RELATIONSHIP OF FACILITATIVE TRAINING ON THE DEVELOPMENT OF RAPPORT

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

CAROLYN W. MOSLEY, M.N.

DENTON, TEXAS

August 1994

Texas Woman's University
Denton, Texas

May 2, 1994
Date

To the Associate Vice President for Research and Dean of Graduate School:

I am submitting herewith a dissertation written by Carolyn W. Mosley entitled "Relationship of Facilitative Training on the Development of Rapport." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Anne Young
Anne Young, Ed.D; Major Professor

We have read this dissertation and recommend its acceptance:

Dr. James Roberts

Ruth Spencer, PhD, OTR

Accepted

Leslie M Thompson
Associate Vice President for Research and Dean of the Graduate School

ACKNOWLEDGMENTS

The writer acknowledges all faculty members, family and friends who gave their support and assistance throughout this endeavor. It is to these individuals that I wish to express my sincere gratitude.

A special thanks to my mother, Lillie Washington and sisters Marilyn Washington and Ora Paisant who cared for my daughter while I commuted from New Orleans to Texas on a weekly basis. Thank you all for such an unselfish sharing of your time, patience and efforts.

Lastly, I am deeply grateful to my daughter, Shantell Mosley, who many times functioned independently and also helped in the entire process by coding and packaging questionnaires. Thank you all for all the extra work and time!

RELATIONSHIP OF FACILITATIVE TRAINING ON THE DEVELOPMENT OF RAPPORT

An Abstract

Carolyn W. Mosley, MN, RN

Major Professor-Dr. Anne Young

Nurses have always been told, "you must have rapport with your patient," yet the characteristics of and the process for developing rapport remained undefined in the nursing literature. Rapport is one of the many concepts in nursing that has an assumed meaning and is identified as an intuitive skill, yet greatly affects patient outcomes such as compliance. Therefore, the purpose of this study was to examine the effect of a facilitative training seminar on the development of rapport. The study utilized an experimental pre and posttest design.

Nurses and clients who volunteered to participate in the study were randomly assigned to an experimental or control group. The population consisted of 40 licensed practical or registered nurses and 40 clients from long term care units. Six hypotheses were formulated for the study with the .05 criterion level for significance being utilized. Nurses completed a demographic data sheet. Only nurses in the experimental group attended a six hour facilitative training seminar.

Mosley's Communication Skills Questionnaire, Mosley's Interpersonal Rapport Perception Questionnaire, and Mosley's

Behavioral Rapport Scale were used as pre and posttest to assess the presence of rapport. Clients completed a demographic data sheet. Mosley's Interpersonal Rapport Perception Questionnaire was completed as pre and posttest by the client.

Data were analyzed using the multivariate analysis of variance and Duncan's post hoc comparison test. Analysis of the data suggested that there was a significant relationship between the taking of the facilitative training program and the identification of rapport by patients cared for by those nurses taking the seminar. Also, nurses participating in the classes demonstrated improved knowledge of the skills needed to develop rapport; perceived that they had more rapport and exhibited more behaviors indicative of rapport than those nurses not taking the classes.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF TABLES (continued)

CHAPTER I

INTRODUCTION

Adherence to medical and/or nursing recommendations has been identified as a major recurrent problem in the health care system and is thought to be directly related to client recidivism with subsequent rehospitalization and high health care expenditures (Ulmer, 1986). One-half of the clients seen in the medical setting fail to adhere in one way or another with their prescribed medical regimen (Ulmer 1986; Hays, & DiMatteo, 1987). Researchers Heiby and Carlson (1986) and O'Hari, O'Hari, Southward and Krayer (1987) reported a correlation between the client's rate of adherence and relationships and/or lack of relationships which exist with the health professional. Travelbee (1971) noted that this relationship cannot occur without rapport. Stuart and Sundeen (1991) described rapport as an intuitive skill that cannot be taught. Also, this critical aspect of the relationship, called rapport, currently has no operational definition in the nursing literature. Therefore, the characteristics indicative of rapport and how these characteristics are developed remain undefined.

