *'izindaba zocansi'* is a term used to cover a multitude of issues related to sex and sexuality.

- In contrast, low-context cultures, such as most Western European cultures, have a direct communication style and are much more explicit verbally. The listener will know exactly what is meant, but the style is not always comfortable and can be perceived as rude, especially by someone from a high-context culture.

Essential health information

It is especially important to consider the patient's heritage, education level and language skills when planning patient education. The assistance of an interpreter may be appropriate. The unfamiliar hospital environment may be threatening when language barriers make it difficult to ask questions. Nurses should:

- provide information on indications, contraindications, potential benefits and adverse effects of alternative therapies in relation to the present diagnosis
- advise the patient about herb–drug interactions
- advise the patient to seek help regarding exploration of therapies that are suitable to them
- advise the patient to keep a log of any adverse reactions and report these to the healthcare practitioner
- when using oils on the patient, advise the family to be cautious of the risk for toxicity or skin irritation
- enquire into allergies when using biologically based therapies
- advise the patient to consult safe and competent practitioners.

Conclusion

The Nursing and Midwifery Council (NMC) in the United Kingdom states that 'nurses must practise in a fair and an anti-discriminatory way, acknowledging the differences in beliefs and practices of individuals or groups' (NMC, 2002). The culture of the patient must be taken into consideration when planning nursing care. Alternative and complementary therapies that will be beneficial for the care of the patient should be assessed. It is not possible for nurses to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare, and these should be assessed as part of a routine nursing assessment.

Suggested activities for learners

Activity 2.1

A male patient is admitted in your unit and the family request to massage him with a body lotion of mixed medicinal herbs which they obtained from a traditional healer. They believe that the lotion will heal the patient of the condition he is suffering from.

They have been instructed to put the lotion all over the body and that the patient should not have a bath for 3 days in order for the medicine to work effectively. The family asks you to allow them to put the lotion on the patient and follow the instructions. Debate the following issues:

1. How would you proceed?
2. How does this enhance or inhibit the achievement of the specific outcomes outlined in this Chapter?

Activity 2.2

A patient in your unit is confused and refuses oxygen therapy, saying it is disturbing him as he would like to communicate with his ancestors. He is desaturating and becomes violent when you try to put the face mask on him. He then requests you to give him space to discuss the treatment (oxygen therapy) you want to give him with his great-grandmother, who is already dead. Debate how you would proceed in this situation.

Activity 2.3

A female patient admitted in your unit with chronic back pain has been scheduled for a spinal operation. Following a visit from relatives she requests to be discharged from the hospital because she is considering acupuncture, and the family has organised an intercessory prayer for her. Explain how you would proceed to deal with this patient.

Environmental hygiene also influences health, and many diseases, such as asthma and other upper respiratory problems, can be directly related to pollution and to less-than-ideal environmental conditions. The need to maintain optimal environmental hygiene can also be considered a human need.

Need for comfort and rest

The word 'comfort' refers to a sense of ease and well-being. Physical comfort means not only the absence of pain, but also includes:

- the position of the body
- the temperature of the environment
- the absence of hunger or thirst
- the absence of annoying distractions and stressful happenings.

Rest is closely tied to comfort and refers to a state of physical inactivity, repose and relaxation. Sleeping and waking, as well as factors that might induce restlessness, must be taken into account. Physical and emotional stress may interfere with an individual's ability to rest. Rest and sleep are essential for normal physical and psychological functioning in order to replenish energy and repair tissues.

Need for safety

The need for safety is multidimensional and includes the following:

- **Physical safety.** In this instance, the need for safety means the avoidance of physical injury and damage to the body. The individual's level of consciousness and awareness, as well as their level of physical fitness and agility, are relevant to this need.
- **Psychological safety.** This pertains to the feeling of being secure and of knowing what to expect from the people around you, as well as being able to cope with events. It means that individuals understand what is happening and trust that their best interests will be safeguarded.

Need for security

Security is based on physical safety, which means adequate food and shelter, as well as freedom from physical harm. Security is all-encompassing and it is a broader concept than physical safety. It relates to:

- a state of comfort within one's environment, and it means that individuals are assured of the means with which to support themselves in society. It implies that an individual is comfortable with their role and satisfied with their position in society.
- protection under the law and from violation of one's fundamental human rights. There is obedience to the law and respect for the worth of human dignity in the society and in healthcare facilities in particular.
- free access to health facilities and services.

Need for sensation and perception

Normal human functioning includes the ability to perceive the environment and respond appropriately to it. Sensation and perception require the ability to see, hear, feel, smell and taste, as well as cognitive abilities that enable an individual to interpret information and to respond appropriately.

Need for sexuality

In the physical context, sexual or reproductive needs refer to those actions or processes that are necessary for the reproduction of the species. These include copulation, conception, gestation and parturition. Sexuality needs are assessed throughout the lifespan, from infancy to older adulthood, as these needs relate to a stage in life. Sexuality is influenced by a variety of factors, such as age, sociocultural background, ethics, self-concept and physical fitness.

Sexuality is more than a physical need because of the psychological and cultural dimensions which must be taken into account when dealing with patients. The socio-cultural aspects of sexuality for females include:

- menstruation
- pregnancy
- abortion
- contraception.

Assessment regarding sexuality needs should take cognisance of the fact that sexual dysfunction (challenges regarding the desire or actual performance of sexual activity) may be as a result of illness, disability, drugs, stress, or other physiological changes like menopause. Nurses must also be aware of patients' need for information about sexual activity and ways in which sexual activity is altered according to the health status of the patient. Comprehensive history taking on the first visit to a health facility regarding sexuality should include:

- a history of sexually transmitted diseases (STD)
- sexual activity or practice
- sexual orientation
- sexual dysfunction.

Psychosocial needs

Psychosocial needs refer to a variety of cognitive, emotional and interpersonal factors that enable individuals to adapt to the environment, form relationships with others, and function successfully within a community.

Need for cognition

The word cognition comes from Latin *cognoscere*, to know. In order for an individual to function adequately in relation to the environment, other individuals and the community, effective thought processes must be developed. Effective thought processes include orientation to the environment and the people in the environment, as well as problem-solving skills and the ability to form concepts and organise thoughts in a logical manner. Memory and the ability to understand and learn are also necessary for adequate cognition.

Need for adaptation

In order to be able to deal with stress and life events effectively, individuals must develop a variety of conscious coping skills. Coping behaviours involve the use of problem-solving techniques and relaxation, as well as the avoidance of stressful situations. Healthy coping implies adaptability and the capacity to deal with change rationally and appropriately. Less healthy coping mechanisms include aggression, withdrawal and substance abuse.

Unconscious coping behaviours include defence mechanisms such as denial, projection, repression and regression. Coping skills are more difficult to assess in children, but children who are able to make their needs known and who are confident of having these needs met are coping effectively. Severe stress in a child may bring out primitive defence mechanisms such as temper tantrums, withdrawal and regression.

Need for self-esteem and self-concept

Self-esteem implies that one has confidence in one's abilities. Adequate self-esteem requires acceptance of the self and feeling good about the self. This includes acceptance of bodily appearance and characteristics. Good bonding in an infant is a prerequisite for the development of self-esteem. A child with good self-esteem will show confidence and be outgoing. Adequate role performance is related to self-esteem needs, as every individual has a need to fulfil their various life roles effectively.

Self-concept relates to how one feels or thinks about oneself. The components of self-concept include identification, body image, role performance and self-esteem. A healthy self-concept requires acceptance of one's personality traits, as well as a realistic perception and acknowledgement of one's faults.

Self-confidence is based on a healthy self-concept and self-esteem which are the basis of sound interpersonal relationships and mental health.

Need for autonomy

Autonomy implies independence, control and the competent management of the cognitive, perceptual and behavioural processes of an individual, within societal definitions of 'normality' or 'mental health', and conforming to accepted social norms.

Autonomy also includes the facility of choice, or the ability to make an informed decision between several alternatives, based on personal beliefs and preferences. The ability to exercise choice also implies the right to have those choices respected.

Need for relatedness

Humans are social beings and need the esteem and cooperation of their fellow human beings. We also have a need to form close associations with others, as the fullest expression of the personality is attained within reciprocal human relationships. Different types of relationships are characterised by different degrees of self-disclosure. Close, intimate relationships demonstrate mutual trust and support, as well as mutual esteem building. These relationships include the following:

- **The nurse–patient relationship.** This is a special type of relationship in that it is intimate and caring without being too close. The nurse knows and cares for their patients, but does not become emotionally involved with them. Nurse–patient relationships are also characterised by empathy and a 'disinterested' concern for the patient's best interests.
- **Family relationships.** Usually influenced by one's role in the family, eg father, mother, daughter, son, etc. The presence or lack of family support is also crucial for dealing with illness.
- **Significant other relationships.** Characterised by emotional ties with one another or other factors.

Need for stimulation

Curiosity is one of the most striking features of human nature. People have an innate need to explore, to develop their potential, to respond to challenges and to achieve. Stimulation is essential for the development of human potential. The environment, education and interaction with other people are all crucial for development. Stimulation also includes the need for leisure time activities, during which individuals express themselves in an informal and pleasurable way. Meaningful work, on the other hand, is an important source of stimulation as it enhances self-esteem.

Need for communication

Communication with others is a natural human activity that is essential for survival and for the formation of

meaningful relationships. Communication is the process of giving and receiving information, and of attaching meaning to information and making use of that meaning. It is a major factor in determining the relationships that people have with others and what happens to them in the world.

Table 3.1 Summary of bio-psychosocial needs

Physical needs	Psychosocial needs	Spiritual needs
Oxygen	Cognition	Meaning-fulness
Circulation	Adaptation	Religious expression
Fluids and electrolytes	Self-esteem and self-concept	
Nutrition	Autonomy	
Elimination	Relatedness	
Temperature regulation	Stimulation	
Skin integrity	Communication	
Mobility and exercise		
Hygiene		
Comfort and rest		
Safety		
Security		
Sensation and perception		
Sexuality		

Need for meaningfulness (existentialism)

Meaningfulness implies the need for meaning and purpose in an individual's life in order to cope with life's challenges, for example illness or even death. Finding meaning in life requires the development of a personal philosophy and ideology to facilitate the process of finding meaning.

Grieving is an essential part of finding meaning in pain, suffering and death. Both patient and family may need to grieve in order to accept and work through the diagnosis of illness or the death of a loved one.

Meaning in life is frequently connected to self-esteem and relatedness, as many people find meaning and self-expression in their relationships with others, and with a higher or divine power.

Spiritual needs

Human nature has a spiritual dimension, which encompasses the need to find meaning in life and a relationship with a higher or divine power. Human spirituality also means defining life values and belief systems, and relating to the self and to others within the framework of those life values and belief systems or philosophies.

Spiritual needs are dynamic as they change with time and circumstances, for example life events such as the illness or death of a loved one.

The terms spirituality and religion are often used synonymously, although the two are not necessarily the same. Spirituality is a broader concept than religion. However, most religious people are spiritual as well. The spiritual needs of the patient include the need for meaningfulness (existentialism) and the need for the expression of religion.

Holistic care in nursing includes giving spiritual care, which includes reason, reflection, religion, relationships and restoration. Assessments of patients on admission should include a comprehensive history taking regarding the patient's religious beliefs with regard to health and illness. This is to ensure that these beliefs and practices are taken into consideration when planning nursing care, as well as their impact on medical treatment and procedures.

Very often, nurses will only ask about religious affiliation and not delve into the specific health beliefs or practices that may impact on healthcare.

Meeting the spiritual needs of the patient

Principles of spiritual care

Some principles include:

- recognition and acceptance of the spiritual dimension of human beings (self-awareness)
- comprehensive assessment to determine the patient's spiritual and religious needs
- good communication; the need to listen in an authentic manner
- empathy and the ability to accept what the patient says
- sympathy to enhance a trusting relationship to allow the patient to feel safe
- use of judicious self-disclosure
- referral to professionals more qualified in spiritual care, eg a hospital chaplain or the religious leader of the patient.

Need for religious expression

For most human beings, spiritual needs are fulfilled within an organised system of belief and worship, whether formal or informal. The religious beliefs and practices of an individual form an important part of that individual's life, particularly in relation to beliefs and practices about birth, death, health and illness. Religious practices and rituals play an important part in enabling individuals to weather life's crises, including ill health.

Regarding praying with the patient, the nurse should make sure that this practice is not in conflict with the policies of the institution. French and Naraynasmy caution that ethical issues arise when praying with patients, and advise that informed consent should be obtained from the patient first. Poole and Cook maintain that praying with a patient may constitute breach of professional boundaries.

In a multicultural society such as South Africa, nurses need to be familiar with the major religious practices common among the population. All cultural and religious affiliations are recognised in the Constitution.

Religious beliefs and practices regarding health

There is growing evidence in literature that there is a connection between spirituality, religion and health. Research indicates that religion strengthens people's ability to cope with life-threatening disease. Some of the major religions' beliefs and practices, and the implications of these for health and nursing, are summarised in Table 3.2.

Integrative healthcare

This approach to health includes the use of complementary and alternative healthcare practices, and may sometimes include conventional medicine, albeit for a brief period. The central belief of this modality of healthcare is that the human body has the capacity to heal itself. As a result, healthcare is geared towards changes in lifestyle and involves the use of natural and manual healing therapies.

Complementary and alternative therapies include acupuncture, chiropractic practice, herbal medicine, homeopathy, osteopathy, aromatherapy and hypnotherapy. African traditional medicine is also regarded as a complementary and alternative therapy.

The traditional health practitioner

According to the World Health Organization, traditional practitioners are those who are recognised by their communities as being capable and competent to provide healthcare services, using methods which are cultural, traditional, spiritual, and religious.

Traditional medicine is widely used in many parts of Africa, including South Africa. There is a belief that conventional medicine may not provide all the answers regarding ill health. South Africa is a multicultural society and many cultural groups use traditional medicine alongside conventional Western medicine.

Muslim people and adherents of Hinduism often approach traditional healers. In South Africa, traditional health practitioners are recognised and regulated under the Traditional Health Practitioners Act 22 of 2007. Traditional health practitioners include diviners, traditional doctors, spiritual healers, traditional surgeons and traditional birth attendants.

Diviners. Diviners are traditional health practitioners who often diagnose ill health by means of casting a specific set of bones on the floor. This is their way of communicating with the ancestors to guide them through the patient-practitioner interface. The bones provide information and messages which are interpreted to facilitate a diagnosis, or an explanation to an individual's problem. The diviners are holistic practitioners who not only attend to physical problems but adopt a more psychosocial perspective. Prescription for treatment is by means of herbs and very often the performance of some rituals.

Traditional doctor, *Inyanga*, herbalist. Traditional doctors use medicinal herbs in the treatment of patients. They usually acquire the skills through an apprenticeship system, where they are taught by an expert. They provide preventive, promotive and curative healthcare.

Spiritual healers. They are often referred to as 'faith-based healers', because they use religion, especially Christianity, as the medium for the healing. Spiritual healers use verses from the Bible as the foundation for diagnosis and healing. They also use holy water, ash and colourful ropes to cast out evil spirits. Healing baths are often used to cleanse the body.

Traditional surgeons. A traditional surgeon is one who performs circumcision as part of a cultural initiation process. This practice is very common among Xhosa people in South Africa and the vhaVenda people in the Limpopo province. Other ethnic groups also participate in this traditional practice in the urban areas of Gauteng. These groups include the Ndebele, Basotho and Zulu people. Other ethnic groups mostly opt for the conventional hospital-based circumcision. (See also Chapter 2 on cultural diversity in healthcare.)

Table 3.2 Health related beliefs and practices of selected religions and implications for health and nursing

Religion	Health-related beliefs and practices	Implications for health and nursing and handling of the situation
African Religions, eg Z.C.C.	• Eating pork is prohibited • Alcoholic beverages are forbidden • Drink special tea or coffee supplied by the church outlets • Priest may anoint the patient with holy water	• Do not give the patient any food with pork, including processed meat • Allow time for the priest to visit, pray with the patient and to anoint with holy water • Patient may request early discharge in order to consult with the church elders for major decisions like consent for operation
Buddhism	• Accepts modern medical science	• May refuse medication in order to protect the body from the effects of chemicals
Hinduism	• Eating meat involves harming a living creature • Cremation is the most common form of body disposal	• Engage with the hospital dietician to provide a vegetarian diet
Islam	• Eating pork or pork-derivative medication is prohibited • No alcohol is allowed • Ritual cleansing before eating and prayer is practised • Fasting during daytime during the month of Ramadan • Uses faith healing, including group prayers • After the death of a patient, a family member may wish to wash the body and position the bed to face Mecca; the head should rest on a pillow • Burial usually takes place as soon as possible within 24 hours	• Cannot eat until the sun has set during the month of Ramadan • May refuse medication if it is porcine-derived • Some female patients prefer female healthcare professionals • Food should be Halaal only • Family to be consulted if a delay to the release of the body is anticipated (in cases where there is a need for a post-mortem) so that the family can make other arrangements
Judaism	• Believes in the sanctity of life • Observance of the day of Sabbath	• Visitation from the rabbi is part of support during illness • May refuse treatment on the Sabbath day • Life support is discouraged • Food should be kosher only • After post-mortem, all body parts to be returned for burial
Christians (Catholics and Protestants)	• Accepts modern medical science • Use prayer and faith healing • Visits from clergy may include holy communion (Sacrament of the Sick) • Patients may request 'non-meat' diets during Lent (the 40 days before and during the Easter period) • Patient may want to keep a religious object such as a rosary with a crucifix	• Allow time for prayer by family, friends and clergy • Are in favour of organ donation • Provide the requested diet unless contra-indicated • Allow patient to keep, but may have to remove when patient goes for X-rays or surgery
Jehovah's Witness	• Blood in any form is not accepted • Blood volume expanders are acceptable if they are not derived from blood	• Will not accept any blood transfusion, even in a life-threatening situation • The health condition of the patient may deteriorate with fatal consequences
Seventh-Day Adventist	• Fasting is practised • Vegetarian diet is encouraged	• Provide vegetarian diet • Meat diet should exclude pork

Traditional birth attendants. A traditional birth attendant is a health practitioner who assists a mother during childbirth and has acquired skills through delivering babies or through apprenticeship. Traditional birth attendants (TBAs) typically also provide care during pregnancy, childbirth, and the post-partum period. They render this service to women in their community and are often paid in kind. In developing countries, traditional birth attendants play a significant role in areas where midwives and doctors are scarce.

Lane and Garod (2016) add that TBAs act as cultural brokers between Western and traditional practices in childbearing and provide women with continuity of care from a known carer. TBAs in South Africa are recognised legally in the Traditional Health Practitioners Act 22 of 2007. They work in collaboration with the health system as per the guidelines of the World Health Organization.

Conclusion

In this Chapter, the bio-psychosocial needs presented correspond to Maslow's needs for survival and provides the foundations for nursing diagnosis and basic nursing. The Chapter forms the basis for the content of the Chapters to follow, where needs including those relating to safety; hygiene and grooming; nutrition; elimination; homeostasis; modality; exercise; and temperature regulation are dealt with. Other needs are covered in Chapters dealing with the respective relevant systems of the body.

Suggested activities for learners

Activity 3.1

A baby is admitted to your ward. On history taking you find that its parents are Jehovah's Witnesses. The medical diagnosis is such that the baby needs urgent corrective abdominal surgery. The parents, bound by their religion, will not give consent for surgery and possible blood transfusion.

In a discussion with colleagues, state how you are going to manage this problem, taking into consideration:

- the theorists' stipulations
- ethical and legal implications
- patients' rights
- the patient's and the family's spiritual needs
- the role of the nurse.

Activity 3.2

A devout Muslim patient dies in your care. A post-mortem has to be done, and this can only be done after a 24-hour period. Describe how you will manage this situation.

positive the reinforcement is, the more likely a behavior is to be learned and retained.

B. F. Skinner (1904–1990) believed that organisms learn as they respond to or "operate on" their environment. His research led to the concept of *operant conditioning*, the basic premise of which is that rewarded or reinforced behavior will be repeated, whereas behavior that is punished will be suppressed. Most of his work was with laboratory animals.

Social Learning Theories

Social learning theory is based on the principle that individuals learn by observing and thinking about the behavior of the self and others and can be seen as spanning both behaviorist and cognitive learning theories.

Bandura

In contrast to Skinner's operant conditioning, Albert Bandura, a foremost social learning theorist, believes that learning occurs through imitation and practice and requires more awareness, self-motivation, and self-regulation of the individual. In Bandura's social learning theory, the individual actively interacts with the environment to learn new skills and behaviors. Social learning theorists contend that this process may not always lead to change in the individual's behavior; in contrast, behaviorist theory says that learning will result in a permanent change in behavior.

Vygotsky (1896–1934)

Lev Vygotsky, referred to as a social constructivist, explored the concept of cognitive development within a social, historical, and cultural context, arguing that adults guide children to learn and that development depends on the use of language, play, and extensive social interaction. These ideas also support the benefit of adult social learning opportunities via group interaction and observation. Vygotsky supported social learning and reinforcement through work, group discussion, and other means of interaction.

Ecologic Systems Theory

Urie Bronfenbrenner (1917–2005) expounded the ecologic systems theory of development. He viewed the child as interacting with the environment at different levels, or systems. Bronfenbrenner believed each child brings a unique set of genes—and specific attributes such as age, gender, health, and other characteristics—to his or her interactions with the environment.

The ecologic systems theory has five levels or systems. The microsystem includes close relationships the child has on a daily basis (e.g., home, school, friends). The mesosystem level includes relationships of microsystems with one another (e.g., the relationship between family and school). The exosystem includes those settings that may influence the child but with which the child does not have daily contact (e.g., parent's job, local school board). The macrosystem level includes the actions, attitudes, and beliefs of the child's culture and society. Finally, the chronosystem involves the time period in which the child is growing up and its influence on views of health and illness.

Theories of Moral Development

Moral development, a complex process that is not fully understood, involves learning what ought to be and what ought not to be done. It is more than imprinting parents' rules and virtues or values on children. The term **moral** means "relating to right and wrong." The terms *morality*, *moral behavior*, and *moral development* need to be distinguished from each other. **Morality** refers to the requirements necessary for individuals to live together in society; **moral behavior** is the way an individual perceives those requirements and responds to them; **moral development** is the pattern of change in moral behavior with age (see Chapter 4 ∞).

Kohlberg (1927–1987)

Lawrence Kohlberg's (1984) theory specifically addresses moral development in children and adults. The morality of an individual's decision was not Kohlberg's concern; rather, he focused on the reasons an individual makes a decision. According to Kohlberg, moral development progresses through three levels and six stages. Levels and stages are not always linked to a certain developmental stage or age because some individuals progress to a higher level of moral development than others.

At Kohlberg's first level, called the *premoral* or *preconventional level*, children are responsive to cultural rules and labels of good and bad, right and wrong. However, children interpret these in terms of the physical consequences of their actions, that is, punishment or reward. At the second level, the *conventional level*, the individual is concerned about maintaining the expectations of the family, group, or nation and sees this as right. The emphasis at this level is conformity and loyalty to one's own expectations as well as society's. Level three is called the *postconventional, autonomous,* or *principled level*. At this level, individuals make an effort to define valid values and principles without regard to outside authority or to the expectations of others (Table 23.5).

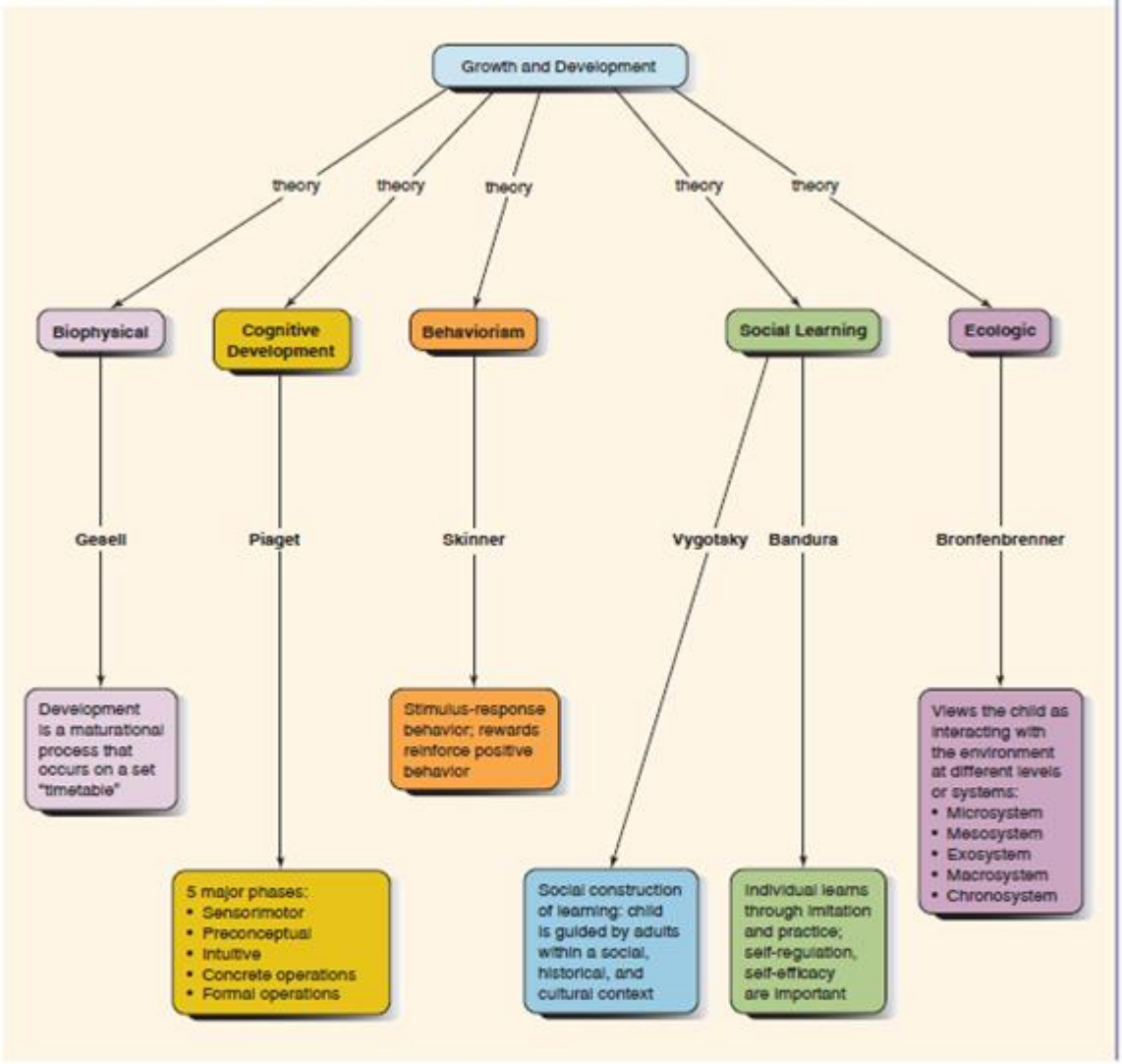
Gilligan (1936–Present)

After more than 10 years of research with female participants, Carol Gilligan reported that women often consider the dilemmas Kohlberg used in his research to be irrelevant. Women scored consistently lower on Kohlberg's scale of moral development despite the fact that they approached moral dilemmas with considerable sophistication. Gilligan believes that most frameworks for research in moral development do not include the concepts of caring and responsibility.

Gilligan (1982) contends that moral development proceeds through three levels and two transitions, with each level representing a more complex understanding of the relationship of self and others and each transition

CONCEPT MAP

Overview of Growth and Development Theories and Theorists



resulting in a crucial reevaluation of the conflict between selfishness and responsibility:

- ***Stage 1: caring for oneself.*** In this first stage of development, individuals are concerned only with caring for the self. They feel isolated, alone, and unconnected to others. There is no concern or conflict with the needs of others because the self is the most important. The focus of this stage is survival. The transition of this stage occurs when individuals begin to view this approach as selfish and move toward responsibility. Individuals begin to realize a need for relationships and connections with other people.
- ***Stage 2: caring for others.*** During this stage, individuals recognize the selfishness of earlier behavior and begin to understand the need for caring relationships with others. Caring relationships bring with them responsibility. The definition of responsibility includes self-sacrifice, where "good" is considered to be "caring for others." Individuals now approach relationships with a focus of not hurting others. This approach causes

TABLE 23.5 Kohlberg's Stages of Moral Development

Level	Stage
I. Preconventional **Egocentric Point of View** Individuals begin to understand the rules of right and wrong.	**1. Punishment and Obedience** Actions are judged in terms of physical consequences.
	2. Individual Instrumental Purpose and Exchange Individuals engage in actions that are right to meet their needs. Individuals separate their own interests from the interest of authorities.
II. Conventional Individuals are concerned about others and their feelings.	**3. Mutual Interpersonal Expectations, Relationships, and Conformity** Individuals are in relationships with others. Individuals pay attention to the feelings of others. Individuals put themselves in the other person's shoes.
Social Perspective Individuals are doing their duty to society.	**4. Social System and Conscience Maintenance** Individuals fulfill the duties assigned by authority figures, thus fulfilling obligations set forth by society's laws.
III. Postconventional Individuals uphold the basic rights, values, and legal contracts of the society.	**5. Prior Rights and Social Contract** Individuals have an obligation to obey the law. There is a commitment to family and work obligations. Individuals have a responsibility to consider the moral and legal point of view in ascertaining what will provide the greatest good for the greatest number.
Universal Focus	**6. Universal Ethical Principle** Individuals follow what is right in accordance with ethical principles.

Adapted from *Essays on Moral Development, Vol 1: The Philosophy of Moral Development*, 1981, by L. Kohlberg, San Francisco, CA: Harper & Row.

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

How Does Socioeconomic Status Affect an Infant's Birth Outcomes?

Campbell and Seabrook (2016) reviewed health-related research to ascertain the effects of low socioeconomic status on adverse birth outcomes. The authors found that the most identified indicator of socioeconomic status was education. The lack of education resulted in adverse infant health outcomes. The infants of college educated women weighed 128 g more than those of women with a high school education. Low socioeconomic background also contributed to poor infant health outcomes. The overview of research collected concluded that decreased education, lower-socioeconomic neighborhood, and jobs requiring heavy lifting yielded adverse birth outcomes.

Implications

Public health and maternal child nurses must pay attention to the socioeconomic status of families under their care. The nurse must provide thorough client education, paying attention to primary prevention.

individuals to be more responsive and submissive to others' needs, excluding any thoughts of meeting their own needs. A transition from goodness to truth occurs when individuals recognize that this approach can cause difficulties with relationships because of the lack of balance between caring for the self and caring for others. Individuals make decisions based on personal intentions and the consequences of actions rather than on how they think others will react.

- ***Stage 3: caring for self and others.*** During this last stage, individuals see the need for a balance between caring for others and caring for the self. The concept of responsibility now includes responsibility for the self and for other people. Care remains the focus on which decisions are made. However, individuals recognize the interconnections between the self and others and realize that if their own needs are not met, other people may also suffer.

Gilligan (1982) believes that because women often see morality in the integrity of relationships and caring, the moral problems they encounter are different from those of men. Men tend to consider what is right to be what is just, whereas for women, taking responsibility for others as a self-chosen decision is what is right (p. 140). The ethic of justice, or fairness, is based on the idea of equality: Everyone should receive the same treatment. This is the development path usually followed by men and widely accepted by moral theorists. By contrast, the ethic of care is based on the premise of nonviolence: No one should be harmed. This is the path typically followed by women but given little attention in the literature of moral theory.

In the development of maturity, according to Gilligan (1982), both viewpoints blend "in the realization that just as inequality adversely affects both perspectives in an unequal relationship, so too violence is destructive

for everyone involved" (p. 174). The blending of these two perspectives can give rise to a new view of human development and a better understanding of human relations.

Theories of Spiritual Development

The spiritual component of growth and development refers to individuals' understanding of their relationship with the universe and their perceptions about the direction and meaning of life. Spirituality and faith are distinctly different from religious beliefs, but religion may allow for their expression.

Fowler

James Fowler describes the development of faith as a force that gives meaning to an individual's life. He uses the term *faith* as a form of knowing, a way of being in relation to "an ultimate environment." To Fowler, "faith is a relational phenomenon; it is an active 'mode-of-being-in-relation' to another or others in which we invest commitment, belief, love, risk and hope" (Fowler & Keen, 1985, p. 18).

Fowler's theory and developmental stages were influenced by the work of Piaget, Kohlberg, and Erikson. Fowler believes that the development of faith is an interactive process between the individual and the environment (Fowler, Streib, & Keller, 2004). In each of Fowler's stages, new patterns of thought, values, and beliefs are added to those already held by the individual; therefore, the stages must follow in sequence. Faith stages, according to Fowler, are separate from the cognitive stages of Piaget: They evolve from a combination of knowledge and values. Stage 0 occurs from the age of 0 to 3. There is a formulation of concepts about self and the environment. The intuitive project stage occurs from the ages of 4 to 6. Children in this stage have a combination of images and beliefs. Children are introduced to images and beliefs from trusted individuals. They also utilize their own imagination and experiences in their spiritual development. The mythic-literal stage ranges from age 7 to 12 and encompasses symbols, stories, and myths that possess spiritual meaning. The synthetic-conventional stage begins with adolescence. The environment is structured by the expectations and judgment of others. After the age of 18, adults build their own spiritual systems. This is known as the individuating-reflexive stage. The paradoxical-consolidative phase occurs after 30 years of age with the awareness of truth from many different viewpoints. The last phase is universalizing. Individuals may not ever reach this stage In this stage, individuals express the principles of love and justice in their lives (Fowler & Keen, 1985).

Westerhoff

Westerhoff (2012) describes faith as a way of being and behaving that evolves from an experienced faith guided by parents and others during an individual's infancy and childhood to an owned faith that is internalized in adulthood and serves as a directive for personal action. The first stage is experienced faith. Infants through early adolescents interact with others in learning faith traditions. Affiliative faith occurs in late adolescence. At this stage, there is active participation in faith-based traditions. Teens feel a sense of belonging to their faith. In young adulthood, individuals begin the stage of searching faith. Young adults may doubt or question their faith. The stage of owned faith occurs in middle adulthood to old age. In this stage, faith becomes very personal, and individuals stand up for what they believe. For the client who is ill, faith—whether in a higher authority (e.g., God, Allah, Jehovah), in the client's own self, in the healthcare team, or in a combination of all—provides strength and trust.

Applying Growth and Development Concepts to Nursing Practice

Different theories explain one or more aspects of an individual's growth and development. Typically, theorists examine only one area of an individual's development, such as the cognitive, moral, or physical aspects. The area chosen for examination usually reflects the researcher's academic discipline and personal interest. Theorists may also limit the population that is studied to a particular part of the lifespan, such as infancy, childhood, or adulthood.

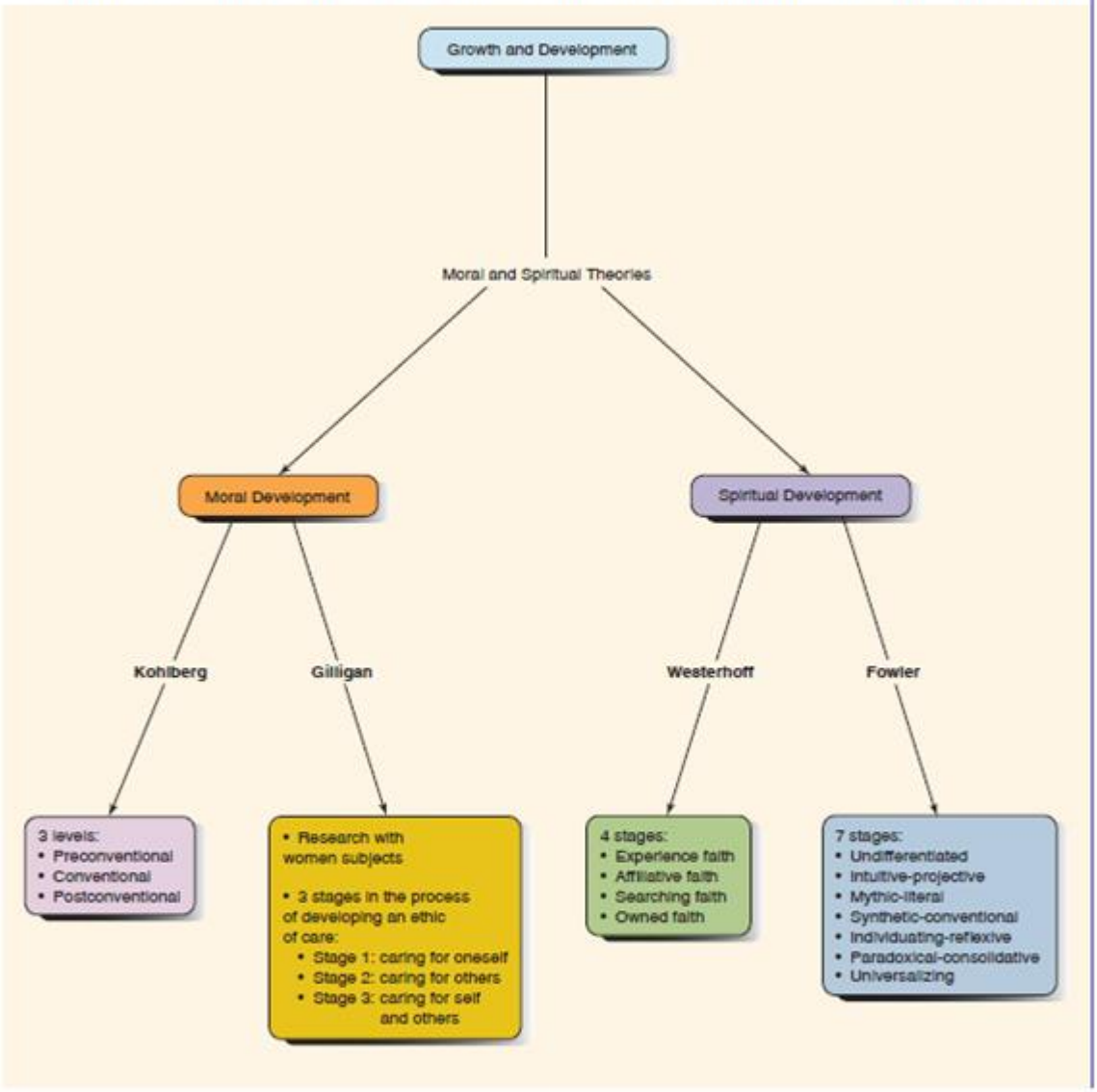
Although such theories can be useful, they have limitations. First, the theory chosen may explain only one aspect of the growth and development process. Yet an individual does not develop in fragmented sections but rather as a whole human being. Thus, the nurse may find it necessary to apply several theories for an adequate understanding of the growth and development of a client.

Another limitation of some theories is the suggestion that certain tasks are performed at a specific age. In most cases, the child or adult does accomplish the task at the time specified by the guidelines. In other cases, however, nurses may find that an individual does not accomplish the task or meet the milestone at the exact time suggested by the theory. Such individual differences are not easily defined or categorized by a single theory. Human development is a complex synthesis of biophysical, cognitive, psychologic, moral, and spiritual development. Nurses should expect individual variations and take these into consideration when applying theories about growth and development. In so doing, they will be better able to understand a client's development and plan effective nursing interventions.

In nursing, developmental theories can be useful in guiding assessment, explaining behavior, and providing a direction for nursing interventions. An understanding of a child's intellectual ability helps a nurse to anticipate and explain certain reactions, responses, and needs. Nurses can then encourage client behavior that is appropriate for that particular developmental stage.

CONCEPT MAP

Overview of Growth and Development Moral and Spiritual Theories and Theorists



Theories are also useful in planning a nursing intervention. For instance, choosing the appropriate toy for a 3-year-old child requires some knowledge of the physical and cognitive development of the child, as well as a sensitivity for individual preferences.

In adult care, knowledge about the physical, cognitive, and psychologic aspects of the aging process is a fundamental aspect of administering sensitive nursing care. For example, nurses can use their familiarity with the theories of development to help clients understand and anticipate the psychosocial changes that take place after retirement or the physical limitations that come with aging.

Spirituality 41

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe the interconnection of spirituality and religion concepts as they relate to health and spiritually sensitive nursing care.
2. Compare and contrast spiritual needs, spiritual disruption, and spiritual health.
3. Appreciate spiritual development by describing spiritual developmental issues of childhood and aging in particular.
4. Describe methods to assess the spiritual and religious preferences, strengths, concerns, or distress of clients and plan appropriate nursing care.
5. Describe nursing care and therapeutics to support religiosity and promote clients' spiritual health.
6. Recognize the importance of providing ethical spiritual care.
7. Describe the influence of spiritual and religious beliefs and practices that can have an impact on a client's healthcare: holy days, sacred texts, prayer and meditation, diet, healing, dress, birth, and death.
8. Describe strategies that can increase a nurse's own spiritual awareness.

