

USING CONVERSATION SKILLS IN A SELF-CARE INTERVENTION
FOR CARE-GIVERS OF STROKE SURVIVORS

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ABSTRACT

Most stroke survivors return home and rely heavily on family and friends for support. Caregiver responsibilities often are underestimated and can result in negative outcomes for the caregiver. Nurses can use specific communication elements to help caregivers improve self-care skills necessary to protect their own health, while caring for their family member. In implementing the six-session Self-Care TALK (SCT) intervention, the nurse interventionist (NI) uses four communication skills to build partnerships with caregivers. The NI: 1) listened with intent 2) affirmed emotions 3) created relational images and 4) planned enactment during the weekly SCT conversations. The SCT intervention was tested with older spouse caregivers of stroke survivors to identify how education and support conversations affect caregiver health. In this secondary analysis, the detailed NI recordings of communication skill use were analyzed to compare use across SCT sessions. Caregivers were age 55 and older, and were caring for a spouse stroke survivor. Using simple random sampling, 10 caregivers were selected from the 20 participants, yielding 60 conversation recordings for analysis. The number of recordings of each specific communication skill was identified for each participant, and totals were compared across participants and between sessions 1 and 6. The NI recording for each skill varied significantly across participants at Session 1 and Session 6. While following protocol, the NI was able to individualize the intervention for each participant. When comparing Session 1 to Session 6, the Listening skill use was significantly greater at Session 1 and there were no differences between Sessions 1 and 6 for the other 3 skills, reflecting consistency over time for skill use with each participant. Communication skill use was adapted to individual caregivers, while adhering to intervention protocol. Individualization is essential in caregiver interventions, and was reflected in the differences of skill use that were recorded across caregivers of stroke survivors.

INTRODUCTION

Stroke is the leading cause of severe, long-term disability in the United States. Each year 795,000 people suffer a new or recurrent stroke (American Heart Association (AHA), 2009). There are about 6.5 million stroke survivors today in the United States and many of them have permanent life-long disabilities that require caregiver support. Stroke often occurs abruptly and without warning, allowing the caregivers of the stroke survivor little time to adapt to their new life. Most caregivers feel inadequately prepared and do not realize the physical and emotional demands of caring for someone with complex needs. This caregiving situation can lead to physical and mental health problems for the caregiver (AHA, 2009).

According to Schultz and Beach (1999), caregiving responsibilities require emotional support and education to help prevent stressors that can otherwise increase the risk of morbidity and mortality among caregivers. The intervention Self-Care TALK (SCT) was based on the Health Promotion in Aging Model (Leenerts & Teel, 2006), and uses four communication skills to build relationships between the advanced nurse practitioner and the caregiver. These four skills include: 1) listening with intent 2) affirming emotions 3) creating relational images and 4) planning enactment. As part of the SCT intervention, these skills were used with older caregivers of stroke survivors to identify how the relational conversations affect caregiver health outcomes, including strain, depression, and perceived health.

Study

Problem

The four relational conversational skills were used during the primary SCT study. For this secondary analysis, frequency of skill use across each SCT session was examined. Although research interventions must follow protocol, interventions with older caregivers also require flexibility to

maximize relevance for each caregiver. Defining nurse interventionist use of conversation skills during the SCT intervention is an essential component in assessment of intervention fidelity.

Purpose

The purpose of this study was to conduct a secondary analysis of nurse interventionist recordings from the recent study of the SCT intervention with older spouse caregivers of stroke survivors. The research question focused on how the advanced practice nurse recordings of relational conversation skills changed across the six SCT sessions with study participants.