Torres (1986), reported that effective communication is a prerequisite to the establishment of a nurse-client

relationship. This relationship is necessary to achieve illness prevention, health maintenance and restoration. Travelbee (1971) suggested that a nurse's ability to establish rapport is dependent on the therapeutic use of self and on communication skills. Both instill in clients a sense of confidence and trust by conveying sincerity and an interest in their care and well being. She stated that client satisfaction and adherence to instructions depend upon the ability of nurses to convey a feeling of understanding, compassion and genuine interest in the client. Good communication between nurses and clients results in a compliant client whereas poor communication results in a noncompliant client (Sachett & Hayes, 1976).

This finding was supported in a study by Warren (1984). She reported that communication and rapport were two factors which were positively correlated with compliance. Other studies that reported a significant positive correlation between communication and compliance were Becker, Drachman & Kirscht (1972) and Kincey, Bradshaw, & Ley (1975). Travelbee (1971) further maintained that rapport is necessary if the nurse is to be effective in interactions with clients.

The absence of rapport in a nurse-client relationship may consequently affect client adherence to medical and/or nursing regimens. For this study, the relationship of

facilitative training on the development of rapport was explored.

Problem Statement

Rapport is a prerequisite for establishing meaningful relationships between nurses and clients (Travelbee, 1971). The problem of this study, therefore, was to answer the following question: Can a formal educational program improve nurses' ability to establish rapport?

Rationale for the Study

As early as 1952, Peplau reported the importance of rapport as an essential component of the interpersonal relationship (Peplau, 1952). Orlando (1961), Peplau (1952), Rogers, Gendlin, Kiesler, and Truax (1967), and Travelbee (1971) indicated that it is necessary to establish rapport with clients, but they did not delineate the process for developing this relationship or identify behaviors characteristic of rapport. Stuart and Sundeen (1991) and Travelbee (1971) maintained that rapport is one of the many concepts in nursing that has an assumed meaning, but also has a profound effect on client behaviors such as compliance. They stated that the meaning and establishment of rapport are often taken for granted or viewed as an intuitive skill. There is also evidence to support that the health professional's interpersonal skills

make a difference in the quality of the relationship and care given. Gerrard (1978) stated that the presence or absence of rapport affect the quality of the relationship which may consequently affect client compliance.

Yoos (1981) stated that the quality of nurse-client interactions is likely to influence compliance. She also maintained that improving the quality of the nurse-client interaction may be one important means by which nurses can influence compliance. Kasch and Knulson (1985) emphasized the importance of the nurse-client relationship in promoting compliance, but the mechanism of promoting this relationship or the essential component in the relationship was not identified.

Flemming (1983) and Travelbee (1971) reported that the establishment of rapport and the quality of the interaction between the nurse and client is critical in the healing process and subsequent follow up care. Ricks (1987) supported this idea when he reported that researchers at the University of California, Los Angeles and University of California, San Diego, found that psychological processes have a role in the regulation of the immune response system. Persons who experience grief and depression, undergo such severe immune system changes that they become more susceptible to disease and possibly even death if appropriate interventions to deal with these responses are

not initiated.

In surveys by Watterson, (1971) and Flemming (1979), the item most highly correlated with consumer satisfaction was courtesy and consideration shown by nurses. The surveys also revealed that clients' satisfaction with nursing care and compliance with treatment tend to be related to the nurses' ability to meet their needs. LaMonica (1983) reported that client anxiety, depression, hostility and dissatisfaction with care are counterproductive to the effective development of coping and adaptive behavior. The inability to cope and/or to adapt to one's situation may lead to negative outcomes such as noncompliance (Travelbee, 1971).

Giuffra (1980) indicated that interventions based upon humanistic approaches lead to therapeutic changes, whereas interventions based on the nurses instincts may lead to dysfunctional outcomes. A humanistic approach encourages the development of a more positive view of the hospitalization experience and health care system. This approach also promotes clients' self care ability and increases motivation to engage in care. Utilization of a humanistic approach in which rapport is an essential ingredient increases learning and strengthens the credibility of all communications between the nurse and the client (Travelbee, 1971).

Research on helping relationships has shown that the helping process can be destructive rather than enhancing to growth depending upon the level of facilitative skills of the helper (LaMonica, 1983). For example, a client's willingness to accept and follow the prescribed treatment regimen may be decreased if the nurse is insensitive to the individual's needs as a person, and is unable to communicate caring and develop rapport with the client.