KEY TERMS

agnostic, *1048*
atheist, *1048*
holy days, *1056*
meditation, *1059*
prayer, *1058*
presencing, *1053*
religion, *1046*
spiritual care, *1048*
spiritual disruption, *1048*
spiritual health, *1049*
spirituality, *1047*
spiritual or religious coping, *1049*
spiritual wellness or well-being, *1049*

Introduction

To provide holistic care, nurses need to care for the physical body and mind, and also need to care in ways that are sensitive to the client's spirit (O'Brien, 2018). Given the mounting research evidence linking spiritual health with physical and mental health (Jim et al., 2015; Koenig, 2015; Lucette, Ironson, Pargament, & Krause, 2016; Salsman et al., 2015), it is assumed that nursing care that supports clients' spiritual health will help promote other dimensions of health. Furthermore, clients often approach their health challenges, decisions, suffering, and so forth, with a worldview that reflects what are typically considered spiritual or religious beliefs (Dobratz, 2016; Mollica, Underwood, Homish, Homish, & Orom, 2016). Failure to appreciate these influential beliefs is to fail to understand what motivates, informs, comforts, and helps a client to cope. Indeed, spiritual beliefs and practices are frequently found to relieve one's suffering; unfortunately, sometimes discomforting spiritual beliefs can likewise intensify suffering (Abu-Raiya, Pargament, & Krause, 2016). Whether beliefs are comforting or discomforting, they are present at the bedside, and they require recognition and sometimes support or scrutiny.

Recognizing a client's spirituality is like standing on holy ground (O'Brien, 2018). The nurse cannot approach care for the spirit as if it were a pressure injury or even as if it were an emotional problem. Spiritual matters are not intangibles that can be fixed, cured, solved, or manipulated. Rather, the nurse's stance toward spiritually sensitive care must be one that seeks to accompany, support, and nurture. This chapter explores how the nurse can attend to the client who presents with a need to relieve spiritual disruption or to enhance spiritual health. Nurses can offer spiritually sensitive nursing care that supports spiritual health, helps with coping and adjustment, or assists a client to face a more peaceful death.

Spirituality and Related Concepts Described

Spirituality and *religion* are words that are often used interchangeably by clients and professionals alike, yet the nursing literature typically distinguishes them as separate concepts. That is, **spirituality** is generally thought to refer to the human tendency to seek meaning and purpose in life, inner peace and acceptance, forgiveness and harmony, hope, beauty, and so forth. An international study about how individuals in China, India, and the United States perceived spirituality concluded that it is a universal phenomenon (McClintock, Lau, & Miller, 2016). These researchers noted that across these diverse cultures, spirituality involved the following attributes:

> love, in the fabric of relationships and as a sacred reality; unifying interconnectedness, as a sense of energetic oneness with other beings in the universe; altruism, as a commitment beyond the self with care and service; contemplative practice, such as meditation, prayer, yoga, or qigong; and religious and spiritual reflection and commitment, as a life well-examined. (p. 1600)

Another aspect of spirituality often recognized is the awareness of something transcendent—a higher power, creative force, divine being, or infinite source of energy (Weathers, McCarthy, & Coffey, 2016). For example, an individual may believe in God, Allah, the Great Spirit, or a Higher Power.

In contrast, the term **religion** is usually applied to ritualistic practices and organized beliefs. Indeed, there has been a tendency in nursing—as in psychology and other fields—to separate these two concepts. Yet trying to make religion an opposite of spirituality (e.g., institutional versus personal, objective versus subjective, narrow versus broad, cerebral versus emotional, bad versus good) is unfair to both concepts. Spirituality and religion are "inherently intertwined" (Taylor, 2012).

According to a 2012 national survey of Americans, about two-thirds view themselves as moderately to very spiritual; nearly 60% self-report that they are moderately to very religious (Hodge, 2015). Furthermore, roughly half of those who are very spiritual also see themselves as very religious. Just because individuals are spiritual does not mean that they view themselves as religious—and vice versa. Indeed, 23% of Americans are "nones"—individuals who are not affiliated with a religion (Pew Research Center, n.d.). Laird, Curtis, and Morgan (2017) observed that American healthcare professionals often think of spirituality and religion in normative ways; that is, we often think of these concepts through Western and Christian (especially Protestant) lenses. They urge awareness of and openness toward diverse spiritualties and religions.

It is important to remember that some individuals do not accept that there is an Ultimate Other or a spiritual reality. An **agnostic** is an individual who doubts the existence of God or believes the existence of God has not been proved. An **atheist** is one without belief in a deity. Atheists report that they often feel discriminated against (Brewster, Hammer, Sawyer, Eklund, & Palamar, 2016) or perceived as angry (Meier, Fetterman, Robinson, & Lappas, 2015) by those in our culture who experience and value spirituality or religion. For example, atheists perceive that others view them as immoral, not good, and needing to give up their beliefs to avoid suffering in an afterlife (Meier et al., 2015). Atheists, unsurprisingly, want to be respected for their "nonbelief" and not have nurses impose their spiritual or religious perspectives.

Spiritual Care or Spiritual Nursing Care?

Pesut and Sawatzky (2006) put forward that **spiritual care** should not be prescriptive (i.e., the following of a set guideline for intervening to resolve a client's spiritual problem). Instead it should be descriptive of ways nurses can offer spiritual support. Therefore, they suggest that:

> Spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the client's reality. At its foundational level, spiritual nursing care is an expression of self . . . . Spiritual nursing care begins from a perspective of being with the client in love and dialogue but may emerge into therapeutically oriented interventions that take direction from the client's religious or spiritual reality. (p. 23)

Although nursing terminology usually uses *spiritual care*, a few nurses use less prescriptive, and probably more appropriate, language such as *spiritually sensitive nursing care* or *spiritual nursing care*. Regardless of terminology, promising findings from recent studies indicate that such care does affect positive client outcomes such as satisfaction with care. Using data obtained from Asian Americans ($n = 805$) recently discharged from a hospital, one study found that this relationship between spiritual needs being met and client satisfaction was best explained by whether nurses provided spiritual care (Hodge, Sun, & Wolosin, 2014).

Spiritual Needs, Spiritual Disruption, Spiritual Health, and Religious Coping

If one assumes that everybody has a spiritual dimension, then it may also be assumed that all clients have spiritual needs that reflect their spirituality. Such needs are not problems to be processed, but perhaps better understood as inner movements, yearnings, or experiences. An awareness of such needs is often heightened by an illness or other health crisis. Clients may find that their beliefs are challenged by their health situation, or may cling to their beliefs more firmly and appreciatively. Or, a client may have a need to express joy or gratitude, or continue through the inwardly rewarding (yet often painful) process of spiritual transformation. Nurses need to be sensitive to indications of the client's spiritual needs and respond appropriately, as discussed later. Examples of spiritual needs are listed in Box 41.1.

Spiritual disruption or religious struggle or pain refers to the inner chaos that can occur when an individual's assumptions and beliefs are threatened or shattered. A question designed to screen for spiritual pain referred to it as "pain deep in your soul or being that is not physical" (Delgado-Guay et al., 2016). Exline, Pargament, Grubbs, and Yali (2014) identified the following as types of spiritual or religious struggle: negative emotions related to God, concerns about demonic forces, interpersonal conflicts with religious individuals or organizations, struggles to live according to moral values, doubts about religious beliefs, guilt, and worry about not finding meaningfulness in life.

BOX 41.1 Spiritual Needs

Spiritual Needs	Illustrations
Need for satisfying meaning to ascribe to illness, to life, to dying, to any loss or serious challenge	"Why would this happen to me? Having cancer is a celestial crapshoot!" "This is so unfair." "Why do bad things happen?"
Need for purpose, vocation, mission	"Now that I can't work anymore, what good is it for me to keep on living?" "What's there for me to do now with my old body?"
Need for believable beliefs, sensible worldview	"I've been told God is in control and is loving, but that doesn't make sense to me anymore."
Guilt, need to restore relationship	"I wonder if I'm being punished for something I did when I was younger." "I know I have to meet my Maker soon, so I'd better get things right with Him."
Shame, imperfection, unworthiness	"I never was good enough for . . . , but now look how sick/disabled/scarred I am!" "I am going to do whatever my family wants me to do." "I'm just using up society's resources. I'm such a burden to my family."
Need to worship, transcend self	"I am so tired/sick/befuddled/anxious, I'm beside myself . . . . I wish I could feel God was involved in this situation." "I never get to go to church because I'm always taking care of my husband."
Need for peace, composure	"I don't feel comfortable being alone or in silence." "I just wish I could make it all turn out the way I want it to."
Need to be grateful	"I know I should count my blessings; things could be worse."
Need to express love	"I keep my problems to myself, because I don't want to trouble my family any more than necessary." "You nurses do so much for me; I wish I could do nice things for you."
Isolation, abandonment, betrayal	"Why don't they come to visit anymore?" "It just seems like all my prayers bounce back to me without being heard."

When caring for clients, the following may be indicators or examples of signs and symptoms of spiritual disruption. The client may:

- Manifest a lack of enthusiasm for life, hopelessness, meaninglessness, sense of emptiness, or inadequate acceptance of self.
- Express feeling abandoned or anger toward a power greater than self or toward a spiritual community.
- Question the credibility of spiritual or religious beliefs; question the meaning of life, death, or suffering.
- Exhibit sudden changes in spiritual practices.
- Request (or refuse) to interact with a spiritual leader.
- Have no interest in religious or spiritually nurturing resources or experiences (Carpenito, 2017, p. 589).

No list could be complete, however, considering the complexity and variability of individuals and their spiritual dimensions.

Spiritual health, or **spiritual wellness or well-being**, is often portrayed as the opposite of spiritual disruption. Spiritual health is thought to not occur by chance, but by choice. That is, spiritual health results when individuals *intentionally* seek to strengthen their spiritual muscles, as it were, through various spiritual disciplines (e.g., prayer, meditation, service, fellowship with similar believers, learning from a spiritual mentor, worship, study, fasting).

Spiritual or religious coping, both positive and negative, has received considerable research attention during the past couple of decades. It refers to the spiritual beliefs or ways of thinking that help individuals cope with their challenges. Numerous studies have shown that positive religious coping helps clients adapt to illness, whereas negative religious coping is associated with maladaptation for both adolescents and adults (King et al., 2017; Reynolds, Mrug, Wolfe, Schwebel, & Wallander, 2016). For example, negative religious coping (e.g., thinking that illness is a punishment and feeling abandoned by God) were associated with depression and poorer quality of life among survivors of stem cell transplants (King et al., 2017).

Spiritual Development

Theories about human development include not just theories about physical, cognitive, and moral development, but also theories about spiritual development (Fowler, 1981). Spiritual development results from complex interactions between "nature and nurture" (Granqvist & Nkara, 2017). Thus, when assessing or supporting client spirituality, it is necessary to appreciate how spirituality and religiosity evolve with age and life experience (see Lifespan Considerations). A normal part of this development for teens

LIFESPAN CONSIDERATIONS **Spiritual Development**

CHILDREN

As with adults, children describe their spiritual health and challenges through the stories they tell and behaviors. And as with adults, they can learn spiritual principles from stories caregivers tell. Although they may not have fully developed cognitively, they can still ask questions about suffering and God and if there is an afterlife (Ferrell, Wittenberg, Battista, & Walker, 2016).

- As you respond, consider the child's cognitive and faith development stages to determine age-appropriate language. Does the child think concretely and literally about spiritual concepts like God and heaven? Or does the child think mythically and abstractly? Follow the child's cues about how to talk.
- Children's spirituality reflects or interacts with that of their authority figure(s) (e.g., parents). The spiritual beliefs and practices of the authority figure(s) will be trusted and adopted by the child. Thus, many of the cues for how to talk with a child will come from that child's parent or guardian. Generally, it is not until the teenage years and young adulthood, when children can reason abstractly, that they begin to independently construct their own spiritual beliefs and practices.

ADOLESCENTS

Teens and young adults, although likely critiquing the religion of their parents and less likely to be openly religious, often will use private religious and spiritual coping strategies (Taylor, Petersen, Oyedele, & Haase, 2015). Indeed, adolescence is a time of "forming a unique identity, gaining the ability to think critically, and differentiating self from families . . . . It is also a time of risk-taking, susceptibility to peer pressure, sensation seeking, impulsivity, and poor future orientation" (Taylor et al., 2015, p. 230). Given these developmental issues, it is important to sensitively attend to adolescents' spiritual well-being. For example, one study documented that the psychologic well-being of adolescents surviving cancer was positively correlated with their level of spiritual well-being, whereas spiritual struggle was negatively correlated with psychologic adjustment (Park & Cho, 2016). Nursing care that is sensitive to adolescent spirituality can include:

- Facilitating spiritual expression via the arts (and using art forms that are age appropriate, such as creating video montages).
- Introducing spiritually supportive resources on the internet.

MIDDLE-AGED AND OLDER ADULTS

By the time they reach middle age, most adults realize that materialism and social achievements do not meet the requirements of the soul; therefore, their focus shifts from self-centeredness towards generativity—care and concern for younger generations (Atchley, 2020).

Many older adults highly value religious coping strategies such as prayer. Evidence shows spiritual well-being to be directly correlated with mental health and less medical illness among older adults (George, Kinghorn, Koenig, Gammon, & Blazer, 2013). It is, therefore, important to address the spiritual issues of older adults. Older clients may be especially concerned about living a purposeful life, maintaining loving relationships to avoid social isolation, and preparing for a good death. Nursing care that attends to such spiritual issues includes the following:

- Supporting meaning-making activities (e.g., conducting a life review or reminiscence therapy, allowing the client to weave together the strands of lived life; encouraging the client to become dedicated to some social, political, religious, or artistic cause; supporting the client to leave a legacy or do an altruistic deed). Such activities provide older adults with a sense of purpose and assist them in making sense of the life they have lived.
- Allowing open discussions about suffering and dying, encouraging client disclosure by asking open-ended questions, and providing responses that are respectful and compassionate. Do not avoid discomforting topics and questions older clients raise by imposing positivity, giving "pat" answers, and otherwise minimizing or avoiding their spiritual pain.
- As appropriate, supporting older clients to reframe the "losses" of aging as "liberations," and confinement (e.g., to a bed or room) as monasticism. Indeed, older adults possess great wisdom and are in a season of life that promotes spiritual growth.

Older adults with dementia present special circumstances for spiritual caregiving. Nurses can help those with early stages of dementia to focus on the positives—the "haves" rather than the losses. Allowing older clients with dementia to tell their stories permits them to maintain some identity (amidst a disease that threatens the very sense of self) and allows the nurse a window into their world. Older clients with dementia can also worship and express their hope and creativity through various art forms (e.g., movement, painting, music). It is also possible for them to experience the compassion of others when they feel their caring touch or hear their soothing voice.

and young adults involves evaluating the beliefs and religiosity of authority figures to form beliefs and practices that are meaningful for them. It is not unusual, however, to find adults who have failed to complete this developmental task. Thus, when serious health challenges occur, the beliefs of childhood that have "not kept up with the times" may fail to be satisfactory for explaining such loss or change.

Spiritual Health and the Nursing Process

The nursing process, which includes assessing, diagnosing, planning, implementing, and evaluating, has often been applied to spiritual care. Although this can be a helpful approach, it is now thought to misguide spiritually sensitive nursing care (Pesut & Sawatzky, 2006). For this introductory discussion of spiritual care, content will be presented following this systematic nursing process. Recognize, however, that spiritual care is *not* about measuring the degree of spiritual health planning to fix spiritual pain, prescribing spiritual intervention, spiritual problem-solving, or manipulating, controlling, or managing spiritual outcomes or health.

●○● NURSING MANAGEMENT

Although nurses can play a pivotal role in supporting clients' spirituality, it is important to remember that the nurse is a spiritual care generalist. Spiritual care experts include chaplains, clergy, and other spiritual mentors with whom clients may identify. Likewise, although many clients view nurses as sources of spiritual support, clients often view

their family and friends or community-based clergy as their primary spiritual caregivers (Daaleman, 2012).

Although there is scanty evidence directly measuring the outcomes of nurse- or even chaplain-provided spiritual care, some research findings suggest that spiritual care in a healthcare institution, especially when provided by the multidisciplinary team, is associated with positive outcomes such as improved client quality of life, decreased hospital cost, and increased use of hospice for clients with advanced cancer (Balboni et al., 2011). There is evidence that clients in a hospital or in a nursing home who have received spiritual care tend to believe they have also received overall good care at that institution (Astrow, Wexler, Texeira, He, & Sulmasy, 2007; Daaleman, 2012; Williams, Meltzer, Arora, Chung, & Curlin, 2011).

Assessing

To provide spiritually sensitive care, the nurse must first assess whether such care is needed or welcome. Data about a client's spiritual beliefs and practices can be obtained through a nursing history as well as from ongoing clinical observations of the client's behavior, verbalizations, mood, and so on. A two-tiered approach to spiritual assessment is helpful, and should include a screening and history.

Screening for Spiritual Disruption

Initially, nurses should screen clients to determine: (a) if spiritual disruption is present and (b) what spiritual support is wanted. Ideally, this screening should occur for any client entering a healthcare system for any significant health challenge. An algorithm for screening developed and tested in a Chicago hospital recommends the following process (King, Fitchett, & Berry, 2013):

- First, inquire, "Is spirituality or religion important to you as you cope with illness?"
- If the client responds with a yes, then ask, "How much strength or comfort do you get from your religion or spirituality right now?" Depending on the client's response, ask if a chaplain or other expert is wanted for discussing spiritual concerns.
- If the client responded to the initial question with a no, then ask, "Has there ever been a time when spirituality or religion was important to you?" Depending on the client's response, ask if a chaplain or other expert can discuss this with the client. (If there never was a time when spirituality was important and the client does not wish to discuss the matter further, then respect that wish.)

Other questions with the potential to screen for spiritual disruption include "How deeply at peace do you feel?" (Park & Sacco, 2016), and "How much pain that is deep in your soul or being and not physical do you have?" (Delgado-Guay et al., 2016). Depending on client responses, nurses can obtain from the client permission for making a referral to a chaplain or other spiritual care expert. See the accompanying Assessment Interview for examples of questions to ask.

Spiritual History

The nurse who has primary responsibility for coordinating a client's care ought also to conduct a spiritual history to gain a basic understanding of the spiritual or religious beliefs and practices pertinent to the client's health and healthcare. Several mnemonics are available to guide such a history. A common one is Puchalski's FICA model:

F = Faith or beliefs—for example, "What spiritual beliefs are most important to you?"
I = Implications or influence—for example, "How is your faith affecting the way you cope now?"
C = Community—for example, "Is there a group of like-minded believers with which you regularly meet?"
A = Address—for example, "How would you like your healthcare team to support you spiritually?" (Williams, Voss, Vahle. & Capp, 2016).

Additional spiritual history prompts are provided in the accompanying Assessment Interview.

Two cautions are important to remember when conducting spiritual assessment. First, a nurse-conducted spiritual assessment should limit itself to client spirituality as it relates to health (Taylor, 2015). That is, it is not the privilege of clinicians to investigate a client's spirituality unless it has a purpose related to providing healthcare. Second, a nurse should never assume that a client follows all the practices of the client's stated religion. Similarly, it is important to remember that the degree of religious

ASSESSMENT INTERVIEW Spirituality

ESSENTIAL CONTENT

- Is spirituality or religion important to you? (Or, how spiritual or religious do you think of yourself as being?)
- What spiritual or religious beliefs and practices are especially important for your healthcare team to know about?
- In what ways can I or we (nurses, healthcare team) support your spirit?

OPTIONAL FOLLOW-UP (USE AS APPROPRIATE)

- How will being sick interfere with your religious practices?
- What spiritual or religious beliefs influence you the most as you make healthcare decisions?
- How is your faith helpful to you? Is it sustaining you the way you would like it to while you are sick? In what ways is it important to you right now?
- Would you like a visit from your spiritual counselor or the hospital chaplain?
- What are your hopes and your sources of strength right now? What comforts you during hard times?

commitment and orthodoxy (i.e., how strictly one incorporates traditional religious prescriptions into daily life) is highly variable within religious traditions. How one Baptist, for example, interprets and lives his religion will be different from his Baptist neighbor. Thus, an assessment that is limited to learning with what religion the client identifies is a very limited assessment.

Although the nurse will continually be assessing, the initial spiritual assessment may best be taken at the end of the intake assessment, or following the psychosocial assessment, after the nurse has developed a relationship with the client or support person. A nurse who has demonstrated sensitivity and personal warmth, creating some rapport, will likely be more successful during a spiritual assessment.

Cues to spiritual and religious preferences, strengths, concerns, or distress may be revealed by one or more of the following:

1. ***Environment.*** Does the client have a Bible, Torah, Koran, other prayer book, devotional literature, religious medals, a rosary, a cross, a Star of David, or religious get-well cards in the room? Does a church send altar flowers or Sunday bulletins?
2. ***Behavior.*** Does the client appear to pray before meals or at other times or read religious literature? Does the client express anger at religious representatives or at a deity?
3. ***Verbalization.*** Does the client mention God or a higher power, prayer, faith, the church, synagogue, temple, a spiritual or religious leader, or religious topics? Does the client ask about a visit from the clergy? Does the client express any of the following: fear of death, concern with the meaning of life, inner conflict about religious beliefs, concern about a relationship with the deity, questions about the meaning of existence or the meaning of suffering, or concern about the moral or ethical implications of therapy?
4. ***Affect and attitude.*** Does the client appear lonely, depressed, angry, anxious, agitated, apathetic, or preoccupied?
5. ***Interpersonal relationships.*** Who visits? How does the client respond to visitors? Does a minister come? How does the client relate to other clients and nursing personnel?

Diagnosing

The prevalence of spiritual disruption varies across studies. For example, 27% of individuals surviving stem cell transplantation and over 40% of individuals with advanced cancer were observed to have spiritual struggles or pain (Delgado-Guay, et al., 2016; King et al., 2017). Nurses, as spiritual care generalists, must be extremely cautious when assessing a client's spiritual health and applying a diagnosis that could be inappropriate. In diagnosing spiritual health, the nurse may find that spiritual problems provide the diagnostic label, or that spiritual disruption is the etiology of the problem.

Spiritual Issues as the Diagnostic Label

Examples of nursing diagnoses that are appropriate for clients with spiritual issues can include spiritual disruption related to situational crises (e.g., illness, unexpected life event) or "sociocultural deprivation" (e.g., inability to attend religious services); spiritual health enhancement, a wellness diagnosis describing spiritual health that acknowledges that some clients respond to adversity with an increased sensitivity to spirituality or spiritual maturation; and potential for spiritual disruption for a client who presently shows no indication of this disruption of spirit yet may if a nurse fails to intervene.

Religious Issues as the Diagnostic Label

Examples of nursing diagnoses that are appropriate for clients with religious issues can include religious struggle, potential for religious struggle, and religious enhancement.

Spiritual or Religious Distress as the Etiology

Spiritual disruption may affect other areas of functioning and indicate other diagnoses. In these instances, spiritual disruption becomes the etiology. An example is impaired coping related to feelings of abandonment by God and loss of religious faith.

Planning

In the planning phase, the nurse identifies therapeutics to support or promote spiritual health in the context of illness.

Planning in relation to spiritual needs may involve one or more of the following:

- Helping clients to practice their religious rituals
- Supporting clients to recognize and incorporate spiritual beliefs in healthcare decision-making
- Encouraging clients to recognize positive meanings for health challenges
- Promoting a sense of hope and peace
- Providing spiritual resources when requested
- Facilitating connection with others (e.g., estranged family, clergy and faith community members).

It is important to remember that the goal of spiritual care is *not* to control clients' spiritual angst for them, tell them how to become transformed by their situation, or impose your goals for them. The plan, rather, is to gently and sensitively support, facilitate, and accompany in ways that will aid health or a good death.

Implementing

Spiritual nursing care includes actions as diverse as recognizing and validating the inner resources of an individual, such as coping methods, humor, motivation, self-determination, positive attitude, and optimism. It can also include assisting the client to leave a legacy by storytelling or recording life stories for family and friends, and encouraging creative expression through art, music, and writing. This keeps the imagination alive and

serves to regenerate the body, mind, and spirit. Fostering ways for clients to keep in touch with nature and maintain a sense of wonder are also forms of spiritual care. Recognizing the seasons, the emergence of flowers in spring, the phases of the moon, the migrations of birds, and the unchanging stars provides examples of orderliness in the universe, even in the midst of chaos and loss.

Numerous nursing therapeutics are available to support and promote client spiritual health. Although diverse, some of the most common nursing therapeutics most desired by clients include (a) providing presence, (b) conversing about spirituality, (c) supporting religious practices, (d) assisting clients with prayer, and (e) referring clients for spiritual counseling (Balboni et al., 2013). One of the few studies examining what spiritual care clients perceive is appropriate for nurses to provide indicated that clients with advanced cancer are positive about such care (Balboni, et al., 2013). This study of 68 clients receiving treatment showed that over 70% reported it appropriate for a nurse to inquire about their spiritual needs, encourage them in their beliefs, or make a chaplain referral; 62% thought it appropriate for a nurse to offer prayer for a client.

Providing Presence

Presencing is a term describing the art of being present, or just being with a client during his or her suffering. To be fully present to a client, a nurse must be purposefully attentive (Fahlberg & Roush, 2016). To be comfortable being fully present to another individual, however, one must be comfortable being fully present to oneself (du Plessis, 2016). Strategies for increasing the ability to be present to a client include:

- Slow down. Calm yourself.
- Make sure that in your "heart" you are willing to be present. Take deep, slow breaths to center yourself. Nurses who listen attentively to clients yet fail to give of self (i.e., inwardly "make room") diminish their effectiveness.
- Sit down; keep your eye level at the same level as the client's.
- Allow silence.
- Smile or exude positive energy while remaining respectful of the client's emotional state (e.g., convey quiet, inner courage if the client is experiencing sorrow or despair). Follow the client's nonverbal cues.
- Focus. With whatever brief or long amount of time you have available, use it maximally by focusing completely on the client. Be physically, emotionally, and mentally present.
- Empathize with the client; actively and deeply listen (Fahlberg & Roush, 2016; Taylor, 2007b).
- Self-disclosures (e.g., telling the client about how you overcame a similar situation) are never appropriate unless the client requests it and it is shared with therapeutic intent rather than for self-serving reasons. (Ask, "Whose needs are being met here?")

Osterman and Schwartz-Barcott (1996) identified four levels or ways of being present for clients:

- Presence (when a nurse is physically present but not focused on the client)
- Partial presence (when a nurse is physically present and attending to some task on the client's behalf but not relating to the client on any but the most superficial level)
- Full presence (when a nurse is mentally, emotionally, and physically present; intentionally focusing on the client)
- Transcendent presence (when a nurse is physically, mentally, emotionally, and spiritually present for a client; involves a transpersonal and transforming experience).

Presencing is often the best and sometimes the only intervention to support a client who suffers under circumstances that medical interventions cannot address. When a client is helpless, powerless, and vulnerable, a nurse's presencing can be most beneficial. Rather than worrying about saying or doing "the right thing," nurses should focus on being fully present. In this way, nurses can promote healing, diminish client anxiety, create a sense of safety, and improve both client and their own satisfaction with the interaction (du Plessis, 2016).

Conversing About Spirituality

Initiating conversation about spiritual or religious concerns with a healthcare professional is likely hard for clients; they presumably wait for an appropriate time with a "safe" clinician. Both physicians and nurses typically find it difficult to talk with clients about this intimate and sometimes socially taboo topic (Best, Butow, & Olver, 2016; Wittenburg, Ragan, & Ferrell, 2017). Sometimes clients do not want to talk about deep inner pain, spiritual or emotional. They may instead find comfort and help from the nurse who genuinely shows interest in their life, family, and hobbies. However, sometimes clients do want to have overtly spiritual discussions with their nurse.

Taylor (2007a) proposed the goal of verbal spiritual care as being "to provide responses to clients which allow the clients to become intellectually, emotionally, and physically aware of their spirituality so that they can experience life more fully" (p. 7). Yet often when clients raise difficult spiritual concerns, clinicians avoid the topic by imposing a positive spin, minimizing the psychospiritual pain, injecting humor, or giving a pat answer. Instead of avoiding these painful and difficult conversations, nurses can provide a healing response by incorporating principles of empathic communication (Taylor, 2007a). For example, the nurse can respond to clients' comments about spirituality with a restatement of what is most central in their comments, an open question to prompt their further reflection, or a statement that tentatively names their feeling. Dimensions of a verbal response that promotes spiritual healing are identified in Table 41.1.

TABLE 41.1 Dimensions of a Spiritually Healing Response

Healing	Not Healing
Client centered *(e.g., "It seems you're feeling like no one cares.")*	Nurse centered *(e.g., "But I care about you!")*
Neutral *(e.g., "Tell me more about your thinking regarding . . . .")*	Judgmental *(e.g., "Why do you think that?")*
Immediate contributors to spiritual pain *(e.g., "Perhaps underneath all the 'why' questions you're asking, you feel abandoned.")*	Distant, tangential, or abstract contributors to spiritual pain *(e.g., "You were wondering what caused your cancer.")*
Accurately names feelings, engages emotion *(e.g., "I'm sensing that your belief makes you calm now.")*	Inaccurately or never names feelings, engages thinking *(e.g., "What do you believe about . . . ?")*

From "Spiritual Pain," by E. J. Taylor, 2007a, *Advance for Nurses, 9*(21), pp. 15–16.

Sometimes clients ask nurses about their spiritual or religious beliefs or practices, which may provoke some nurse anxiety. However, it is likely the client wishes to get better acquainted with the nurse to determine if the nurse is safe to disclose to, or because the client wants to equalize the relationship. Occasionally, the client is collecting data, that is, he or she wants to learn a new comforting or meaningful spiritual perspective. The Practice Guidelines feature titled *Can a Nurse Self-Disclose Personal Spiritual Beliefs?* describes how a nurse can be cautious before sharing personal spiritual or religious beliefs with a client so as not to unethically impose these perspectives.

Assisting Clients with Prayer or Meditation

Many nurses pray with clients when they request it (Minton, Isaacson, & Banik, 2016; Taylor, Park, & Pfeiffer, 2014). Prayer allows individuals to connect with each other and with the divine. To pray for another is also a way for loving individuals to express care. While most clients may say that prayer makes them feel better, it is also possible that prayer could raise to awareness a spiritual struggle or a disappointment and questions about "unanswered prayers" (Taylor, 2012).

Does prayer heal clients? A recent Cochrane review of the evidence from several randomized experiments that investigated the efficacy of intercessory prayer (that is, having an individual unknown to a client pray for the client's physical healing) concluded that the findings equivocally suggest no clear positive or negative effect of intercessory prayer on health outcomes (Roberts, Ahmed, Hall, & Davison, 2009). A more helpful perspective regarding prayer is offered by Bishop (2003), who observed:

PRACTICE GUIDELINES Can a Nurse Self-Disclose Personal Spiritual Beliefs?

When self-disclosing personal spiritual perspectives, the healthcare professional can maintain a therapeutic relationship with the client by remembering the following:

- *Do not disclose to gratify your needs. Ask yourself, "Whose needs are being met when I share my beliefs?"* If you are disclosing your beliefs because you think they will benefit the client, yet the client has no desire to know your beliefs, then you are meeting your needs. Asking a client if you can share your beliefs may be inappropriate, given that clients often perceive they are "at your mercy" and may feel uncomfortable declining your offer. For example, asking, "Do you mind if I ask a personal question?" often obliges the vulnerable client to say yes, even though they wish to say no. Instead, carefully observe for when a client indicates a desire for your perspective.
- *When clients ask you about your spirituality, you may find it helpful to first assess why they are asking.* For example, "Your question about 'why?' is a tough one. What brings you to ask it now?" or "I love talking about my beliefs, but what in particular is it that you'd like to know?" Or, "Before I answer, could we explore what this means to you?" *The why behind their question should guide your response.*
- *Any time you disclose your personal beliefs, follow up the self-disclosure with an open question or reflection of feelings.* Always return the ball to the client's court. For example, "As you can see, I'm not sure of this myself, but can you tell me what would be comforting to you?" or "I wonder what is going on inside you now?"
- *Use self-disclosure infrequently and keep the disclosures short.* A request about what you believe is not a request for a religious discussion.
- *When responding to a client's query about your spiritual beliefs, try to incorporate the client's language when framing your response.* In this way, you may avoid using loaded words that could create tension. For example, if a client asks you about how they can "make things right," you can couch your response using this language, rather than talk about "repentance" and "being saved" if that is your normal language.
- *Keep your answer honest, authentic.* Sometimes this means simply saying, "I don't know."
- *If you are asked a question with which you are uncomfortable or unable to answer, you can still use the moment for healing purposes.* Healing can still occur when you use the communication skills to increase self-awareness. For example, "You know, I have to admit, I'm uncomfortable with your question. I may be uncomfortable with it because I don't like the answers I've heard others give for it. Perhaps asking the question makes you feel uncomfortable, too." [pause for response] Or, "I've been wondering that myself for a long time. Sometimes I wonder if it is . . . , but I don't know. What ideas have you considered?"
- *Make a referral to a spiritual care specialist.* Assuming the client would like to further explore the spiritual questions that are brought to the surface by health challenges, initiate a referral through the chaplain or spiritual caregiver if the client assents.

From *What Do I Say? Talking with Patients About Spirituality*, by E. J. Taylor, 2007b, Philadelphia, PA: Templeton Press.

religious counselors will assist members of their faith who are not members of their specific religious community. For example, a priest may attend a client in the hospital or at home even though the client is not a member of the priest's parish. Be sure to obtain a client's approval before initiating a referral. The client often will have a preferred spiritual care provider to contact.

Referrals may be necessary when the nurse makes a diagnosis of spiritual disruption. In this situation, the nurse and religious counselor can work together to meet the client's needs. One situation the nurse may encounter is client refusal of necessary medical intervention because of religious tenets. In this case, the nurse encourages the client, primary care provider, and spiritual adviser to discuss the conflict and consider alternative methods of therapy. The nurse's major role is to provide information the client needs to make an informed decision and to support the client's decision.

Supporting Religious Practices

During the assessment of the client, the nurse will have obtained specific information about the client's religious preference and practices. Nurses need to consider specific religious practices that will affect nursing care, such as the client's beliefs about birth, death, dress, diet, prayer, sacred symbols, sacred writings, and holy days as discussed earlier in this chapter. See Practice Guidelines for ways the nurse can help clients to continue their usual spiritual practices. Box 41.2 provides health-related information about specific religions.

PRACTICE GUIDELINES **Supporting Religious Practices**

- Create a trusting relationship with the client so that any religious concerns or practices can be openly discussed and addressed.
- When unsure of client religious needs, ask how nurses can assist in having these needs met. Avoid relying on personal assumptions when caring for clients.
- Do not discuss personal spiritual beliefs with a client unless the client requests it. Be sure to assess whether such self-disclosure contributes to a therapeutic nurse–client relationship.
- Inform clients and family caregivers about spiritual support available at your institution (e.g., chapel or meditation room, chaplain services).
- Allow time and privacy for, and provide comfort measures prior to, private worship, prayer, meditation, reading, or other spiritual activities.
- Respect and ensure safety of the client's religious articles (e.g., icons, amulets, clothing, jewelry).
- If desired by client, facilitate clergy or spiritual care specialist visitation. Collaborate with chaplain (if available).
- Prepare client's environment for spiritual rituals or clergy visitations as needed (e.g., have chair near bedside for clergy, create private space).
- Make arrangements with a dietitian so that dietary needs can be met. If institution cannot accommodate client's needs, ask family to bring food.
- Acquaint yourself with the religions, spiritual practices, and cultures of the area in which you are working.
- Remember there can be a difference between facilitating and supporting a client's religious practice and participating in it yourself.
- Ask another nurse to assist you if a particular religious practice makes you uncomfortable.
- All spiritual therapeutics must be done within agency guidelines.

BOX 41.2 **Health-Related Information About Specific Religions: A Sampler**

Amish, Mennonite—Likely will not have insurance coverage; rely on religious community for support.

Anglicans, Episcopalians, Roman Catholics—Appreciate receiving Eucharist (Holy Communion), a ritual of ingesting bread and wine (or grape juice) led by clergy or lay leaders to commemorate death of Jesus. Forehead may be marked by priest with ashes on Ash Wednesday (40 days before Easter); no need to wash off. Lenten season (Ash Wednesday to Easter) may involve some degree of abstention from food.

Buddhist—May be vegetarian. Practice meditation (may desire incense, visual focal point, use breathing or chanting).

Christian Scientist—Typically oppose Western medical interventions, relying instead on lay and professional Christian Science practitioners.

Hindu—Most eat no beef; many are vegetarian. Cleanliness highly valued. Many food preferences (e.g., foods fresh or cooked in oil).

Jehovah's Witnesses—Abstain from most blood products; need to discuss alternative treatments such as blood conservation strategies, autologous techniques, hematopoietic agents, non-blood volume expanders, and so on; contact local Jehovah's Witness hospital liaison committee.

Jews—Some observe kosher diet to varying degrees (e.g., avoid pork and shellfish, do not mix dairy and meat). Sabbath observance varies (e.g., Orthodox Jews avoid traveling in vehicles, writing, turning on electric appliances and lights).

Latter-Day Saints (LDS or Mormons)—Avoid alcohol, caffeine, smoking. May prefer to wear temple undergarments. Arrange for blessing with local elders, if requested.

Muslim—Respect modesty, avoid exposing the body. Provide same-gender nurse if possible. Support prayers five times daily (may need to assist with ritual washing and positioning beforehand). Allow for family and imam (religious leader) to follow Islamic guidelines for burial when a Muslim client dies. Eat no pork, drink no alcohol. Children, pregnant women, older adults, and the ill exempt from daytime fast during month of Ramadan.

Roman Catholics—Sacrament of the Sick (previously known as Last Rites) appropriate for the ill. Be aware that some may think rite or offer of prayer means they are dying.

Seventh-Day Adventists—Avoid unnecessary treatments on Saturday (Sabbath), which begins Friday sundown, ends Saturday sundown. Adventists prefer restful, spirit-nurturing, family activities on Sabbaths. Likely to be vegetarian and abstain from caffeinated beverages. Do not smoke or drink alcohol.

- Do not prescribe or urge clients to adopt certain spiritual beliefs or practices, and do not pressure them to relinquish such beliefs or practices.
- Strive to understand personal spirituality and how it influences caregiving.
- Provide spiritual care in a way that is consistent with personal beliefs.

Clinical Alert!

Although some clients are eager for clinicians to offer spiritual care (and yet may feel embarrassed to ask for it), others may be uncertain about or opposed to such offers (Balboni et al., 2013; Park & Sacco, 2016). Clients often confuse religiosity with spirituality; this may contribute to their uncertainty about receiving spiritual care from nurses. Observing and using the client's language for spirituality (e.g., "being at peace" or "faith") and exhibiting large measures of sensitivity and respect will help nurses to talk therapeutically with clients to provide spiritual care.

Holy Days

Solemn religious observances and feast days throughout the year may be referred to as **holy days** and may include fasting or special foods, reflection, rituals, and prayer. Believers who are seriously ill are often exempted from such requirements. Clients may be used to spending such days with family and attending religious services. Examples of such holy days are Rosh Hashanah and Yom Kippur (Jewish); Good Friday and Christmas (Christian); Buddha's birthday (Buddhists); Mahashivratri, a celebration of Lord Shiva (Hindu); and the month-long Ramadan (Islam). Because some religions follow calendars other than the Gregorian calendar, a multifaith calendar can be used to identify the holy days of the various religious groups.

The concept of the Sabbath is common to both Christians and Jews, in response to the biblical commandment "Remember the Sabbath day to keep it holy." Most Christians observe the "Lord's Day" on Sunday, whereas Jews and sabbatarian Christians (e.g., Seventh-Day Adventists) observe Saturday as their Sabbath. Muslims traditionally gather on Friday at noon to worship and learn about their faith. Clients who are devout in their religious practices may want to avoid any special treatments or other intrusions on their day of rest and reflection.

Sacred Texts

Individuals often gain strength and hope from reading religious writings when they are ill or in crisis. Each religion has sacred and authoritative scriptures that provide guidance for its adherents' beliefs and behaviors (Taylor, 2012). In addition, sacred writings frequently tell instructive stories of the religion's leaders, kings, and heroes. In most religions, these scriptures are thought to be the word of the Supreme Being as written down by prophets or other human representatives. Christians rely on the Old and New Testaments of the Bible, Jews on the Hebrew Bible, and Muslims on the Koran; Hindus have several holy texts, or Vedas; Sikhs cherish the Adi Granth; and Buddhists value the teachings of the Tripitakas. Scriptures generally set forth religious law in the form of warnings and rules for living (e.g., the Ten Commandments). This religious law may be interpreted in various ways by subgroups of a religion's followers and may affect a client's willingness to accept treatment suggestions; for example, blood transfusions are in conflict with the biblical interpretations of Jehovah's Witnesses.