Significance to Nursing

Being the caregiver of a stroke survivor can impact the caregiver's life in many aspects. Nurses can help caregivers learn skills necessary to protect their own health, while also caring for another. In the SCT studies, the nurse interventionist (NI) uses communication skills to build relationships with the caregivers during the six intervention sessions. Each of the SCT sessions are practicing healthy habits, building self-esteem, focusing on the positive, avoiding role overload, communicating, and building meaning. The NI used a partnership approach through telephone conversation with the caregiver. Together the NI and the caregiver worked together as a team to promote the health and well being for the caregiver through self-care. Understanding how skill recordings vary across SCT sessions will indicate whether or not the NI was able to adapt to each individual caregiver's unique needs while also adhering to study protocol.

Review of Literature

This review of literature for this secondary analysis includes a discussion of self-care of the elderly, nurse-patient communication, nursing practice as a partnership, modes of relating in caring conversations, and relational conversation skills.

Self-Care of the Elderly

The number of older people in Western countries is rapidly growing, especially in the oldest age group (Backman & Hentinen, 1999). Self-care has been identified traditionally as activities that are associated with promoting health and general well-being. Activities of daily living such as exercise, nutrition, and relaxation are often used to measure self-care (Backman & Hentinen, 1999).

External and internal factors can affect the self-care of an older person. External factors can include living conditions, services available, and social support. Social support is one of the most important ways to promote health promotion and self-care of older adults (Backman & Hentinen, 1999). The social support also helps shape the overall attitude and outlook of persons towards self-care (Backman & Hentinen, 1999). According to McCormack (2003) having a clear picture of what the patient values in their life is very important. This gives the nurse baseline information to compare current decisions and behaviors of the patient related to daily self-care (McCormack, 2003). Health and the level of functioning are key internal factors that can affect self-care (Backman & Hentinen, 1999). Other internal factors that can have an impact on self-care include coping strategies and hardiness (Backman & Hentinen, 1999).

Nurse-Patient Communication

Communication with patients is one of the most important aspects of caring for older people (Caris-Verhallen, De Gruijter, Kerkstra, & Bensing, 1999). Several studies suggest that lack of communication is the biggest complaint and largest source of dissatisfaction in patients (Caris-Verhallen et al., 1999). Communication skills are essential in nursing education and practice.

Lack of communication skills have been identified specifically in relation to care of older people, sexually transmitted disease clinics, cancer care, and unconscious intensive care patients (Chant, Jenkinson, Randle, & Russel, 2002). There are deficiencies in teaching of certain skills that

are considered necessary for effective communication in various healthcare situations. The specific skills nurses lacked were in communicating with patients and their families who made telephone inquiries to wards. Nurses provided inadequate or wrong information and did not treat the caller appropriately (Chant et al., 2002). Another skill that was lacking was media communications and it is suggested that is incorporated in skills training. Another limitation to communication skills is that nursing schools tend to emphasize the “mechanistic” rather than relational communication skills (Chant et al, 2002). The communication skills that are focused on in schools often are “learning skills, such as empathy, questioning, confrontation, and self-disclosure, as concrete, discrete behavioral actions and learning lists of skills.” (Chant et al, 2002, p. 15). Instead of students learning important conversational skills, they are learning lists of skills that are not as applicable to daily nursing practice. There needs to be more emphasis placed on connecting with patients and relationship development instead of learning a discrete set of skills (Chant et al, 2002). Morrison and Burnard (1997, p. 177) further emphasized this by stating, “...caring and communicating are inseparably linked. You cannot hope to communicate effectively if you do not care about the person on the receiving end.”

Nursing Practice as a Partnership

The core of nursing is a process of professional partnership (Jonsdottir, Litchfield, Pharris, 2004). In a partnership, the nurse is fully present to the patient and is able to relate and be open to their personal needs and suggestions. The nurse’s job is to hold the patient in “unconditional warm regard” as their patient and a fellow human being just like they are. The nurse’s sole agenda should be focused on what is going on with the patient in regards to their current health condition and going along with the flow of the conversation and finding what other meaning their conversation holds (Jonsdottir et al, 2004).