Although it has been acknowledged that nurse-client interactions are an important factor in dealing with the problem of compliance, no published nursing research studies were found which examined the relationship between rapport, the development of a nurse-client relationship and compliance. No studies were found which identified the process for developing rapport. Improving the quality of nurse-client interactions will depend on maximizing the facilitative competencies of the nurse. The proposed study is necessary to first identify whether the skills needed to establish rapport can be taught through utilization of Mosley's Facilitative Training Program. Additionally, the study is important to nursing because establishment of rapport could serve as the vehicle to improve the health of the client and decrease noncompliance leading directly to cost effectiveness and cost containment for both the client and health care industry.

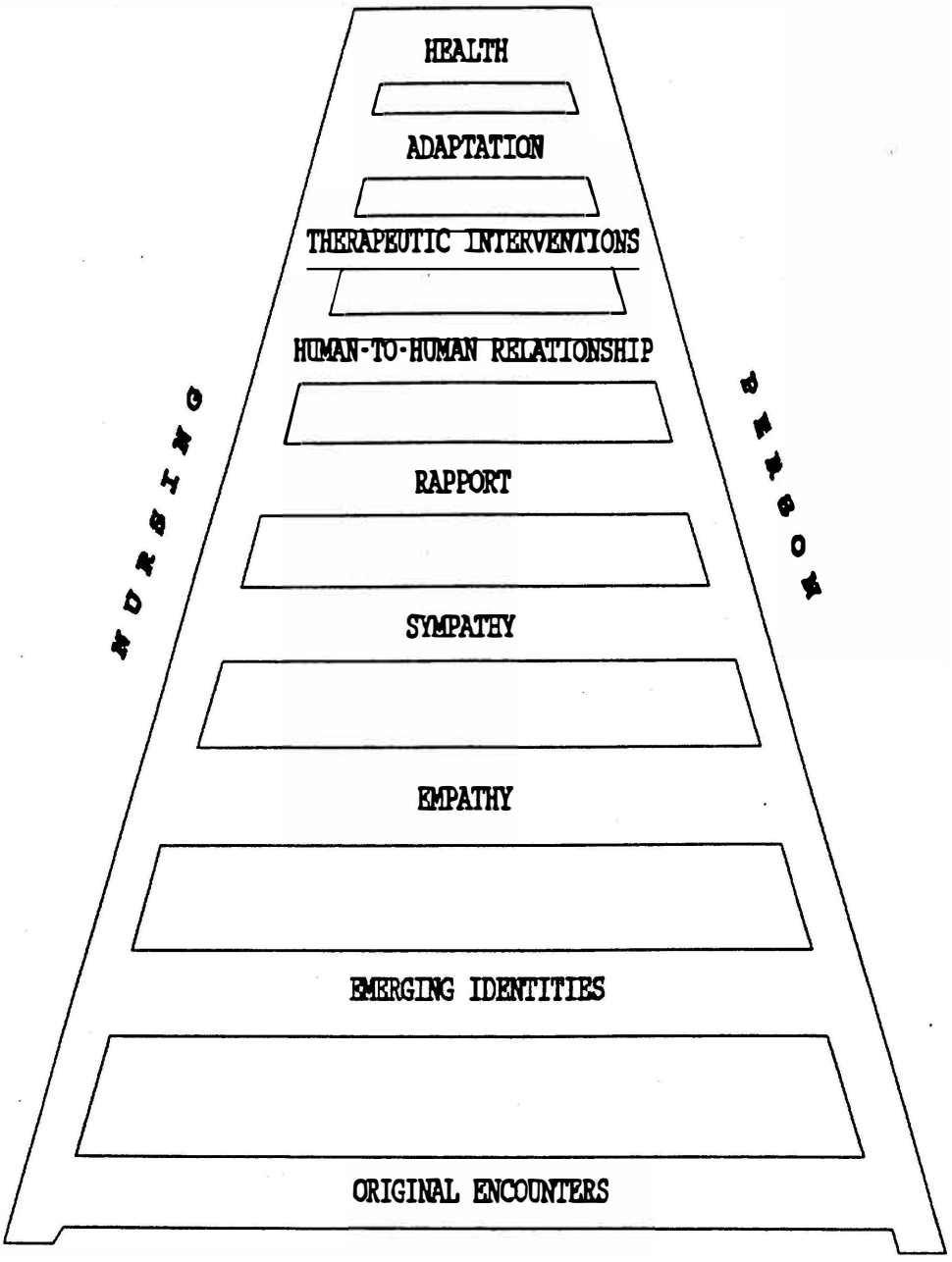
Conceptual Framework

Mosley's Humanistic-Rapport Ladder (MH-RL) (Figure 1), the conceptual framework for this study, evolved from Joyce Travelbee's interpersonal theory of nursing. Travelbee's (1971) theory is considered humanistic because it is based on existential beliefs and it focuses on the uniqueness and dignity of the human being (Meleis, 1991). Travelbee's theory is interpersonal and provides a body of knowledge that can assist nurses to observe more intelligently and intervene more sensitively in nursing situations (Fawcett, 1984).

Nursing was defined by Travelbee (1971) as an interpersonal process whereby the nurse assists an individual, family or community to prevent or cope with the experience of illness or suffering. This interpersonal process is facilitated by the nurse's therapeutic use of self. Travelbee (1971) defined therapeutic use of self as the ability to use one's personality consciously in an attempt to establish a relationship with another individual and to structure nursing intervention. Therapeutic use of self requires self-insight, self-understanding, an understanding of human dynamics, and the ability to intervene effectively. Using the self therapeutically, the nurse attempts to establish a human-to-human relationship after first progressing through four phases, original

Figure 1

Mosley's Humanistic-Rapport Ladder
(A Model for Practice)



encounters, emerging identities, empathy, and sympathy, which culminated in rapport.

The focus and goal of the original encounter phase is to view the person as a unique human being rather than as a stereotype. When the nurse is able to see the person as a unique human being, the phase of emerging identities begins. The nurse and the person begin to establish a bond based on their similarities and differences. At this point, empathy is felt on a conscious level. Sympathy occurs when the nurse experiences a desire to alleviate the person's distress. The experience of rapport follows. Travelbee (1971) described rapport as a process, a happening, an experience or series of experiences undergone simultaneously only by the nurse and the person. Rapport