Sacred Symbols

Sacred symbols include jewelry, medals, amulets, icons, totems, or body ornamentation (e.g., tattoos) that carry religious or spiritual significance. They may be worn to pronounce one's faith, to remind the practitioner of the faith, to provide spiritual protection, or to be a source of comfort or strength (Taylor, 2012). Clients may wear religious symbols at all times, and they may wish to wear them when they are undergoing diagnostic studies, medical treatment, or surgery. For example, clients who are Roman Catholic may carry a rosary for prayer; a Muslim may carry a mala, or string of prayer beads (Figure 41.2 ■).

Individuals may have religious icons or statues in their home, car, or place of work as a personal reminder of their faith or as part of a personal place of worship or meditation. Hospitalized clients or long-term care residents may wish to have their spiritual icons or statues with them as a source of comfort.

Prayer and Meditation

Prayer involves humans experiencing the divine (however that is perceived). Some would describe prayer as an inner experience for gaining awareness of self (including Self—or the immanent manifestation of the divine). Others may view it as a conversation with the divine (e.g., to entreat or dialogue). These differing perspectives likely reflect

Figure 41.2 ■ Clients may bring objects to the hospital to use in prayer or other religious rituals. Caregivers should respect such objects, because they usually have great significance for clients.
Jesus Cervantes/Shutterstock.

the theological variations about how the divine relates to humanity. For example, some view the divine as transcendent (e.g., God in Heaven), while others experience the divine as immanent (e.g., the inner light or wisdom within individuals). A more complex perspective would accept that the divine engages with humanity in both—or many—ways (Borg, 1997; Taylor, 2012).

More than half of Americans (55%) pray at least daily (Pew Research Center, n.d.). However, the ways they pray vary. For example, ritual prayers (e.g., Hail Mary and memorized prayers that can be repeated) may be comforting for those who are unable or uncomfortable with a more conversational prayer (e.g., where one praises or petitions God). Other prayer experiences may be meditational, allowing for moments of silence while focused on nothing, a meaningful phrase, or a certain aspect of the divine (Fosarelli, 2008; Taylor, 2012). Although meditational and colloquial prayer experiences have been found to be associated with spiritual well-being and quality of life in healthy adults, ritual and petitionary prayer experiences may be most comforting and appropriate for those who are ill and unable to concentrate (Taylor, 2012).

Some religions have prescribed prayers that are printed in a prayer book, such as the Anglican or Episcopal Book of Common Prayer or the Catholic Missal. Some religious prayers are attributed to the source of faith; for example, the Lord's Prayer for Christians is attributed to Jesus, and the first sutra for Muslims is attributed to Mohammed.

Some religions prescribe daily prayers or dictate specific times for prayer and worship: the five daily prayers, or Salat, of Muslims (performed while facing east toward Mecca at dawn, noon, midafternoon, sunset, and evening); the daily Kaddish of Jews; or the seven canonical hours of prayer of Roman Catholics. Individuals who are ill may want to continue or increase their prayer practices. They may need uninterrupted quiet time during which they have their prayer books, rosaries, malas, or other icons available to them (Taylor, 2012).

Meditation is of Buddhist origin yet pervades Western societies. Mindfulness meditation techniques have been adapted for Christian prayer and as a nonreligious lifestyle strategy for improving health and overall well-being. Numerous studies document various physical, psychologic, and spiritual benefits for those who practice mindfulness regularly. Mindfulness techniques vary, but key elements include focused attention on the present moment or the body's experience; awareness, depth, and steadiness of breathing; and putting judgmental and intrusive thoughts "on hold." Mindfulness can be taught individually or in groups by a mindfulness expert; manualized training to nurses can prepare them to support clients to meditate (Boccia, Piccardi, & Guariglia, 2015; Buttle, 2015).

Beliefs Affecting Diet

Many religions have prescriptions regarding diet. It is important that healthcare providers prescribe diet plans with an awareness of the client's dietary and fasting beliefs. There may be rules about which foods and beverages are allowed and which are prohibited. For example, Orthodox Jews are not to eat shellfish or pork, and Muslims are not to drink alcoholic beverages or eat pork. Members of the Church of Jesus Christ of Latter-Day Saints (Mormons) are not to drink caffeinated or alcoholic beverages. Older Catholics may choose not to eat meat on Fridays because this was prescribed in years past. Buddhists and Hindus are often vegetarian, not wanting to take life to support life. Religious prescriptions may also dictate how food is prepared; for example, many Jews require kosher food, which is food prepared according to Jewish rules.

Some solemn religious observances are marked by fasting, which is the abstinence from food or certain foods for a specified period of time. Some religions also restrict beverages during a fast; others allow drinking of water or other sustaining beverages on fast days. Examples of religions that observe fasting include Islam, Judaism, and Eastern Orthodox Christians. During the month of Ramadan, devout Muslims eat no food and avoid beverages during daylight hours; the fast is broken after sunset. Members of Jewish synagogues fast on Yom Kippur, and devout Catholics may fast on Good Friday. Most religions lift the fasting requirements for seriously ill believers for whom fasting may be a detriment to health (e.g., clients with diabetes, pregnant women). Some religions may exempt nursing mothers or menstruating women from fasting requirements (Taylor, 2012).

Beliefs About Illness and Healing

Clients may have religious beliefs that attribute illness to a spiritual disease or sin. Some clients may think that disease is caused by the presence of sin and evil in this world, whereas others may believe the disease is a punishment for sin in their past. Indeed, how clients view the divine, interpret good and evil, and so forth, inevitably influences their thinking about illness and decision-making about treatment. Healing for such clients may appear to be unrelated to current treatment practices. When relevant, the nurse should assess the client's beliefs related to health and, if possible, include aspects of healing that are part of the client's belief system in the planning of care. For example, many religious traditions have rituals of healing such as anointing by a leader of the local religious community (Taylor, 2012).

Beliefs About Dress and Modesty

Many religions have traditions that dictate dress. For example, Orthodox and some conservative Jewish men believe that it is important to have their heads covered at all times and therefore wear yarmulkes. Orthodox Jewish women cover their hair with a wig or scarf as a sign of respect to God. Mormons may wear temple undergarments in compliance with religious dictates. For some individuals, it is imperative that they not shave certain hair (e.g., sideburns for Hasidic Jewish men, any hair for a Khalsa [dedicated] Sikh).

Some religions require that women dress in a conservative manner, which may include wearing sleeves and modestly cut tops, and skirts that cover the knees. Many Islamic cultures may require that the body (torso, arms, and legs) be covered, as well as the head (i.e., burkha or hijab). Hindu women accustomed to wearing saris prefer to cover all of the body except arms and feet (Figure 41.3■). Hospital gowns may make women wishing to comply with religious dress codes feel uneasy and uncomfortable. Clients may be especially disconcerted when undergoing diagnostic tests or treatments, such as mammography, that require body parts to be bared or shaved. Nurses need to facilitate respectful solutions at such times (Taylor, 2012).

Beliefs Related to Birth

For all religions the birth of a child is an important event giving cause for celebration. Many religions have specific ritual ceremonies that consecrate the new child to God. For example, while a baby is being born, its Muslim mother may recite a prayer. As soon as it is born, its father or someone else will recite a call to prayer into the infant's ears. Likewise, Hindus will perform a number of religious rituals when a baby is born. Most Christian parents will have their babies christened or baptized at some point; however, for some, if their infant is dying, they may want a baptism as soon as possible. In such dire circumstances, Christian parents of seriously ill infants may want baptism performed at birth by a religious nurse or primary care provider if a chaplain or clergy member is not present.

Figure 41.3 ■ Hindu woman dressed in a sari.
Hongqi Zhang/123RF.

In the Jewish and Islamic traditions, male circumcision is obligatory, whereas Hindus never practice circumcision. When nurses are aware of the religious needs of families and their infants, they can support families in fulfilling their religious obligations (Taylor, 2012).

Beliefs Related to Death

Spiritual and religious beliefs play a significant role in the believer's approach to death just as they do in other major life events. Many believe that the individual who dies transcends this life for a better place or state of being. Research findings suggest these religious beliefs may influence end-of-life care choices, such as whether to seek hospice care, have an advance care plan, or desire for resuscitation (Ohr, Jeong, & Saul, 2016; Van Norman, 2017).

Some religions have special rituals surrounding dying and death that must be observed by the faithful. Observance of these rituals provides comfort to the dying individual and loved ones. Some rituals are carried out while the individual is still alive, and can include special prayers, singing or chants, and reading of sacred scriptures. Roman Catholic priests perform the Sacrament of the Sick (previously referred to as the Last Rites) when clients are very ill or near death; Orthodox Christians have a similar ritual. Muslims who are dying want their body or head turned toward Mecca, whereas Hindus may want to face south. In the Muslim, Hindu, and Jewish traditions, a ritual bath and body preparation for burial may be done by a family member or by a ritual burial society (Taylor, 2012).

Many religious traditions also support rituals during specified periods of mourning after the death. Jews and Muslims have a tradition of burial within 24 hours following death. Hindus cremate the body within 24 hours; then the bereaved family observes a period of isolation given their defilement from living with the deceased. Jews "sit Shiva" (gather to pay respects) for several days in the home of the deceased. Buddhists perform prayers and rituals to aid the deceased to a better next life (Taylor, 2012).

During a terminal illness the client and family should be asked about end-of-life observances that could impact healthcare. The nurse can support the family of the deceased by providing an environment conducive to the performance of their traditional death rituals.

Clinical Alert!

Sharing Beliefs

Before sharing personal beliefs or practices, a nurse must consider questions such as the following:

- For what purpose am I sharing my beliefs or practices? By doing so, am I meeting my needs or my client's?
- Is my spiritual care reflecting a spiritual assessment?
- Am I preying on a vulnerable client?
- Am I offering my beliefs or practices in a manner that allows my client to refuse comfortably?
- Does my spiritual care hurt or contribute to a therapeutic relationship with the client?

Evaluating

Just as there is a question regarding the appropriateness of using the prescriptive nursing process to frame spiritual care, caution is needed when discussing the evaluation of spiritual care. Does spiritually sensitive nursing care lead to observable and measurable client outcomes? If it does not, then is it unsuccessful or unimportant? And what outcomes indicating movement toward improved spiritual health are appropriate for nurses to consider? Indeed, Taylor (2007b) suggested that clinicians' spiritually healing responses often move a client *incrementally* toward spiritual healthiness. Nurses with theistic religious beliefs might add that a client's movement toward spiritual health is evidence of God's grace, and ultimately something that is not within the purview of any clinician or individual. Given that many healthcare institutions require that spiritual care be documented in a nursing care plan, an example of how this is done is on page 1062.

Spiritual Self-Awareness for the Nurse

Nurses cannot hear, never mind respond to, a client's spiritual need unless they hear and respond to their own need and consider how countertransference can occur (Bowman, 2017; Taylor, 2007b). Indeed, the notion that effective healers are "wounded healers" has long existed. A nurse's spiritual needs, pains, or woundedness can affect how he or she cares for clients. Nurses who are unaware of, afraid of, or misunderstand their spiritual needs will be very limited in their ability to accurately identify and explore a client's spiritual needs. When clients realize the nurse does not understand them they become quiet, change the topic, give superficial responses to queries, or in other ways indicate lack of interest in continuing to talk about their spirituality.

Instead, the nurse can use his or her woundedness and spiritual self-awareness as a bridge or tool for healing communication. A healing response requires recognizing a client's innermost feelings. Awareness of one's own deeper feelings—one's own spiritual themes and inevitable woundedness—is requisite to being able to hear another's. Thus, a nurse's life story with its joys and hurts becomes a source of information for interpreting the client's story.

Healers do not need to have shared the same *experiences* as have clients, but to be compassionate they do need to recognize how they have shared similar *emotions* (Taylor, 2007b). For example, a nurse may not be able to share with a client the extreme experience of losing a limb, but can likely identify times in life when he or she felt loss, anger, or bewilderment about why tragedy happens. Recognizing and addressing the fears that are inevitable responses to caring for clients (e.g., our own fear of dying or being hurt, our fear of hurting others, or of being overwhelmed by the pain of others) is an essential requisite to spiritual care.

Beckman, Boxley-Harges, Bruick-Sorge, and Salmon (2007) offered the following strategies for nurses who wish to increase their spiritual awareness so that it can impact client care positively:

- ***Write a self-epitaph.*** Sum up in a couple of lines what is significant about your life or how you would like to be remembered.
- ***Explore personal end-of-life issues.*** Imagine having a terminal diagnosis. What feelings would you have? What would be your priorities for the time and energy you had left?
- ***Create a personal loss history.*** Answer questions such as these: What was your first experience of death? What was the most recent or difficult death in your life? How did you cope? What is your coping style at times like this? How did you feel your grief?
- ***List significant values.*** Write down what possessions, individuals, activities, roles, personal attributes, and so forth, you prize most.
- ***Conduct a spiritual self-assessment.*** Consider what gives you strength and hope. What makes you joyful or despairing? How do you explain or relate to suffering? What is your sense of purpose or mission in life? What nurtures your spirit?

You may want to test out client spiritual assessment questions on yourself! Another aspect of a spiritual self-assessment is to reflect on what has influenced your spirituality most. How does the religion of your family affect you? How would you describe your spiritual "journey"? And importantly, how does your spirituality influence your vocation—your choosing to be a nurse?

Critical Thinking Checkpoint

Terry is a 32-year-old male who received several pints of blood following an automobile crash 10 years ago. Five years ago he was diagnosed with AIDS and is now in the hospital with pneumonia and severe diarrhea. He is very ill and very discouraged. While you are caring for Terry, he comments, "I might as well die right now because I'm not going to get well. My folks were Methodist, but I guess I'm being punished because I'm not very religious."

1. Terry stated that he was "not very religious." Does that mean that he is not spiritual? Explain.
2. What data suggest that Terry may be experiencing spiritual disruption?
3. How might illness affect one's spiritual beliefs? Religious beliefs?
4. How might a spiritual assessment be of benefit to both you and Terry?
5. What questions might be helpful to ask to further understand Terry?
6. What might you say to show Terry empathy?

Answers to Critical Thinking Checkpoint questions are available on the faculty resources site. Please consult with your instructor.

6. Sexuality

It is essential for nurses to consider the sexuality of their patients as part of holistic, patient-centred care. Sexuality is a fundamental aspect of human identity and well-being, impacting physical, emotional, and psychological health. Addressing this aspect of care helps create an inclusive and supportive environment, ensuring that patients' sexual health, preferences, and needs are respected and understood. The following pages will help you with the Specific Learning Outcomes focused on sexuality.

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2 Practising nursing within a culturally diverse society

LEARNING OBJECTIVES

On completion of this Chapter, the learner should be able to:

- describe how a nurse can provide culturally competent nursing care
- discuss the development of effective relationships with patients, their families and significant others through culturally appropriate care and communication
- plan healthcare taking into account the cultural requirements of patients
- explain the principles of patients' advocacy in respect of cultural needs
- discuss the interface between Western medicine and alternative/traditional practitioners
- give health information and/or health education that is culturally appropriate and acceptable to patients and their families.

KEY CONCEPTS AND TERMINOLOGY	
acculturation	The paradigm shift that patients must undergo in order to change their culture and adopt the culture of the healthcare provider.
amulet	An object that protects a person from trouble such as ornaments or jewellery worn to chase evil spirits away.
charms	Objects that have power or a spell over evil.
culture	A way of life, which encompasses the ideas, customs, and social behaviour of a particular people or society.
cultural diversity	The variety of human cultures in a specific region.
cultural knowledge	The knowledge the healthcare professional has about specific or diverse groups' fundamental norms, customs, belief and values.
paradigm	System of understanding and organising knowledge.
supernatural	Something that has a force beyond scientific understanding or the laws of nature.
traditional practitioners	People who practice traditional medicine.

PREREQUISITE KNOWLEDGE

- Batho-Pele principles
- Patients' rights
- Human rights.

MEDICO-LEGAL CONSIDERATIONS

- The fulfilment of cultural requirements is a patient's right, and failure on the part of a nurse to meet this need can be interpreted as negligence.

- Failure to give accurate and adequate information to a patient may also be construed as negligence, particularly if the patient must make major decisions relating to their healthcare, or if the patient is expected to manage their medical condition at home. In order for health information to be acceptable and understood by a patient, the information must be put across in a manner that takes cultural factors into account. Failure to do this is likely to cause a patient to be non-compliant.
- Disregard of cultural requirements is an instance of discrimination and may involve the healthcare institution, and the individual nurse, in legal action.

ETHICAL CONSIDERATIONS

- Nurses have an ethical obligation to
  - respect the culture and preserve the dignity of patients at all times
  - apply cultural knowledge and sensitivity in order to avoid offending or discriminating against patients based on their cultural backgrounds.
- Every patient has a right
  - to participate in their own healthcare, including having their cultural needs met
  - to health information and health education that is accessible, understandable, acceptable, appropriate and congruent with their cultural requirements
  - not to be discriminated against because they wish to consult an alternative or traditional practitioner.

Practice alert!

In situations where patients strongly wish to consult alternative or traditional practitioners, it is imperative that they are made to understand the full implications of their choice.

ESSENTIAL HEALTH LITERACY

Holistic nursing care includes cultural nursing as culture impacts on the patient's health behaviour. It is essential for the nurse to have a brief background of the patient's culture and information that will assist to comply with the patient's wish for alternative treatment. Patients must be encouraged to communicate their wishes and also be given a chance to exercise them if need be. However, possible effects of the alternative medicine on their health and illness must be explained to the patient for them to make informed decisions.

Introduction

Nursing is an interpersonal activity, with the goal of restoring or maintaining the health of patients. Interpersonal activities such as nursing care are, by definition, built on relationships and communication. To be effective in facilitating the healthcare of patients, nurses should develop a good nurse–patient relationship and should be able to communicate effectively with patients. It is essential for nurses to develop insight into the culture of their patients, as well as an understanding of how the individual patient's culture impacts on health behaviour. Acquiring cultural knowledge assists with the integration of health-related beliefs, practices and cultural values (Campinha-Bacote, 2010). Nurses must be able to gain knowledge about the culture of a patient by asking the right questions and by demonstrating sensitivity towards the patient's beliefs and culture. Health and illness behaviour must be understood in the light of a patient's cultural context if a nurse is to fulfil their role in helping the patient to achieve or maintain optimum health.

In the light of current policy directions in South Africa, a nurse may need to work with indigenous or alternative health practitioners. To do this harmoniously and effectively, nurses must develop an elementary understanding of the basic principles and philosophical outlook of these practitioners. Therefore, the nurse must develop cultural competence in the delivery of healthcare. Cultural competence is a set of congruent behaviours, practices, attitudes and policies that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations. The process of developing cultural competence includes desire, awareness, skill and knowledge (Campinha-Bacote, 2010). The aim of this Chapter is to assist you to develop sensitivity towards the traditions and respect for the culture of patients and the community.

The concept of culture

Culture is a shared set of norms, values, perceptions and social conventions that give cohesion to a group, race or

community, enabling them to live together and function effectively and harmoniously. It is a key influence on the way in which an individual perceives and responds to the world. Culture, however, is simply one set of factors among many that mould the individual and their response to the world and to society. Individual behaviour is heavily influenced by culture, but culture is a framework and not a stereotype.

Culture consists of the following aspects:

- Observable phenomena, such as manner of dress, diet, architecture, language, writing and the arts.
- Norms and values, including ideas about how people should behave, about right and wrong, and good and bad. These norms and values are usually taken for granted within a culture; they are universally accepted within that culture, having been absorbed by people at a very early age. Each individual learns about their own culture from an early age, and also learns how to function within that particular worldview.

Culture is not inherited; it is acquired during the process of socialisation in childhood. Subgroups or subcultures exist within every society. Organisations, occupations and professions also have their own micro-cultures that individuals accept and adapt to when they join the group. Culture is therefore an integrated pattern of human knowledge, belief, and behaviour that is a result of, and integral to, the human capacity for learning and transmitting knowledge to succeeding generations. It is learned and shared, dynamic and changing. Cultural awareness is thus a deliberate and cognitive process through which sensitivity to a person's values, beliefs and practices develop.

The importance of culture

Culture consists of language, ideas, beliefs, customs, taboos, codes, institutions, tools, techniques, and works of art, rituals, ceremonies, and symbols. It has played an important role in human evolution, allowing human beings to adapt the environment to their own purposes.

In a diverse society such as South Africa, cultural differences are very evident; and to be effective in their profession, nurses must be able to work with people whose culture and traditions are different from their own. However, without sufficient knowledge of other people's culture, it will be difficult to work with or understand people whose culture is different from their own. It is vitally important for the nurse to acquire sufficient knowledge of the cultures they work with in order to avoid offensive stereotyping.

Cultural insight and knowledge are also essential for nurses given the interpersonal nature of their work. Much of the effectiveness of nursing care is due to interpersonal interactions with patients and the nature of the nurse–patient relationship. There are several nursing theories and models of care that highlight the centrality of culture and trans-cultural nursing, such as: the cultural safety model; Leininger's theory of Culture Care Diversity and Universality and the Sunrise model; the Giger and Davidhizar Trans-cultural Assessment Model; and Campinha-Bacote's cultural competence in healthcare model.

2.1 The acquisition of cultural knowledge and understanding

Some suggestions on how to acquire cultural knowledge and understanding:

- Nurses should develop an awareness of their own cultural assumptions and prejudices.
- Written or visual material on other cultures can be useful to build general knowledge, provided that such material is not biased or prejudiced.
- Once a nurse has developed a good relationship with a patient, the nurse can ask questions. If the right questions are asked in a respectful manner and the response is received respectfully, much can be learned.
- A nurse should not automatically assume that they know best and that their way of doing things is the only way. Nurses must allow space for the preferences of their patients, which includes cultural and religious preferences.

Cultural issues in healthcare

Every human society has its own particular culture. Variation among cultures is attributable to such factors as differing physical habitats and resources, the range of possibilities inherent in areas such as language, ritual, social organisation and historical phenomena such as the development of links with other cultures. An individual's attitudes, values, ideas and beliefs are greatly influenced by the culture (or cultures) in which they live. Culture change takes place as a result of ecological, socioeconomic, political, religious, or other fundamental factors affecting a society or an individual such as health and illness.

There are several cultural factors that act as barriers to effective healthcare. Because South Africa is a diverse society, nurses need to develop an understanding of the cultural dimensions of a number of health-related issues. Many of these issues may be closely allied to religious practices, but all need to be taken into account when

dealing with patients and the community. Because nursing care is interpersonal and because nursing involves meeting the needs of patients, cultural factors such as modesty, hygiene practices, attitudes to pain and illness, diet and food, as well as death and dying must be understood and taken into account when planning nursing care. These and other issues are discussed below.

Diet

Diet is an important cultural characteristic, and it is an area that nurses must find out about during the assessment of their patients. Information should be obtained about, for example, which foods may or may not be eaten, or if there is any special method of preparation. This is important as certain food taboos are based on cultural and religious beliefs. For example, pork is the well-known food taboo of some religions in African and Muslim people.

In a hospital setting, efforts should be made to supply the appropriate diet for each patient. If the dietary requirements of the hospital in-patient cannot be met, it may be necessary to approach the family with a view to having them bring in food for the patient, if the condition of the patient allows. A thorough knowledge of the diet of the patient, including the ways in which food is prepared, is essential when giving health education to the patient. Health education should be contextualised according to the patient's individual lifestyle, and this means taking careful note of specific characteristics, whether cultural or individual. In instances where health education and advice are not appropriate to a patient's lifestyle and culture, the advice may not be followed and this will be to the detriment of the patient.

Hygiene practices

Hygiene practices often differ from culture to culture. Muslim people, for example, always wash their hands as well as the urethral and/or anal area after using the toilet. For some cultural groups, a bath is not regarded as hygienic, and only a shower will suffice. For other groups, specific hygiene measures are taken during menstruation. Nurses should take note of these and any other hygiene requirements that they encounter and try to meet the needs of their patients in the best way possible.

Family hierarchy and lines of communication

Culture is instrumental in communication. Language is a powerful instrument that can be used to get to know the other person's culture. Family hierarchy and lines of communication are sometimes significant when consent has to be obtained for treatment or for a surgical procedure.

In South Africa, the current legislation allows people 18 years and older to give consent to medical treatment autonomously. However, in many African groups, consent to an operation or other form of treatment is a major decision. Sometimes a patient will ask to go home and consult the elders of the clan, and in some instances the ancestors are consulted. Many African groups require that consent for an operation on a child must be obtained from the child's family or from the senior male relative, and the mother will feel unable to give consent without consulting the father or a male relative. This can create difficulties where the child is acutely ill and is in need of emergency treatment or surgery and the father is not available. In such a case, it may be necessary for the Medical Superintendent to give consent. In many groups, health matters relating to reproductive health or to sexual matters, such as contraception, must often be discussed with the husband first, before talking to both husband and wife, as it is the husband who takes decisions in the home and nothing will happen if only the wife has received the advice.

It is important for the nurse to find out about lines of communication in the various cultural groups because nursing care is based on good communication, and it is essential at all times to make sure that the lines of communication with all stakeholders are appropriate and effective.

Disposal of body parts

If an organ has to be removed or a limb amputated, it is essential to find out from the patient or from the relatives whether any special measures are needed for the disposal of the tissue or limb. In many cultural groups, the body parts must be given burial and not simply sent to the incinerator. This requirement is particularly important in the case of amputation. The requirement is often not so stringent in the case of organs and parts of organs or tissues.

In South Africa, matters relating to human tissues are legislated in the National Health Act 61 of 2003, which repealed the Human Tissue Act 65 of 1983.

Organ donation pratices also vary between different cultures; some groups will not consent because of the belief that the deceased must be buried with all their body parts intact. Organ donation is not universally accepted among African cultures, although there is no specific prohibition in traditional African belief and it may vary depending on the particular group or set of religious beliefs. Orthodox Jewish people and many Muslim people are also likely to refuse organ donation, out of a cultural belief that the body must be buried intact and not necessarily out of any specific religious prohibition. Some groups may refuse permission for post-mortem examination, for example Orthodox Jewish people and Muslim people.

Death, dying and the disposal of the body

As this is the last thing that the family will do for the patient, most families have a strong desire to ensure that things are done in accordance with what the patient would have wanted. It is important to find out, for example, whether the family would like a priest to be called, as would be the case with a Roman Catholic patient. Also important would be to find out whether the family expect to be allowed to stay with the dying person and, if so, which specific family members. In the case of Jewish patients, it is customary for the family to watch at the bedside of a dying relative, but this function is also provided by Jewish community organisations that may be contacted to perform this function if the family is unable to do so.

In some cultures, specific rituals are carried out at the bedside of a dying patient. The care of the body after death is also an important cultural aspect. In some African cultures, after the death of a person in hospital, the family may come to collect the spirit of the dead person from the bed where the patient passed on. Nurses should find out whether it is acceptable for the staff to remove tubes and lines and lay the body out, or if there is any specific procedure to be followed before doing the last offices. For example, an individual known as the *Wagter*, who is sent by the relevant Jewish community organisation, lays out a Jewish patient who has died, although it is usually expected that the nursing staff will remove the tubes and lines. Jewish and Muslim patients are accommodated in their own separate sections of the mortuary and have their own burial organisations.

Amulets and charms

Beliefs in charms and amulets are a widespread phenomenon, and are found in many cultures. Amulets and charms are believed to facilitate healing and to protect the patient from harm. The use of charms is not only found among so-called primitive groups but is found in many Western groups. Among Mediterranean groups, for example, belief in the 'evil eye' is common and charms are worn to ward off the evil eye. Some amulets are religious in nature, such as holy pictures and holy medals, but their purpose remains the same: to promote healing by supernatural means and to protect the individual from harm.

Generally, amulets and charms should not be removed unless it is clearly necessary, eg if the patient is going for operation in the theatre. It may also be necessary to remove amulets in order to facilitate treatment. If it is indeed necessary to remove an amulet, the patient and family should be informed of the need and of the reason for it. Sometimes amulets can be moved to other places on the body, or they can be placed at the bedside, or sent home with the family, but usually the hospitalised patient prefers to keep such items with them. Amulets should never simply be discarded, as this can cause great offence to the patient and/or family.

The role of women

The role and social position of women varies between societies, and often depends on whether the society is matriarchal or patriarchal. In many cultures, a woman is a perpetual minor, always under the guardianship and supervision of a male relative. Women in such a position usually need to consult with their husbands or senior male relatives before taking decisions, even those relating to health. Among many African groups, it is the male head of the household who must decide if a member of the household can be taken to a hospital or clinic for treatment. This often means that women must wait for absent heads of households to return before a decision can be taken. A great deal of education and empowerment is needed to change these patterns.

Sexuality

Sexuality is a universal human trait, but the social regulation and expression of sexuality varies from culture to culture. The area of sexuality covers relations between the sexes, modesty, rituals and practices related to the female menstrual cycle, and, very importantly for nurses, the manner in which intimate matters may be discussed.

In many cultures, the frank discussion of sexual matters is regarded as uncouth. It is common to find that it is unacceptable for sexual matters to be discussed between the sexes; women talk to women about sexuality and men talk to men. It follows, therefore, that any discussion on matters related to sexuality, such as contraception or safe sexual practices, must be approached correctly and very carefully. For some, it is necessary to discuss such matters with the head of the household; if they accept, then the family will follow their lead. Depending on the group, it is often prudent to have a male nurse talk to male patients or male family members, and female nurses to talk to female patients or female family members. A young unmarried female is frequently not seen as an appropriate person with whom to discuss intimate matters.

The way in which intimate topics and those of a sexual nature are discussed is also important. Frank graphic descriptions are often not acceptable and may cause offence, and the nurse must find ways to get the message across by using terminology that is acceptable to the patients and their families.

Other cultural issues related to areas of cultural diversity are family organisation, language, personal space, touching, eye contact, gestures, healthcare beliefs, and spirituality and religion.

Cultural perspectives on health and illness

Beliefs on healthcare systems vary among cultures, thus patients regard healthcare differently. Every culture has a system for healthcare based on the values and beliefs that have existed for generations. Nurses have an increased responsibility to meet the needs of an increasingly diverse society in order to reduce health disparities and improve healthcare quality. Beliefs about health and illness are an important cultural factor in healthcare. The challenge for nurses rendering healthcare in a Western-oriented healthcare system, such as the one in South Africa, is to bring the health/illness paradigm of patients into alignment with the system. Health and illness beliefs fall into three major groups, described in the sections that follow.

The magico-religious paradigm

In this paradigm, illness has a supernatural cause, as opposed to injury, which has a specific and obvious cause. Consequently, the cure for illness lies in the supernatural or spiritual dimension. It is widely believed among African cultures that illness may be brought on by a malicious spell or by the neglect of or a transgression against the ancestors. The cure for illness, while it may involve medication, is spiritual and involves rituals, prayer and possibly some form of sacrifice. Health may be seen as a sign of supernatural favour, and illness as a curse or punishment. In this paradigm, it is also commonly believed that the actions of one individual may affect the health of the community.

People who adhere to this belief system do not necessarily reject Western scientific approaches to therapy, but scientific treatment methods are not seen as being the sole agent in effecting a cure. For many African cultures, the two systems exist in parallel, and both are regarded as being effective. For treatment within a modern scientific framework to be successful, however, patients must be allowed expression of the spiritual dimension and access to practitioners who practise within the magico-religious framework.

Patient education is an important factor in bringing the two systems into alignment for a patient, and the nurse is a key agent in this process. Accurate health education that takes into account and shows respect for the patient's health or illness beliefs and behaviours must be offered.

The biomedical paradigm

This is the dominant belief system among Western cultures, but not necessarily the only one. According to this paradigm, there is a demonstrable cause–effect relationship for all types of illness. These causes may be due to environmental factors, trauma, pathogens, fluid and chemical imbalances or structural changes. All forms of ill health thus have a specific cause and can be cured or alleviated by eliminating or neutralising the identified cause.

This belief system underpins the practice of modern medicine, but the wholeness of the individual and the relationship with the spiritual dimension are frequently lost sight of. Healthcare within a biomedical paradigm can often be experienced as dehumanising and harsh. Within this system it is the nurse who preserves a holistic approach to the patient. Nurses always strive to meet their patients' needs and to ensure that all aspects of the patients' humanity are taken into account. It is easy to become a mere technician in this model and it is important for nurses to guard against this.

The holistic paradigm

In this paradigm, human beings are seen as a part of nature and as having a need to maintain balance and harmony with the laws that govern the cosmos. Disturbing the cosmic balance causes disharmony, chaos and disease. Explanations for ill health and disease are based on disharmony between the human organism and the forces of the universe.

The holistic paradigm is widely held among many cultures, including Western cultures. Many forms of alternative healing in both the East and the West are based on the holistic paradigm, and it is the dominant paradigm among Asian cultures. Florence Nightingale's philosophy that the role of the nurse and the nursing profession is to provide an environment in which the patient can recover naturally reflects this holistic paradigm. This philosophy forms one of the foundations of the practice of nursing.

Integrative and complementary healthcare

Integrative therapy includes a more collaborative approach to patient care and encompasses the treatment of patients with both traditional and alternative therapies concurrently. Complementary therapies include a range of philosophies, approaches and therapies that Western medicine does not commonly use, accept, study or understand. The concept of wellness means more than being healthy or without a disease. However, no illness is purely physical. The effects of illness manifest themselves physically, mentally, socially, spiritually and otherwise. Humans are complex beings. The interactions between mind, body, emotions and spirit connect individuals to their environment and other people. Patients from different cultures may have used alternative therapies as their primary approach to health and illness care, and may want to continue the therapies while in hospital. Nurses need to be knowledgeable about the different cultural beliefs and alternative practices. Integrative and

complementary therapies are holistic and treat the person as a whole. They can be grouped into the therapies as discussed below.

Alternative medical systems. These are practices such as homeopathic or naturopathic medicine, and traditional medicine which includes herbal medicine, acupuncture and massage. These therapies are practised by many cultures throughout the world. In South Africa, culture and the law play a pivotal role in herbal medicine, which is regulated under the Traditional Health Practitioners Act 22 of 2007. An example of alternative practice in the South African context is circumcision, which can be done by either traditional groups or dedicated healthcare practitioners, at different cultural circumcision schools or at medical healthcare facilities, respectively.

Mind–body interventions. This includes meditation, hypnosis, dance, music and art therapy, and prayer. The therapies enhance the mind's ability to affect bodily functions.

Biologically based treatments. These treatments include products such as herbal medicines, special diets and biological therapies.

Manipulative and body-based methods. The therapies include chiropractic and massage therapy. Massage therapy in hospital may also be used in conjunction with physiotherapy.

Energy therapies. These therapies include focusing on energy originating from within the body, or from other sources such as therapeutic touch or magnetic fields, and includes reiki, physio acoustics and bio-electromagnetics.

Collaborative, comprehensive and/or alternative healthcare provision

Alternative healthcare includes health therapies that are used in place of traditional medicine.

Patients are increasingly using alternative therapies from alternative practitioners, and among African cultures the practice of consulting a herbalist, traditional healer or *sangoma* when ill is common. These kinds of practitioners play a pivotal role in the African community. The importance of indigenous practitioners and the esteem in which they are held in the community are the basis for the frequent calls that are made for these traditional practitioners to be integrated into the health system.

Traditional practitioners consult the ancestors regarding the patient's health by throwing bones or by going into a trance. Following the diagnosis, a remedy will be prescribed, again in consultation with the ancestors. These remedies are invariably herbal and are often designed to cleanse, usually by causing purging. Other remedies include tonics and vitamin preparations. Dosage and strength are imprecise and extremely variable, and some concoctions may be highly toxic if too large a dose is taken. The prescription of medication is usually accompanied by some form of ritual and/or prayer designed to enhance the treatment. Sometimes an amulet is given to the patient to complement the treatment and should be worn until the course of treatment has been completed.

Both Western and Eastern holistic practitioners may also prescribe medication, again mostly herbal based. Dosages tend to be far more precise, but some herbal preparations can be toxic if taken in too high a dose. In holistic practice, medication is designed to help restore the patient to a state of harmony or balance. Some alternative practitioners such as osteopaths use physical manipulation to achieve a cure by restoring the vertebral column to correct alignment.

Traditional, alternative and holistic practitioners enjoy wide respect and are frequently consulted by patients in addition to Western scientific practitioners. The problem is one of identifying a set of principles for a relationship between Western scientific medicine and the various forms of indigenous and alternative medicine. Often this is not a dilemma that the patient will discuss with their Western scientific doctor, because the said doctor is quite likely to disapprove of the patient consulting an alternative practitioner. Nurses are, however, quite often asked to give advice regarding the use of alternative practitioners. It is therefore important for nurses to have a sound knowledge of what treatments the various types of practitioners offer and to be able to identify those that would be harmless and those that might cause the patient harm. Openness should be encouraged, and nurses should find out whether a patient has consulted a traditional or alternative practitioner and, if so, whether any form of medication is being taken.

Recent dialogue with African traditional herbalists has led to the establishment of some guidelines. If the patient has consulted a traditional healer and then consulted a Western scientific practitioner, they should return to the herbalist to discuss this. Sometimes traditional medication can be continued, but more often it is advisable to discontinue the traditional medication until the Western medication has been completed. In many areas of South Africa, outreach programmes and training programmes are in place to educate herbalists and *sangomas* regarding the interaction between traditional medicine and Western medicine. Included in such outreach programmes are principles of referral, particularly in relation to the

nature of conditions that should be referred to a Western practitioner and when to refer.

In the area of health education, traditional practitioners play an invaluable role. In the case of conditions such as tuberculosis, it is of paramount importance that the patient continue with the treatment, whether or not traditional medication is taken in addition. Traditional practitioners are also an important link in the campaign against HIV/Aids. It is important to convince a patient not to discontinue Western treatment simply because they are consulting a traditional practitioner. This principle applies particularly where regular forms of treatment such as dialysis are concerned, and where stopping the Western treatment could be life threatening.

In the case of a hospitalised patient who is acutely or even critically ill, the use of traditional medication is definitely dubious, if not actually dangerous, and should be discontinued. The problem with the vast majority of traditional herbal remedies is that they have never been scientifically analysed, and they often contain unknown ingredients that may be potentially harmful to an acutely ill patient.

2.2 Practices to be encouraged in cultural exchanges

- Being aware of diversity and respecting it, even celebrating it
- Recognising that cultural factors are important in the health and illness of patients
- Being knowledgeable and respectful about the cultural groups one encounters
- Recognising one's own biases, prejudices and blind spots, and working to overcome these when dealing with patients
- Finding ways to care for patients in culturally appropriate and acceptable ways
- Striving to give holistic care in all situations.

A nurse's interface with different cultures

A nurse is the patient's advocate as well as the coordinator of care. It is the nurse who meets the basic needs of the patient, and many of these needs must be met in a culturally appropriate manner, or at least in a way that shows respect for the patient's culture, norms and values and does not give offence. An example of cultural advocacy could be a patient who refuses hospital treatment due to observation of cultural practices. In South Africa, refusal of hospital treatment and the right to a second opinion or health provider of own choice are included in the Patients' Rights Charter, which is enshrined in the Constitution of the Republic of South Africa, 1996. The nurse should therefore consider the patient's rights in conjunction with their culture and wishes.

Nurses also frequently carry the major responsibility of giving health education and ensuring that patients and their families have understood the information given to them. Nurses are thus the primary caregivers and healthcare practitioners, and they interact with many cultures. Nurses need to develop a broad store of cultural knowledge, and they also need to develop a high degree of cultural sensitivity. Cultural sensitivity embodies the principle of respect and awareness of one's own norms and values, as well as those of the patient. Culturally sensitive nursing involves caring for a patient in a way that matches the patient's perceptions of their health problems with their treatment goals.

A nurse's role within the multidisciplinary team from a cultural perspective

It is not possible for the average nurse to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare

2.3 Pitfalls to be avoided in cultural exchanges

- Ignorance and lack of understanding of other cultural groups
- Stereotyping, such as assuming that all individuals belonging to a particular cultural group conform to a general pattern or behave in a certain way; it should be considered that all patients are individuals and that their behaviour and reactions are also determined by other factors, such as family, education, and environment
- Judging other groups by one's own norms and values – certain basic principles, such as the concern for hygiene, are practically universal, but may be expressed in different ways
- Assigning negative attributes or characteristics to people from another cultural group
- Seeing the worldview and experience of other groups as inferior – this leads to prejudice, discrimination and racism
- Taking a paternalistic attitude of 'I know what is good for you'
- Being culturally blind and proceeding as though cultural differences do not exist. The practice of giving dietary advice that is based exclusively on a typical Western diet is such an example.

and these should be assessed as part of a routine nursing assessment. These key aspects are:

- Diet and food habits
- Rituals and taboos relating to key events in the lifecycle such as sexuality, birth and death
- Health and illness beliefs
- Types of practitioner consulted
- Health/illness behaviours and decision-making, including family or clan involvement
- Relationship with health professionals, as in many cultures the medical practitioner is expected to tell the patient what is wrong, not the other way around
- Genetically based biological variations, such as blood values, bone structure and bone density
- Practices related to modesty
- The discussion of sensitive issues.