Dialogue is considered a natural conversation between the nurse and patient in addressing the health issues at hand (Jonsdottir et al, 2004). The dialogue between nurses and patients should be individual and nothing said should be considered “right” or “wrong,” “good” or “bad” (Jonsdottir et al, 2004). The main focus of the nurse and patient is to expand the understanding of the situation at hand. The nurse’s ability to acknowledge and value each of the patient’s experiences and to understand their perception of the health care experience is fundamental to forming a partnership (McCormack, 2003).

The ending of the relationship is most important and it brings meaning to the relationship as a whole. It has been found that the insight gained from partnerships is the key to articulating a conclusion with the patient and understanding the relationship’s meaning (Jonsdottir et al, 2004). While the beginning of the relationship is meaningful as a new blossoming relationship, “it is the ending that shapes the meaning of the partnership” (Jonsdottir et al, 2004, p. 244).

In today’s evolving world of technology, the emphasis of service has been on a “fast speed,” and a “fast talking,” healthcare environment (Jonsdottir et al, 2004). This change in healthcare has caused little room for responding to the personal needs of patients and families. Families and patients are sometimes not given the attention they deserve as healthcare has become so limited to “instrumental treatments” (Jonsdottir et al, 2004). According to Broyard (1990, p. 34), “Technology deprives me of the intimacy of my illness, makes it not mine but something that belongs to science.”

For nurses to continue to form strong bonds with their patients, the focus should not be solely on the medical diagnoses but also on uniqueness and meaning of the illness to the patient. This is the core of nursing practice as a partnership. Nurses need to engage in dialogue with the patient that helps the patient find meaning and a more useful way of living life.

Modes of Relating in Caring Conversations

There are many ways of relating to a patient in a caring conversation. According to Fredriksson (1999) the modes of presence, touch, and listening in a caring conversation should be taken into clinical consideration. Communicating with patients is more than just a simple conversation.

Presence is divided into two parts which include: “being there” and “being with” (Fredriksson, 1999, p. 1170). The phrase “being there” means that the nurse is attentive during the interaction and has no outside influences or distractions. The nurse is “grounded” (p.1171) and has their full attention on what the patient has to say (Fredriksson, 1999). The other term “being with,” according to Pettigrew (1990, p. 505) means “The nurse enters the patients world and will remain with the patient, enduring one’s feelings of discomfort and awkwardness, and – in the process- expose one’s humanness and offer comfort.”

Listening is imperative in nursing and is necessary in order to connect with a patient at a deeper level. In order to listen to another person effectively, an individual must be able to quiet yourself. According to Fredriksson (1999), a person must be silent in order to listen to another person with openness. Perry (1996, p.9) states, “This involves not only silencing your mouth, but silencing your mind.” If a nurse has many outside distractions and is unavailable at an emotional level, this can be devastating to the listening process. According to Gibbons (1993, p. 599):

If we focus on our own emotional discomfort, we will be unavailable emotionally because our attention will be diverted to our feelings about the pain that is being expressed. This will distract us, and we will not be able to hear the message that lies behind the words that are being spoken.

Some of the outcomes of listening carefully and without distraction are forming a caring, well-rounded relationship that is strong and has meaning. Listening also helps the nurse

understand the experiences the patient has been through and give them respect for what they have experienced in their lifetime.

Relational Conversation Skills

The four relational conversation skills used in the primary SCT study are listening with intent, affirming emotions, creating relational images, and planning enactment. Listening intently is gaining information to personalize care, affirming emotions conveying respect for uniqueness, creating relational images reinforcing positive health beliefs, and relationships to support care goals, and planning enactment focusing on individual self-care activities to promote health (Leenerts & Teel, 2005).

This review of literature focused on self care of the elderly, nurse-patient communication, nursing as a partnership, modes of relating in caring conversations and relational conversation skills. All of these factors tie into understanding how the nurse-caregiver relationship evolves overtime, and how it can be achieved at the highest level.