is comprised of a cluster of interrelated thoughts and feelings; these thoughts, feelings and attitudes being transmitted, or communicated by one human being to another. Travelbee stated that effective communication and the nurses use of self therapeutically, strongly affected the nurses ability to establish rapport and a human-to-human relationship. In a human-to-human relationship, the nurse and the person relate to each other as unique human beings. According to Travelbee (1971), the human-to-human relationship is the means through which the purpose of nursing is accomplished.

The person was identified in Travelbee's theory as an individual, family or community. Travelbee explicitly identified persons as biological organisms who are affected, influenced and changed by heredity, environment, culture, and life experiences.

Health, as defined by Travelbee (1971) is the synthesis of subjective health and objective health. Subjective health is defined by the person's self appraisal of their physical, emotional and spiritual status. Objective health is the absence of discernible disease, disability or defect as measured by physical examination, or laboratory test. Travelbee stated that subjective and objective assessment of health could differ.

Environment was defined broadly by Travelbee (1971) as the "human condition." She stated that all persons are subject to the human condition and each person experiences the human condition in a personal way. Persons are changed by the human condition, yet, as the human condition changes them, they change the human condition.

MH-RL was developed using the central ideas of the aforementioned theoretical framework, and the personal ideas and interpretations of the investigator. MH-RL is classified by the investigator as an interactional model, and as such, the model is designed to emphasize social acts and interrelationships between people. The focus of the

model is on the identification of actual and potential problems in interpersonal relationships and the delineation of interventions. The major characteristics of interactional models are perception, communication, role and self concept (Fawcett, 1984). MH-RL satisfies all the criteria for an interactional model as identified by Fawcett (1984). The model focuses on the interactive process between the nurse and the person. The goal of MH-RL is to assist the person, family or community to prevent or cope with the experience of illness and to maintain or restore health. Through communication and the therapeutic use of self, the nurse interacts with the person to identify actual and potential problems for which nursing interventions are delineated.

The concepts of MH-RL, incorporating the definitions of nursing, person, environment and rapport as identified in Travelbee's theoretical framework, are defined as follows:

The Person is a unique, social being, family, or community with the ability to perceive, think, feel, choose, set goals, and make decisions. A person is a biological organism who is affected and influenced by the environment, culture and life experiences (Travelbee, 1971).