Culture and communication

The importance of culture in communication cannot be overemphasised. It is essential for nurses to develop a basic insight into the culture of all the patients that they deal with. Failure to develop this insight will hamper health communication and nurses may be seen as being insensitive or even rude as a result of their lack of understanding of the patient's culture. Where language is a problem, translators may be useful. It is also important for nurses to use the correct channels of communication, such as a senior male relative when necessary.

Communication in a cultural context

Cultural context is the care, beliefs, values and practices of a culture that shape a person's environment.

Culture profoundly influences interpersonal communication, and it is essential for nurses to have a basic understanding of the norms and values of the cultural groups with whom they will be working in order to communicate effectively with these groups. Culture determines several key aspects of communication, such as:

- **How to greet.** For example, in African cultures it is not polite to get straight to the matter under discussion without first greeting the other participants and enquiring after their health. Among African cultures it is the older or more senior person who is greeted, and indicates when to speak and when not to speak. In many cultures, a junior person waits to be invited to speak, or waits until the more senior people have had their say and only then may they speak.
- **Expressing anger and other strong emotions.** In most societies, direct physical expressions of anger are not acceptable, as this can be dangerous and lead to injury and even death. Showing grief is another matter. In some cultures, it is a mark of love and esteem for a departed relative if those left behind cry and give way to strong overt signs of grief like screaming or tearing at clothes. In other societies, control is expected on the death of a loved one. A controlled reaction does not necessarily mean that the relatives did not care for the person who has died. In other cultures, a man is not supposed to cry, or should cry privately.
- **Eye contact.** In Western societies, looking the other person directly in the eye is taken as a mark of openness and honesty. In other cultures, like African cultures for example, sustained direct eye contact is not polite, particularly from a junior to a senior person, or even female to male.
- **Gesturing and touching.** Generally, areas that may be touched during communication depend on the degree of intimacy of the communicators and the context of the communication. During sexual intercourse, the partners are very intimate and all parts of the body may be touched. In everyday social interaction between work colleagues there is not a high degree of intimacy, and thus only the hands, arms and shoulders may be touched during communication, especially when greeting or congratulating a person. In some cultures, it is the norm to kiss the cheeks of the other person when greeting, irrespective of gender.

Cultures can be categorised according to whether they are individualistic or collectivistic, as well as by their communication style. Cultures may have high-context communication styles or low-context communication styles.

- Individualistic cultures, such as most Western European cultures, stress individual goals and achievements. These cultures tend to promote competition, and they place great value on achievement.
- Collectivistic cultures, such as are found in Africa, stress group activities and group achievements. These place great value on cooperation and group cohesion.
- Cultures characterised by a high-context communication style tend to be indirect or overly polite in communication, having a great concern for perceptions and leaving much to be gleaned from the context and circumstances of the communication, which means that the other person in the communication needs to have a degree of insight into the context and circumstances of the communication in order to be able to fully understand the communication. Many Eastern as well as African cultures have a high-context communication style, and it can be difficult for an individual from a different cultural background to work out the full meaning of the communication unless time has been spent in developing the necessary insight to

be able to communicate effectively. In African cultures, much communication is implied and the listener must pick this up from the context. Much is left unsaid or is conveyed through nonverbal means, or by riddles and euphemisms, which the listener must understand in order to grasp the full drift of the communication. For example, in the African context the expression *'izindaba zocansi'* is a term used to cover a multitude of issues related to sex and sexuality.

- In contrast, low-context cultures, such as most Western European cultures, have a direct communication style and are much more explicit verbally. The listener will know exactly what is meant, but the style is not always comfortable and can be perceived as rude, especially by someone from a high-context culture.

Essential health information

It is especially important to consider the patient's heritage, education level and language skills when planning patient education. The assistance of an interpreter may be appropriate. The unfamiliar hospital environment may be threatening when language barriers make it difficult to ask questions. Nurses should:

- provide information on indications, contraindications, potential benefits and adverse effects of alternative therapies in relation to the present diagnosis
- advise the patient about herb–drug interactions
- advise the patient to seek help regarding exploration of therapies that are suitable to them
- advise the patient to keep a log of any adverse reactions and report these to the healthcare practitioner
- when using oils on the patient, advise the family to be cautious of the risk for toxicity or skin irritation
- enquire into allergies when using biologically based therapies
- advise the patient to consult safe and competent practitioners.

Conclusion

The Nursing and Midwifery Council (NMC) in the United Kingdom states that 'nurses must practise in a fair and an anti-discriminatory way, acknowledging the differences in beliefs and practices of individuals or groups' (NMC, 2002). The culture of the patient must be taken into consideration when planning nursing care. Alternative and complementary therapies that will be beneficial for the care of the patient should be assessed. It is not possible for nurses to undertake an in-depth study of every culture that they encounter. Certain key aspects, however, are important in healthcare, and these should be assessed as part of a routine nursing assessment.

Suggested activities for learners

Activity 2.1

A male patient is admitted in your unit and the family request to massage him with a body lotion of mixed medicinal herbs which they obtained from a traditional healer. They believe that the lotion will heal the patient of the condition he is suffering from.

They have been instructed to put the lotion all over the body and that the patient should not have a bath for 3 days in order for the medicine to work effectively. The family asks you to allow them to put the lotion on the patient and follow the instructions. Debate the following issues:

1. How would you proceed?
2. How does this enhance or inhibit the achievement of the specific outcomes outlined in this Chapter?

Activity 2.2

A patient in your unit is confused and refuses oxygen therapy, saying it is disturbing him as he would like to communicate with his ancestors. He is desaturating and becomes violent when you try to put the face mask on him. He then requests you to give him space to discuss the treatment (oxygen therapy) you want to give him with his great-grandmother, who is already dead. Debate how you would proceed in this situation.

Activity 2.3

A female patient admitted in your unit with chronic back pain has been scheduled for a spinal operation. Following a visit from relatives she requests to be discharged from the hospital because she is considering acupuncture, and the family has organised an intercessory prayer for her. Explain how you would proceed to deal with this patient.

Environmental hygiene also influences health, and many diseases, such as asthma and other upper respiratory problems, can be directly related to pollution and to less-than-ideal environmental conditions. The need to maintain optimal environmental hygiene can also be considered a human need.

Need for comfort and rest

The word 'comfort' refers to a sense of ease and well-being. Physical comfort means not only the absence of pain, but also includes:

- the position of the body
- the temperature of the environment
- the absence of hunger or thirst
- the absence of annoying distractions and stressful happenings.

Rest is closely tied to comfort and refers to a state of physical inactivity, repose and relaxation. Sleeping and waking, as well as factors that might induce restlessness, must be taken into account. Physical and emotional stress may interfere with an individual's ability to rest. Rest and sleep are essential for normal physical and psychological functioning in order to replenish energy and repair tissues.

Need for safety

The need for safety is multidimensional and includes the following:

- **Physical safety.** In this instance, the need for safety means the avoidance of physical injury and damage to the body. The individual's level of consciousness and awareness, as well as their level of physical fitness and agility, are relevant to this need.
- **Psychological safety.** This pertains to the feeling of being secure and of knowing what to expect from the people around you, as well as being able to cope with events. It means that individuals understand what is happening and trust that their best interests will be safeguarded.

Need for security

Security is based on physical safety, which means adequate food and shelter, as well as freedom from physical harm. Security is all-encompassing and it is a broader concept than physical safety. It relates to:

- a state of comfort within one's environment, and it means that individuals are assured of the means with which to support themselves in society. It implies that an individual is comfortable with their role and satisfied with their position in society.
- protection under the law and from violation of one's fundamental human rights. There is obedience to the law and respect for the worth of human dignity in the society and in healthcare facilities in particular.
- free access to health facilities and services.

Need for sensation and perception

Normal human functioning includes the ability to perceive the environment and respond appropriately to it. Sensation and perception require the ability to see, hear, feel, smell and taste, as well as cognitive abilities that enable an individual to interpret information and to respond appropriately.

Need for sexuality

In the physical context, sexual or reproductive needs refer to those actions or processes that are necessary for the reproduction of the species. These include copulation, conception, gestation and parturition. Sexuality needs are assessed throughout the lifespan, from infancy to older adulthood, as these needs relate to a stage in life. Sexuality is influenced by a variety of factors, such as age, sociocultural background, ethics, self-concept and physical fitness.

Sexuality is more than a physical need because of the psychological and cultural dimensions which must be taken into account when dealing with patients. The socio-cultural aspects of sexuality for females include:

- menstruation
- pregnancy
- abortion
- contraception.

Assessment regarding sexuality needs should take cognisance of the fact that sexual dysfunction (challenges regarding the desire or actual performance of sexual activity) may be as a result of illness, disability, drugs, stress, or other physiological changes like menopause. Nurses must also be aware of patients' need for information about sexual activity and ways in which sexual activity is altered according to the health status of the patient. Comprehensive history taking on the first visit to a health facility regarding sexuality should include:

- a history of sexually transmitted diseases (STD)
- sexual activity or practice
- sexual orientation
- sexual dysfunction.

Psychosocial needs

Psychosocial needs refer to a variety of cognitive, emotional and interpersonal factors that enable individuals to adapt to the environment, form relationships with others, and function successfully within a community.

Need for cognition

The word cognition comes from Latin *cognoscere*, to know. In order for an individual to function adequately in relation to the environment, other individuals and the community, effective thought processes must be developed. Effective thought processes include orientation to the environment and the people in the environment, as well as problem-solving skills and the ability to form concepts and organise thoughts in a logical manner. Memory and the ability to understand and learn are also necessary for adequate cognition.

Need for adaptation

In order to be able to deal with stress and life events effectively, individuals must develop a variety of conscious coping skills. Coping behaviours involve the use of problem-solving techniques and relaxation, as well as the avoidance of stressful situations. Healthy coping implies adaptability and the capacity to deal with change rationally and appropriately. Less healthy coping mechanisms include aggression, withdrawal and substance abuse.

Unconscious coping behaviours include defence mechanisms such as denial, projection, repression and regression. Coping skills are more difficult to assess in children, but children who are able to make their needs known and who are confident of having these needs met are coping effectively. Severe stress in a child may bring out primitive defence mechanisms such as temper tantrums, withdrawal and regression.

Need for self-esteem and self-concept

Self-esteem implies that one has confidence in one's abilities. Adequate self-esteem requires acceptance of the self and feeling good about the self. This includes acceptance of bodily appearance and characteristics. Good bonding in an infant is a prerequisite for the development of self-esteem. A child with good self-esteem will show confidence and be outgoing. Adequate role performance is related to self-esteem needs, as every individual has a need to fulfil their various life roles effectively.

Self-concept relates to how one feels or thinks about oneself. The components of self-concept include identification, body image, role performance and self-esteem. A healthy self-concept requires acceptance of one's personality traits, as well as a realistic perception and acknowledgement of one's faults.

Self-confidence is based on a healthy self-concept and self-esteem which are the basis of sound interpersonal relationships and mental health.

Need for autonomy

Autonomy implies independence, control and the competent management of the cognitive, perceptual and behavioural processes of an individual, within societal definitions of 'normality' or 'mental health', and conforming to accepted social norms.

Autonomy also includes the facility of choice, or the ability to make an informed decision between several alternatives, based on personal beliefs and preferences. The ability to exercise choice also implies the right to have those choices respected.

Need for relatedness

Humans are social beings and need the esteem and cooperation of their fellow human beings. We also have a need to form close associations with others, as the fullest expression of the personality is attained within reciprocal human relationships. Different types of relationships are characterised by different degrees of self-disclosure. Close, intimate relationships demonstrate mutual trust and support, as well as mutual esteem building. These relationships include the following:

- **The nurse–patient relationship.** This is a special type of relationship in that it is intimate and caring without being too close. The nurse knows and cares for their patients, but does not become emotionally involved with them. Nurse–patient relationships are also characterised by empathy and a 'disinterested' concern for the patient's best interests.
- **Family relationships.** Usually influenced by one's role in the family, eg father, mother, daughter, son, etc. The presence or lack of family support is also crucial for dealing with illness.
- **Significant other relationships.** Characterised by emotional ties with one another or other factors.

Need for stimulation

Curiosity is one of the most striking features of human nature. People have an innate need to explore, to develop their potential, to respond to challenges and to achieve. Stimulation is essential for the development of human potential. The environment, education and interaction with other people are all crucial for development. Stimulation also includes the need for leisure time activities, during which individuals express themselves in an informal and pleasurable way. Meaningful work, on the other hand, is an important source of stimulation as it enhances self-esteem.

Need for communication

Communication with others is a natural human activity that is essential for survival and for the formation of

meaningful relationships. Communication is the process of giving and receiving information, and of attaching meaning to information and making use of that meaning. It is a major factor in determining the relationships that people have with others and what happens to them in the world.

Table 3.1 Summary of bio-psychosocial needs

Physical needs	Psychosocial needs	Spiritual needs
Oxygen	Cognition	Meaning-fulness
Circulation	Adaptation	Religious expression
Fluids and electrolytes	Self-esteem and self-concept	
Nutrition	Autonomy	
Elimination	Relatedness	
Temperature regulation	Stimulation	
Skin integrity	Communication	
Mobility and exercise		
Hygiene		
Comfort and rest		
Safety		
Security		
Sensation and perception		
Sexuality		

Need for meaningfulness (existentialism)

Meaningfulness implies the need for meaning and purpose in an individual's life in order to cope with life's challenges, for example illness or even death. Finding meaning in life requires the development of a personal philosophy and ideology to facilitate the process of finding meaning.

Grieving is an essential part of finding meaning in pain, suffering and death. Both patient and family may need to grieve in order to accept and work through the diagnosis of illness or the death of a loved one.

Meaning in life is frequently connected to self-esteem and relatedness, as many people find meaning and self-expression in their relationships with others, and with a higher or divine power.

Spiritual needs

Human nature has a spiritual dimension, which encompasses the need to find meaning in life and a relationship with a higher or divine power. Human spirituality also means defining life values and belief systems, and relating to the self and to others within the framework of those life values and belief systems or philosophies.

Spiritual needs are dynamic as they change with time and circumstances, for example life events such as the illness or death of a loved one.

The terms spirituality and religion are often used synonymously, although the two are not necessarily the same. Spirituality is a broader concept than religion. However, most religious people are spiritual as well. The spiritual needs of the patient include the need for meaningfulness (existentialism) and the need for the expression of religion.

Holistic care in nursing includes giving spiritual care, which includes reason, reflection, religion, relationships and restoration. Assessments of patients on admission should include a comprehensive history taking regarding the patient's religious beliefs with regard to health and illness. This is to ensure that these beliefs and practices are taken into consideration when planning nursing care, as well as their impact on medical treatment and procedures.

Very often, nurses will only ask about religious affiliation and not delve into the specific health beliefs or practices that may impact on healthcare.

Meeting the spiritual needs of the patient

Principles of spiritual care

Some principles include:

- recognition and acceptance of the spiritual dimension of human beings (self-awareness)
- comprehensive assessment to determine the patient's spiritual and religious needs
- good communication; the need to listen in an authentic manner
- empathy and the ability to accept what the patient says
- sympathy to enhance a trusting relationship to allow the patient to feel safe
- use of judicious self-disclosure
- referral to professionals more qualified in spiritual care, eg a hospital chaplain or the religious leader of the patient.

Need for religious expression

For most human beings, spiritual needs are fulfilled within an organised system of belief and worship, whether formal or informal. The religious beliefs and practices of an individual form an important part of that individual's life, particularly in relation to beliefs and practices about birth, death, health and illness. Religious practices and rituals play an important part in enabling individuals to weather life's crises, including ill health.

Regarding praying with the patient, the nurse should make sure that this practice is not in conflict with the policies of the institution. French and Naraynasmy caution that ethical issues arise when praying with patients, and advise that informed consent should be obtained from the patient first. Poole and Cook maintain that praying with a patient may constitute breach of professional boundaries.

In a multicultural society such as South Africa, nurses need to be familiar with the major religious practices common among the population. All cultural and religious affiliations are recognised in the Constitution.

Religious beliefs and practices regarding health

There is growing evidence in literature that there is a connection between spirituality, religion and health. Research indicates that religion strengthens people's ability to cope with life-threatening disease. Some of the major religions' beliefs and practices, and the implications of these for health and nursing, are summarised in Table 3.2.

Integrative healthcare

This approach to health includes the use of complementary and alternative healthcare practices, and may sometimes include conventional medicine, albeit for a brief period. The central belief of this modality of healthcare is that the human body has the capacity to heal itself. As a result, healthcare is geared towards changes in lifestyle and involves the use of natural and manual healing therapies.

Complementary and alternative therapies include acupuncture, chiropractic practice, herbal medicine, homeopathy, osteopathy, aromatherapy and hypnotherapy. African traditional medicine is also regarded as a complementary and alternative therapy.

The traditional health practitioner

According to the World Health Organization, traditional practitioners are those who are recognised by their communities as being capable and competent to provide healthcare services, using methods which are cultural, traditional, spiritual, and religious.

Traditional medicine is widely used in many parts of Africa, including South Africa. There is a belief that conventional medicine may not provide all the answers regarding ill health. South Africa is a multicultural society and many cultural groups use traditional medicine alongside conventional Western medicine.

Muslim people and adherents of Hinduism often approach traditional healers. In South Africa, traditional health practitioners are recognised and regulated under the Traditional Health Practitioners Act *22 of* 2007. Traditional health practitioners include diviners, traditional doctors, spiritual healers, traditional surgeons and traditional birth attendants.

Diviners. Diviners are traditional health practitioners who often diagnose ill health by means of casting a specific set of bones on the floor. This is their way of communicating with the ancestors to guide them through the patient-practitioner interface. The bones provide information and messages which are interpreted to facilitate a diagnosis, or an explanation to an individual's problem. The diviners are holistic practitioners who not only attend to physical problems but adopt a more psychosocial perspective. Prescription for treatment is by means of herbs and very often the performance of some rituals.

Traditional doctor, *Inyanga*, herbalist. Traditional doctors use medicinal herbs in the treatment of patients. They usually acquire the skills through an apprenticeship system, where they are taught by an expert. They provide preventive, promotive and curative healthcare.

Spiritual healers. They are often referred to as 'faith-based healers', because they use religion, especially Christianity, as the medium for the healing. Spiritual healers use verses from the Bible as the foundation for diagnosis and healing. They also use holy water, ash and colourful ropes to cast out evil spirits. Healing baths are often used to cleanse the body.

Traditional surgeons. A traditional surgeon is one who performs circumcision as part of a cultural initiation process. This practice is very common among Xhosa people in South Africa and the vhaVenda people in the Limpopo province. Other ethnic groups also participate in this traditional practice in the urban areas of Gauteng. These groups include the Ndebele, Basotho and Zulu people. Other ethnic groups mostly opt for the conventional hospital-based circumcision. (See also Chapter 2 on cultural diversity in healthcare.)

Table 3.2 Health related beliefs and practices of selected religions and implications for health and nursing

Religion	Health-related beliefs and practices	Implications for health and nursing and handling of the situation
African Religions, eg Z.C.C.	• Eating pork is prohibited • Alcoholic beverages are forbidden • Drink special tea or coffee supplied by the church outlets • Priest may anoint the patient with holy water	• Do not give the patient any food with pork, including processed meat • Allow time for the priest to visit, pray with the patient and to anoint with holy water • Patient may request early discharge in order to consult with the church elders for major decisions like consent for operation
Buddhism	• Accepts modern medical science	• May refuse medication in order to protect the body from the effects of chemicals
Hinduism	• Eating meat involves harming a living creature • Cremation is the most common form of body disposal	• Engage with the hospital dietician to provide a vegetarian diet
Islam	• Eating pork or pork-derivative medication is prohibited • No alcohol is allowed • Ritual cleansing before eating and prayer is practised • Fasting during daytime during the month of Ramadan • Uses faith healing, including group prayers • After the death of a patient, a family member may wish to wash the body and position the bed to face Mecca; the head should rest on a pillow • Burial usually takes place as soon as possible within 24 hours	• Cannot eat until the sun has set during the month of Ramadan • May refuse medication if it is porcine-derived • Some female patients prefer female healthcare professionals • Food should be Halaal only • Family to be consulted if a delay to the release of the body is anticipated (in cases where there is a need for a post-mortem) so that the family can make other arrangements
Judaism	• Believes in the sanctity of life • Observance of the day of Sabbath	• Visitation from the rabbi is part of support during illness • May refuse treatment on the Sabbath day • Life support is discouraged • Food should be kosher only • After post-mortem, all body parts to be returned for burial
Christians (Catholics and Protestants)	• Accepts modern medical science • Use prayer and faith healing • Visits from clergy may include holy communion (Sacrament of the Sick) • Patients may request 'non-meat' diets during Lent (the 40 days before and during the Easter period) • Patient may want to keep a religious object such as a rosary with a crucifix	• Allow time for prayer by family, friends and clergy • Are in favour of organ donation • Provide the requested diet unless contra-indicated • Allow patient to keep, but may have to remove when patient goes for X-rays or surgery
Jehovah's Witness	• Blood in any form is not accepted • Blood volume expanders are acceptable if they are not derived from blood	• Will not accept any blood transfusion, even in a life-threatening situation • The health condition of the patient may deteriorate with fatal consequences
Seventh-Day Adventist	• Fasting is practised • Vegetarian diet is encouraged	• Provide vegetarian diet • Meat diet should exclude pork

Traditional birth attendants. A traditional birth attendant is a health practitioner who assists a mother during childbirth and has acquired skills through delivering babies or through apprenticeship. Traditional birth attendants (TBAs) typically also provide care during pregnancy, childbirth, and the post-partum period. They render this service to women in their community and are often paid in kind. In developing countries, traditional birth attendants play a significant role in areas where midwives and doctors are scarce.

Lane and Garod (2016) add that TBAs act as cultural brokers between Western and traditional practices in childbearing and provide women with continuity of care from a known carer. TBAs in South Africa are recognised legally in the Traditional Health Practitioners Act 22 of 2007. They work in collaboration with the health system as per the guidelines of the World Health Organization.

Conclusion

In this Chapter, the bio-psychosocial needs presented correspond to Maslow's needs for survival and provides the foundations for nursing diagnosis and basic nursing. The Chapter forms the basis for the content of the Chapters to follow, where needs including those relating to safety; hygiene and grooming; nutrition; elimination; homeostasis; modality; exercise; and temperature regulation are dealt with. Other needs are covered in Chapters dealing with the respective relevant systems of the body.

Suggested activities for learners

Activity 3.1

A baby is admitted to your ward. On history taking you find that its parents are Jehovah's Witnesses. The medical diagnosis is such that the baby needs urgent corrective abdominal surgery. The parents, bound by their religion, will not give consent for surgery and possible blood transfusion.

In a discussion with colleagues, state how you are going to manage this problem, taking into consideration:

- the theorists' stipulations
- ethical and legal implications
- patients' rights
- the patient's and the family's spiritual needs
- the role of the nurse.

Activity 3.2

A devout Muslim patient dies in your care. A post-mortem has to be done, and this can only be done after a 24-hour period. Describe how you will manage this situation.

Sexuality 40

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe sexual development across the lifespan.
2. Define sexual health.
3. Discuss variations in sexual expression.
4. Give examples of how the family, culture, religion, and personal expectations and ethics influence one's sexuality.
5. Describe physiologic changes during the sexual response cycle.
6. Identify the forms of altered sexual function.
7. Identify basic sexual questions the nurse should ask during client assessment.
8. Formulate nursing diagnoses and interventions for the client experiencing sexual problems.
9. Recognize health promotion teaching related to reproductive structures.

KEY TERMS

anal stimulation, *1032*
androgyny, *1030*
body image, *1030*
coitus, *1032*
cross-dressing, *1032*
desire phase, *1034*
dysmenorrhea, *1027*
dyspareunia, *1037*
excitement phase, *1035*
female orgasmic disorder, *1037*
female sexual arousal disorder, *1036*
gender expression, *1030*
gender identity, *1030*
genital intercourse, *1032*
hypoactive sexual desire disorder, *1036*
intersex, *1031*
male erectile disorder, *1036*
male orgasmic disorder, *1037*
masturbation, *1025*
menstruation, *1025*
oral-genital sex, *1032*
orgasmic phase, *1035*
resolution phase, *1035*
sexual orientation, *1030*
sexual self-concept, *1030*
transgender, *1030*
vaginismus, *1037*
vestibulitis, *1037*
vulvodynia, *1037*

Introduction

All humans are sexual beings. Regardless of gender, age, race, socioeconomic status, religious beliefs, physical and mental health, or other demographic factors, we express our sexuality in a variety of ways throughout our lives.

Human sexuality is difficult to define. Sexuality is an individually expressed and highly personal phenomenon that evolves from life experiences. Physiologic, psychosocial, and cultural factors influence an individual's sexuality and lead to the wide range of attitudes and behaviors seen in humans. Satisfying or "normal" sexual expression can be described as whatever behaviors give pleasure and satisfaction to those adults involved, without threat of coercion or injury to self or others. What constitutes normal sexual expression, however, varies among cultures and religions.

Development of Sexuality

The development of sexuality begins with conception and continues throughout the lifespan. Table 40.1 outlines characteristics of sexual development typically seen throughout the lifespan, with nursing interventions and teaching guidelines for each developmental stage.

In this chapter, *sex* refers primarily to the biology of being male, female, or some other anatomic state, and to sexual activity. *Gender* refers to the psychologic sense of being feminine or masculine and is related to the terms *woman* and *man*.

Birth to 12 Years

The ability of the human body to experience a sexual response is present before birth. When babies find their fingers and toes, they also find their genitals. They seem to experience a pleasurable sensation from the touch but one would not call this a sexual experience. By the age of 3, more purposeful **masturbation** (excitation of one's own or another's genital organs by means other than sexual intercourse) begins, although males do not ejaculate until after puberty. By age 2 1/2 or 3, children have beginning awareness of genital differences between males and females.

Around age 9 or 10, the first physical changes of puberty begin—the development of breast buds in girls and the growth of pubic hair. As the adrenal glands mature, they produce more testosterone and estradiol, which contributes to the first experiences of sexual attraction to another individual. Girls learn about **menstruation** (monthly uterine bleeding) and related self-care.

TABLE 40.1 Sexual Development Throughout Life

Stage	Characteristics	Nursing Interventions and Teaching Guidelines
INFANCY Birth–18 months	Differentiates self from others gradually. External genitals are sensitive to touch. Male infants have penile erections; females, vaginal lubrication.	Self-manipulation of the genitals is normal. Caregivers need to recognize these behaviors as common in children.
TODDLER 1–3 years	Able to identify own gender.	Body exploration and genital fondling is normal. Use names for body parts.
PRESCHOOLER 4–5 years	Becomes increasingly aware of self. Explores own and playmates' body parts. Learns correct names for body parts. Learns to control feelings and behavior.	Answer questions about "where babies come from" honestly and simply. Parental overreaction to exploration of genitals and masturbation can lead to feelings that sex is "bad."
SCHOOL AGE 6–12 years	Has strong identification with parent of the same gender. Tends to have friends of the same gender. Has increasing awareness of self. Increased modesty, desire for privacy. Learns the role and concepts of own gender. At about 8 or 9 years becomes concerned about specific sex behaviors and often approaches parents with explicit concerns about sexuality and reproduction.	Provide parents and children with opportunities to express their concerns and ask questions regarding sex. Answer all questions with factual data and perhaps follow up with appropriate books and other material. Advise parents to discuss basic information about sexual intercourse, menstruation, and reproduction with children at about 10 years of age. Give children reading material and then discuss it with them.
ADOLESCENCE 12–18 years	Primary and secondary sex characteristics develop. Menarche usually takes place. Develops relationships with interested partners. Masturbation is common. May participate in heterosexual or same-sex activity. Are at risk for pregnancy and sexually transmitted infections (STIs).	Adolescents require information about body changes. Peer groups have great importance at this time and assist in forming gender roles. Dating helps adolescents prepare for adult roles. Parents influence values and beliefs regarding behavior. Teenagers require information about contraceptive measures and precautions to take with regard to STIs.
YOUNG ADULTHOOD 18–40 years	Sexual activity is common. Establishes own lifestyle and values. Many couples share financial obligations and household tasks.	Young adults often require information about measures to prevent unwanted pregnancies (i.e., abstinence or contraceptive devices). Require information to prevent STIs. Require regular communication to understand partner's sexual needs and to work through problems and stresses.
MIDDLE ADULTHOOD 40–65 years	Males and females experience decreased hormone production. Menopause occurs in females usually anywhere between ages 40 and 55. The climacteric occurs gradually in males. The quality rather than the number of sexual experiences becomes important. Individuals establish independent moral and ethical standards.	Females and males may need help adjusting to new roles. Clients may require counseling to help them reevaluate and direct their energies. Encourage couples to look at the positive aspects of this time of life.
LATE ADULTHOOD 65 years and older	Interest in sexual activity often continues. Sexual activity may be less frequent. Female's vaginal secretions diminish, and breasts atrophy. Males produce fewer sperm and need more time to achieve an erection and to ejaculate.	Older adults often continue to be sexually active. Couples may require counseling about adapting their affection and sexual needs to physical limitations.

Adolescence

During early adolescence (12 to 13 years), primary and secondary sex characteristics continue to develop, necessitating more information about body changes. For boys, the testes and scrotum increase in size, the skin over the scrotum becomes darker, pubic hair grows, and axillary sweating begins. Development of the genitals to adult size takes about 5 to 6 years. For girls, the pelvis and hips broaden, the breast tissue develops, pubic hair grows (see Figure 29.25 in Chapter 29 ∞), axillary sweating begins, and vaginal secretions become milky and change from an alkaline to an acid pH.

First-time sexual activity varies dramatically according to geographical region of the world, religion, and other social conventions. In the United States, a 2017 study of more than 14,000 high school students indicated that 39.5% of students had ever had sexual intercourse, 53.8% of those had used a condom during sexual intercourse, and 9.7% had had sexual intercourse with four or more individuals during their life (Kann et al., 2018).

Teenage girls may have irregular menstruation initially, which can lead to embarrassment because of stained clothing. They can be taught to be aware of subtle signs of impending menstruation, such as tender breasts, water retention or bloating, or the appearance of skin eruptions or pimples. Girls should also be counseled regarding the variety of feminine hygiene products available (e.g., sanitary pads and tampons) so they can make intelligent choices. Parents and nurses should advise teenage girls to wash their hands thoroughly before and after inserting a tampon, to change tampons frequently, to alternate them with sanitary pads, and to use pads at night. These measures will help to decrease infection, including the risk of "toxic shock," a particular type of *Staphylococcus aureus* infection. Thorough cleaning of the genital area and wiping from front to back will also decrease infection and prevent odors.

Dysmenorrhea (painful menstruation) is prevalent among adolescent females. Cramping, lower abdominal pain radiating to the back and upper thighs, nausea, vomiting, diarrhea, and headaches may occur for a few hours up to 3 days. Dysmenorrhea results from powerful uterine contractions, which cause ischemia and cramping pain. The symptoms of dysmenorrhea are treated with administration of analgesics such as aspirin, application of heat to the abdomen, certain exercises such as abdominal muscle strengthening, biofeedback, and nonsteroidal anti-inflammatory medications, such as ibuprofen.

All adolescents want to know about sexual behaviors but are often uneasy about discussing these concerns with their parents. Nurses, the schools, and the family need to provide accurate information. During the nursing assessment, teenagers should be asked directly what they know about sex, contraception, and reproduction. Sometimes a lot of the teenager's information is based on popular myths and little, if any, on fact. The nurse should discuss factual information about sex, sexual actions and their consequences, the individual's right to decide regarding ways to express oneself sexually, and the responsibilities of each individual regarding sexual activity. See Table 40.2.

Sexually transmitted infections (STIs) are the most common bacterial infections among adolescents. Teens need education about these diseases, preventive measures, and early treatment. The common types and symptoms of STIs for which teenagers should seek medical care are listed in Box 40.1. The nurse should also inform teens about the methods of birth control: abstinence, pills, timed-release transdermal patches and implants, diaphragms, intrauterine devices, the rhythm method, and condoms to prevent an unplanned pregnancy. These are discussed later in this chapter.

TABLE 40.2 Common Sexual Misconceptions

Misconception	Fact
Nearly all males over 70 years old have erectile dysfunction.	Sexual ability is not lost due to age. Changes are commonly due to disease or medication.
Masturbation causes certain mental instabilities.	Masturbation is a common and healthy behavior.
Sexual activity weakens an individual.	There is no evidence that sexual activity weakens an individual.
Females who have experienced orgasm are more likely to become pregnant.	Conceiving is not related to experiencing orgasm.
Nice girls should not feel entitled to their own sexual satisfaction.	As women become more comfortable with their own sexuality, they advocate for their own sexual fulfillment.
A large penis provides greater sexual satisfaction than a small penis.	There is no evidence that a large penis provides greater satisfaction.
Alcohol is a sexual stimulant.	Alcohol is a relaxant and central nervous system depressant. Chronic alcoholism is associated with erectile dysfunction.
Intercourse during menstruation is dangerous (i.e., it will cause vaginal tissue damage).	There is no physiologic basis for abstinence during menses.
The face-to-face coital position is the moral or proper one.	The position that offers the most pleasure and is acceptable to both partners is the correct one.

BOX 40.1 Common Symptoms of Sexually Transmitted Infections

Infection	Male	Female
Candidiasis	Itching, irritation, discharge, plaque of cheesy material under foreskin.	Red and excoriated vulva; intense itching of vaginal and vulvar tissues; thick, white, cheesy or curd-like discharge.
Chlamydial urethritis	Urinary frequency; watery, mucoid urethral discharge.	Commonly a carrier; vaginal discharge, dysuria, urinary frequency.
Genital warts (condyloma acuminatum)	The infection is caused by the human papilloma-virus (HPV). Single lesions or clusters of lesions growing beneath or on the foreskin, at the external meatus, or on the glans penis. On dry skin areas, lesions are hard and yellow-gray. On moist areas, lesions are pink or red and soft with a cauliflower-like appearance.	Certain strains of HPV have been linked to cervical cancer. Lesions appear at the bottom part of the vaginal opening and on the perineum, labia, inner walls of the vagina, and cervix.
Gonorrhea	Painful urination; urethritis with watery white discharge, which may become purulent.	May be asymptomatic; or vaginal discharge, pain, and urinary frequency may be present.
Herpes genitalis (herpes simplex of the genitals)	Primary herpes involves the presence of painful sores or large, discrete vesicles that last for weeks; vesicles rupture. Recurrent herpes is itchy rather than painful; it lasts for a few hours to 10 days.	
Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)	Symptoms can appear any time from several months to several years after acquiring the virus. The individual has reduced immunity to other diseases. Symptoms include any of the following for which there is no other explanation: persistent heavy night sweats; extreme fatigue; severe weight loss; enlarged lymph glands in neck, axillae, or groin; persistent diarrhea; skin rashes; blurred vision or chronic headache; harsh, dry cough; thick gray-white coating on tongue or throat.	
Syphilis	Chancre, usually on glans penis, that is painless and heals in 4–6 weeks; secondary symptoms—skin eruptions, low-grade fever, inflammation of lymph glands—in 6 weeks to 6 months after chancre heals.	Chancre on cervix or other genital areas that heals in 4–6 weeks; symptoms same as for male.
Trichomoniasis	Slight itching; moisture on top of penis; slight, early morning urethral discharge. Many males are asymptomatic.	Itching and redness of vulva and skin inside thighs; copious watery, frothy vaginal discharge.
Zika	Few if any symptoms. May include mild fever, rash, headache, joint pain, conjunctivitis (red eyes), or muscle pain. The virus can spread from mother to fetus causing severe birth defects, especially failure of normal brain development.	

Young and Middle Adulthood

In young adulthood, many individuals form intimate relationships with long-term implications. These relationships may take the form of dating, cohabitation, or marriage. Note, however, that some individuals do not form intimate relationships until late adulthood and that some never form these types of relationships.

Young adult men and women are often concerned about normal sexual response, for both themselves and their partners. In heterosexual relationships, problems may arise because of basic differences in male and female expectations and responses. Gay and lesbian couples may fare better in this respect. Couples need to communicate their needs to each other early in their courtship so a successful intimate relationship can develop and grow. Young adults should also know that because sexual needs and responses may change, each partner should listen and respond to the needs of the other.

During middle adulthood both males and females experience decreased hormone production, causing the climacteric, usually called menopause in women. These events often affect the individual's sexual self-concept, body image, and sexual identity. See Chapter 25 for further information on menopause.

Older Adulthood

Older adults may define sexuality far more broadly and include in their definition such things as touching, hugging, romantic gestures (e.g., giving or receiving flowers), comfort, warmth, dressing up, joy, spirituality, and beauty. Interest in sexual activity is not lost as individuals age. For men, however, more time is needed to achieve an erection and to ejaculate (the erection may last longer than at a younger age); more direct genital stimulation is required to achieve an erection; the volume of ejaculated fluid decreases; and the intensity of contractions with orgasm may decrease. The refractory period after orgasm is longer.

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

What are the risks and rewards of adolescents becoming sexually active?

Sexual debut is the term used to describe the first experience of intercourse. In this study, Golden, Furman, and Collibee (2016) followed 174 adolescents over 10 years, gathering data 7 times. A great deal of data was collected on variables such as anxiety, depression, substance abuse, self-worth, and sexual activity. The data were analyzed to determine whether the associations of timing of sexual debut and the risk and reward variables differed by demographics.

These analyses revealed that sexual debut was related to rewards, including increases in romantic appeal and sexual satisfaction. Early sexual debut was related to risks, such as greater substance use, more internalizing and externalizing symptoms, and lower global self-worth. Rewards associated with an early debut included greater romantic appeal, dating satisfaction (males only), and sexual satisfaction (males only). Although there are some inherent risks with sexual activity, the results suggest that sexual debut at a normative or late age is also associated with a decrease in some risks and an increase in rewards.

Implications

Nurses working with teens are compelled to understand teen behavior in the context of current values of those individuals and to resist the temptation to put that behavior in the perspective of their own or earlier generations. Assessment of behavior as safe or risky will change over time as improved methods of prevention, early detection, and treatment of sex-related conditions evolve. This study reminds the nurse to consider both the risks and rewards of becoming sexually active from the adolescent's point of view.

Older women remain capable of multiple orgasms and may experience an increase in sexual desire after menopause. Vaginal lubrication and elasticity decrease with menopause and decreased estrogen, and phases of the sexual response cycle may take longer to occur. There is a possibility of pain during sexual activity and intercourse (dyspareunia) related to vaginal dryness or chronic health conditions (e.g., diabetes or arthritis). Lack of privacy may be a concern for older adults who live with family or in a rehabilitation or long-term care facility.

Many products are available to assist older adults with enhancing their sexual experiences. These range from simple lubricants to medications and surgically implanted devices that enable penile erections. Although older adults' technique may require modification, the nurse should never assume that they are less interested in or less motivated to have an active sex life.

Sexual Health

Sexual health is an individual and constantly changing phenomenon falling within the wide range of human sexual thoughts, feelings, needs, and desires. For most individuals, sexual health is not a concern until its absence or impairment is noticed. An individual's degree of sexual health is best determined by that individual, sometimes with the assistance of a qualified professional.

The Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment (2012) defines sexual health in the United States as follows:

> Sexual health is a state of well-being in relation to sexuality across the lifespan that involves physical, emotional, mental, social, and spiritual dimensions. Sexual health is an inextricable element of human health and is based on a positive, equitable, and respectful approach to sexuality, relationships, and reproduction that is free of coercion, fear, discrimination, stigma, shame, and violence. Sexual health includes: the ability to understand the benefits, risks, and responsibilities of sexual behavior; the prevention and care of disease and other adverse outcomes; and the possibility of fulfilling sexual relationships. (p. 41)

Sexual health occurs when sexual relationships are respectful, safe, and pleasurable. Sexual rights, which are essential for sexual health, are listed in Box 40.2.

BOX 40.2 Sexual Rights

1. The right to equality and non-discrimination
2. The right to life, liberty, and security of the person
3. The right to autonomy and bodily integrity
4. The right to be free from torture and cruel, inhuman, or degrading treatment or punishment
5. The right to be free from all forms of violence and coercion
6. The right to privacy
7. The right to the highest attainable standard of health, including sexual health; with the possibility of pleasurable, satisfying, and safe sexual experiences
8. The right to enjoy the benefits of scientific progress and its application
9. The right to information
10. The right to education and the right to comprehensive sexuality education
11. The right to enter, form, and dissolve marriage and other similar types of relationships based on equality and full and free consent
12. The right to decide whether to have children, the number and spacing of children, and to have the information and the means to do so
13. The right to the freedom of thought, opinion, and expression
14. The right to freedom of association and peaceful assembly
15. The right to participation in public and political life
16. The right to access to justice, remedies, and redress

From *Declaration of Sexual Rights*, by the World Association for Sexual Health, 2014. Reprinted with permission. Retrieved from http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf

Components of Sexual Health

Components of sexual health are sexual self-concept, body image, gender identity, and gender expression. Also see Chapter 39 ∞ for further discussion of self-concept, role, image, and identity.