RESEARCH METHODOLOGY

This current study used data from an intervention study in which SCT was tested with older spouse caregivers of stroke survivors. The current study is a secondary analysis of nurse interventionist SCT session recordings, to determine how the use of the four relational conversation skills changed across the six SCT sessions in caregivers of stroke survivors.

Design

The primary study, “Promoting Stroke Caregiver Health via Self-Care TALK: Education and Support Telephone Partnerships with Nurses” involved an intervention group who had six weekly telephone conversations with a nurse about health and self-care. Calls lasted 30 minutes and were

scheduled at the caregivers' convenience. Intervention group participants received a notebook of materials related to health at the beginning of the study. The control group continued with usual care, and received the notebook of materials after the final data collection was completed. For intervention group participants, the nurse interventionist also recorded detailed field notes during each SCT session.

For the analysis of the nurse interventionist recordings, data from half of the study sample were used. Of the 20 intervention participants, 10 were randomly selected. Each of the ten participants had six interview sessions in the SCT study, so data from 60 sessions were available for analysis.

Subjects

The subjects involved in this study were a convenience sample that consisted of men and women over the age of 55 years. Participants lived with and cared for their spouse or partner who had suffered from a first-ever stroke between six months and three years before entry into the study. Participants had telephones, were able to hear well enough to engage in a telephone conversation, and were fluent in English. Following informed consent, subjects were given a self-care resource book, and the first telephone conversation was scheduled. Caregivers were referred from stroke centers, neurologists, and stroke support groups and were between the ages of 56-89 years (67.50 mean, 11.77 SD). Five of the caregivers were women and all 10 were Caucasian.

Setting

In the SCT study, the nurse interventionist (NI) prepared for each session by reviewing session protocol and previous session notes. The NIs also used a quiet office for the SCT conversations, so they could participate without interruption.

Procedures

Detailed field notes were recorded by the NI during each SCT session and these recordings provided the data for this secondary analysis. The NI recordings from each of the 60 conversations were analyzed for frequency of recording of the four relational conversational skills.

Data Analysis

The mean, range and standard deviation of skill use were calculated and examined for change across sessions. Conversation skill use was compared between sessions 1 and 6, to determine if recording of skill use changed over time. Using a one-sample t-test, each relational conversation skill was compared between session one and session six, to test whether the recording of skill use changed over time. In addition to the quantitative analysis of the recordings, an interview was conducted with a NI, to explore how the conversational skills were used during the SCT sessions and to explore impressions of change over time regarding conversational skill use.

FINDINGS

The NI recording for each skill varied significantly across participants at Session 1. While following protocol, at baseline the NI was able to individualize the intervention for each participant.

Conversational Skills: Sessions 1, N=10, Differences Across Participants

Conversational Skill	Mean (SD)	t-test	df
Listening 1	26.7 (14.17)	5.96	9
Affirming 1	7.60 (3.41)	7.06	9
Creating 1	4.40 (2.87)	5.88	9
Planning 1	6.90 (3.90)	5.60	9

When looking at differences in conversational skills between sessions one and six, the NI recording of listening was significantly greater at session one, compared to session six. There were no differences in recordings of the other three skills between sessions one and six.

Conversational Skills: Differences Between Sessions 1 and 6, N=10

	Mean	SD	t	df	Sig. (2- tailed)
Listening	11.70	8.03	4.61	9	.001
Affirming	1.20	5.05	.75	9	.472
Creating	.00	2.40	.00	9	1.00
Planning	-.20	3.79	-.17	9	.871

How did you prepare for the sessions?