Nursing is an intellectual, emotional and

interpersonal process. It is a helping relationship involving the nurse's therapeutic use of self. Nursing is a response to human needs. Nursing's purpose is achieved through the development of rapport and human-to-human relationships which evolve from four phases: original encounter, emerging identities, empathy and sympathy (Travelbee, 1971). The nurse's role within this model is viewed as a supportive one, with support being provided directly or indirectly to enable the person to meet their health needs. Supportive nursing care is therefore defined as verbal and/or nonverbal nursing actions which have the potential to relieve the person's anxiety, to give realistic reassurance and to assist in adapting to the environment.

The environment is everything interfacing with the person, all which influence the person or are influenced by the person -- "the human condition," (Travelbee, 1971). The person and environment are viewed as enmeshed with one another. The environment has no real boundaries and is implied when the term "person" is used. The environment, therefore, is not identified separately from the person in the model.

The original encounter phase occurs when the nurse first meets the person. Initially, the person is viewed as a client and the nurse as a nurse. The nurse and the

person relate to each other as "nurse" and "client," thus the beginning of the establishment of the nurse-client relationship. Interactions are usually superficial. Little consideration may be given to the uniqueness of the person. The nurse and person observe and develop inferences and value judgments about each other. Both are categorized and stereotyped according to past experiences. Only when these stereotypes are displaced, can the nurse and client begin to view each other as unique human beings. The goal of the nurse is to perceive the human being in the "client." The nurse facilitates this process by exhibiting the following characteristics: genuineness, competence, non-possessive warmth, caring and a respectful attitude (Rogers, 1951).

During the emerging identities phase, the nurse and person begin to establish a bond and to view the other less as a category and more as a human being. For example, the person begins to perceive the nurse as a different, unique human being and not as the personification of all nurses. A basic respect for the person is implied. Although the relationship may continue on a superficial level, the nurse and person are beginning to transcend their respective roles and perceive the uniqueness in each other.

Empathy is basically the ability to enter into or share with and comprehend the psychological state of

another individual (LaMonica, 1983). Empathy is the ability to comprehend the meaning and relevance of the thoughts and feelings of the individual. Some "degree" of trust is needed in empathizing with another person. Empathy is an experience of mutual understanding characterized by the nurse attempting to maintain a non-judgmental attitude while interacting and conveying acceptance. Each person is accepted unconditionally with all strengths and weaknesses. The nurse and the person experience a closer relationship than when they first met. The superficiality which characterized the relationship gradually decreases. The result of the empathic process is the ability to predict the behavior of the person with whom one has empathized.

Sympathy follows or is the result of the empathic process. Sympathy is the process in which an individual is able to comprehend the stress of another, is moved or touched by another's distress and desires to alleviate the cause (Travelbee, 1971). The nurse shares in the feelings of the person and experiences compassion. Sympathy is a higher level process than empathy (Travelbee, 1971). Sympathy is a higher process because it requires a disciplined intellectual approach and the nurses' therapeutic use of self if the therapeutic aspect of the experience is to be retained. Sympathy is a positive

feeling characterized by deep personal concern and interest.

Sympathy is warmth, kindness, compassion and a caring quality experienced on a feeling level and communicated to another. The tenderness and compassion of sympathy may be communicated verbally or nonverbally. Nonverbally, a look, glance, gesture, or manner in which the nurse performs her duties conveys sympathy. Sympathy means that the nurse cares but in caring gives emotional support. Sympathy is often confused with pity. According to Travelbee (1971), sympathy is not pity. Pity is a dehumanizing way of relating to others and is characterized by relating to persons as objects rather than human beings. The sympathetic phase is characterized by the emergence of trust and confidence.

The goal of rapport follows which provides a relationship in which nursing interventions can occur which will ultimately promote positive client outcomes. Rapport is defined as an experience between the nurse and the other person in which thoughts, feelings, interests or concerns are transmitted or communicated by one person to the other (Travelbee, 1971). Rapport, as referred to in MH-RL, occurs on a deeper level than the rapport nurses state exist in the "nurse-client relationship." For example, the ability to elicit a health history or to carry on an

amicable conversation does not mean that rapport was present. Rapport as implied by this model is much more than communicating. It goes beyond the superficial to a much deeper experience between the nurse and person. It is in this deeper experience that the nurse has the capacity to affect change.