One's **sexual self-concept** (how one values oneself as a sexual being) determines with whom one will have sex, the gender and kinds of individuals one is attracted to, and the values about when, where, with whom, and how one expresses sexuality. A positive sexual self-concept enables individuals to form intimate relationships throughout life. A negative sexual self-concept may impede the formation of relationships.

Body image, a central part of the sense of self, is constantly changing. Pregnancy, aging, trauma, disease, and therapies can alter an individual's appearance and function, which can affect body image. How an individual feels about their body is related to the individual's sexuality. Individuals who feel good about their bodies are likely to be comfortable with and enjoy sexual activity. Individuals who have a poor body image may respond negatively to sexual arousal. A major influence on body image for women is the media focus on physical attractiveness and breast size. Likewise, many men worry about penis size. The myth that "larger is better," particularly if it stays erect for a substantial time, is pervasive in North America. An individual's body image can suffer when the individual is unable to achieve these expectations.

Androgyny, or flexibility in gender roles, is the belief that most characteristics and behaviors are human qualities that should not be limited to one specific gender or the other. Being androgynous does not mean being sexually neutral or imply anything about one's sexual orientation. Rather, it describes the degree of flexibility an individual has regarding gender-stereotypic behaviors. Adults who can behave flexibly regarding their sexual roles may adapt better than those who adopt rigid stereotyped gender roles.

Gender identity is one's self-image as a female or male. It has a physical component and it also includes social and cultural norms. Gender identity results from developmental events that may or may not conform to an individual's apparent biological sex. Once gender identity is established, it cannot be easily changed.

Gender expression is the outward manifestation of an individual's sense of maleness or femaleness as well as what is perceived as gender-appropriate behavior. Each society defines its roles for males and females (Figure 40.1 ■).

In North America, traditional adult male roles have historically included breadwinner, lover, father, and athlete. Expected male behaviors included wearing trousers, demonstrating physical strength, and expressing feelings in a controlled fashion. Women traditionally express their emotions more freely and are gentler in their physical responses; they also have a broader choice of clothing than men do. These gender expressions are becoming much less common or expected.

Figure 40.1 ■ Gender expression may be apparent at an early age.
BB Arov/PhotoEdit.

Sexual health includes both freedoms and responsibilities. Sexually healthy individuals engage in activities that are freely chosen. Individuals also have freedom of their sexual thoughts, feelings, and fantasies. Sexually healthy individuals are ethically motivated to exercise behavioral, emotional, economic, and social responsibility for themselves.

Sexual Expression

There is tremendous variation in how individuals experience and express their sexuality. There are also many differences in the priority individuals place on sexuality in their lives. Sexual expression includes sexual orientation, gender identity, and performance preferences.

Sexual Orientation

One's attraction to individuals of the same sex, other sex, or both sexes is referred to as **sexual orientation**. Sexual orientation lies along a continuum with a wide range between extremes of exclusive attraction. This is one reason why the number of terms used to describe sexuality is increasing. The term LGBTQQ is frequently used. It stands for lesbian, gay, bisexual, transgender, queer, and questioning. In general, same-sex attraction has been called *homosexuality*; women attracted only to women are referred to as *lesbians*; men attracted to men are referred to as *gay* (although *gay* is also a general term for *homosexual*); individuals attracted to individuals of both genders are referred to as *bisexual*; someone who identifies with a different gender than their anatomic designation is **transgender**; someone who rejects gender stereotypes may be considered *queer*; and those who have not decided on their orientation may be *questioning*. Many other terms may also be used. The nurse should feel comfortable asking for the client's definition of a term if unsure of its meaning.

The origins of sexual orientation are still not well understood. Some biological theories describe sexual

orientation in terms of the genetic composition of the individual. Psychologic theories stress the role of early learning experiences and cognitive processes. Other theories acknowledge the confluence of genetics and the environment in developing sexual orientation.

Estimates of the percentage of the population with a homosexual orientation vary. Because these individuals grow up acutely aware of the discrimination they face in North America, many do not disclose their sexual orientation. A survey of over 1.6 million Americans from 2012 to 2016 demonstrated that 4.1% of adults self-identify as lesbian, gay, bisexual, or transgender, and among those born after 1980, the number is 7.3 % (Gates, 2017).

Gender Identity

Western culture is deeply committed to the idea that there are only two sexes. Biologically speaking, however, there are many gradations running from female to male (Figure 40.2 ■). Sometimes gender is clear, in other cases there is a blending of both genders within the same individual, and in some it is unclear.

Intersex

An increasing number of babies are born with an **intersex** condition in which there are contradictions among chromosomal sex, gonadal sex, internal organs, and external genital appearance (Rich, Phipps, Tiwari, Rudraraju, & Dokpesi, 2016). The gender of such an infant is ambiguous. This means that an intersexed individual has some parts usually associated with males and some parts usually associated with females. Two of the most common syndromes leading to intersex are congenital adrenal hyperplasia and androgen-insensitivity syndrome. Intersex anatomy may not be apparent at birth. Sometimes it is undetected until puberty, until the individual is identified as an infertile adult, or until the individual dies and is autopsied.

Figure 40.2 ■ Gender identity may not be a straightforward classification.
Karen Roach/123RF.

Transgenderism

For the transgender individual, sexual anatomy contradicts gender identity. Those who are born physically male but are emotionally and psychologically female are called male-to-female (MtF) transgender persons. Those who are born female but are emotionally and psychologically male are called female-to-male (FtM) transgender persons. Transgender and transsexual are commonly confused terms that both refer to gender identity. Transgender is a broader term that includes all individuals who do not identify with the gender that corresponds to the sex they were assigned at birth. Transsexual is a narrower term that includes individuals who desire to physically transition to the gender with which they identify.

Transgender is not considered a disorder. In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (referred to as the DSM-5), transgender individuals may be viewed as having *gender dysphoria* only if they have clinically significant distress or impairment in social, school, or other important areas of functioning (Ross, 2017). Most transgender individuals report that they have felt gender dysphoria since early childhood. They often suffer for many years and try to hide the situation from family and friends. Many transgender individuals report living in poverty, psychologic trauma, attempted suicide, mistreatment in school, harassment, and sexual assault (James et al., 2016). As self-understanding and acceptance have increased, many transgender individuals have lived part or full time as members of the other sex. Their sexual orientation may be heterosexual, homosexual, or bisexual. The process of moving from one gender to another is referred to as *transition*. Some individuals decide to undergo sexual reassignment procedures, which involve varying amounts of hormone treatments and surgery. The World Professional Association for Transgender Health publishes *Standards of Care* and *Ethical Guidelines*, which describe the psychiatric, psychologic, medical, and surgical management of gender dysphoria and how professionals can offer assistance to those with this condition.

Based on nursing codes and standards, nurses have an obligation to treat transgender individuals according to the same ethical and social mandates as any other client. In 2018, the American Nurses Association authored the position statement *Nursing Advocacy for LGBTQ+ Populations*. The nurse should follow the following guidelines in care of all clients:

- Do not assume the client's gender or sexual orientation.
- Use gender-neutral language as much as possible. Do not use terms such as "sir" or "miss" without confirming the client's preference. If you make a mistake, acknowledge it.

- Reflect and seek clarification if the client expresses a concept you do not understand.
- Collaborate with all members of the healthcare team to create a welcoming and inclusive environment.
- Identify community and web-based transgender health resources.

Cross-Dressers

Cross-dressing (dressing in the clothing of the other sex) makes individuals' outward appearance consistent with their inner identity and gender role and increases their comfort with themselves. Cross-dressing is a conscious choice and may occur at home or in public settings. The frequency of the activity ranges from rarely to often. Cross-dressers may have a different name to go with the personality and wardrobe. If the social climate is one with rigid gender roles, some individuals may need to express their feminine or masculine identity by creating a separate world and persona within that social climate.

Sexual Practices

Over a lifetime, sexual fantasies and single-partner sex are the most common sexual behaviors. Male-to-female or female-to-female **oral–genital sex** is known technically as cunnilingus. This involves kissing, licking, or sucking of the female genitals including the mons pubis, vulva, clitoris, labia, and vagina. Fellatio is oral stimulation of the penis by licking and sucking. The term "sixty-nine" refers to simultaneous oral–genital stimulation by two individuals. Preconceptions and myths are a major deterrent for those who have not tried oral sex. However, like most sexual practices, oral–genital sex is not completely free of the potential for STI transmission, and safe sex practices must be used.

Anal stimulation can be a source of sexual pleasure because the anus has a rich nerve supply. Stimulation may be applied with fingers, mouth, or sex toys such as vibrators. The anus is surrounded by strong muscles, and the rectum contains no natural lubrication. Thus inserting a finger or penis in the rectum requires relaxation and water-soluble lubricant.

A common form of sexual activity for heterosexual couples is **genital intercourse**. Penile–vaginal intercourse (**coitus**) can be both physically and emotionally satisfying. Various positions are used for this kind of intercourse; the most common is lying face to face (with female or male on top). Side-lying, standing, sitting, and rear-entry positions are also used. Side-lying, female-on-top, and rear-entry positions facilitate clitoral stimulation, either by penile or manual contact. The choice of intercourse positions and activities depends on physical comfort and beliefs, values, and attitudes about different practices.

During intercourse, the man moves the penis back and forth along the vaginal walls by rhythmic thrusting movements of his hips. The woman may move her own body to match the partner's hip movements. Movements continue until orgasm is achieved by one or both partners. Simultaneous orgasm can be difficult to achieve. After coitus, caressing, hugging, and kissing can increase the shared intimacy.

The other form of genital intercourse is anal intercourse, during which the penis is inserted into the anus and rectum of the partner. Anal intercourse is commonly practiced by gay men, but heterosexual couples engage in it as well. Positions for anal intercourse are similar to those for penile–vaginal intercourse, with minor differences due to the position of the anus. Current practice dictates the use of a condom to prevent the transmission of infections. Because anorectal tissue is not self-lubricating, a lubricant must be used on the condom. Also, because normal bacterial flora from the bowel can produce infection in other parts of the body, the used condom should be removed and another applied before inserting the penis into other body orifices.

Many other varieties of sexuality are beyond the scope of this text. These include several or many partners, nudism, swinging, group sex, fetishism, sexual sadism, and sexual masochism.

Factors Influencing Sexuality

Many factors influence an individual's sexuality. Discussed here are family, culture, religion, and personal expectations and ethics.

Family

For the majority of us, the family is the earliest and most enduring social relationship. Families are the fabric of our day-to-day lives and shape the quality of our lives by influencing our outlooks on life, our motivations, our strategies for achievement, and our styles for coping with adversity. Within our families we develop our gender identity, body image, sexual self-concept, and capacity for intimacy. Through family interactions we learn about relationships and gender roles and our expectations of others and ourselves (Figure 40.3 ■).

Figure 40.3 ■ Children often imitate their parents' roles.
Orange Line Media/Shutterstock.

From earliest beginnings, children observe their parents and model themselves after these role models. If parents can share affection with each other and other family members, children will most likely become adults who can give and receive affection. If parents seldom hug, hold hands, or kiss each other, their children may become adults who are very uncomfortable with romantic touch. If family expectations for gender expression is very rigid, arguments and hurt feelings will abound if an individual from this system is partnered with an individual who grew up in an androgynous family system. Family messages about sex range from "sex is so shameful it shouldn't be talked about" to "sex is a joyful part of adult relationships." The following are common sexual messages children get from their families:

- Sex is dirty.
- Premarital sex is sinful.
- Good girls don't do it.
- Masturbation is disgusting.
- Men should be the sexual experts.
- Sex is mainly for procreating.
- Bodies, including genitals, are beautiful.
- Sex should be fun for both women and men.
- Sexual thoughts and feelings are natural.
- Masturbation is a common, pleasurable activity.
- There is great variety in sexual behaviors.

Culture

Culture influences the sexual nature of dress, rules about marriage, expectations of role behavior and social responsibilities, and sex practices. Societal attitudes vary widely. Attitudes about childhood sexual play with self or children of the same gender or other gender may be restrictive or permissive. Premarital and extramarital sex and homosexuality may be culturally unacceptable or tolerated. Polygamy (several mates or marriage partners) or monogamy (one mate or marriage partner) may be the norm. Gender expression also varies from culture to culture. Culture is so much a part of everyday life that it is taken for granted. We assume that others share our own views, including those for whom we provide care. It is impossible to provide sensitive nursing care if we believe that our own culture is more important than, and preferable to, any other culture.

Cultures differ regarding which body parts they find to be erotic. In some cultures, legs are erotic and breasts are not. Body weight may also be a determinant of sexual attractiveness. There is a great deal of pressure in American culture to be very thin. Women considered obese in America are found highly attractive in other countries. Public nudity ranges from women's entire bodies and faces being covered in some Islamic societies to complete nudity in some cultures in New Guinea and Australia.

Female circumcision, also known as female genital mutilation, female ritual cutting (FRC), or female genital cutting (FGC), is a practice in parts of Africa, the Middle East, and Asia that has also spread to other regions due to immigration. Some of the cultural beliefs behind the practice include the following: Female genitals are offensive to men, if not removed the clitoris will become the size of a penis, the labia gets in the way of intercourse, the cutting enhances fertility, and it prepares the woman for childbirth. Removal of the clitoris may or may not be accompanied by removal of the labia and closure of the vaginal entrance except for a small opening. Long-term medical complications include urinary incontinence, chronic urinary tract infections, vaginal scarring, pain syndromes, infertility, and sexual dysfunctions. FGC has been banned by the United Nations and several national and international organizations (World Health Organization, 2016).

Male circumcision is controversial. Some professional groups support newborn circumcision believing it will prevent the spread of HIV and other infections (Brady, 2016). Others say there is insufficient evidence of potential medical benefits. In addition to the medical issues, there are also ethical concerns related to performing elective surgery on children too young to provide consent (Svoboda, Adler, & Van Howe, 2016). In June 2013, Germany banned the circumcision of boys under the age of 18. However, circumcision is also a religious ritual among Jews and Muslims. Newborn circumcision rates vary according to geographic region in the United States.

Religion

Religion influences sexual expression. It provides guidelines for sexual behavior and acceptable circumstances for the behavior, as well as prohibited sexual behavior and the consequences of breaking the sexual rules. The guidelines or rules may be detailed and rigid or broad and flexible. Some religions view forms of sexual expression other than male–female intercourse as unnatural and hold virginity before marriage to be the rule.

Many religious values conflict with the more flexible values of society that have developed during the past few decades (often labeled the "sexual revolution"), such as the acceptance of premarital sex, unwed parenthood, homosexuality, and abortion. These conflicts create marked anxiety and potential sexual dysfunctions in some individuals. See Chapter 41 for additional information about religious values.

Personal Expectations and Ethics

Although ethics is integral to religion, ethical thought and ethical approaches to sexuality can be viewed separately from religion. Cultures have developed written or unwritten codes of conduct based on ethical principles. Personal expectations concerning sexual behavior come from these cultural norms. What one individual or culture views as bizarre, perverted, or wrong may be natural and right to another. Examples include values regarding masturbation, oral or anal intercourse, and cross-dressing. Many individuals accept a variety of sexual expressions if

they are performed by consenting adults, are practiced in private, and are not harmful. Individuals need to explore and communicate clearly about various types of acceptable sexual expression to prevent domination of sexual decision-making by any individual. To assess a few of your personal values, complete the statements in Box 40.3.

BOX 40.3 Assessing Personal Sexual Values

- I believe sexual satisfaction is . . .
- When I think of my parents having sex, I . . .
- If I cared for a transgender client, I would . . .
- When I think about lesbians, gays, and bisexuals, I . . .
- Masturbation is . . .
- My beliefs about oral sex are . . .

Sexual Response Cycle

Commonly occurring phases of the human sexual response follow a similar sequence in both females and males regardless of sexual orientation. It does not matter if the motive for being sexually active is true love or passionate lust. Table 40.3 provides a summary of the physiologic changes associated with each phase of the cycle.

The response cycle starts in the brain, with conscious sexual desires called the **desire phase**. Sexually arousing stimuli, often called erotic stimuli, may be real or symbolic. Sight, hearing, smell, touch, and imagination (sexual fantasy) can all invoke sexual arousal. Sexual desire fluctuates within each individual and varies among individuals. If individuals suppress or block out conscious sexual desires, they may experience no physiologic response.

TABLE 40.3 Physiologic Changes Associated with the Sexual Response Cycle

Phase of the Sexual Response Cycle	Signs Present in Both Sexes	Signs Present in Males Only	Signs Present in Females Only
Excitement and plateau	Muscle tension increases as excitement increases. Sex flush, usually on chest. Nipple erection.	Penile erection; glans size increases as excitement increases. Appearance of a few drops of lubricant, which may contain sperm.	Erection of the clitoris. Vaginal lubrication. Labia may increase 2 to 3 times in size. Breasts enlarge. Inner two-thirds of vagina widens and lengthens; outer third swells and narrows. Uterus elevates.
Orgasmic	Respirations may increase to 40 breaths/min. Involuntary spasms of muscle groups throughout the body. Diminished sensory awareness. Involuntary contractions of the anal sphincter. Peak heart rate (110–180 beats/min), respiratory rate (40/min or greater), and blood pressure (systolic 30–80 mmHg and diastolic 20–50 mmHg above normal).	Rhythmic, expulsive contractions of the penis at 0.8-sec intervals. Emission of seminal fluid into the prostatic urethra from contraction of the vas deferens and accessory organs (stage 1 of the expulsive process). Closing of the internal bladder sphincter just before ejaculation to prevent retrograde ejaculation into bladder. Orgasm may occur without ejaculation. Ejaculation of semen through the penile urethra and expulsion from the urethral meatus. The force of ejaculation varies from man to man and at different times but diminishes after the first two to three contractions (stage 2 of the expulsive process).	Approximately 5–12 contractions in the orgasmic platform at 0.8-sec intervals. Contraction of the muscles of the pelvic floor and the uterine muscles. Varied pattern of orgasms, including minor surges and contractions, multiple orgasms, or a simple intense orgasm similar to that of the male.
Resolution	Reversal of vasocongestion in 10–30 min; disappearance of all signs of myotonia within 5 min. Genitals and breasts return to their pre-excitement states. Sex flush disappears in reverse order of appearance. Heart rate, respiratory rate, and blood pressure return to normal. Other reactions include sleepiness, relaxation, and emotional outbursts such as crying or laughing.	A refractory period during which the body will not respond to sexual stimulation; varies, depending on age and other factors, from a few moments to hours or days.	

7. Loss, grief, death and dying

Loss, grief, death, and dying are inevitable aspects every nurse will encounter in their professional practice. Nurses play a crucial role in supporting patients and their families through these difficult experiences, offering emotional support, compassionate care, and guidance. Understanding the different stages of grief and the varied ways individuals cope with loss is essential to providing empathetic and effective care. By addressing these sensitive issues with respect and dignity, nurses help ease suffering, promote comfort, and ensure that patients receive compassionate end-of-life care tailored to their needs and wishes.

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Loss, Grieving, and Death 43

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe types and sources of losses.
2. Discuss selected frameworks for identifying stages of grieving.
3. Identify clinical symptoms of grief.
4. Discuss factors affecting a grief response.
5. Identify measures that facilitate the grieving process.
6. List clinical signs of impending and actual death.
7. Describe the process of helping clients die with dignity.
8. Describe the role of the nurse in working with families or caregivers of dying clients.
9. Describe nursing measures for care of the body after death.

KEY TERMS

actual loss, *1085*
algor mortis, *1101*
anticipatory grief, *1086*
anticipatory loss, *1086*
bereavement, *1086*
cerebral death, *1094*
closed awareness, *1096*
complicated grief, *1086*
end-of-life care, *1099*
grief, *1086*
heart-lung death, *1094*
higher brain death, *1094*
hospice, *1098*
livor mortis, *1101*
loss, *1085*
mortician, *1101*
mourning, *1086*
mutual pretense, *1096*
open awareness, *1096*
palliative care, *1099*
perceived loss, *1085*
persistent vegetative state (PVS), *1094*
rigor mortis, *1100*
shroud, *1101*
undertaker, *1101*

Introduction

Everyone experiences loss, grieving, and death during his or her life. Individuals may suffer the loss of valued relationships through life changes, such as moving from one city to another; separation or divorce; or the death of a parent, spouse, or friend. Individuals may grieve changing life roles as they watch grown children leave home or they retire from their lifelong work. Losing valued material objects through theft or natural disaster can evoke feelings of grief and loss. When individuals' lives are affected by civil or national violence, they may grieve the loss of valued ideals such as safety, freedom, or democracy.

In the clinical setting, the nurse encounters clients who may experience grief related to declining health, loss of a body part, terminal illness, or the impending death of self or a significant other. The nurse may also work with clients in community settings who are grieving losses related to a personal crisis (e.g., divorce, separation, financial loss) or disaster (war, earthquakes, or terrorism). Therefore, it is important for the nurse to understand the significance of loss and develop the ability to assist clients as they work through the grieving process.

Nurses may interact with dying clients and their families or caregivers in a variety of settings, from a fetal demise (death of an unborn child), to the adolescent victim of an accident, to the older client who finally succumbs to a chronic illness. Nurses must recognize the influences on the dying process—legal, ethical, spiritual, biological, psychologic—and be prepared to provide sensitive, skilled, and supportive care to all those affected.

Loss and Grief

Loss is an actual or potential situation in which something that is valued is changed or no longer available. Individuals can experience the loss of body image, a significant other, a sense of well-being, a job, personal possessions, or beliefs. Illness and hospitalization often produce losses.

Death is a loss both for the dying individual and for those who survive. Although death is inevitable, it can stimulate individuals to grow in their understanding of themselves and others. Individuals experiencing loss often search for the meaning of the event, and it is generally accepted that finding meaning is needed in order for healing to occur. However, individuals can be well adjusted without searching for meaning, and even those who find meaning may not see it as an end point but rather as an ongoing process.

Types and Sources of Loss

There are two general types of loss, actual and perceived. An **actual loss** can be recognized by others. A **perceived loss** is experienced by an individual but cannot be verified by others. Psychologic losses are often perceived losses

because they are not directly verifiable. For example, a woman who leaves her employment to care for her children at home may perceive a loss of independence and freedom. Both losses can be anticipatory. An **anticipatory loss** is experienced before the loss actually occurs. For example, a woman whose husband is dying may experience actual loss in anticipation of his death.

Loss can be viewed as situational or developmental. Losing one's job, the death of a child, and losing functional ability because of acute illness or injury are situational losses. Losses that occur in normal development—such as the departure of grown children from the home, retirement from a career, and the death of aged parents—are developmental losses that can, to some extent, be anticipated and prepared for.

There are many sources of loss: (a) loss of an aspect of oneself—a body part, a physiologic function, or a psychologic attribute; (b) loss of an object external to oneself; (c) separation from an accustomed environment; and (d) loss of a loved or valued individual.

Aspect of Self

Losing an aspect of self changes an individual's body image, even though the loss may not be obvious. A face scarred from a burn is generally obvious; loss of part of the stomach or loss of the ability to feel emotion may not be as obvious. The degree to which these losses affect an individual largely depends on the integrity of the individual's body image.

During old age, changes occur in physical and mental capabilities. Again the self-image is vulnerable. Old age is the stage when people may experience many losses: of employment, of usual activities, of independence, of health, of friends, and of family.

External Objects

Loss of external objects includes (a) loss of inanimate objects that have importance to the individual, such as losing money or the burning down of a family's house; and (b) loss of animate (live) objects such as pets that provide love and companionship.

Familiar Environment

Separation from an environment and individuals who provide security can cause a sense of loss. The 6-year-old is likely to feel loss when first leaving the home environment to attend school. Immigrants who leave their country to settle down in another also experience loss and helplessness in the form of culture shock (Arredondo-Dowd, 1981; Henry, Stiles & Biran, 2005).

Loved Ones

Losing a loved one or valued individual through illness, divorce, separation, or death can be very disturbing. In some illnesses (such as Alzheimer's disease), an individual may undergo personality changes that make friends and family feel they have lost that individual.

Grief, Bereavement, and Mourning

Grief is the total response to the emotional experience related to loss. Grief is manifested in thoughts, feelings, and behaviors associated with overwhelming distress or sorrow. **Bereavement** is the subjective response experienced by the surviving loved ones. **Mourning** is the behavioral process through which grief is eventually resolved or altered; it is often influenced by culture, spiritual beliefs, and custom. Grief and mourning are experienced not only by the individual who faces the death of a loved one but also by the individual who suffers other kinds of losses. Grieving permits the individual to cope with the loss gradually and to accept it as part of reality. Grief is a social process; it is best shared and carried out with the assistance of others.

Working through one's grief is important because bereavement may have potentially devastating effects on health. Among the symptoms that can accompany grief are anxiety, depression, weight loss, difficulties in swallowing, vomiting, fatigue, headaches, dizziness, fainting, blurred vision, skin rashes, excessive sweating, menstrual disturbances, palpitations, chest pain, and dyspnea. The grieving and the bereaved may experience alterations in libido, concentration, and patterns of eating, sleeping, activity, and communication.

Although bereavement can threaten health, a positive resolution of the grieving process can enrich the individual with new insights, values, challenges, openness, and sensitivity. For some, the pain of loss, though diminished, recurs for the rest of their lives.

Types of Grief Responses

A normal grief reaction may be abbreviated or anticipatory. Abbreviated grief is brief but genuinely felt. This can occur when the lost object is not significantly important to the grieving individual or may have been replaced immediately by another, equally esteemed object. **Anticipatory grief** is experienced in advance of the event such as the wife who grieves before her ailing husband dies. A young individual may grieve before an operation that will leave a scar. Because many of the normal symptoms of grief will have already been expressed in anticipation, the reaction when the loss actually occurs is sometimes quite abbreviated.

Disenfranchised grief occurs when an individual is unable to acknowledge the loss to others. Situations in which this may occur often relate to a socially unacceptable loss that cannot be spoken about, such as suicide, abortion, or giving a child up for adoption. Other examples include losses of relationships that are socially unsanctioned and may not be known to others (such as with extramarital relationships).

Unhealthy grief—that is, pathologic or **complicated grief**—exists when the strategies to cope with the loss are maladaptive and out of proportion or inconsistent with cultural, religious, or age-appropriate norms.

The disorder, referred to by physicians as *persistent complex bereavement disorder*, may be said to exist if the preoccupation lasts for more than 12 months and leads to reduced ability to function normally (Boelen, Lenferink, Nickerson, & Smid, 2018). Many factors can contribute to complicated grief, including a prior traumatic loss, family or cultural barriers to the emotional expression of grief, sudden death, strained relationships between the survivor and the deceased, and lack of adequate support for the survivor.

Complicated grief may take several forms. *Unresolved* or *chronic grief* is extended in length and severity. The same signs are expressed as with normal grief, but the bereaved may also have difficulty expressing the grief, may deny the loss, or may grieve beyond the expected time. With *inhibited grief*, many of the normal symptoms of grief are suppressed and other effects, including physiologic, are experienced instead. *Delayed grief* occurs when feelings are purposely or subconsciously suppressed until a much later time. A survivor who appears to be using dangerous activities as a method to lessen the pain of grieving may experience *exaggerated grief*.

Complicated grief after a death may be inferred from the following data or observations:

- The client fails to grieve; for example, a husband does not cry at, or absents himself from, his wife's funeral.
- The client avoids visiting the grave and refuses to participate in memorial services, even though these practices are a part of the client's culture.
- The client develops persistent guilt and lowered self-esteem.
- Even after a prolonged period, the client continues to search for the lost loved one. Some may consider suicide to affect reunion.
- After the normal period of grief, the client experiences physical symptoms similar to those of the individual who died.
- The client's relationships with friends and relatives worsen following the death.

Many factors contribute to unresolved grief after a death:

- Ambivalence (intense feelings, both positive and negative) toward the lost individual
- A perceived need to be brave and in control; fear of losing control in front of others
- Endurance of multiple losses, such as losing an entire family, which the bereaved finds too overwhelming to contemplate
- Extremely high emotional value invested in the dead individual; failure to grieve in this instance helps the bereaved avoid the reality of the loss
- Uncertainty about the loss—for example, when a loved one is "missing in action"
- Lack of support systems.

Stages of Grieving

Many authors have described stages or phases of grieving, perhaps the most well known of them being Kübler-Ross (1969), who described five stages: denial, anger, bargaining, depression, and acceptance (Table 43.1). Engel (1964) identified six stages of grieving: shock and disbelief,

TABLE 43.1 Client Responses and Nursing Implications in Kübler-Ross's Stages of Grieving

Stage	Behavioral Responses	Nursing Implications
Denial	Refuses to believe that loss is happening. Is unready to deal with practical problems, such as prosthesis after the loss of a leg. May assume artificial cheerfulness to prolong denial.	Verbally support client but do not reinforce denial. Examine your own behavior to ensure that you do not share in client's denial.
Anger	Client or family may direct anger at nurse or staff about matters that normally would not bother them.	Help client understand that anger is a normal response to feelings of loss and powerlessness. Avoid withdrawal or retaliation; do not take anger personally. Deal with needs underlying any angry reaction. Provide structure and continuity to promote feelings of security. Allow clients as much control as possible over their lives.
Bargaining	Seeks to bargain to avoid loss (e.g., "let me just live until [a certain time] and then I will be ready to die").	Listen attentively, and encourage client to talk to relieve guilt and irrational fear. If appropriate, offer spiritual support.
Depression	Grieves over what has happened and what cannot be. May talk freely (e.g., reviewing past losses such as money or job), or may withdraw.	Allow client to express sadness. Communicate nonverbally by sitting quietly without expecting conversation. Convey caring by touch.
Acceptance	Comes to terms with loss. May have decreased interest in surroundings and support people. May wish to begin making plans (e.g., will, prosthesis, altered living arrangements).	Help family and friends understand client's decreased need to socialize. Encourage client to participate as much as possible in the treatment program.

TABLE 43.2 Engel's Stages of Grieving

Stage	Behavioral Responses
Shock and disbelief	Refuses to accept loss. Has stunned feelings. Accepts the situation intellectually, but denies it emotionally.
Developing awareness	Reality of loss begins to penetrate consciousness. Anger may be directed at agency, nurses, or others.
Restitution	Conducts rituals of mourning (e.g., funeral).
Resolving the loss	Attempts to deal with painful void. Still unable to accept new love object to replace lost person or object. May accept more dependent relationship with support person. Thinks over and talks about memories of the lost object.
Idealization	Produces image of lost object that is almost devoid of undesirable features. Represses all negative and hostile feelings toward lost object. May feel guilty and remorseful about past inconsiderate or unkind acts to lost person. Unconsciously internalizes admired qualities of lost object. Reminders of lost object evoke fewer feelings of sadness. Reinvests feelings in others.
Outcome	Behavior influenced by several factors: importance of lost object as source of support, degree of dependence on relationship, degree of ambivalence toward lost object, number and nature of other relationships, and number and nature of previous grief experiences (which tend to be cumulative).

From "Grief and Grieving," by G. L. Engel, 1964, *American Journal of Nursing*, 64(9), pp. 93-98. Adapted with permission.

developing awareness, restitution, resolving the loss, idealization, and outcome (Table 43.2). Sanders (1998) described five phases of bereavement: shock, awareness of loss, conservation/withdrawal, healing, and renewal (Table 43.3).

Whether an individual can integrate the loss and how this is accomplished are related to that individual's development, personality, and emotional preparedness. In addition, individuals responding to the very same loss cannot be expected to follow the same pattern or schedule in resolving their grief, even while they support each other.

Manifestations of Grief

The nurse assesses the grieving client or family members following a loss to determine the phase or stage of grieving. Physiologically, the body responds to a current or anticipated loss with a stress reaction. The nurse can assess the clinical signs of this response (see Chapter 42 ∞).

Manifestations of grief considered normal include verbalization of the loss, crying, sleep disturbance, loss of appetite, and difficulty concentrating. Complicated grieving may be characterized by extended time of denial, depression, severe physiologic symptoms, or suicidal thoughts.

Factors Influencing the Loss and Grief Responses

Several factors affect an individual's response to a loss or death. These factors include age, significance of the loss, culture, spiritual beliefs, gender, socioeconomic status, support systems, and the cause of the loss or death. Nurses can learn general concepts about the influence of these factors on the grieving experience, but the constellation of these factors and their significance will vary from client to client.

Age

Age affects an individual's understanding of and reaction to loss. With familiarity, individuals usually increase their understanding and acceptance of life, loss, and death.

Individuals rarely experience the loss of loved ones at regular intervals. As a result, preparation for these experiences is difficult. Other life losses, such as losing a pet, a friend, youth, or a job, can help individuals anticipate the more severe loss of death of loved ones by teaching them successful coping strategies.

CHILDHOOD

Children differ from adults not only in their understanding of loss and death but also in how they are affected by losing others. Losing a parent or other significant individual can threaten the child's ability to develop, and regression sometimes results. Assisting the child with the grief experience includes helping the child regain the normal continuity and pace of emotional development.

Some adults may assume that children do not have the same need as an adult to grieve the loss of others. In situations of crisis and loss, children are sometimes pushed aside or protected from the pain. They can feel afraid, abandoned, and lonely. Careful work with bereaved children is especially necessary because experiencing a loss in childhood can have serious effects later in life (Figure 43.1 ■).

EARLY AND MIDDLE ADULTHOOD

As individuals grow, they come to experience loss as part of normal development. By middle age, for example, the loss of a parent through death seems a more normal occurrence compared to the death of a younger individual. Coping with the death of an aged parent has even been viewed as an essential developmental task of the middle-aged adult.

TABLE 43.3 Sander's Phases of Bereavement

Phase	Description	Behavioral Responses
Shock	Survivors are left with feelings of confusion, unreality, and disbelief that the loss has occurred. They are often unable to process normal thought sequences. Phase may last from a few minutes to many days.	Disbelief Confusion Restlessness Feelings of unreality Regression and helplessness State of alarm Physical symptoms: dryness of mouth and throat, sighing, weeping, loss of muscular control, uncontrolled trembling, sleep disturbance, loss of appetite Psychologic symptoms: egocentric phenomenon, preoccupation with thoughts of the deceased, psychologic distancing
Awareness of loss	Friends and family resume normal activities. The bereaved experience the full significance of their loss.	Separation anxiety Conflicts Acting out emotional expectations Prolonged stress Physical symptoms: yearning, anger, guilt, frustration, shame, crying, sleep disturbance, fear of death Psychologic symptoms: oversensitivity, disbelief and denial, dreaming, sense of presence of the deceased
Conservation/withdrawal	During this phase, survivors feel a need to be alone to conserve and replenish both physical and emotional energy. The social support available to the bereaved has decreased, and they may experience despair and helplessness.	Withdrawal Despair Diminished social support Helplessness Physical symptoms: weakness, fatigue, need for more sleep, a weakened immune system Psychologic symptoms: hibernation or holding pattern, obsessional review, grief work, turning point
Healing: the turning point	During this phase, the bereaved move from distress about living without their loved one to learning to live more independently.	Assuming control Identity restructuring Relinquishing roles, such as spouse, child, or parent Physical symptoms: increased energy, sleep restoration, immune system restoration, physical healing Psychologic symptoms: forgiving, forgetting, searching for meaning, closing of the circle, hope
Renewal	In this phase, survivors move on to a new self-awareness, an acceptance of responsibility for self, and learning to live without the loved one.	New self-awareness Acceptance of responsibility Process of learning to live without Physical symptoms: functional stability, revitalization, caring for physical needs Assumption of responsibility for self-care needs Psychologic symptoms: living for oneself, loneliness, anniversary reactions, reaching out to others, time for the process of bereavement

From *Grief: The Mourning After: Dealing with Adult Bereavement*, 2nd ed., by Catherine M. Sanders, 1999, New York, NY: John Wiley & Sons, Inc.

Figure 43.1 ■ Children experience the same emotions of grief as adults.
Kzenon/123RF.

The middle-aged adult can experience losses other than death. For example, losses resulting from impaired health or body function and losses of various role functions can be difficult for the middle-aged adult. How the middle-aged adult responds to such losses is influenced by previous experiences with loss, the individual's sense of self-esteem, and the strength and availability of support.

LATE ADULTHOOD

Losses experienced by older adults include loss of health, mobility, independence, and work role. Limited income and the need to change one's living accommodations can also lead to feelings of loss and grieving.

For older adults, the loss through death of a longtime mate is profound. Although individuals differ in their ability to deal with such a loss, some research suggests that health problems for widows decrease and health problems of widowers increase following the death of the spouse (Trevisan et al., 2016). This may be because the widows are relieved of the stresses of caring for their spouse while the widowers have lost the care provided by their spouse, although this would vary depending on culture and gender norms.

Because the majority of deaths occur among older adults, and because the number of older adults is increasing in North America, nurses will need to be especially alert to the potential problems of older grieving adults. These problems may intensify because the very old grieving individual may have children who, themselves, are older and possibly unwell. Some older adults no longer have living peer support people and the nurse may need to fill some of that role.

Significance of the Loss

The significance of a loss depends on the perceptions of the individual experiencing the loss. One individual may experience a great sense of loss over a divorce; another may find it only mildly disrupting. Several factors affect the significance of the loss:

- Importance of the lost individual, object, or function
- Degree of change required because of the loss
- The individual's beliefs and values.

For older adults who have already encountered many losses, an anticipated loss such as their own death may not be viewed as highly negative, and they may be apathetic about it instead of reactive. More than fearing death, some may fear loss of control or becoming a burden.

Culture

Culture influences an individual's reaction to loss. How grief is expressed is often determined by the customs of the culture. Unless an extended family structure exists, grief is handled by the nuclear family. The death of a family member in a typical nuclear family leaves a great void because the same few individuals fill most of the roles. In cultures where several generations and extended family members either reside in the same household or are physically close, the impact of a family member's death may be softened because the roles of the deceased are quickly filled by other relatives.

Some individuals believe that grief is a private matter to be endured internally. Therefore, feelings tend to be repressed and may remain unidentified. Individuals socialized to "be strong" and "make the best of the situation" may not express deep feelings or personal concerns when they experience a serious loss.

Some cultural groups value social support and the expression of loss. In some groups, expressions of grief through wailing, crying, physical prostration, and other outward demonstrations are acceptable and encouraged. Other groups may frown on this demonstration as a loss of control, favoring a more quiet and stoic expression of grief. In cultural groups where strong kinship ties are maintained, physical and emotional support and assistance are provided by family members.

Spiritual Beliefs

Spiritual beliefs and practices greatly influence both an individual's reaction to loss and subsequent behavior. Most religious groups have practices related to dying, and these are often important to the client and support people. To provide support at a time of death, nurses need to understand the client's particular beliefs and practices (see Chapter 41 ∞).

Gender

The gender roles into which many individuals are socialized in the United States affect their reactions at times of loss. Males are frequently expected to "be strong" and show very little emotion during grief, whereas it is acceptable for females to show grief by crying. When a wife dies, the husband, who is the chief mourner, may be expected to repress his own emotions and to comfort sons and daughters in their grieving.

Gender roles also affect the significance of body image changes to clients. A man might consider his facial scar to be "macho," but a woman might consider hers ugly. Thus the woman, but not the man, would see the change as a loss.

Socioeconomic Status

The socioeconomic status of an individual often affects the support system available at the time of a loss. A pension plan or insurance, for example, can offer an individual who is widowed or disabled a choice of ways to deal with a loss; an individual who is confronted with both severe loss and economic hardship may not be able to cope with either.

Support System

The individuals closest to the grieving individual are often the first to recognize and provide needed emotional, physical, and functional assistance. However, because many individuals are uncomfortable or inexperienced in dealing with losses, the usual support people may instead withdraw from the grieving individual. In addition, support may be available when the loss is first recognized, but as the support people return to their usual activities, the need for ongoing support may be unmet. Sometimes, the grieving individual is unable or unready to accept support when offered.

Cause of Loss or Death

Individual and societal views on the cause of a loss or death may significantly influence the grief response. Some diseases are considered "clean," such as cardiovascular disorders, and engender compassion, whereas others may be viewed as repulsive and less unfortunate. A loss or death beyond the control of those involved may be more acceptable than one that is preventable, such as a drunk driving incident. Injuries or deaths that occur during respected activities, such as "in the line of duty," are considered honorable, whereas those occurring during illicit activities may be considered the individual's just rewards.

Implementing

Besides providing physical comfort, maintaining privacy and dignity, and promoting independence, the skills most relevant to situations of loss and grief are those of effective communication: attentive listening, silence, open and closed questioning, paraphrasing, clarifying and reflecting feelings, and summarizing. Less helpful to clients are responses that give advice and evaluation, those that interpret and analyze, and those that give unwarranted reassurance. Communication with grieving clients must relate to their stage of grief. Whether the client is angry or depressed affects how the client hears messages and how the nurse interprets the client's statements.