For each of the intervention sessions to be successful, it was very important that the interventionist be organized. The NI prepared for each session by reading over prior sessions. The NI especially paid attention to planning enactment so she could remember who the caregivers were and what the circumstances were. She had the session protocol and notebook, previous sessions to refer back too and a sample session in front of her during the phone conversations. She also spent time on centering, or spending quiet time alone so she could just think about that person she was about to have a session with. These were all important for the nurses to incorporate into each session in order to avoid distractions and to use relational conversational skills consistently across the sessions. During each of the sessions the interventionist found that writing and talking at the

same time and coming up with a new topic to discuss with the caregiver was difficult. She tried to write down everything that they said, but she had a more difficult time writing down what she had said to the patient. She tried to make little notations off to the side when she could. The NI also thought it was difficult in the beginning for the responses so there was not a pause, but it got easier for her as the sessions went on. At the end of each of the sessions, the NI immediately typed their wording of what they said and categorized it by skill.

What does listening intently, relational images, affirming emotions, and creating relational images mean to you?

According to Leenerts and Teel (2006), listening with intent is gaining information to personalize care. According to the NI, this included what the person had to say. She stated that “I was worried about the reply, so I had a hard time listening in the beginning.” She also conveyed that “I was always worried about what to say next, so I suppose listening did change throughout the sessions.” This indicated that other factors in the sessions such as being nervous and worrying could have affected how the interventionist listened during some of the sessions.

Creating relational images is reinforcing positive health beliefs and relationships to support care (Leenerts & Teel, 2006). The interventionist said she obtained from what they said and I would bring it up with them again in later sessions.

Affirming emotions is conveying respect for uniqueness (Leenerts & Teel, 2006). According to the NI, often she did not know how to start in the beginning. She would always say ‘Oh that is wonderful’ and I had a hard time tuning into the negatives. She always had to draw those things out. Of the four skills that the interventionists were required to learn, she thought affirming emotions was a difficult skill to learn. She was just learning, so she was afraid to say certain things. She would not think much of it until she went back and reviewed the session at the end. This

suggests that the NI's struggled learning certain skills and may have been reluctant to use them because they were unsure or not confident in what they were trying to say.

Planning enactment is when the NI focuses on the individual self-care activities to promote health (Leenerts & Teel, 2006). The NI thought that planning enactment was always mutual. The NI and the caregivers always reviewed each session and if other events significant other than caregiving was going on, like their son was sick, she would make note of it. This suggests that planning enactment some weeks may not have been quite as productive if other events were going on in the caregiver's lives.

What did you think of the conversational skills as they were named?

The interventionists agreed that there were four separate skills and none of them could be combined. The NI felt like affirming emotions is related to relational images. She also felt like planning enactment was not much of a goal. She would just follow up each week with things from the previous week over and over and did not really know where to draw the line. The NI thought there needs to be some way to say it is resolved. This finding shows that some of the conversational skills such as "affirming emotions" and "creating relational images" may not have been clear to the interventionist if she felt like they were somewhat related to each other. They may have been used interchangeably in the sessions. The NI agreed that learning the skills in the beginning was challenging and applying them in conversations with the caregivers got easier overtime.

DISCUSSION

Skill use recordings varied across caregivers, which indicates the flexibility of the NI to adapt to each caregiver and their unique and individual needs. The NI recorded more examples of listening during the first session, which suggests the particular need for learning about the caregiver's uniqueness during the earlier sessions.

When each of the relational conversational skills were compared across session one through six, listening was found to be recorded more during session one. This indicated that initially the nurse was strongly focusing on what the caregiver had to say and getting to know them at a deeper level. The other conversational skills stayed relatively consistent throughout each of the sessions.

IMPLICATIONS FOR PRACTICE

In each of the 30-minute conversations the skills listening with intent, affirming emotions, creating relational images, and planning enactment were all adapted to each individual caregiver while adhering to intervention protocol. The NI spent time before each session preparing for each individual caregivers unique qualities that were learned from previous sessions in order to adapt to their individual needs. With 6.5 million stroke survivors alive today, caregivers have a lot of responsibilities to care for the stroke survivors' everyday needs. The SCT intervention needs to be tested further, but so far is encouraging and has lots of possibilities. Through the use of specific conversation skills, nurses can provide helpful support for older family caregivers.

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