Rapport is the central concept of MH-RL ladder. Rapport provides the broad base of support needed to complete the climb to the top of the ladder. A person who shares this type of relationship with their nurse will express satisfaction with care, participate in self-care activities, and adhere to health care recommendations. Rapport is the necessary element needed to foster positive client outcomes. Rapport, in this model, is characterized by a deep level of trust, mutual understanding, attentive listening, facilitative communication, positive body language and interpersonal closeness - warmth, honesty, and respect.

It is not expected that nurses will experience this type of rapport with all persons. However, every encounter the nurse has with a person should be utilized in an effort to establish this type of rapport. The phases original encounter, emerging identities, empathy, sympathy and rapport emphasize that some emotional involvement is necessary. Emotional involvement is both cognitive and

affective. It is the ability to care for and about another human being, and to do so in such a way that one is not incapacitated by one's caring and concern. Many factors exist which affect one's ability to become emotionally involved. Prerequisites include recognition and acceptance of one's self as a distinct entity, and the concurrent ability to perceive others as unique human beings. The ability to express and control one's feelings when interacting with a person, family or community and to do this on a conscious level is also essential.

According to Travelbee (1971), emotional involvement requires knowledge, insight and self-discipline on the part of nurses. Nurses must possess the openness and freedom to express self as one human being to another human being. Being involved helps nurses assist human beings. Involvement does not hinder nursing action but facilitates it as long as the emotional involvement is on a mature level. Only by becoming involved can the nurse relate as one human being to another human being (Travelbee, 1971).

The presence of rapport makes the human-to-human relationship possible. This model does not use the standard "nurse-client relationship" terminology. When persons relate to each other as nurse and client, there is a tendency for the nurse to treat persons as clients, often losing sight of them as human beings. Human-to-human

implies that the nurse and the other person have reached a point which transcends the facade of nurse and client (Travelbee, 1971). In other words, a human-to-human relationship is one step further than the nurse-client relationship. A human-to-human relationship implies that the humanity of each person has been reached. A human-to-human relationship is an experience between the nurse and the client in which they relate to each other as unique human beings rather than as nurse to client.

The establishment of the human-to-human relationship is dependent on the nurse's therapeutic use of self. Travelbee (1971) stated that therapeutic use of self is the ability to use one's personality consciously to establish a relationship and to structure interventions. It involves self insight, self understanding and an understanding of human dynamics. Communication is a central concept in the establishment of rapport and a human-to-human relationship (Travelbee, 1971). The establishment of a human-to-human relationship with persons is done with the expressed purpose of achieving the goal of nursing.

Once rapport and a human-to-human relationship have been established, nursing care directed toward preventing or coping with the experience of illness and suffering, and maintaining or restoring health can then occur. The model depicts this as <u>therapeutic intervention.</u> Interventions

which address the needs identified by the person and nurse are considered therapeutic. Although assessment and identification of needs can occur without rapport, without it the incongruence of needs identified by the nurse and the other person increases. Interventions based on inaccurately assessed needs lead to dysfunctional outcomes (Giuffra, 1980).

Therapeutic intervention is considered synonymous with the working phase of the "nurse-client relationship" (Travelbee, 1969; Torres, 1986). It is during this time that the nurse and the person work together to meet the needs identified earlier in the relationship. Therapeutic interventions should include every thing in the person's environment which influence the person and is influenced by the person. Actual behavioral change is the focus of therapeutic intervention.

In this model, therapeutic intervention is designed to promote adaptation that contributes to positive client outcomes leading to health. Adaptation includes a psychosocial component involving the person's reevaluation of self, a behavioral component indicating an acceptance of change or loss, compliance with the recommended plan of care or efforts at rehabilitation which then facilitates a physiological and/or psychological adjustment leading to health as identified by the person and nurse.

Health is a state of wholeness or integrity of the individual. Health is a synthesis of objective and subjective health. Subjective health is the persons' self appraisal of their physical, emotional and spiritual status. That is, persons are as healthy as they perceive themselves to be. Objective health is the absence of disease, disability or defect as indicated by physical, psychological exams and/or laboratory tests whose findings fall within the normal parameters for one's society (Travelbee, 1971).