Besides using effective communication skills, the nurse implements a plan to provide client and family teaching and to help the client work through the stages of grief.

Facilitating Grief Work

- Explore and respect the client's and family's ethnic, cultural, religious, and personal values in their expressions of grief.
- Teach the client or family what to expect in the grief process, such as that certain thoughts and feelings are normal (acceptable) and that labile emotions, feelings of sadness, guilt, anger, fear, and loneliness, will stabilize or lessen over time. Knowing what to expect may lessen the intensity of some reactions.
- Encourage the client to express and share grief with support people. Sharing feelings reinforces relationships and facilitates the grief process.
- Teach family members to encourage the client's expression of grief, not to push the client to move on or enforce his or her own expectations of appropriate reactions. If the client is a child, encourage family members to be truthful and to allow the child to participate in the grieving activities of others.
- Encourage the client to resume normal activities on a schedule that promotes physical and psychologic health. Some clients may try to return to normal activities too quickly. However, a prolonged delay in return may indicate complicated grieving.

Providing Emotional Support

- Use silence and personal presence along with techniques of therapeutic communication. These techniques enhance exploration of feelings and let clients know that the nurse acknowledges their feelings.
- Acknowledge the grief of the client's family and significant others. Family support persons are part of the grieving client's world.
- Offer choices that promote client autonomy. Clients need to have a sense of some control over their own lives at a time when much control may not be possible.
- Provide information regarding how to access community resources: clergy, support groups, and counseling services.
- Suggest additional sources of information and help such as:
  a. Bereavement Network Europe
  b. Hong Kong Family Welfare Society
  c. Australian Centre for Grief and Bereavement
  d. National Hospice and Palliative Care Organization.

Examples of nursing actions appropriate for clients in various stages of the grief process are shown in the Concept Map on page 1102.

Evaluating

Evaluating the effectiveness of nursing care of the grieving client is difficult because of the long-term nature of the life transition. Criteria for evaluation must be based on goals set by the client and family.

Client goals and related desired outcomes for a grieving client will depend on the characteristics of the loss and the client. If outcomes are not achieved, the nurse needs to explore why the plan was unsuccessful. Such exploration begins with reassessing the client in case the nursing diagnoses were inappropriate. Examples of questions guiding the exploration include these:

- Do the client's grieving behaviors indicate dysfunctional grieving or another nursing diagnosis?
- Is the expected outcome unrealistic for the given time frame?
- Does the client have additional stressors previously not considered that are affecting grief resolution?
- Have nursing orders been implemented consistently, compassionately, and genuinely?

Dying and Death

The concept of death is developed over time, as the individual grows, experiences various losses, and thinks about concrete and abstract concepts. In general, humans move from a childhood belief in death as a temporary state, to adulthood in which death is accepted as very real but also very frightening, to older adulthood in which death may be viewed as more desirable than living with a poor quality of life. Table 43.4 describes some of the specific beliefs common to different age groups. The nurse's knowledge of these developmental stages helps in understanding some of the client's responses to a life-threatening situation.

Responses to Dying and Death

The reaction of any individual to another individual's impending or real death, or to the potential reality of his or her own death, depends on all the factors regarding loss and the development of the concept of death. In spite of the individual variations in clients' views about the cause of death, spiritual beliefs, availability of support systems, or any other factor, responses tend to cluster in the phases described by theorists (see Tables 43.1 to 43.3).

Both the client who is dying and the family members grieve as they recognize the loss. Signs and symptoms for the nursing diagnosis of grieving include denial, guilt,

Table 56.9 Pain control in mucositis

Classification	Agent	Dosage
Local anaesthetics	Lignocaine Benzydamine Hydrochloride mouthwash	2% viscous: 15 ml 4-hourly, rinse and expel 10% spray: 2 sprays 2–3-hourly to affected area Gel: apply to affected area as required 5–30 ml 3–4-hourly
	Benzocaine	Lozenges: suck 1–2 tds Spray: 2 sprays 2–3-hourly
Topical NSAIDS	Benzydamine	0.15% solution, 15 ml 4-hourly, rinse and expel Ointment: apply to affected area as required
Topical salicylates	Choline salicylate	Apply gel with gentle massage 4–6-hourly
Coating and protective agents	Sucralfate suspension	15–30 ml as a mouthwash 2–4-hourly, rinse and expel
Diphenhydramine	Diphenhydramine elixir and Kaopectate® (equal parts) solution	15–30 ml 2–4-hourly, rinse and expel
	Diphenhydramine elixir, aluminium hydroxide antacid, lignocaine viscous (equal parts) solution	15–30 ml 2–4-hourly, rinse and expel
Topical morphine	Anecdotal evidence shows that a solution containing combinations of morphine with any of the above preparations is effective	Lignocaine viscous 2% mixed with a 15-mg ampoule of morphine sulphate; rinse and expel OR Benzocaine gel mixed with a 15-mg ampoule of morphine sulphate applied topically

End-of-life care

Impending death naturally affects everyone involved with the patient: the family, caregivers and friends, and of course the patient themselves. Caregivers should be particularly careful of how they treat the patient during this time and of what they say. The patient's family easily becomes aware of every little thing that is said or done to their loved one. Remember that even when patients have reached a stage when they are not aware of their surroundings, they should still be cared for with dignity and respect. Each patient will react differently to the terminal phase, which will depend on factors such as their previous experiences with illness, their current physical condition, and other psychosocial issues. However, according to Dr Elizabeth Kubler-Ross, the dying person will experience five stages in coping with the knowledge of terminal illness, namely denial, anger, bargaining, depression and acceptance.

Denial: Stage 1

Denial is a useful psychological defence mechanism that may be used by the patient to block threatening reality by ignoring it. It is often the first reaction to approaching death and/or any sad news. It is a necessary short-term reaction from which the patient will gradually recuperate, thus enabling the patient to adapt to changes and approaching death.

A patient may overcome this phase easily, depending on how the news is conveyed, how much time there is to assimilate it, and the mechanisms they have used previously to cope with stressful situations.

Anger: Stage 2

When the patient realises that impending death is a reality, they are likely to react with anger – anger that this is happening to them and resentment that others are alive

and well. The thought of the loss they will experience angers them, such as loss of their loved ones, their possessions, independence and life. They will also feel powerless and unable to control their own life.

Short-term anger is to be expected, but if this persists, caregivers need to take steps to deal with it. One method is to encourage expression of the feelings of anger. If the patient does not do this, they may become agitated, uncooperative, withdrawn or depressed. Prolonged anger will impact on the patient's ability to act rationally, make constructive decisions and adapt positively to necessary changes.

Sometimes the patient's anger will be projected onto innocent people who simply want to help, eg family members and healthcare providers. The family may withdraw their eagerness to help because of their own lack of understanding.

Bargaining: Stage 3

Bargaining is an attempt by the patient to delay the inevitable by making certain promises and/or agreements with their god/higher power, and these tend to remain a secret between the patient and their god.

Depression: Stage 4

Depression is the patient's way of reacting to the losses that the illness has brought. If identified quickly, depression can be treated and the patient's response to antidepressants is usually good. However, this may be difficult to pick up early, particularly if the patient hides their negative feelings. Many factors can contribute to depression, such as the loss of freedom as a result of constant hospitalisations and financial burdens.

Acceptance: Stage 5

Acceptance is the phase reached when patients have accepted the knowledge of their impending death and are resigned to it. Usually, they have overcome the feelings of anger and depression.

However, even though patients may have come to terms with their death, they will not be without fear. The most common fears are the following:

- Not being able to help themselves
- Dying all alone and not being found
- Leaving their loved ones behind
- Not knowing how their loved ones will cope when left alone
- Not having done enough for their family
- Being penalised for failing their family
- Exposure of their changed body image, eg presence of stoma, removed breast
- Leaving planned projects unattended and incomplete
- Fear of the unknown and of not knowing what will happen to them after death.

It is the responsibility of the healthcare provider to ensure that the rights of the dying patient are upheld and respected.

56.4 Rights of the dying patient

The rights of the dying patient are as follows:

- To be treated as a living person until the time of death
- To die with dignity
- To be treated with respect – their name, person and belongings.
- To be involved in their own care and decision-making
- To be free from pain
- To be assisted in retaining realistic hope
- To be allowed to verbalise their feelings and emotions
- To be kept up to date with open, honest and truthful information
- Not to die alone.

Support of the patient and significant others when death is inevitable, including the bereavement period

Dying should be viewed as a journey that the dying person has to walk alone, but a journey that can be supported by others. As death approaches, it is usual for those close to the dying person to offer help and support.

Death is the final act of life, and the healthcare provider has a special opportunity to offer care, assistance and comfort to the dying person. Healthcare providers should also extend the support to the patient's family/significant others.

Much has been written about control and management of symptoms. It must be remembered that the dying person has the same basic needs as that of other patients, so the healthcare provider should do the following:

- Provide sufficient water for drinking purposes if it can be tolerated.
- Feed according to the patient's needs and nutritional demands.
- Provide for elimination needs, and keep records of intake and output.
- Provide for skin care and promote comfort, massaging pressure areas, padding bony prominences and assisting with changing positions.
- Attend to personal hygiene to promote comfort.

- Ensure that the patient is able to rest in a neat, orderly and peaceful environment.
- Provide affection and support to allay anxiety and promote a trusting nurse–patient relationship.
- Offer respect even at the hour of death.
- Help with relief from fear, doubt and feelings of guilt.
- Provide assurance that the patient's loved ones and friends who will be left behind will be comforted and cared for.
- Communicate with the patient's loved ones and friends.
- Refer the patient for pastoral counselling to ensure fulfilment of spiritual needs.
- Communicate with the patient even when they are in a coma by explaining the procedures to be performed, sitting in silence with the patient, holding their hand and/or stroking their hair.

As the time of death comes closer, support and companionship become even more important. At this time, even healthcare providers may feel powerless as death is rapidly approaching, but the patient may be at peace during this period, especially if they have accepted their death and know that no miracle can be performed to reverse the situation.

Early signs of impending death

The early signs of death are the following:

- Increased sleepiness, with the patient sleeping almost all the time
- Increased anorexia and loss of desire to drink even fluids
- Wasting
- Confusion
- Unfinished business – symbolic language
- Less frequent speech, which may stop altogether
- Oedema due to fluid build-up as the body fails to absorb fluids
- Waxy pallor of the skin – more noticeable in white individuals.

Advanced signs of impending death

Advanced signs of death are the following:

- Coma or semi-coma; however, the patient may become aware of the presence of family members
- There are signs of respiratory distress, followed by Cheyne-Stokes breathing.
- Tips of ears, nose, fingers, toes and lips become cyanosed, cold and mottled.
- Sometimes the skin may darken with the decrease in circulation.
- The skin may feel cold and clammy.
- There may be oliguria and/or anuria.
- Breathing may become noisy as a result of secretions pooling in the pharynx and hypopharynx – often referred to as the 'death rattle'.
- The face becomes ashen grey.
- Pre-terminal restlessness or agitation may occur, especially if the patient has unfinished business.
- Eyes become sunken, starry and glazed.
- There is possible urinary and faecal incontinence.

Clinical signs and symptoms associated with decreased survival time

The following signs and symptoms are associated with decreased survival time:

- Poor performance status, eg the patient stays in bed for 50% of the day
- Rapid loss of weight or wasting
- Progressive cachexia, with loss of 30% lean body mass
- Neurological manifestations such as fatigue, lethargy and confusion
- Rapid progression of the disease
- Hypoxia manifested by confusion and restlessness
- Noisy tachypnoea or death rattle
- End organ failure.

Psychosocial factors associated with decreased survival time

Some factors include the following:

- Physical or emotional exhaustion of social support
- Increased demands on the caregivers by the patient
- Patient becomes hopeless and wants to give up
- The patient desires death and verbalises this wish.

The role of the nurse

During this time, the role of the nurse is to focus on the following care:

- Ensure that the patient is allowed unrestricted visiting around the clock.
- Allow and encourage the family/significant others to deliver some of the necessary care if they so desire.
- Comfort the patient and family.
- Offer emotional support.
- Do not give false hope.
- Maintain and respect the patient's privacy even when unconscious.
- Treat the patient with courtesy and respect.
- Continue to reassure and communicate with the patient even in the absence of a response.
- Honour the patient's cultural customs and religious principles.

- Continue to visit and stay with the patient, helping if the patient is anxious.
- Attend to all the patient's basic health needs; during the last hours, the patient may refuse to eat and at this stage must not be forced to do so.
- When verbal communication is no longer possible, sit with the patient and hold their hand as a way of demonstrating that you still care.
- Simplify medication by stopping those that are no longer beneficial, and administer only essential drugs such as analgesics, antiemetics, anxiolytics and anti-secretory drugs.
- Administer medication sublingually, rectally and/or by subcutaneous injection if the patient is unable to swallow.
- Encourage family members to show their support through their presence.

Support for family

The death of a loved one is one of the most intense stressors that a family has to go through, therefore it is extremely important to provide support.

Because the family/significant others have been involved with the care of their loved one, their own social support system may have diminished, resulting in the isolation of the family. Because of this, and because feelings of grief may start long before the death of the loved one, bereavement support should be initiated before this happens and must continue until the family is able to cope with their loss. How long this period lasts will vary from family to family.

Bereavement counselling aims to do the following:

- Give people the opportunity to talk about events leading up to the death and the death itself.
- Reassure the people that the feelings of anger, disbelief, sadness, pain and loss are normal when one has lost a loved one.
- Assist and allow the bereaved to express their feelings of loss.
- Enable the bereaved to accept their loss and to face the future and start living actively again.

Healthcare providers should understand that death is handled differently within different cultures and that cultural beliefs must be respected. For Africans, death is not an issue of easy acceptance, even if there has been good communication between the healthcare team and family members. Terminal illness is seen as a failure of modern Western medicine, particularly when a patient has been on treatment for some time. Depending on the belief in their cultural customs and even if the patient is critically ill, the family may request discharge of the patient so that a traditional healer can be consulted. The family may even request discharge while the disease is still treatable, especially when no known causative factors can be identified. In these cases, it is believed that a traditional healer or *sangoma* will be able to identify the cause by virtue of the power vested in them by the ancestors. In African culture, the approaching death of an elderly person requires that the adult children and grandchildren be at the bedside to hear the last wishes of the dying person and also to give them a clear path to allow their soul to depart. The final wishes of the dying person must be honoured so that no bad luck befalls the family. The dying person's last words supersede the written will.

The death of a loved one is a stressful event and the family may behave irrationally and make unrealistic demands on healthcare providers. The healthcare provider should do the following:

- Guide and offer support.
- Encourage the family to vent their emotions.
- Sit down with the family and use them as a therapeutic tool.
- Show empathy, understanding and respect.
- Encourage family members to stay with the patient and communicate with them even if the patient cannot respond – emphasise that the patient will be aware of their presence.
- If the death vigil becomes overwhelming and exhausting, encourage relatives to take turns so that they can have resting periods.
- When death occurs, allow family members to stay with the body for some time if there is no pressure of bed occupancy.
- Allow relatives to perform last rituals according to their culture, such as washing the body.

When death occurs, the family/significant others will express their grief in a variety of ways – with sadness, crying, guilt, apathy, or anger directed at the healthcare team.

Grief may bring on physical symptoms, such as chest pains, chest tightness, inability to breathe, hyperventilation and fainting.

Reactions to the death of a loved one

The family's loss may result in some or all of the reactions discussed below.

Disruption of normal life
This could be caused by denial, disbelief, despair, acute emotional pain, auditory hallucinations of the voice of the deceased, insecurity, guilt, loneliness, numbness and shock. This stage usually lasts for seven days or less.

Dysphoria
This will result in anxiety, anger, apathy, disrupted activities, guilt, insomnia, inability to concentrate and an overwhelming sadness. Dysphoria may be prolonged over several weeks, but from the third week onward the bereaved should start to adapt to their loss. From that time and as dysphoria diminishes, normal activities will be resumed, new goals will be established, and a sense of hope restored.

Support for healthcare providers

Group support for healthcare providers in a palliative care setting offers the opportunity to reflect, debrief and grow as a person. Stressful as it may be to care for the terminally ill, it is also very rewarding for the following reasons:

- Symptom relief can be achieved.
- Psychological adjustment can be facilitated.
- Patients and family offer inspiration.
- Personal development can be achieved by facing one's limitations personally and professionally.
- There is a sense of belonging and working in a supportive team where shared decisions and responsibilities are undertaken.

Caring for the caregivers

Caregivers working with terminally ill patients have to deal with an enormous amount of stress and sometimes suffer from 'compassion fatigue' for the following reasons:

- They have to break bad news to family members or patients almost every day.
- They have to cope with situations where a medical cure has failed.
- They are repeatedly exposed to the death of people with whom they have formed a relationship.
- They have to remain calm and objective when the patient and/or family members express their anger, grief and any other negative feelings.
- They experience emotional conflicts.
- Their personal belief systems are sometimes challenged as they deal with multicultural patients.

For these reasons, it is important for caregivers who provide palliative care to form and attend support groups, where they will be able to reflect and debrief on the situations they have to cope with.

Support groups should be able to call on other caregivers as needed, such as pastoral services for spiritual support and upliftment, clinical psychologists, social workers or psychotherapists to provide individual or group counselling.

Caregivers providing care at home must also be supported so that they can be temporarily relieved of their duties, even if only for a few hours, so that they can take time off from providing for the daily activities and needs of the dying person. Ideally, a support system should be made accessible for each caregiver so that they do not become exhausted.

Home care for the terminally ill patient

Because some patients associate hospitals with death, they prefer to be cared for in their own homes, where the surroundings and people are familiar, and where they feel they still have some control over their own lives. If possible, this should be allowed. Home care should be provided by or under the supervision of a registered healthcare provider. The care provided at home differs from that provided in a hospital or other institution.

The advantages and disadvantages are as follows:

- For home care to be successful, the 'lay caregiver' – who is often a family member – should have the following attributes:
  - They should be fit and healthy, and able to cope with looking after a seriously ill person (their physical and mental condition must allow them to assume this responsibility).
  - The caregiver should be fully informed about medication administration, observation and the management of possible side effects.
  - The patient must be able to receive continuous nursing support through frequent/daily home visits.
  - The caregiver must be able to communicate closely with the family so that when new problems arise, they are kept fully informed.
  - It is also useful if the caregiver is aware of support groups in the area.
- Even when home care works well, there may be times when a major crisis erupts that requires the patient to be hospitalised. In these instances, it must be possible for the patient to be admitted without delay.

Although providing care for a terminally ill person at home may be rewarding, it can also be stressful for the caregiver because of the following reasons:

- The patient has to be looked after for 24 hours a day every day.
- The caregiver may lack the necessary experience to care for a terminally ill person.
- They most probably have other responsibilities, for instance caring for children or employment.
- There may be limited social support for when the burden becomes overwhelming.
- The physical, emotional, social and economic burdens may become overwhelming at times.
- The emotional strain may be particularly difficult if the relationship between the caregiver and the patient is a very close one.
- The patient may have experienced some personality changes due to the illness, and may be difficult to deal with, or may be forgetful and unable to recognise close family.
- The caregiver may become resentful because they are unable to leave the home to have time to themselves. If the caregiver is not emotionally strong, these mixed feelings can take a heavy toll.

Advantages of home care

Advantages of home care include the following:

- The patient and family feel that they have more control over their lives.
- The family are more relaxed and confident in their own home.
- It is less expensive to care for a loved one at home, unless highly technical equipment has to be used.
- The family can deal with one person and can form a relationship with them.
- Care can be provided in a comfortable and familiar environment, which is less threatening for both the family and the patient.
- There are no restrictions on visiting and the family has easy access to their loved one.

Barriers to effective home care

The following barriers exist:

- Sometimes the presence of the healthcare provider may be viewed as an intrusion on the family's privacy.
- The healthcare provider displays a lack of sensitivity, and disregards the family's wishes.
- The normal routine is disrupted when healthcare providers are not able to visit at a fixed time.
- There may be personality conflicts between the patient, the healthcare provider and the family
- There may be financial pressures as medical expenses may prove to be stressful for the family.
- There will be a loss of privacy caused by various members of the multidisciplinary team making home visits.
- A sense of alienation may be experienced by the healthcare provider at home. Support group and information services should be available to reduce this.

For home care to be successful for the dying patient, it should comply with the following criteria:

- Care must be patient centred.
- All stakeholders who will be providing home care must be well informed.
- A multidisciplinary team approach should be used.
- Comprehensive management of symptoms must be done after assessment.
- Referral to relevant resources must be planned and initiated early.

Conclusion

Good nursing and palliation of unpleasant symptoms is an essential aspect of end-of-life care. The effective management of pain and other symptoms can contribute a great deal to the patient's quality of life and also to the peace of mind of the patient's family.

8. Conflict

Conflict management is vital in the nursing environment because effective teamwork and communication are essential to providing high-quality patient care. Conflicts can arise from differing opinions, stress, or workload pressures, and if not addressed properly, they can negatively affect staff morale, patient safety, and overall work efficiency. By employing conflict management strategies, nurses can foster a collaborative and supportive atmosphere, resolve issues before they escalate, and maintain a positive workplace culture. This ultimately leads to better decision-making, stronger relationships among healthcare teams, and improved patient outcomes.

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Critical thinking Box 9.19

Promoting quality care – challenging poor practice

- A child has knocked a drink over. The team leader witnesses the accident and sees a colleague ignore the child and walk straight past the mess. The team leader asks politely if they could fetch another drink and clear up the spillage but their colleague says it's not their job and walks off.
- The key nurse has written a care plan with the patient, detailing their relaxation exercise programme and how they will request support from staff if needed. The plan has been communicated clearly to the team. When the key nurse returns next day the patient is upset because the nurse on duty refused to help with the relaxation exercise despite having time to do so. The patient cannot see the point of 'working in partnership' if nothing happens. The key nurse checks the nursing notes where it clearly states that the patient had not asked to practise the relaxation exercises.
- A student overhears a resident's daughter asking a colleague why her mother's soiled clothes have not been changed for 4 days. The colleague shrugs and says: 'You'd better write to the home manager'.

Student activities

- Discuss with your mentor what the nurse observing the poor practice/behaviour should do to safeguard the child/patient/resident.
- How should the nurse challenge a colleague's practice/behaviour in a way that ensures the problem is not repeated while maintaining their colleague's dignity and showing respect for the individual?

leader? Is a leader always the person in charge? Are those in responsible positions always leaders?

All nurses, including students, need the communication skills to influence the behaviour of others, e.g. educating patients and carers about their health. They also need to influence the behaviour of their colleagues. Nurses use leadership skills to inform, teach and support colleagues and also to challenge each other's practice. The ability to gracefully challenge other people's behaviour in a way that is clear, informative and respectful is an essential aspect of delivering quality interventions and services (Box 9.19).

Relationships with families and main carers

Relationships with main carers and families are as important as the ones with patients. As discussed above, nurses facilitate good relationships with carers by clearly describing their roles, responsibilities and boundaries.

Good relationships with families/carers are vital for the health outcomes of the patient. They are also important in ensuring that families/carers are supported in their caring role. Caring for carers has been a low priority for some nurses. However, carers' needs are increasingly being addressed through support and lobbying from carer organizations, government initiatives and patient involvement bodies (see Ch. 3).

Working with carers enhances the experience of patients. Good support is far reaching and makes a positive difference to people's lives. Any working involvement requires effective

Critical thinking Box 9.20

Colin and Jeanette

Colin is the main carer to his daughter Jeanette who is a young woman of 20 with a moderate learning disability. Jeanette has been admitted for surgery and Colin is very worried about her reaction to hospital. He states that, although he is tired from physical caring, he would like to stay with Jeanette so that he knows she is settled, comfortable and not anxious. He explains that when Jeanette is anxious she can quickly become depressed and introverted, which sometimes results in self-harming behaviour as a coping mechanism.

The nurse admitting Jeanette recognizes that Colin is the expert regarding Jeanette's physical and emotional needs, but realizes that Colin is tired and as main carer, he also has substantial needs.

Student activities

- What communication and interpersonal skills would you utilize in meeting Colin's needs?
- What dilemmas exist for the nurses supporting and caring for Colin and Jeanette?
- Discuss with your mentor how you could agree a plan with Colin, which meets both his and Jeanette's needs.

interpersonal skills and good communication strategies and systems. For example, the scenario in Box 9.20 requires tact, commitment, courtesy, empathy, rapport, matching language, and understanding how the nurse's and carer's beliefs and values may influence their actions.

Barriers to communication

Effective communication skills and strategies are clearly important for nurses. However, it is recognized that such skills are not always evident and nurses do not always communicate well with patients, carers and colleagues. This generalization is reason for concern. The barriers to effective communication outlined below will help nurses to understand the challenges, how these impact on practice and possible strategies to overcome them.

Conflict

Conflict is a common effect of two or more parties not sharing common ground. Conflict management is a skill that nurses need to develop in order to reduce the negative effects of conflict and restore the beneficial effects of harmonious relations. Conflict can be healthy in that it often offers alternative views and values. However, it becomes a barrier to communication when the emotional 'noise' detracts from the task and purpose. We manage conflict in a variety of ways – some are more effective than others (Borkowski 2015):

- Competition – where we enter into a win-or-lose battle
- Avoidance – where we do not confront the problem hoping that this will reduce it
- Compromise – where we negotiate common ground but lose some of our desired outcome

Dealing with anger and hostile behaviour Box 9.21

- Acknowledge the person's anger and the right to their feelings
- Allow the expression of anger in appropriate safe ways – verbalizing anger, discharge of anger in non-destructive acts. Anger is self-limiting unless re-stimulated
- Try and stay calm (use self-coaching and relaxation techniques). Provide psychological containment. Stay in the 'same gear', avoid any tendency to retaliate or appease
- Be aware of your body language. Try not to communicate threatening non-verbal signals
- Don't try to defend the situation or individuals the person is angry about
- Avoid a struggle of wills – someone has to lose. Look for compromise
- Be aware of power issues in the helping relationship and a person's need to rebel, or the need to reclaim power and assert autonomy
- Set limits. Encourage self-restraint. Raise awareness of response cost
- Help the person explore the immediate cause of their anger
- Help the patient to engage in problem-solving. Be clear about what you can and cannot do
- Accept that some anger may be projected or displaced onto you
- Don't take unnecessary risks. Be aware of the indicators of high risk. If a person's anger is not subsiding but is in danger of escalating into destructive or violent acts, take whatever action is necessary to protect yourself and others
- Debrief with colleagues after the incident. Decide if you need any additional support.

(Reproduced from Watkins P. 2009. Mental Health Practice: a guide to compassionate care, Second ed. Butterworth Heinemann, Edinburgh, p 48, with permission.)

- Accommodation – where we lose some of desired outcome for the sake of the other persons desired outcome
- Collaboration – where we come together and negotiate the best possible options for both parties to come away feeling satisfied.

Nurses aim for collaborative relationships with patients, peers and families. Adopting competitive or avoidant strategies tend to lead to increased problems later.

Often the most frightening result of conflict is when people 'act out' their anger towards others. In this situation, nurses use their therapeutic skills in developing rapport through empathy and positive regard. They will need to clearly and gently direct the situation using active listening skills, summarizing, paraphrasing and guiding the angry person into a more managed discussion. Box 9.21 offers specific guidance on dealing with anger and hostile behaviour in a mental health setting.

If, in the rare situations that the other person becomes physically aggressive, nurses use 'break-away' techniques and call for assistance. Some nurses are specially trained in physical control techniques such as Control and Responsibility (C&R) and Management of Actual or Potential Aggression (MAPPA). It is the nurse's duty to maintain as safe an environment as possible in such situations.

Task-orientated culture

Nurses work in busy environments; they have to complete a specific amount of work in a day and work with a variety of other professionals, patients and carers. The roles are hard, challenging and tiring. There is a culture to get the work done, to 'do the diary', meet physical needs and ensure that documentation is up-to-date, etc. Some nurses still consider colleagues who spend time talking with patients to be avoiding the 'real' work and lazy.

People like to 'fit in' to the dominant culture and do not want to be outside the group. Nurses and students who might have been confident in spending time with patients in an area where this was valued, when faced with a task-orientated culture have the dilemma of fitting into the group or being outside the group and spending time engaging with patients. However, as evidence shows us, care, engagement and compassion speed up the healing process. It is thus important that the nursing practitioner finds a balance between the tasks at hand and communicating with the individual patients in order to enhance the healing process.

Internal noise, mental/emotional distress

Shannon and Weaver's model (Fig. 9.2, p. 183) refers to internal 'noise' that has an impact on the communication process. Fear and anxiety can affect the person's ability to listen to what the nurse is saying. People with feelings of fear and anger can find it difficult to hear. Illness and distress can alter a person's thought processes. For example, if a patient is experiencing visual or auditory hallucinations, they can find it very difficult to concentrate on what is being communicated because they are occupied with other stimuli.

Reducing the cause of the anxiety, distress, anger, or visual/auditory hallucination would be the first step to improving communication. This can be achieved in a number of ways and it is for the patient and nurse to choose which is likely to be most effective. Ways of reducing internal 'noise' include:

- Choose a quiet environment if possible
- Deal first with the issue that is foremost in the patient's mind before embarking on the nurse's topic
- Ask the patient when it would be good for them to talk. Do not assume that you as the nurse are always wanted or the patient is always in a position to be with you
- Are you choosing a particularly difficult time to discuss an issue? Consider what is happening for the patient at the moment
- Are you the right person to do this? Does someone else have a better nurse-patient relationship?
- Is there an optimum time of the day when the patient's treatment is more effective, i.e. when they are less confused or drowsy, in less pain, experiencing fewer hallucinations, less anxiety, less fear?
- Ensure that the patient's pain has been assessed and pain relief given (see Ch. 23)
- Ensure you have as much privacy as is practically possible
- Let the patient know you need to talk to them; give them

- Create an enabling and trusting environment in the unit. Maintaining positive relations in the unit can be challenging. Maintaining open communication related to different values and convictions, holding regular climate meetings, exercising positive conflict management, and using the most relevant contingency leadership style by the unit manager are crucial. The principles of positive interpersonal communication skills should be followed. Ethical debates to discuss differences in ethical convictions, or how to overcome them, can result in positive motivation. Ethical decisions in particular should be clarified, since they influence the quality of clinical care. If ethical challenges in the unit are ignored, it could be demotivating.
- Role modelling by the unit manager is important. The personal example set by the unit manager is a strong incentive to the healthcare practitioners in the unit. Role modelling in respect of general professional conduct, updated knowledge and skills, direct care in the unit, productivity, commitment to the profession and a positive attitude, is one of the most important environmental motivators in the unit.
- The responsibility of the unit manager with regard to motivation in the unit is important. When the practitioners 'enjoy their work', productivity in the unit will also be higher and staff retention will be good.

Conflict management in the healthcare unit

Conflict is a situation where there is a conflict of values/interests between two persons or groups. These interests normally appear to be irreconcilable. A person can experience personal conflict related to a decision that has to be made, where he or she is uncertain about the right thing to do. Conflict can also be interpersonal (between two persons) or intergroup (between night and day staff, for example). Interorganisational conflict is also possible, for example between two institutions (clinics, training schools, etc.) (Muller, 2009:185).

Sources of conflict

Different sources of conflict that might arise in the unit are described in this section (Muller, 2009:185–186).

Employees

The attitude of employees, as well as differences in personality, can stimulate conflict. A competitive attitude among personnel can give rise to conflict because of a 'win-win' motive. Age and cultural differences, as well as the differences in training of the healthcare practitioners, are also sources of conflict.

Responsibilities

If the individual responsibilities of employees are not explicitly clarified, conflict may arise. Inadequate delegation in the unit, absence of job descriptions and duty sheets/lists for each employee breed conflict. Thus role conflict may arise, especially when there are significant age and cultural differences between employees. The younger healthcare practitioner may, perhaps, be in charge of a unit while the older, experienced healthcare practitioner occupies a lower position as a result of personal circumstances. The way in which responsibilities are delegated to employees in such a situation could give rise to conflict in the unit.

Conflict of values

A difference in the values of healthcare practitioners can also give rise to conflict. Cultural differences go hand in hand with differences in philosophical convictions (world/life views). Differences in values, especially in respect of the attributes/ characteristics of quality nursing care in the nursing unit, can lead to conflict.

Communication

Adequate communication in the nursing unit is essential in order to avoid conflict. It is lack of information, in particular, which stimulates conflict, for example feedback from meetings where all the members were not present or about new decisions. All the principles of interpersonal communication are, furthermore, important in avoiding conflict in the unit. The establishment of practical and feasible communication networks/strategies in the unit is a prerequisite for the reduction of conflict.

Management style

The management and leadership styles of the unit manager are decisive in respect of conflict in the unit. Autocratic styles will, of necessity, stimulate conflict. Thus, a participative management style (see Chapters 6 and 11) by the unit manager is better, not only to avoid conflict in the unit, but to improve total harmony and cooperation.

Conflict management style

There are different styles of handling conflict, which are effective to a greater or lesser extent. These styles vary between avoidance, attack, compromise, consolation or confronting. The different styles of conflict management are described and named below (Muller, 2009:186–187).

Avoidance

Avoiding conflict is the easiest way of handling it because no effort is made to confront the issue. People who use this style deny there is a conflict; or refuse to discuss the matter or convince themselves there isn't a conflict.

Confronting

People who strongly defend their point of view against that of others in a conflict show strength of their convictions. However, they are often also intolerant of the views of others and strive to win by domination. This is a win/lose approach in which both parties are resolved to come out on top.

Accommodating

This is the style people who dislike conflict choose, often because they are alarmed by it and feel uncomfortable disagreeing with others. They manage by appeasing and placating – basically by letting the other party have its own way. The drawback with appeasement is that the central problem is not addressed.

Compromising

Compromising is a conflict management style favoured by those who like negotiating. Both parties give in on some point in order to meet the other party halfway so they end the conflict equally. The disadvantage of compromising is that the parties may harbour resentment at what each has had to concede.

Collaborating

Collaborating is the most satisfactory way of resolving a conflict because it is based on careful consideration of each party's stand and a search for solutions that will resolve the problem without either party having to make humiliating concessions. To bring about a solution through collaboration satisfactory to both sides, the parties and the facilitator need to think creatively and to be courageous and mature enough to examine the truth frankly.

The principles of conflict management

The following principles should be applied in a conflict management situation (Muller, 2009:187–188).

1. Identify the conflict

In this first step it is important to identify the conflict and to admit that there is a problem. The nature and extent of the conflict should be analysed. What is the problem? What are the causes of the problem and conflict? What is the extent of the problem? Is there conflict between two persons, or are groups

involved, for example the night and day staff? For how long has conflict existed? The scope, nature and complexity of conflict is thus determined in the first step.

2. Confrontation

In the second step, the interest groups or persons confront each other. Confrontation is a purposeful effort to assist the interest groups in their investigation of the causes and consequences of the conflict. The purpose of confrontation is a search for the truth. The following confrontation rules are followed:

- Use personal statements, namely 'I,' 'my'.
- Encourage free exchange of feelings, ideas, values and attitudes between the two parties. Use statements openly in respect of personal relations and share your feelings about the other person's conduct openly with them, for example, 'I become frustrated when you ...'
- Be specific in respect of the other person's observable conduct and the feelings that such conduct creates in you, for example: 'I feel frustrated when you arrive late for duty because it means that I have to delegate the work to someone else, which is unfair.'
- Be absolute with regard to accusations; in other words, specify the incident, the date, etc.: 'You arrived late for duty on Friday, 3 May, and on ...'
- Concentrate on the here and now incidents – let bygones be bygones.
- Avoid the hit-and-run approach: give the other person time to react to the accusations and to state their case.
- Avoid personal judgements: 'One could have expected it from someone like you, considering your upbringing.'
- Show mutual respect for each other (neighbourly love).
- Use positive interpersonal communication skills.

3. Solution

During the confrontation session, the two parties should list possible alternative solutions. Now the best possible alternative is selected and the two parties agree to implement the solution. A plan of action is drawn up and both parties commit themselves to its implementation. This plan should promote harmony in the unit. A written record of the agreement should be kept.

4. Review

The degree of peace and harmony should be assessed. The unit manager assesses the degree of peace, as well as the fulfilment of the peace plan by both parties. If peace has not been achieved adequately, confrontation may once again be necessary.

Consequences of conflict

Conflict can be constructive or destructive in the healthcare services unit. During conflict, focal points are identified and brought into the open, which would not otherwise be the case. When healthcare practitioners have experienced difficult times as a group, for example a conflict, team cohesion usually improves. Sometimes conflict situations result in potential leadership coming to the fore and the unit manager can utilise that person as a leader at a later stage (Muller, 2009:189).

Conflict can also be destructive, however, with resultant inadequate task performance by the members. The quality of healthcare essentially suffers when a high degree of conflict is present in the unit. The attitude of employees is negative in the presence of conflict and the absence of harmony and love for one another in the unit also has a negative influence on healthcare practitioner-patient relationships.

It is important, therefore, that the unit manager should possess the necessary skills to deal effectively with conflict in the unit or between the employees of two or more units in order to improve the quality of healthcare in the unit.

Critical success factors for a positive practice environment

The following critical success factors are applicable:

- The healthcare unit manager is acquainted with the principles related to a positive practice environment and applies the principles in the unit.
- The healthcare unit manager enables a positive practice environment in the unit with due regard to the following: being both skilled clinically and communicatively; true collaboration between team members; effective decision-making; appropriate staffing levels with competent staff; meaningful recognition and authentic leadership.
- Knowing and implementing the National Core Standards (NDoH, 2011) as the baseline for any healthcare service unit in addition to the ethical-legal framework in which the healthcare practitioner and the healthcare organisation function.
- Buy-in from senior management in the establishment and maintenance of a positive practice environment.
- There is an institutional diversity management strategy to enable adequate and optimal diversity management within the healthcare service unit.

- Open communication
- Caring

20.11.4 Obstacles in interpersonal relationships

These obstacles include the following:

- Differences in perceptions
- Semantics (differences in meaning of words and symbols)
- Organisational structure
- Cultural differences
- Generational differences

Interpersonal relationships between group members may have one or more outcomes, namely:

- A strengthening of relationships, which will lead to satisfaction for both members and organisation, and quality client care
- A dismantled, weakened relationship, which will lead to unhappiness among members and in the organisation and might undermine the quality of client care
- A harmonious environment
- Work dissatisfaction, which may lead to labour unrest.

Maxwell (2002: 11) claims that happiness, success and fulfilment are linked to our ability to interact with fellow group members.

20.12 Conflict management

Conflict may arise when one person blocks the efforts or ideas of another. Roussel et al. (2006: 199) define conflict as "an expressed struggle between at least two interdependent parties, who perceive incompatible goals, scarce rewards and interference from the other party in achieving their goals". Conflict may have both positive and negative effects on individuals and organisations (Booyens 1993: 512; Sullivan & Decker 1988: 514), and may thus be classified as either constructive or destructive.

- *Constructive conflict.* This results in the clarification of important problems and issues and in the solution of problems. It helps individuals to recognise their differences within an organisation and serves as a powerful motivator in that it helps individuals to develop understanding and skills and to benefit from their differences (Roussel et al. 2006: 199).
- *Destructive conflict.* This is the consequence of conflict that is poorly managed. It creates distrust among health professionals in an organisation, lowers their self-concept, depresses staff morale, reduces cooperation, increases differences and leads to irresponsible and harmful behaviour such as fighting and name calling, thus lowering productivity.

20.12.1 Characteristics of conflict

A conflict situation is characterised by the following:

- At least two people or groups are engaged in some kind of interaction.
- The interaction is characterised by behaviour that is aimed at defeating, hampering or oppressing the opponent.
- The goals or values of the parties involved are perceived as mutually exclusive.
- The parties involved confront each other with opposing actions and counteractions.
- Each party tries to create a relatively favaourable position of power in relation to the other (Roussel et al. 2006: 200).

20.12.2 Causes of conflict

> ***Activity 20.9 Causes of conflict***
>
> Study the causes of conflict on the CD.

20.12.3 Stages of conflict

McNamara (2007) states that conflict management requires awareness of the stages in the development of conflict, which include the following:

- *Potential for conflict.* This exists in situations where a lack of resources or divergent cultures may result in conflict. It's also seen where there is a competitive situation that could easily become real conflict. In the workplace there are, for example, obvious differences between groups of people.

- *Open conflict.* This can be triggered by an incident and suddenly become real conflict.
- *Aftermath of conflict.* This is a stage where a problem may have been resolved but the potential for conflict still exists.

20.12.4 Signs of conflict

The following signs of conflict should be noted.

- *Between individuals*
  - Colleagues not speaking to each other or ignoring each other
  - Contradicting or bad-mouthing one another
  - Deliberately undermining or not cooperating with each other to the detriment of the team
- *Between groups of people*
  - Cliques or factions meeting to discuss issues separately, although the issues affect the whole organisation
  - Groups using threatening slogans or symbols to show that they are right and everyone else is wrong.

20.12.5 Conflict management

20.12.5.1 Discipline

Roussel et al. (2006: 204) outline the following rules that help in administering discipline:

- Discipline should be progressive.
- The punishment should be reasonable and should fit the offence.
- Assistance should be offered to resolve on-the-job problems.
- When discipline is administered, tact should be used.
- The best approach for each employee should be determined. Nurse managers should always be consistent and should show no favouritism.
- The individual should be disciplined, not the whole group. Disciplining a group for a violation of rules and regulations by one member makes the other members resentful and defensive, and increases conflict.
- Discipline should be clear and specific.
- Discipline should be objective and the manager should stick to facts.
- Discipline should be firm; the manager should adhere to the decision taken.
- When emotions run high during a disciplinary session, the session should be concluded and a second meeting scheduled as soon as possible.
- Managers should always build respect, trust and confidence in their ability to handle discipline.

20.12.5.2 Communication in conflict management

Communication is important in establishing and maintaining a therapeutic environment. Conflicting parties are often wholly concerned with preparing a defence to the opposing viewpoint and often do not listen to each other.

> ***Activity 20.10 Communication in conflict***
>
> Study the description of communication in conflict on the CD.

20.12.6 Approaches for managing conflict

Roussel et al. (2006: 206), Meyer et al. (2004: 201) and Booyens (1993: 516) outline the following approaches to conflict management.

20.12.6.1 Compromise

The compromise is an intermediate approach that lies between assertiveness and cooperativeness. A middle ground is sought to resolve a conflict. Each side gets only a part of what it wants, so neither side really gets what it wants. This approach should be used when the goal is to get a quick solution for a limited period.

20.12.6.2 Avoidance

The avoidance approach is an unassertive, cooperative approach to conflict and does not actually address the conflict, which is simply side-stepped, postponed or withdrawn from. Avoidance usually occurs when there are different power relations between two parties. Individuals who use this approach in conflict resolution tend not to voice their

opinion freely. It is an approach that is used to allow the conflicting parties time to calm down and gather information for a future talk that should be convened within reasonable time limits.

20.12.6.3 Competition

This is an assertive and uncooperative approach that some managers use by exerting the power of their position at the expense of followers, thus creating a win–lose situation. An autocratic manager who makes decisions without involving followers may also show a win–lose orientation towards conflict management. When this approach is used in conflict resolution, too often it lowers staff morale and their commitment to the organisation's goals becomes diminished. This approach may be used when a quick, unpopular decision is needed or when the person enforcing her or his decision is very knowledgeable about the issue and is thus able to make a sound decision.

20.12.6.4 Accommodation

Accommodation is an unassertive and cooperative approach where one party is prepared to give up its own needs for the sake of the other party and allows it to win. This approach has an element of self-sacrifice. The non-assertive individual feels it is more important to maintain harmonious interpersonal relationships than to express her or his needs or opinion more firmly and will, if necessary, even apologise to get the conflict resolved.

20.12.6.5 Collaboration

The collaborative approach is both assertive and cooperative. Both parties are committed to finding a solution to the problem that will satisfy the concerns of all those involved in the conflict. The underlying concerns of the parties are addressed and an alternative that meets both sets of concerns is sought. This approach may be used when there is a high level of trust, when the nurse manager wants to gain commitment from others and when the goal is to cultivate ownership. It may, however, take more time than the results are worth.

20.13 Role-modelling

Twentyman et al. (2007) define role-modelling as "the facilitation and nurturance of the individual in attaining and maintaining and/or promoting health through purposeful interventions". All health care practitioners should act as role-models, whether they recognise it or not. Role-modelling enables them to share with others the values that the profession cherishes. For role-modelling to be effective, health care practitioners should establish their credibility in the work environment and develop a trusting relationship with clients and with the members of the multidisciplinary team.

20.13.1 Characteristics of a role-model

Searle and Pera (1997: 213–214) and Twentyman et al. (2007) describe a role-model as someone who

- holds a respected position in society and acts in a manner that is expected from someone in that position
- has rights, responsibilities, privileges and obligations
- has been socialised into her or his role
- experiences role stress when fulfilling her or his role obligations
- observes the laws of the country
- continues to develop professional competence so as to keep up to date with new developments in the profession
- upholds the profession through registering with the statutory body (e.g. South African Nursing Council) and the professional association so as to protect the interests of the public and uplift the image of the nursing profession
- works as a member of the multidisciplinary health team for the benefit of the client
- interacts with everyone in a sincere manner
- is a confident professional who acts with conviction
- treats people with respect and dignity
- controls her or his emotions in stressful situations
- is competent and uses nursing skills based on professional knowledge

9. Stress and coping

Understanding stress and coping mechanisms is crucial for nurses, as they often work in high-pressure environments that can lead to physical and emotional exhaustion. By recognizing how stress affects both themselves and their patients, nurses can adopt healthier coping strategies to manage their own well-being and prevent burnout. Additionally, understanding different coping mechanisms allows nurses to better support patients who are dealing with illness, trauma, or anxiety. This knowledge helps nurses provide more empathetic care, foster resilience in themselves and others, and maintain a stable, effective healthcare environment.

References:

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Stress and Coping 42

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Differentiate the concepts of stress as a stimulus, as a response, and as a transaction.
2. Describe the three stages of Selye's general adaptation syndrome.
3. Identify physiologic, psychologic, and cognitive indicators of stress.
4. Differentiate four levels of anxiety.
5. Identify behaviors related to specific ego defense mechanisms.
6. Discuss types of coping and coping strategies.
7. Identify essential aspects of assessing a client's stress and coping patterns.
8. Identify nursing diagnoses related to stress.
9. Describe interventions to help clients minimize and manage stress.

KEY TERMS

alarm reaction, *1068*
anger, *1071*
anxiety, *1071*
burnout, *1078*
caregiver burden, *1074*
coping, *1074*
coping mechanism, *1074*
coping strategy, *1074*
countershock phase, *1069*
crisis intervention, *1078*
depression, *1072*
ego defense mechanisms, *1072*
fear, *1071*
general adaptation syndrome (GAS), *1068*
local adaptation syndrome (LAS), *1068*
shock phase, *1068*
stage of exhaustion, *1069*
stage of resistance, *1069*
stimulus-based stress models, *1068*
stress, *1067*
stressor, *1067*
transactional stress theory, *1070*

Introduction

Stress is a universal phenomenon. All individuals experience it. Parents refer to the stress of raising children, working individuals talk of the stress of their jobs, and students at all levels talk of the stress of school. Stress can result from both positive and negative experiences. A bride preparing for her wedding, a graduate preparing to start a new job, and a husband concerned about caring for his wife and family following a diagnosis of cancer all experience stress reactions.

The concept of stress is important because it provides a way of understanding the individual as a being who responds in totality (mind, body, and spirit) to a variety of changes that take place in daily life.

Concept of Stress

Stress is a condition in which an individual experiences changes in the normal balanced state. A **stressor** is any event or stimulus that causes an individual to experience stress. When an individual faces stressors, responses are referred to as *coping strategies, coping responses,* or *coping mechanisms*.

Sources of Stress

There are many sources of stress. They can be broadly classified as internal or external stressors, or developmental or situational stressors. *Internal stressors* originate within an individual, for example, infection or feelings of depression. *External stressors* originate outside the individual, for example, a move to another city, a death in the family, or pressure from peers. *Developmental stressors* occur at predictable times throughout an individual's life (Table 42.1). *Situational stressors* are unpredictable and may occur at any time during life. Situational stress may be positive or negative. Examples of situational stress include:

- Death of a family member
- Marriage or divorce
- Birth of a child
- New job
- Illness.

The degree to which any of these events has positive or negative effects depends to some extent on an individual's developmental stage. For example, the death of a parent may be more stressful for a 12-year-old than for a 40-year-old.

Effects of Stress

Stress can have physical, emotional, intellectual, social, and spiritual consequences. Usually the effects are mixed, because stress affects the whole individual. Physically, stress can threaten an individual's physiologic

Physiologic Indicators

Responses to stress vary depending on the individual's perception of events. The physiologic signs and symptoms of stress result from activation of the sympathetic and neuroendocrine systems of the body. Box 42.1 lists physiologic indicators of stress.

BOX 42.1 Stress

- Pupils dilate to increase visual perception when serious threats to the body arise.
- Sweat production (diaphoresis) increases to control elevated body heat due to increased metabolism.
- Heart rate and cardiac output increase to transport nutrients and by-products of metabolism more efficiently.
- Skin is pallid because of constriction of peripheral blood vessels, an effect of norepinephrine.
- Sodium and water retention increase due to release of mineralocorticoids, which increases blood volume.
- Rate and depth of respirations increase because of dilation of the bronchioles, promoting hyperventilation.
- Urinary output decreases but there may be urinary frequency or urgency.
- Mouth may be dry.
- Possible constipation and flatus or diarrhea may occur.
- For serious threats, mental alertness improves.
- Muscle tension increases to prepare for rapid motor activity or defense.
- Blood sugar increases because of release of glucocorticoids and gluconeogenesis.

Psychologic Indicators

Psychologic manifestations of stress include anxiety, fear, anger, depression, and unconscious ego defense mechanisms. Some coping patterns are helpful; others are a hindrance, depending on the situation and the length of time they are used or experienced.

Anxiety and Fear

A common reaction to stress is **anxiety**, a state of mental uneasiness, apprehension, dread, or foreboding or a feeling of helplessness related to an impending or anticipated unidentified threat to self or significant relationships. Anxiety can be experienced at the conscious, subconscious, or unconscious level. According to the National Institutes of Mental Health (2017), approximately 18% of adult Americans have anxiety disorders, although this figure may be low due to underreporting or alternative diagnoses.

Anxiety may be manifested on four levels:

1. *Mild anxiety* produces a slight arousal that enhances perception, learning, and productive abilities. Most healthy individuals experience mild anxiety, perhaps as a feeling of mild restlessness that prompts them to seek information and ask questions.
2. *Moderate anxiety* increases the arousal to a point where the individual expresses feelings of tension, nervousness, or concern. Perceptual abilities are narrowed. Attention is focused more on a particular aspect of a situation than on peripheral activities.
3. *Severe anxiety* consumes most of the individual's energies and requires intervention. Perception is further decreased. The individual, unable to focus on what is really happening, focuses on only one detail of the situation generating the anxiety.
4. *Panic* is an overpowering, frightening level of anxiety causing the individual to lose control. It is less frequently experienced than other levels of anxiety. The perception of a panicked individual can be affected to the degree that the individual distorts events.

Mild or moderate anxiety motivates goal-directed behavior. In this sense, anxiety is an effective coping strategy. For example, mild anxiety motivates students to study. Excessive anxiety, however, often has destructive effects. Table 42.2 lists indicators of these levels.

Fear is an emotion or feeling of apprehension aroused by impending or seeming danger, pain, or another perceived threat. The fear may be in response to something that has already occurred, in response to an immediate or current threat, or in response to something the individual believes will happen. The nursing student may be fearful in anticipation of the first experience in a client care setting. The student may fear that the client will not want to be cared for by the student or that the student might inadvertently harm the client. The object of fear may or may not be based in reality.

Anxiety and fear differ in four ways:

- The source of anxiety may not be identifiable; the source of fear is identifiable.
- Anxiety is related to the future, that is, to an anticipated event. Fear is related to the past, present, and future.
- Anxiety is vague, whereas fear is definite.
- Anxiety results from psychologic or emotional conflict; fear results from a specific physical or psychologic entity.

Anger

Anger is an emotional state consisting of a subjective feeling of animosity or strong displeasure. A verbal expression of anger can be a signal to others of one's internal psychologic discomfort and a call for assistance to deal with perceived stress. In contrast, hostility is usually marked by overt antagonism and harmful or destructive behavior; aggression is an unprovoked attack or a hostile, injurious, or destructive action or outlook; and violence is the exertion of physical force to injure or abuse. Verbally expressed anger differs from hostility, aggression, and violence, but it can lead to destructiveness and violence if the anger persists unabated.

A clearly expressed verbal communication of anger, when the angry individual tells the other individual about the anger and carefully identifies the source, is constructive. This clarity of communication gets the anger out into the open so the other individual can deal with it and help to alleviate it. The angry individual "gets it off the chest" and prevents an emotional buildup.

TABLE 42.2 Indicators of Levels of Anxiety

	Level of Anxiety			
Category	**Mild**	**Moderate**	**Severe**	**Panic**
Verbalization changes	Increased questioning	Voice tremors and pitch changes	Communication difficult to understand, loud speech, threats, demands	Communication may not be understandable
Motor activity changes	Mild restlessness	Tremors, facial twitches, and shakiness	Increased motor activity, inability to relax	Increased motor activity, agitation
	Sleeplessness	Increased muscle tension	Fearful facial expression	Unpredictable responses
Perception and attention changes	Feelings of increased arousal and alertness	Narrowed focus of attention	Inability to focus or concentrate	Trembling, poor motor coordination
		Able to focus but selectively inattentive	Easily distracted	Perception distorted or exaggerated
	Uses learning to adapt	Learning slightly impaired	Learning severely impaired	Unable to learn or function
Respiratory and circulatory changes	None	Slightly increased respiratory and heart rates	Tachycardia, hyperventilation	Dyspnea, palpitations, choking, chest pain, or pressure
Other changes	Easily startled, tension-relieving behavior (e.g. fidgeting)	Mild gastric symptoms (e.g., "butterflies in the stomach")	Headache, dizziness, nausea, confusion, diaphoresis (sweating)	Feeling of impending doom, paresthesia, sweating, hallucinations

Adapted from "Anxiety and Obsessive-Compulsive Disorders," by M. J. Halter in *Varcarolis' Foundations of Psychiatric-Mental Health Nursing: A Clinical Approach* (8th ed., Chapter 15), by M. J. Halter, 2018, St. Louis, MO: Elsevier; and "Disorders of Anxiety, Stress, and Trauma," by M. L. Potter in *Psychiatric Mental Health Nursing: From Suffering to Hope* (Chapter 13), by M. L. Potter and M. D. Moller, 2016, Boston, MA: Pearson.

Depression

Depression is a common reaction to events that seem overwhelming or negative. **Depression**, an extreme feeling of sadness, despair, dejection, lack of worth, or emptiness, affects millions of Americans a year. The signs and symptoms of depression and the severity of the problem vary with the client and the significance of the precipitating event. Emotional symptoms can include feelings of tiredness, sadness, emptiness, or numbness. Behavioral signs of depression include irritability, inability to concentrate, difficulty making decisions, loss of sexual desire, crying, sleep disturbance, and social withdrawal. Physical signs of depression may include loss of appetite, weight loss, constipation, headache, and dizziness. Many individuals experience short periods of depression in response to overwhelming stressful events, such as the death of a loved one or loss of a job; prolonged depression, however, is a cause for concern and may require treatment.

Ego Defense Mechanisms

Ego defense mechanisms are unconscious psychologic adaptive mechanisms or, according to Anna Freud (1967), mental mechanisms that develop as the personality attempts to defend itself, establish compromises among conflicting impulses, and calm inner tensions. Defense mechanisms are the unconscious mind working to protect the individual from anxiety. They can be precursors to conscious cognitive coping mechanisms that will ultimately solve the problem. Like some verbal and motor responses, defense mechanisms release tension. Table 42.3 describes these mechanisms and lists examples of their adaptive and maladaptive use.

Cognitive Indicators

Cognitive indicators of stress are thinking responses that include problem-solving, structuring, self-control or self-discipline, suppression, and fantasy. *Problem-solving* involves thinking through the threatening situation, using specific steps to arrive at a solution. The individual assesses the situation or problem, analyzes or defines it, chooses alternatives, carries out the selected alternative, and evaluates whether the solution succeeded.

Structuring is the arrangement or manipulation of a situation so threatening events do not occur. For example, a nurse can structure or control an interview with a client by asking only direct, closed questions so the client will not wander into areas that may be stressful. Structuring can be productive in certain situations. An individual who schedules a dental examination semiannually to prevent severe dental disease is using productive structuring.

Self-control (*discipline*) is assuming a manner and facial expression that convey a sense of being in control or in charge. When self-control prevents panic and harmful or nonproductive actions in a threatening situation, it is a helpful response that conveys strength. Self-control carried to an extreme, however, can delay problem-solving and prevent an individual from receiving the support of others, who may perceive the individual as handling the situation well, as cold, or as unconcerned.

TABLE 42.3 Defense Mechanisms

Name	Definition	Example
Altruism	Emotional conflicts and stressors dealt with by performing helpful service to others that results in satisfaction and pleasure	Serving as a volunteer to a disaster area.
Compensation	Making up for a perceived or real inability by focusing on another area and becoming proficient (may be conscious or unconscious)	A 16-year-old boy is not good at sports. He strives to get the top grades in his class and become a member of his school's honor society.
Conversion	Transfer of a mental conflict into a physical symptom	A concert pianist develops paralysis of his right hand prior to performing his first concert.
Denial	Avoiding, ignoring, or rejecting a real situation and the feelings associated with it	A man tells his wife that he wants a divorce. The wife responds by saying all couples have difficulties and that she is sure he will feel differently tomorrow.
Displacement	Transfer of emotions from one person or object onto another less threatening and more neutral person or object (sometimes called the "scapegoat" defense mechanism)	The staff nurse is yelled at by the unit supervisor at work. When she gets home, the nurse yells at her 12-year-old son for no apparent reason.
Humor	Emphasizing ironic or amusing aspects of a conflict or stressor	A nurse with cold hands comments, "Cold hands but a warm heart" before taking a patient's pulse.
Identification	Process whereby an individual takes on thoughts, mannerisms, or tastes of another individual whom the individual admires	A college student decides to become a physical therapist after spending 3 months in physical therapy due to a knee injury.
Intellectualization	Excessive reasoning or logic to transfer disturbing feelings into the intellectual sphere	A student tells her parents that no one could have done better than she did on the course exam, because the exam material was not covered well enough, and the course instructor is not a very good teacher.
Introjection	Attributing to oneself the qualities of another—intense identification in which the qualities are incorporated into the individual's own ego structure	A patient states he is "General Napoleon" and walks around the unit with his right hand over his heart.
Isolation	Separating ideas, thoughts, and actions from feelings associated with them	A nurse stops on the highway to assist in an accident. The victim's arm has been severed from the body. The nurse does not focus on feelings about the situation but focuses on applying pressure to the wound site, calling for help, and comforting the victim.
Projection	Unconsciously attributing one's thoughts or impulses to another person	Roommate A gets angry at Roommate B for being angry and not listening, when it is actually Roommate A who is angry and has not been listening.
Rationalization	Justifying illogical ideas, actions, or feelings by using acceptable explanations (most common defense mechanism—a form of self-deception)	The college student did not do well on her exam. She calls home and tells her parents that she did not get enough sleep the night before the exam.
Reaction formation	Developing the opposite behavior or emotion to unacceptable feelings or behaviors	A student does not like the teacher or the course being taught by the teacher. The student brings the teacher articles related to the course and comments how much he likes the teacher and her course.
Repression	The unconscious exclusion of unwanted experiences, ideas, emotions; repression is a first line of psychologic defense against anxiety	A 7-year-old girl displays signs of sexual abuse. Although her family is suspicious of who might have abused her and when, the girl cannot recall anything about the recent visit she had with the potential abuser.
Sublimation	The unconscious substituting of acceptable behaviors for unacceptable behaviors	An 18-year-old male who felt inadequate when compared to his brothers and was bullied in school joins the Marines.
Suppression	The conscious denial of a disturbing situation or feeling (Think of the individual as consciously "sitting on" the feelings as compared to repression, in which the individual is not aware.)	One student asks another if he is worried about the exam in their class tomorrow. The student replies, "I'd rather not think about that right now."
Undoing	Making up for an intolerable act or experience to lessen or alleviate feelings of guilt	After being caught by his mother stealing money out of her purse, the 10-year-old boy washes his hands excessively.

Suppression is consciously and willfully putting a thought or feeling out of mind: "I won't deal with that today. I'll do it tomorrow." This response relieves stress temporarily but does not solve the problem. A man who keeps ignoring a toothache, pushing it out of his mind because he fears the pain of having a filling, will not obtain relief of his symptoms.

Fantasy or *daydreaming* is likened to make-believe. Unfulfilled wishes and desires are imagined as fulfilled, or a threatening experience is reworked or replayed so it ends differently from reality. Experiences can be relived, everyday problems solved, and plans for the future made. The outcome of current problems may also be fantasized. For example, a client awaiting the results of a breast biopsy may fantasize the surgeon as saying, "You do not have cancer." Fantasy responses can be helpful if they lead to problem-solving. For example, the client awaiting breast biopsy results might say to herself, "Even if the doctor says, 'You have cancer,' as long as he also says it can be treated, I can accept that." Fantasies can be destructive and nonproductive if an individual uses them to excess and retreats from reality.

Coping

Coping may be described as dealing with change—successfully or unsuccessfully. A **coping strategy (coping mechanism)** is a natural or learned way of responding to a changing environment or specific problem or situation. According to Folkman and Lazarus (1991), coping is "the cognitive and behavioral effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 210).

Two types of coping strategies have been described: problem focused and emotion focused. *Problem-focused coping* refers to efforts to improve a situation by making changes or taking action. *Emotion-focused coping* includes thoughts and actions that relieve emotional distress. Emotion-focused coping does not improve the situation, but the individual often feels better. Both types of strategies may occur together (Eatough & Chang, 2018).

Coping strategies are also viewed as long term or short term. *Long-term coping strategies* can be constructive and practical. In certain situations, talking with others and trying to find out more about the situation are long-term strategies. Other long-term strategies include a change in lifestyle patterns such as eating a healthy diet, exercising regularly, balancing leisure time with working, or using problem-solving in decision-making instead of anger or other nonconstructive responses.

Short-term coping strategies can reduce stress to a tolerable limit temporarily but are ineffective ways to permanently deal with reality. They may even have a destructive or detrimental effect on the individual. Examples of short-term strategies are using alcoholic beverages or drugs, daydreaming and fantasizing, relying on the belief that everything will work out, and giving in to others to avoid anger.

Coping strategies vary among individuals and are often related to the individual's perception of the stressful event. Three approaches to coping with stress are to alter the stressor, adapt to the stressor, or avoid the stressor. An individual's coping strategies often change with a reappraisal of a situation. There is never only one way to cope. Some individuals choose avoidance; others confront a situation to cope. Still others seek information or rely on religious beliefs.

Coping can be adaptive or maladaptive. *Adaptive coping* helps the individual to deal effectively with stressful events and minimizes distress associated with them. *Maladaptive coping* can cause unnecessary distress for the individual and others associated with the individual or stressful event. In nursing literature, effective and ineffective coping are often differentiated. *Effective coping* results in adaptation; *ineffective coping* results in maladaptation.

Although the coping behavior may not always seem appropriate, the nurse needs to remember that coping is always purposeful. The effectiveness of an individual's coping is influenced by several factors, including:

- The number, duration, and intensity of the stressors
- Past experiences of the individual
- Support systems available to the individual
- Personal qualities of the individual.

If the duration of the stressors is extended beyond the coping powers of the individual, he or she becomes exhausted and may develop increased susceptibility to health problems. Reaction to long-term stress is seen in family members who undertake the care of an individual in the home for a long period. This stress is called **caregiver burden** and produces responses such as chronic fatigue, sleeping difficulties, and high blood pressure. In the case of caregiver burden, the caregiver also becomes the nurse's client and a care plan to intervene should be created (Hartnett, Thom, & Kline, 2016). Prolonged stress can also result in mental illness. As coping strategies or

TABLE 42.4 Examples of the Negative Effects of Stress on Basic Human Needs

Needs	Effects
Physiologic	Altered elimination pattern Change in appetite Altered sleep pattern
Safety and security	Expresses nervousness and feelings of being threatened Focuses on stressors, inattention to safety measures
Love and belonging	Isolated and withdrawn Becomes overly dependent Blames others for own problems
Self-esteem	Fails to socialize with others Becomes a workaholic Draws attention to self
Self-actualization	Preoccupied with own problems Shows lack of control Unable to accept reality

defense mechanisms become ineffective, the individual may have interpersonal problems, work difficulties, and a significant decrease in the ability to meet basic human needs (Table 42.4).

●○● NURSING MANAGEMENT

Assessing

Nursing assessment of a client's stress and coping patterns includes (a) nursing history and (b) physical examination of the client for indicators of stress (e.g., nail biting, nervousness, weight changes) or stress-related health problems (e.g., hypertension, dyspnea). When obtaining the nursing history, the nurse poses questions about client-perceived stressors or stressful incidents, manifestations of stress, and past and present coping strategies. During the physical examination, the nurse observes for verbal, motor, cognitive, or other physical manifestations of stress. Remember, however, that clinical signs and symptoms may not occur when cognitive coping is effective.

In addition, the nurse should be aware of expected developmental transitions (predictable tasks that must be accomplished if the client is to grow psychologically as well as physically; see Chapters 23 to 26). Individuals go through different developmental stages from infancy to old age when certain tasks are expected to be completed or resolved. When these tasks are carried over and not resolved, stress increases as they become older. For example, if an infant does not learn to trust those around him during infancy, this mistrust may accompany him through life, influencing his relationships and possibly being the root of dysfunction, stress, and ineffective coping. This knowledge helps the nurse identify additional stressors and the client's response to them (see Table 42.1). Questions to elicit data about the client's stress and coping patterns are shown in the accompanying Assessment Interview.

Diagnosing

Examples of nursing diagnoses that are appropriate for clients who have problems related to stress, adaptation, and coping are: anxiety; caregiver stress; denial; and difficult, altered, or impaired coping (individual or family).

ASSESSMENT INTERVIEW **Stress and Coping Patterns**

- On a scale of 1 to 10, where 1 is "very minor" and 10 is "extreme," how would you rate the stress you are experiencing in the following areas?
  a. Home
  b. Work or school
  c. Finance
  d. Recent illness or loss of loved one
  e. Your health
  f. Family responsibilities
  g. Relationships with friends
  h. Relationship with parents or children
  i. Relationship with partner
  j. Recent hospitalization
  k. Other (specify)
- How long have you been dealing with these stressors?
- How do you usually handle stressful situations? If the client does not adequately describe, prompt with the following:
  a. Cry
  b. Get angry
  c. Talk to someone (Who?)
  d. Withdraw from the situation
  e. Control others or situation
  f. Go for a walk or perform physical exercise
  g. Try to arrive at a solution
  h. Pray
  i. Laugh, joke, or use some other expression of humor
  j. Meditate or use some other relaxation technique such as yoga or guided imagery
- How well does your usual coping strategy work?

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

Do Nurses Who Participate in Unsuccessful Resuscitations Experience Significant Stress?

Thousands of clients in critical care settings require CPR every year and about half of them do not survive. In this study, McMeekin, Hickman, Douglas, and Kelly (2017) explored stress, coping, and institutional support in critical care nurses who participated in unsuccessful hospital CPR (codes). The theoretical framework of the study was Lazarus and Folkman's Transactional Model of Stress and Coping. Almost 400 nurses across the United States completed the demographic data and three surveys. Postcode stress levels were high, as were symptoms of posttraumatic stress disorder (PTSD). Denial, self-distraction, self-blame, and behavioral disengagement were coping strategies associated with PTSD but not with the level of stress.

Implications

There are several limitations in this study including the convenience sample and self-report of remembered feelings. Although the sample size was adequate for statistical analysis, it represents a very small percentage of all the critical care nurses who experience unsuccessful codes. Thus, the study needs replication. However, the findings indicate that the problem of stress in this population is likely significant and researchers and employers should strive to identify issues and propose activities that would minimize the negative impact on nurses. In particular, the use of negative coping strategies should be addressed.

Planning

The nurse develops plans in collaboration with the client and significant support people when possible, according to the client's state of health (e.g., ability to return to work), level of anxiety, support resources, coping mechanisms, and sociocultural and religious affiliation. The nurse with little experience intervening with clients undergoing stress may wish to consult with a more experienced nurse to develop effective plans. The nurse and client set goals to change the existing client responses to the stressor or stressors.

The overall client goals for individuals experiencing stress-related responses are to:

- Decrease or resolve anxiety.
- Increase ability to manage or cope with stressful events or circumstances.
- Improve role performance.

A sample nursing care plan and a concept map are shown on pages 1080–1082.

Planning for Home Care

Clients hospitalized and experiencing stress may require ongoing nursing support or referral to community agencies that can provide support to meet client needs and enhance client coping. Determining how much and what type of planning and home care follow-up is needed is based in great part on the nurse's knowledge of how the client and family have coped with previous stressors and the nature of the present stressor.

Implementing

Although stress is part of daily life, it is also highly individual; a situation that to one individual is a major stressor may not affect another. Some methods to help reduce stress will be effective for one individual; other methods will be appropriate for a different individual. A nurse who is sensitive to clients' needs and reactions can choose those methods of intervention that will be most effective for each individual.

Encouraging Health Promotion Strategies

Several health promotion strategies are often appropriate as interventions for clients with stress-related nursing diagnoses. Among these are physical exercise, optimal nutrition, adequate rest and sleep, and time management.

Exercise

Regular exercise promotes both physical and emotional health. Physiologic benefits include improved muscle tone, increased cardiopulmonary function, and weight control. Psychologic benefits include relief of tension, a feeling of well-being, and relaxation. Federal guidelines recommend 150 minutes of moderate-intensity weekly exercise for adults (U.S. Department of Health and Human Services, 2018).

Nutrition

Optimal nutrition is essential for health and in increasing the body's resistance to stress. To minimize the negative effects of stress (e.g., irritability, hyperactivity, anxiety), people need to avoid excesses of caffeine, salt, sugar, and fat, and deficiencies in vitamins and minerals. Guidelines for a well-balanced, healthy diet are detailed in Chapter 46 ↩.

Clinical Alert!

Many clients have "comfort foods"—foods they like to eat that make them feel better emotionally. These should be allowed whenever they are not contraindicated by the client's health condition.

Sleep

Sleep restores the body's energy levels and is an essential aspect of stress management. To ensure adequate sleep, clients may need help to attain comfort (such as pain management) and to learn techniques that promote peace of mind and relaxation. (See the *Using Relaxation Techniques* section.)

Time Management

Individuals who manage their time effectively usually experience less stress because they feel more in control of their circumstances. Clients who feel overwhelmed often need help to prioritize tasks and to consider whether modifications can be made to decrease role demands. Working parents, for example, may need to consider delegating tasks to family members or hiring part-time help. Controlling the demands of others is also an important aspect of effective time management because requests made by others cannot always be met. Clients may need to learn to develop an awareness of which requests they can meet without undue stress, which ones can be negotiated, and which ones need to be declined. Feelings of control can be enhanced when clients schedule a daily or weekly period of time to deal with specific tasks. Time management must address both what is important to the client and what can realistically be achieved. For example, clients need to consider whether a clean house and time spent with the children can both be accomplished satisfactorily and, if not, which is more important. Clients feeling overwhelmed need to re-examine the "should do," "ought to do," and "must do" situations in their lives and develop realistic self-expectations.

Minimizing Anxiety

Nurses carry out measures to minimize clients' anxiety and stress. For example, nurses encourage clients to take deep breaths before an injection, explain procedures before they are implemented including sensations likely to be experienced during the procedure,

administer a massage to help the client relax, and offer support to clients and families during times of illness. The nurse recognizes that quick action may be necessary to avoid the contagious nature of anxiety. That is, the anxious feeling of one individual makes others around him or her also anxious. This can include family members, other clients nearby, or healthcare providers. General guidelines for helping clients who are stressed and feeling anxious are outlined in Box 42.2.

BOX 42.2 Minimizing Stress and Anxiety

- Listen attentively; try to understand the client's perspective on the situation.
- Provide an atmosphere of warmth and trust; convey a sense of caring and empathy.
- Determine if it is appropriate to encourage clients' participation in the plan of care; give them choices about some aspects of care but do not overwhelm them with choices.
- Stay with clients as needed to promote safety and feelings of security and to reduce fear.
- Control the environment to minimize additional stressors such as reducing noise, limiting the number of individuals in the room, and providing care by the same nurse as much as possible.
- Implement suicide precautions if indicated.
- Communicate in short, clear sentences.
- Help clients to:
  a. Determine situations that precipitate anxiety and identify signs of anxiety.
  b. Verbalize feelings, perceptions, and fears as appropriate. Some cultures discourage the expression of feelings.
  c. Identify personal strengths.
  d. Recognize usual coping patterns and differentiate positive from negative coping mechanisms.
  e. Identify new strategies for managing stress (e.g., exercise, massage, progressive relaxation).
  f. Identify available support systems.
- Teach clients about:
  a. The importance of adequate exercise, a balanced diet, and rest and sleep to energize the body and enhance coping abilities.
  b. Support groups available such as Alcoholics Anonymous, Weight Watchers or Overeaters Anonymous, and parenting and child abuse support groups.
  c. Educational programs available such as time management, assertiveness training, and meditation groups.

Mediating Anger

Often nurses find clients' anger difficult to handle. Caring for the client who is angry is difficult for two reasons:

- Clients seldom state, "I feel angry or frustrated," or indicate the reason for their anger. Instead, they may refuse treatment, become verbally abusive or demanding, threaten violence, or become overly critical. Their complaints rarely reflect the cause of their anger.
- Anger from clients can elicit fear and anger in the nurse, who may respond in a manner that intensifies the client's anger, even to the point of violence. Nurses may respond in a way that reduces their own stress rather than the client's stress.

Ienacco (2016) recommends the following strategies for dealing with clients' anger:

- Remember that there is a difference between anger (a subjective feeling) and aggression (a harmful behavior).
- Approach each client with a calm, reassuring manner. This will help the client feel less threatened and more secure. Express compassion and concern.
- Involve clients in their own care as much as possible. This will increase their sense of control, which helps decrease anger.
- When a client's aggression is escalating, you must protect the safety of that client, other clients, yourself, and other staff.
- Call for help immediately if your interventions have not de-escalated the client's aggressive behavior.

Safety Alert! SAFETY

A nurse who is concerned for his or her own safety while working with an angry client should withdraw from the situation or obtain support from another individual.

Using Relaxation Techniques

Several relaxation techniques can be used to quiet the mind, release tension, and counteract the fight-or-flight responses of GAS discussed earlier in this chapter. Nurses can teach these techniques to clients. Nurses should also encourage clients to use these techniques when they encounter stressful health situations. Examples of these situations are (a) during childbirth, (b) postoperatively to cope with pain, and (c) before and during a painful procedure. Many agencies now have relaxation tapes available that the client can borrow or purchase. Some clients make their own recordings. Specific relaxation techniques are discussed in Chapter 22 ∞ and include the following:

- Breathing exercises
- Massage
- Progressive relaxation
- Imagery
- Biofeedback
- Yoga
- Meditation
- Therapeutic touch
- Music therapy
- Humor and laughter.

Reflective practice Box 11.6

Essential skills clusters (ESCs)

Care, compassion and communication

You are asked to provide some information to a patient. The senior nurse explains what to do but you are still unsure of the facts. You present the information in an ambivalent way.

Organizational aspects of care

Later, the senior nurse asks you how it all went. You have just been asked to help a patient drink and really cannot stop but feel you need to because of the seniority of the nurse.

Nutrition and fluid management

The senior nurse is quite insistent and you are helping a patient to drink.

Student activities

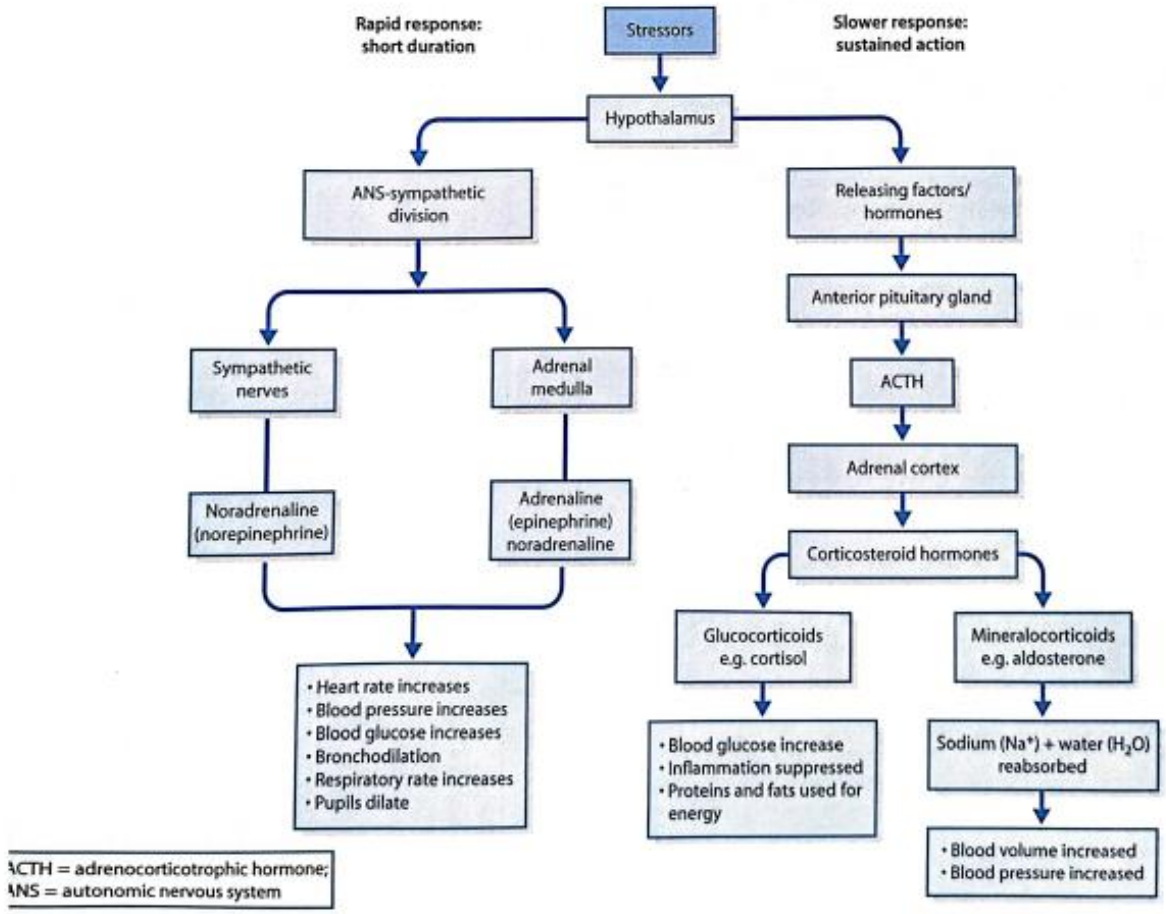
- What should you do and how does this make you feel?
- Consider which elements in the ESCs are being addressed in this scenario?
- Discuss your conclusions with your mentor.

The effects of patients' and colleagues' behaviours can have an impact on your stress level. Some of the challenges to the nurse's role caused by stress are outlined in Box 11.6.

The stress response

The term stress response can be described by the adaptive physiological changes that occur to enhance a person's ability to deal with demanding situations. While the adaptive changes are occurring in response to the stress situation, the internal environment, e.g. blood chemistry, must be maintained within a normal range for optimum cell function (see Ch. 19). This ability to maintain the internal environment within the normal range is known as homeostasis. Allostatic load refers to the cumulative cost to the body of maintaining homeostasis while responding to stressors; when these resources are overloaded, then there is a serious risk to health.

When increased mental and physical activity are needed, the necessary physiological responses are regulated by two interdependent control systems:



11.1 • Stress response (simplified).

- The autonomic nervous system (ANS), the part of the nervous system which is generally outside conscious control
- The endocrine system that uses chemical messaging systems (hormones) (Fig. 11.1).

The ANS is divided into the sympathetic and the parasympathetic divisions, but while periods of stress and anxiety lead to a general stimulation of the nervous system, it is the effects of the sympathetic division that predominate.

The sympathetic division is responsible for mobilizing the body's resources in response to stress by releasing the neurotransmitter noradrenaline (norepinephrine) at the effector organs. The adrenal medulla (middle part of the adrenal glands) is also stimulated to release adrenaline (epinephrine) and noradrenaline into the bloodstream. Noradrenaline and adrenaline are related catecholamines, which cause effects that include the 'fight or flight' response of increased heart and respiratory rates, blood pressure, etc.

Releasing factors/hormones from the hypothalamus in the brain stimulate the pituitary gland, which regulates other endocrine structures. Pituitary hormones, e.g. adrenocorticotrophic hormone (ACTH), stimulate the release of corticosteroid hormones from the adrenal cortex (outer part of the adrenal glands). Corticosteroid hormones – known as glucocorticoids, e.g. cortisol – increase the availability of the body's energy resources, alter immune responses and generally prepare the body for action and potential injury. Other corticosteroids, known as mineralocorticoids, e.g. aldosterone, influence sodium and water retention.

Corticosteroids are involved in chronic long-term stress and also influence mood and behaviour. Table 11.1 outlines some effects of the stress response, their adaptive function and the potential impact on health.

To summarize, the sympathetic nervous system and endocrine system coordinate a response that increases available energy, endurance and pain tolerance and enhances the ability to survive injury. However, as this increased state of arousal is often uncomfortable and is costly in terms of resources, there may be negative health effects associated with both acute short-term stress and chronic long-term stress. In acute states, the most significant problems are often due to behavioural changes, whereas the physiological changes occurring in chronic stress appear to increase vulnerability to a range of disorders.

Selye (1956) described the stress response as being triphasic (having three stages): an alarm stage, a resistance stage and an exhaustion stage (Fig. 11.2, p. 234). Selye's model – the General Adaptation Syndrome (GAS) – was the first real attempt to develop a general theory of stress and clarify the role of stress in health and illness. However, the model focused on the underpinning physiology and failed to adequately address psychological and social factors. Despite these problems, the model has been highly influential in stress research.

Stress-related health problems

A general view of the effects of both stress and anxiety is that they evolved to influence physiology, cognition, affect

Table 11.1 Stress response – effects and potential consequences

Effects	Adaptive function	Acute symptoms	Chronic problems
Physical effects			
Increased heart rate and force	Increase in blood supply to tissues	Palpitations	Arterial disease: CHD, stroke (see Ch. 17)
Increased blood pressure	As above	Headache	
Sodium and water retention	Increased plasma volume and blood pressure in preparation for injury		As above
Redistribution of blood supply	Increased blood supply to body core and large skeletal muscles	Skin pallor Gastrointestinal problems	
Increased respiratory rate and volume. Dilatation of bronchi	Increase in oxygenation	Breathlessness	Changes in blood chemistry Panic
Increased muscle tone	Fast reaction	Trembling	Muscle pain/aches
Immune system stimulation	Migration of leucocytes into tissues Body prepares defences in case of injury	Activation of autoimmune disorders	Slower healing (see Ch. 25) Reduced immune surveillance Increased risks of infection (see Ch. 15) and cancer
Increased platelet adhesiveness	Faster haemostasis in case of injury		
Increase in blood glucose and fatty acids	Increased energy		Weight gain Arterial disease Protein used for energy reduces muscle mass
Increase in basal metabolic rate	Increased energy and endurance	Feeling hot Sweating	Exhaustion Slower healing

Table 11.1 Stress response – effects and potential consequences – cont'd

Effects	Adaptive function	Acute symptoms	Chronic problems
Cognitive effects			
Increased alertness	Increased vigilance Avoid danger	Jumpy, overreacts	Sleep disturbance (see Ch. 10)
Focus on potential threat	All mental resources available Increased problem-solving	Cannot concentrate on other things Overarousal reduces efficiency (see p. 228)	Memory disturbance
Sensitized to novel, unexpected, unpredictable, intense, uncontrollable events	Reduces risk, avoids danger	Impulsive/automatic 'fight/fl ght' behaviours	Avoidance behaviours lead to anxiety states Accident risk increases
Context-specific memories	Potential help in problem-solving, recall previous solutions	Intrusive, unpleasant memories Mood links to memories	Negative mood state Past failure affects self-efficacy
Flashbulb memories	Situation labelled as potentially dangerous Reduces exposure to future risk	Memory and mood stay active in consciousness	Non-threatening situations labelled as dangerous Behaviour labelled as unreliable Increases hesitancy and uncertainty
Narrowing of perceptual field	Linked to focusing attention, dealing with threat is the priority	Misses important detail Focuses on irrelevant detail	Memory problems Accident risk increases
Reduced complex problem-solving relates to emotional state	Increased use of rapid automatic responses for danger avoidance	Consequences of behaviour not considered	High levels of arousal significantly impair conscious problem-solving
Rapid associative learning	Rapid identification of potential threats	High potential for association of non-threatening events with danger	Phobias
Emotional effects			
Experienced as a negative affective state	Motivates behaviour to reduce the feelings	Possible aggressive or attack behaviours Inappropriate avoidance/escape behaviours	Feels out of control Relationship or legal problems Use of drugs, alcohol and tobacco
High levels of anxiety; people may freeze	Reduces visibility to potential predators	Unable to function effectively	Reduces self-esteem Other people make judgements of competence
Emotion perceived as evidence for belief	Allows fast responses	People frequently aware that concerns are illogical and feel embarrassed	Maintain self-esteem by using defence mechanisms
Managing stressors is associated with self-esteem	Learn to predict potential for effective actions	Self-esteem linked to beliefs about abilities and value	Low self-esteem associated with many mental health problems

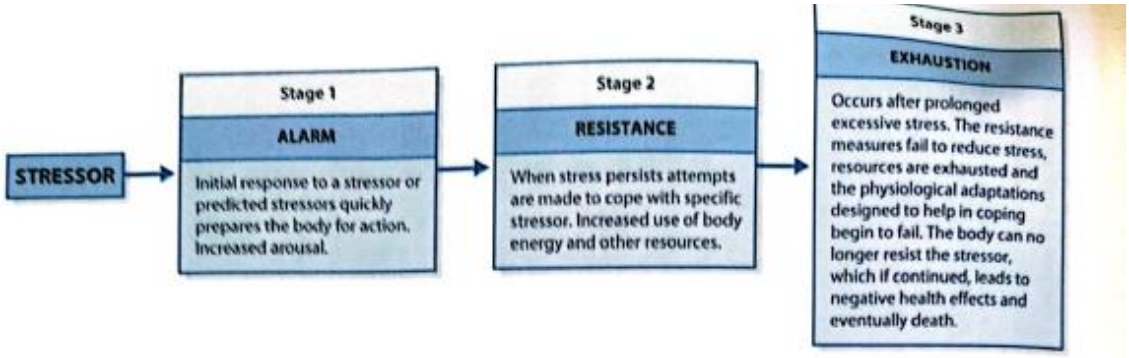


Fig. 11.2 • General adaptation syndrome

and behaviour in order to increase the chances of surviving in difficult and dangerous environments. However, life has changed and the evolved mechanisms are less useful in dealing with the complex and enduring stress associated with modern life. Stress depletes physical and mental resources, while reducing behaviour control.

Chronic stress in particular is strongly associated with a wide range of health problems because of physiological and psychological 'wear and tear' and inefficient use of energy. This may be associated with behavioural changes that increase other risks and reduce an individual's ability to deal with new challenges.

In someone with a pre-existing vulnerability, exposure to increased stress may be the stimulus to trigger illness; it may then influence recovery and other health-related behaviours. Those with existing conditions may experience a worsening of symptoms, e.g. anginal pain (see Ch. 17) or increased frequency of migraine attacks.

Sociocultural, psychological and biological variables combine to produce a range of disorders. The interaction between these factors is now widely accepted as the only way to make sense of body functioning. Increasingly, the immune system is becoming the focus for understanding the relationship between stress and illness; an area of study called psychoneuroimmunology.

Managing stress and anxiety

This part of the chapter outlines the general principles and methods that individuals may use in managing stress and anxiety.

The huge variation in the ways that stress presents and the ways it might affect the person mean that a range of techniques need to be considered. The main reason for this variation is attributable to the fact that, after an initial, often automatic reaction to a situation (primary appraisal), people make a series of judgements, which will largely control the responses (secondary appraisal) (Fig. 11.3). Box 11.6 (p. 231) asked 'what you should do in a specific situation'; consider now if there may have been another way of coping.

While recognizing the role of physiology, Lazarus and Folkman (1984) suggested that an individual's previous learning and experience significantly affects the way in which they react to life events; others can look at the same event and come up with differing interpretations. In this view of stress and anxiety, it is not the stimulus itself that is problematic, it is the individual's appraisal of the stimulus and their belief about their ability to manage its effect.

This model emphasizes cognition. Judgements are made about the stressor and the person's ability to change their behaviour or thoughts in such a way as to master or reduce the effects of the stressor. These responses are coping strategies, which may be adaptive (managing the event without increasing other problems) or maladaptive (where coping strategies might fail or increase stress). This framework is particularly important in understanding many of the principles of stress management.

Everyone uses ways of minimizing stress and improving rest and relaxation (see Ch. 10), such as socializing, reading, listening to music, holidays, etc. Various coping strategies are discussed below.

Avoidance

Avoidance commonly involves reducing exposure to stimuli that cause stress or anxiety, attempts to ignore the demands/threats or to suppress the negative feelings. Avoidance is a very common reaction to threat when often the first reaction is to escape, thus avoiding further exposure. To ignore stressors, people might engage in distracting tasks, use defence mechanisms (see pp. 229–231) or simply refuse to recognize the importance of the stimulus. People might try to induce positive feelings, e.g. comfort eating, 'treating' themselves or using stimulant (usually illegal) drugs, sedatives or alcohol.

People frequently resort to sedatives and alcohol to help manage the unpleasant feelings associated with stress and anxiety. They might attempt to 'drown out' overwhelming feelings associated with severe trauma, loss or threat by using a sufficiently high dose to induce insensibility. Sometimes, the use of anxiolytic drugs, e.g. diazepam, can be used in

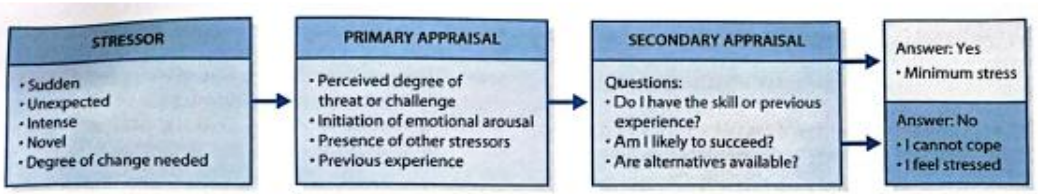


Fig. 11.3 • Primary and secondary appraisal of stressors

similar ways during short episodes of intense anxiety or distress but, like alcohol, continued use over long periods (can lead to habituation) is associated with a range of health and interpersonal problems. This does not address the causes or problems faced by people and while they might allow a person to cope with an acute and intense trauma, they have no place in long-term management. Continued management in this way can lead to complications and the development of further psychological problems such as depression.

Dealing with the stressor

The most direct approach to dealing with demands is to take action to meet those demands. This approach is often the most adaptive, particularly for low-level stressors when people can use problem-solving and evaluate the potential consequences of their actions. When the stress experienced is associated with very high levels of arousal, problem-solving is impaired and actions may not be well considered.

Among the most effective and easiest interventions nurses can use to reduce anxiety and stress, is to provide useful and understandable information (see Chs 9, 23, 24). Patients should know what to expect in relation to illness, recovery and specific interventions. This is important in allowing the person and their family to prepare themselves and recognize the difference between normal and abnormal sensations – without information, every unusual sensation causes anxiety. Nurses may need to adapt information or ways of communicating, and seek help from family and carers when patients find it difficult to understand the situation, e.g. a person with a learning disability or cognitive impairment.

To deal successfully with a range of demands, people learn and use a series of skills. When demands and expectations are predictable, learning useful skills can be structured and planned (Box 11.7).

Reflective practice Box 11.7

Dealing with stressors

A student nurse may feel anxious about doing something for the first time, e.g. giving an injection. Preparatory information can reduce anxiety and frequent practice with supervision allows the nurse to feel sufficiently confident that eventually little or no anxiety is experienced.

Student activities

- Think about a nursing intervention that caused you anxiety.
- What helped you to feel confident? Discuss this with your mentor.

When people feel confident in their abilities to control and meet demands, little stress is experienced and successful outcomes become more likely. People often experience positive feelings of achievement when they manage challenging situations and their beliefs about their coping abilities are enhanced. Assertion training by increasing skills in negotiation and relating to others may enhance this perception of control.

Explaining that anxiety is a normal response to many situations is also a useful way of giving people 'permission' to talk about anxieties. Again the nurse must be imaginative in finding ways to help people with learning disabilities or dementia to express/communicate their anxieties.

Imposing structure

In situations that involve multiple and complex stressors, the ability to prioritize is important. This could involve making 'to do' lists, prioritizing demands in order of importance and managing the time available to deal with the demands. The principle here is a simple one: for life to be manageable, it needs to be managed (Box 11.8).

Controlling the emotion

Strategies are principally about changing appraisals about the situation. This could involve reassessing the importance of an event and reassessing personal ability to cope with the perceived demands. People may deliberately remind themselves of past successes in managing similar events or make positive statements about their coping abilities. Improving self-awareness helps people recognize the stressors that appear particularly important to them and to recognize

Health promotion Box 11.8

Time management

Using a diary to note important events, e.g. appointments, submission dates, and keeping track of arrangements is the most effective way of controlling the demands made on time. A diary allows the person to consider the practicalities of accepting extra commitments and to prioritize how much time to devote to each. This allows realistic judgements to be made about how many issues can be addressed in the given time.

The diary is only a tool; the person needs to be able to use the information in negotiating their commitments with others and must be prepared to say no when necessary. These ideas help people to deal with stressors in which direct action is appropriate and likely to be useful.

Common irrational beliefs Box 11.9

- Everything we do must be approved of by others
- We must be loved by everyone
- We must be competent and successful in everything
- Certain things are wrong and the perpetrators should be punished
- When things are not as we like, it is a catastrophe
- It is easier to avoid difficulties and responsibilities than to face them
- Past behaviour will determine our present behaviour
- We are victims of our emotions and have no control over them so cannot help how we feel.

the effects of stress early, allowing them to address the situation before the feelings become overwhelming.

Most current research supports the view that it is people's beliefs about the situation and their abilities to cope that control emotional reactions. Changing these beliefs can therefore alter the meaning of the situation and the responses to it. Unfortunately, the underpinning beliefs that inform the way in which people appraise threats or demands lead to habitual and automatic responses based on previous experience. Thus, many people are basically unaware of why they feel like they do and as a consequence, do not check the accuracy of their beliefs.

The cognitive therapies provide frameworks to help people understand these principles and techniques for re-evaluating belief systems. This involves helping individuals recognize that it is not the event that causes distress, but their beliefs about the event that lead to the emotional consequences.

Ellis (1994), who developed a cognitive approach called Rational Emotive Therapy, suggests that people evaluate situations by using simple exclamatory statements about the event. Characteristically, they first make an evaluation of the event, which is sensible and rational, followed by an irrational statement about its meaning. It is the irrational statements which have little or no supporting evidence that cause the emotional reaction. Moreover, people tended to have generalized, irrational beliefs that add to stress interpretations (Box 11.9).

Table 11.2 outlines the sequence of events in creating distress and an example of ways in which people can challenge these beliefs and therefore change the feelings.

People need to identify the beliefs that cause problems and then learn to challenge them. A useful strategy is to note the events/situations which cause stress and then try to identify why they are important.

Enhancing coping resources

A wide range of strategies can enhance coping, including:

- Increasing energy reserves by increasing 'wellness' – by taking exercise, good nutrition (see Ch. 19) and adequate rest and sleep (see Ch. 10), etc.
- Taking responsibility for self-care of long-term disorders increases control and confidence that enhances coping. Indeed, the person-focused outcome in *Essence of Care 2010 Benchmarks for Self Care* is 'People have control over their care' (DH 2010, p 7)
- Learning new skills that help to deal with demands or feared situations more effectively
- Learning specific skills that induce feelings of calmness and relaxation, these feelings being incompatible with feeling stressed or anxious.

Table 11.2 Example of cognitive sequencing

	Stage	Example
A	Activating event – actual or inferred, current or predicted	Student has to present course work to peers and lecturers
B	Beliefs – often in the form of rigid and unqualified demands in the form of 'musts', 'shoulds' and 'oughts' Appraisals are often automatic and habitual – people need to learn how to identify them	Rational appraisal: • People will be evaluating my performance • I will feel and look anxious Irrational appraisal: • My presentation must be perfect or the others will think I am stupid • If they see how nervous I am they will think I'm a useless nurse • If I can't answer questions everyone will know how ignorant I am
C	Consequences – emotional, behavioural and physiological responses to appraisal. Often unpleasant and leads to inappropriate, unhelpful behaviour	Increasing self-focus and anxiety, reducing performance Dry mouth, difficulty speaking, unable to remember points Awareness of each increases anxiety The appraisal becomes a self-fulfilling prophecy and is taken as evidence that the beliefs were right
D	Disputing the disturbance-producing appraisals. Subjecting beliefs to rational evaluation. Questioning the evidence for the belief	Are you the only one who is anxious? Isn't it normal? Would you think badly of someone who is anxious? As a student why do you expect to be perfect?
E	Effective – as in the actions chosen. Those based on rational thinking are more likely to be effective in managing stressors	Seeing anxiety as normal and common and accepting that expectations about their own behaviour are unrealistic help to reduce belief Unpleasant feelings reduced with increased likelihood of appropriate behaviours

Relaxation techniques

Over the centuries in diverse cultures and under various guises, the ability to relax the body and mind has been seen as an important skill, particularly for those who had to problem-solve and make effective decisions.

If an individual can reduce emotional arousal and focus their thoughts onto problem-solving, then they are better able to more clearly analyze the situations and generate solutions.

The techniques are widely used in healthcare, e.g. pain management (Ch. 23), insomnia (Ch. 10), prenatal preparation for labour, even though the underpinning evidence is inconclusive. However, the feelings induced by effective relaxation techniques are usually perceived by patients as pleasant and restful and there is little evidence of side-effects or safety concerns. Using relaxation becomes more effective with regular practice.

Although there are considerable differences between individual relaxation techniques, there does appear to be some common themes. These usually include:

- Control or awareness of the physical body, e.g. position, etc.
- Control of or an awareness of breathing
- A specific mental focus, e.g. words/phrases (a mantra), visual stimuli, candles, prayer mats, mental images/fantasy, physical sensations and a gradual shift from external concerns to internal sensations.

Box 11.10 describes one relaxation technique, but for information about other techniques such as imagery, see Further reading, e.g. Payne and Donaghy 2010. These techniques can be used to help patients or for personal stress management; generally they tend to be most appropriate in situations where direct action or problem solving is unlikely to be helpful.

A relaxation technique – the parasympathetic flop Box 11.10

- Sit or stand in a comfortable position, and focus your awareness on how your body currently feels, become aware of muscle tension, areas of discomfort and symptoms of stress
- Become aware of your breathing, consider rate and regularity. Take control of your breathing and begin using slow abdominal or diaphragmatic breathing (breathing deeply, push out the abdomen)
- On each breath out, focus on the feelings you get when all of the chest muscles relax and deliberately think about your other muscles relaxing at the same time. Let your body sag, let your shoulders drop and allow your head to lean forward
- Remain in this state, repeating the breathing exercise until you feel more comfortable and then stretch and start moving quite slowly
- Before finishing, return your attention to your body and breathing; you should find that breathing is slower and your body feels more comfortable
- With practice you should be able to relax more quickly and more deeply.

Complementary and alternative medicine (CAM) therapies

It is important to remember that some CAM therapies (Chs 10, 23) are linked to particular faiths and will not be acceptable to all groups. There can also be ethical concerns about using methods that have no evidence-based information for safety and efficacy.

On the other hand, inducing relaxation is perhaps the one area in which many CAM therapies have shown considerable promise. Meditation, massage, reflexology, yoga, tai chi exercises, progressive relaxation, visualization and hypnosis can all be useful in helping a person manage the effects of stress. Massage techniques are particularly useful in children and in individuals with sensory impairment; the fact that they may reduce pain might also lessen the impact of pain as a stressor.

Nurses have various responsibilities when patients are using complementary or alternative therapies. These nurses are expected to be familiar with the purpose, use, effectiveness, and potential risks of the therapies. They have to assess the patient's knowledge about the use of these therapies, singly or in combination. They should give additional information as needed, based on available data, about side-effects and contraindications to assist the patient in decision making. They are expected to explain that botanical preparations and some dietary supplements have no governmental regulated guarantees of safety or effectiveness. Nurses have a pivotal role to suggest to patients to keep a daily record of each therapy used and the extent of changes in the symptoms. They can review this with the patient to determine cause and effect of symptoms and they can provide information on changes. Additionally, nurses are expected to encourage patients not to substitute treatment but to report any treatment being used. They have to assist patients to access current research information on the therapy used and to encourage the patient to determine if the therapy is acceptable (Murray et al. 2014).

Ability to tolerate stress

Despite the wish for a predictable controllable life, everyone is faced with periods of uncertainty and feelings of helplessness in dealing with the problems of living and indeed dying. There are techniques such as the AWARE technique that improves stress tolerance. The person is encouraged to:

- Accept the feelings, not fight or avoid them. Choose to set aside time to think about the things that worry you. Replace anger, or fear or rejection of the feelings with recognition and acceptance
- Watch it, study the feelings, be a dispassionate observer, learn about them without attempting to change anything. Avoid making judgements of good or bad, watch variations like a bystander
- Act in relation to how you feel; if you want to act anxious then do so, you can also choose to act in different ways. You retain control and choice over your behaviour. Slow down if you need to but keep going. The important thing is not to do things simply to avoid the feelings

- Repeat the exercise; the more time spent studying your feelings the better, become an expert in your own experiences. The more the feelings become an object of study the less discomfort you will experience
- Expect good outcomes but be realistic; you cannot eradicate anxiety so do not try. During monitoring you will discover variations; notice the good points and pay attention to increasing control.

The role of the nurse

The nurse's role in stress management and health promotion has extensive coverage in the competency domains (generic and field-specific) and the essential skills clusters (ESCs) of *Standards for pre-registration nursing education* (Nursing and Midwifery Council 2010).

The nurse's role is likely to be influenced by their field of practice. The advice nurses give to individuals in order to enhance coping skills, should be tailored to fit the needs of that person. This will require the use of initiative and development of learning packages for practice, after all, nurses are often ideally placed to educate patients about the nature and effects of stress. The implementation of these skills will promote healthy living that contributes to 'wellness' and increase resistance to the adverse effects of stress. Nurses are required to encourage their patients to use positive coping strategies such as seeking help and support from others. They are also expected to dedicate themselves to meet the needs of others, prepare by thinking of future problems, realistic solutions and consequences thereof, expressing their feelings and thoughts directly, recognizing the amusing aspects of situation and maintain the ability to laugh, reflect on their thoughts, feelings, motivations, and behaviour and respond appropriately to self-evaluation (Murray et al. 2014).

Global skills in stress management

In all fields of practice, stress management is an essential nursing skill in order to be able to function somewhere near your optimum level. Although essential for all fields, mental health nursing has taken a lead as an exemplar for self-management and collaborative management of stress and anxiety. Much of the work undertaken by mental health staff is stress related.

Other than the skills highlighted throughout this chapter there are some key approaches that help practitioners to avoid unhealthy levels of stress and to continue to function. The skill of looking relaxed while you are not is not easy to master. A level of confidence (but not arrogance) is needed and a level of knowledge that addresses most situations.

The awareness that if you look anxious, others around you will pick up on this and start to feel anxious is important. Self-control and an awareness of posture and distance to the stressful event or patient is needed. Although potentially anxious inside, it is necessary to actively listen and not to appear defensive. Giving short but pertinent answers is a necessity and in some instances, the use of touch may help someone in distress. Being confident enough to engage the person's attention in order to divert their focus away from the stressor is one of the key skills needed. Once you have their attention, it is important that you have some strategy in mind to offer. This can be helping to establish the level of distress/disruption being experienced, to allowing someone to detail the confusing feelings they have. Someone trying to tell you why they are upset is not always systematic and logical – if they could order it logically, they probably would not have the problem. Being able to listen and maintain appropriate eye contact is one skill, but responding and acting on what is said is equally important (Ch. 9). Ensuring that you understand what is causing the stress and then being able to reflect this in your own words can help to show that you have listened with empathy and are aware of the process of events and consequences. The final simplistic stage would be advice and action. Remember that if you cannot act immediately, allocate time to revisit the person. Just a few simple words later can mean a great deal, especially if it involves something you have said you would do and can demonstrate that you have done so. Ultimately, much of the work needs to be done by the person experiencing the stress with you as facilitator.

Stress and people

This part of the chapter describes the more specific aspects of stress that relate to nurses and nursing. This includes work-related stress, which is extremely important in healthcare settings. Stress affecting patients and their carers is addressed with suggested interventions for reducing its adverse effects. In many instances, the more general information on causes, effects and interventions can be used to inform the nurse's actions, both in self-care and the care of others.

Stress and nursing

Over a period of 12 months from 2009–2010, the estimated prevalence of self-reported work-related stress, anxiety and depression in the UK was 435 000. Furthermore, stress was one of the most commonly reported work-related illnesses (the other being musculoskeletal disorders) (Health and Safety Executive 2010).

The nurse's role is inherently stressful due to the unpredictable nature of ill-health. In order to address the chance of the workforce becoming stressed, stress intervention measures should focus on stress prevention for individuals as well as tackling organizational issues (McVicar 2003). The managers of the environment and the nurse require vigilance to identify triggers early and take the necessary steps to remedy the situation. A major contributor to stress is the increased rate of practice and organizational change. Rapid changes to service provision can potentially lead to a stressful working environment (Price 2008).

One important feature is that nursing is fundamentally an interpersonal activity – nurses deal with people. Many of these encounters are with strangers and in situations that are already emotionally charged where patients and their families are frequently anxious, angry or distressed.

In order to understand the potential for stress, it is important to realize that while most nurses would identify

Reflective practice Box 11.11

Nurses and stress

Identify a patient from a clinical placement who caused you to feel uncomfortable or stressed.

Student activities

- Reflect upon the characteristics of this patient that caused your discomfort.
- Think about the people, behaviours or conditions frequently seen in your chosen field of practice which might generate stress and anxiety for you.
- Consider the importance of attitudes and judgements in dealing with patients.
- Talk to your mentor about some potentially damaging consequences of this type of stress and anxiety for nurses and the care they deliver to patients.

angry or aggressive patients as causing stress, there are other less obvious issues to consider. These include:

- People who, despite efforts to help them, fail to recover
- People whose condition affects their verbal and non-verbal communication skills (see Ch. 9)
- People with visible signs of illness, skin lesions or disfigurement
- People who are experts in managing their condition
- People who have been victims of violence or other forms of abuse
- Anxious relatives who complain or become aggressive
- People whose behaviour is bizarre, unpredictable or aggressive
- People whose lifestyle choices may have contributed to their condition, e.g. overeating, smoking, drug or alcohol misuse, high-risk sexual behaviours.

These issues are common to many areas of nursing and often have an emotional impact on the nurses involved in providing care (Box 11.11).

There are also significant stressors that arise from the working environment. Those commonly identified by qualified nurses include:

- Increasing demands made upon them
- Lack of resources
- Inadequate staffing
- Shift work conflicts with family commitments
- Poor management.

Whereas student nurses frequently have other concerns, some feel that their role is poorly defined, they change practice areas frequently and need to balance this with assignments. Galbraith and Brown (2011) suggest that stress management programmes for student nurses are important given the high dropout rates.

Burnout

It is no surprise that some individuals working in high-stress environments, particularly if combined with significant external stress and poor levels of support, can feel powerless to contribute effectively at work. This failure of a person's coping resources in the work environment is often referred to as 'burnout'.

Many students start their course with high hopes and expectations; indeed many people still consider nursing to be a vocation in which helping others becomes the person's primary goal in life. While humanity should be thankful that such people exist, they often set themselves unrealistically high goals and expectations, dramatically increasing their risk for burnout.

There is no general definition of burnout but Maslach et al. (1996) suggest that it is a syndrome characterized by:

- Emotional exhaustion and excessive tiredness
- Depersonalization (person loses the feeling of their own reality, everything seems dreamlike)
- Reduction in personal accomplishment and the sense of pleasure
- Reduction in morale
- Increased absenteeism
- Changes in interpersonal behaviour and relationship problems
- Increased use of alcohol or drugs
- Reduced concern for, and involvement with, their patients.

Physical symptoms are common and are similar to anxiety:

- Feeling tense all the time
- Muscle pains
- Headaches
- Poor sleep (Ch. 10)
- Indigestion
- Sweating
- Palpitations.

Patrick and Lavery (2007) identified that in nursing, these factors are prevalent in burnout (Box 11.12) and stated that long hours and unexpected demands have detrimental effects on staff stress levels and consequently levels of burnout. They

Ethical issues Box 11.12

Dave

You are on placement with Dave, a fellow first-year student. Over the last month he has become snappy with patients, is often late on duty and looks unkempt. He seems harassed and frequently gets personal phone calls that he either asks others to say that he is not there, or takes them in private.

Student activities

- What do you think might be happening to Dave?
- Identify ways in which you might help Dave. What ethical issues (see Ch. 7) and professional issues should you consider?
- What other actions might you take to reduce the negative effects of this situation?
- Discuss these issues with your mentor.

Resource

Nursing and Midwifery Council, 2008. The code: Standards of conduct, performance and ethics for nurses and midwives. Online. Available: www.nmc-uk.org/Nurses-and-midwives/Standards-and-guidance1/The-code/ September 2015.

also suggest that increasing age and fewer working hours were associated with lower levels of emotional exhaustion and depersonalization.

Associated with the potential for burnout is the emotional labour attributed to the caring role. This can affect all levels and as indicated earlier, the toll on not attending to stress levels can be high. Most nurses only tend to address the stress of caring once it has already had an impact on their functioning. For junior staff, the use of reflection and frequent discussions with mentors, supplemented by pastoral support from university tutors can help to refocus any fears or anxiety. 'A problem shared…' is a good mantra.

The influence of culture on managing stress

Culture is defined by Friedman (1998) as cited by Peu et al. (2008) as blueprint for people's way of living, thinking, behaving and feeling. It serves as a guide to direct people on how to deal with difficult situations. Culture personally moulds individuals to behave in an acceptable way. It enhances patterns of leadership and governance. However, there are cultures that are copied and not appropriately applied, which may lead to variety of conflicts and fights.

There are various ways in which culture may influence management of stress negatively and positively. In a positive way South Africa, as a multicultural and diverse country, is rich with variety of lifestyles and practices (Jiyane, Phiri and Peu 2012) and they learn many ways of managing stress. This was supported by Lubbe (2008) who added that South Africa is a country in which you will encounter people of different religious and spiritual beliefs.

Among South African ethnic groups, extended families, including elderly people, aunt and uncles are used to reduce the extent of stressors among the families. These family members follow norms and traditions of the family to address stressors in a silent way. These stressors include marriage conflicts, daughter-in-law and mother-in-law conflicts as well as other family conflicts. Normal process are taught and implemented within these families to reduce the level of stress that may affect family members.

However, South Africa is facing many challenges that are related to cultural conflicts. These cultural conflicts arise when ethnic groups are not guided by the principles of transcultural approaches. People are expected to respect one another and accommodate each other. As an individual one need to be honest, sensitive, and be aware that her or his culture is not better than another culture. According to the constitution (Act No. 108 of 1996) every individual has the right to equality, to human dignity and to their own language and culture. The constitution further indicates that communities have the right to enjoy a shared culture, practice a shared religion and use their language. This privilege is enjoyed by the 11 ethnic groups acknowledged in South Africa.

Managing work-related stress

However, while nursing is considered to be a stressful job, several important features of the work counter the negative effects of work-related stress. Nursing can be very rewarding work and if there are good supportive relationships, nurses appear to tolerate and cope with potential stressors very well. The ability to discuss work pressures and develop new adaptive skills have been identified as protective so frequently in studies that providing mentorship and clinical supervision opportunities is considered central to good practice. Another important consideration is that an individual who identifies that they are stressed can use the problem-solving process of care planning to meet their own needs.

Schaufeli and Enzmann (1998) developed a matrix that provides a useful summary of the interventions that can reduce stress-related problems caused through work (Table 11.3).

Traumatic stress

Some events, particularly if they are sudden, intense and life-threatening may so overwhelm a person's coping ability that the capacity to process emotions is impaired. These events include being involved in serious accidents, natural disasters, violent crime or life-threatening illness/injury. In nurses, the sudden unexpected death of a patient, dealing with major incidents/accidents and exposure to threats or violence may generate the same types of response, generally described as an acute stress reaction.

Normal and frequently adaptive responses to extreme stress are shock and denial, both of which 'switch off' the

Table 11.3 Matrix of organizational stress management interventions

	Primary stress reduction	Secondary stress management	Tertiary stress treatment
Individual perspective	Personal stress Time management Assertiveness communication	Healthy lifestyles Reflection Clinical supervision Mentorship Relaxation Support	Counseling/intervention from Occupational Health Diet Exercise
Group/team perspective	Team building Team role Clarifying boundaries	Group development, diagnosis and intervention, workload analysis Team supervision	Therapeutic teamwork, renegotiate team role
Organization/systems perspective	Job description Clarify roles Individual performance review	Workload management Risk analysis (see Ch. 13) Employee participation	Employee assistance programmes Cultural change

immediate emotional response. Emotional shock is described as feeling stunned, dazed or numb. In health staff dealing with disasters, denial may leave them feeling disconnected from the horror of the situation but more importantly, it allows them to function. However, these initial effects are temporary and because they prevent people making sense of emotions at the time, are typically followed by a number of other effects, which may include the following:

- Feelings are experienced more intensely, often with a sense of threat or danger
- Emotions feel difficult to control
- Vivid memories or 'flashbacks' of the event suddenly and unpredictably come to mind, often associated with intense fear or distress. The 'flashbacks' become a source of anxiety; people might dread them occurring and avoid any potential reminders
- Sleep, eating and interpersonal relationships become disrupted.

For the majority, these symptoms will gradually reduce but how they are experienced and their duration is highly variable.

Managing traumatic stress

Symptoms persisting longer than 6 months are called post-traumatic stress disorder (PTSD), which may require more specialist help. Therapies are based on cognitive behavioural psychotherapy and some people benefit from antidepressants. Even when the symptoms are severe, many people will recover with appropriate help.

The guiding principle in dealing with others who have experienced traumatic stress is to provide a safe, supportive environment with the opportunity to talk if required. The best interventions appear to be in preparing people to deal with potential trauma. Individuals, who understand what reactions can be expected, and how feelings of guilt and responsibility are common but usually inaccurate, are less likely to develop long-term problems. For example, training in the management of aggressive patients should not only address the skills involved, they also need to address the psychological effects of aggression on the nurse.

Stress: patients and carers

It is important to remember that many patients are not ill, but may still experience stress, e.g. people having a health checkup or during pregnancy (see pp. 243–244).

Feeling well, being physically fit and well-nourished all contribute to the ability to deal with stressors and contribute to confidence and self-worth. However, when health is compromised, people must deal with the added stress associated with their condition, at a time when their coping resources are also reduced. Illness is a poorly-defined concept: it may describe the presence of a specific disease but the word has much broader connotations. The word can be linked with or used to describe anything that causes evil, harm, pain or trouble, and historically, was used to describe things going badly or getting worse. Even when describing specific conditions, the link is with disease, i.e. to have 'no ease'.

Many of the common effects of illness present significant physical and psychological challenges that can reduce or exhaust a person's coping resources. These can include:

- Lack of sleep (Ch. 10)
- Malnutrition and fluid deficits (Ch. 19)
- Toxins such as in infections, treatment side-effects, previous substance misuse or smoking
- Trauma or surgery
- Pain (Ch. 23).

In primary care, the interplay between physical and emotional health is well understood; it is estimated that up to 80% of consultations have a significant psychological component. This provides an example of how anxiety can be adaptive: if people were not concerned about their health they might not seek help.

Yet even when the problem is primarily stress-related the person usually presents with physical symptoms, which can make choosing the best interventions very difficult. Healthcare services also often deal with the consequences of social problems, such as poverty or relationship difficulties, which overwhelm coping resources and adversely affect health.

When admission to hospital is required, it is likely that this will be accompanied by the sense of threat. This may be intensified for people with learning disabilities, children and also for carers of people with complex needs. Again the main mediator of the anxiety experienced will be based on the meaning the person attaches to the condition.

Two related issues, body image and expressing sexuality/sexual identity, can also be highly significant in the person's response to illness.

Body image

Body image is the mental representation people have of their body and physical appearance. The view of physical self is central to a sense of identity, social value and self-esteem. Changes in body image, particularly if they involve loss of function, impaired ability to communicate or visible signs of illness and injury can be particularly traumatic. Where the change is likely to be temporary, individuals may simply detach from the situation, putting their life on 'hold' by adopting the sick role and making no attempt to adapt. This avoidance strategy can be highly adaptive in such situations. However, a change that is likely to be permanent often leads to grief-like reactions, in which initial shock is followed by profound depression and anger. In these cases, adaptation can be difficult and delayed.

Expressing sexuality

Expressing sexuality is linked to gender identity, attractiveness, fertility and sexual functioning and gives a person a sense of value and self-esteem. Changes caused by trauma or illness that have an impact on these areas appear to have emotional effects that are far more pronounced than would be expected from simple functional loss. The presence of visible lesions, stoma formation or loss of body parts, e.g. female breast, or sudden weight changes are all particularly

difficult to cope with. Loss of sexual functioning, factors affecting sexual performance, e.g. erectile dysfunction, and infertility may reduce self-efficacy and increase stress and depression.

Coping with illness

Illness can often highlight major differences in the demands made by the situation and the resources a person has available to deal with them. Coping often involves ongoing appraisals and reappraisals of a situation (making sense of something that does not necessarily make sense) in which individuals may attempt to alter the problem or their emotional responses to the problem.

Attempting to alter the problem is problem-focused coping and depends on the person believing that the problem is controllable or changeable. Ideally, actions should be based on analysis of the situation and planning solutions before the problem is dealt with. However, often actions are based on attempts to confront situations assertively which may involve actions based on anger, thus increasing risk.

Emotion-focused coping strategies that aim to control the emotion are frequently used when the person believes that they cannot change the stressor, either because they believe that they lack the resources/skills or the situation is insoluble, e.g. bereavement (see Ch. 12).

Social support provides emotional support through empathy, understanding, caring, etc., supporting self-esteem and offering practical help or information. People differ in their needs for social support. For those who like to cope alone, social support can be detrimental.

Helping patients and carers to cope – role of the nurse

Although dealing with distressed individuals can be emotionally draining, the nurse needs to maintain an aspect of calm and helpful concern, while showing care and compassion. Nurses can help the person focus on the important issues, provide useful though often limited information, help the person to identify what immediate actions are needed and offer practical help as when acutely stressed, attention and memory may be impaired.

Nurses should anticipate the potential for stress and anxiety in their patients and plan actions to prevent or minimize the more damaging effects. It is important to recognize that many of the anxieties a patient may have are realistic and so prevention may be difficult. As there is also the problem that anxiety and stress often affect logical thinking and memory, interventions are best made before feelings become too strong, ideally before the stressful event. Patients and their carers, with appropriate and timely help from the nurse, may cope much more effectively.

Patients/carers may also be reluctant to discuss anxieties, so as to avoid embarrassment; again the nurse can prevent problems by introducing such subjects into conversation. Communicating in this way and with tact, can give the person 'permission' to talk about difficult subjects.

There are important mediators of stress and anxiety that the nurse must consider in planning care. Cognitively, both stress and anxiety reflect feelings of vulnerability. There is a perception that demands/threats will overwhelm a person's ability to cope.

Stress and vulnerable individuals

Children, some people with learning disabilities, those with cognitive impairment and others who do not understand stressful events and have limited coping resources, will be particularly vulnerable and are more likely to respond differently to life events.

The effects of long-term stress on childhood development have been well documented and have been associated with problems in adulthood. Young children who live in institutions or are maltreated by their family are at danger of developing behavioural or emotional problems (Loman and Gunnar 2010). This can alter the child's future ability to deal with stress-related events.

In common with adults, stress in childhood may relate to issues other than illness, such as bullying (p. 243). Their behaviour may change, e.g. becoming withdrawn, tearful, depressed, headaches, etc. Children are affected by stress within families such as that caused by abusive relationships and domestic abuse/violence (see Useful websites, e.g. Childline; Further reading, e.g. DH 2010, Trevillion et al. 2011).

Children have limited experience of dealing with demands and inadequate coping strategies, thus anxiety is a frequent experience for children. Young children in particular may also have a very limited ability to communicate their distress to adults. To understand stress in children, it is important to consider their age, the developmental stage and communication skills.

Children are skilled at judging the emotional state of their parents/carers and can become distressed in response to adult anxiety. This is important for a child who is admitted to hospital, as they already have an increased level of stress caused by the admission and the environment.

Children attempt to make sense of illness and to cope by using much more basic defence mechanisms, such as regression (see p. 230). Nurses assessing stress and anxiety in children often find that behaviour is a better indicator of a child's distress than their verbal reports (Box 11.13).

Age-related stress behaviours — Box 11.13

- *Infant* (birth to 12 months) – sleep problems accompanied by excessive screaming; feeding problems, which may result in weight loss, failure to thrive, etc.
- *Toddler* (1–3 years) – behavioural problems, e.g. difficulties in socializing with other children, may be excessively shy or aggressive (boys are more aggressive than girls)
- *Pre-school age* (4–5 years) – social isolation with problems relating to adults and other children
- *Primary school age* – excessive levels of aggression. May exhibit depression. Behavioural problems, e.g. use of violence (learn that violence is a way to resolve conflict)
- *Adolescents* – problems with social interaction and in some cases violent or criminal behaviour.