Health, as implied by this model, may not only be the absence of disease or illness which is a characteristic of many nursing models. This model takes into consideration the cancer client in remission who, because of the diagnosis, may be labeled by some models as ill. This model allows the person to be considered healthy based on the subjective and objective definitions of health. Health is the synthesis of the subjective and objective definition of one's health status (Travelbee, 1971). If the subjective and objective appraisals of the person's health status differ, the person's health state is questionable. A questionable health state warrants reassessment and additional health teaching.

The ability of the nurse to establish rapport with the client will vary for each situation. Progression, through

the phases leading to rapport may occur sequentially and/or concurrently.

Interrelationship of Concepts

The schematic representation of MH-RL shows the interrelationship of the concepts. The symbolic use of the ladder illustrates the importance of the relationship the nurse shares with the client. The model illustrates a reciprocal relationship (the arrows on either side of the legs of the ladder show the interaction) between the nurse and person wherefore both are needed and must relate if the ladder is to be functional. If one [person/leg] is removed, the ladder is no longer functional in that progression up the rungs of the ladder becomes difficult if not impossible.

The nurse's and person's relationship to the other concepts in the model is also clearly depicted by the symbol of the ladder. The nurse is important and necessary for the functioning of each rung of the ladder. For example, if the [nurse/leg] of the ladder is attached at the top rung of health but is unattached from the rung of original identities through the rung of adaptation, these rungs would not be functional in that it would be impossible for the person to successfully reach the rung of health. The same process is true for the [person/leg]. Additionally, the model depicts the relationship of the

rungs to the legs of the ladder. If the rungs of emerging identities through the rung of human-to-human relationship were removed, the attempt to ascend the ladder at the rung of therapeutic interventions would be risky, difficult and almost impossible. Health would be out of reach. Therefore, the symbol of the ladder clearly illustrates how the function of each concept is important to the functioning of other concepts.

With a strong functioning ladder, the nurse and the person enter the ladder from the first rung and progress through four phases, characterized by increasing emotional involvement, which culminate in the establishment of rapport. Rapport is the central concept in MH-RL as depicted by its placement centrally on the rungs of the ladder. Rapport evolves as a result of the nurses therapeutic use of self and communication. Rapport is needed in order to affect therapeutic change.

A human-to-human relationship occurs as a result of the rapport experience and is the means through which the purpose of nursing is achieved. Therapeutic interventions directed at meeting the needs of the person are possible as a result of the human-to-human relationship. Interventions focused on needs as perceived by the person and nurse facilitate adaptation. Adaptation, reflected as a psychological, physiological and behavioral adjustment,

culminates in health as identified by the person and nurse.

Application of Model

Travelbee (1971) explicitly described the nature of the nursing process. Travelbee identified the nursing process as a combination of intellect and emotion and stated that nursing requires a disciplined, intellectual approach and therapeutic use of self. MH-RL identifies an approach which requires utilization of the nurses' intellect and use of self therapeutically when determining and planning care. The approach can be compared to the steps of the nursing process and the phases of the "nurse-client" relationship as shown in Table 1.

The nurse and person enter the model at the first rung of the ladder, original encounter. It is during the original encounter phase that assessment starts. The nurse begins to make observations that lead to inferences which are validated with the person. While interacting with the person the nurse strives to convey genuineness, competence, respect, warmth, and honesty, and to begin the establishment of trust. Communication techniques which facilitate the goal of establishing rapport are used. An atmosphere is created whereby stereotyping is reduced; the nurse sees the person as a unique individual and information is shared by the nurse and person.

Table 1

Comparison of Mosley's Humanistic Rapport Ladder to the Nursing Process

Nursing Process	**Phases of Nurse - Client Relationship**	**Mosley's Humanistic Rapport Ladder**
Evaluation	Termination	Health Adaptation
Intervention	Working	Therapeutic Intervention
Plan		Human-to-human relationship Rapport Sympathy
Assessment	Orientation	Empathy Emergency Identities Original Encounters

For example, the nurse sees the "person" who is to experience surgery rather then the "typical client" who is to experience surgery. This communication and sharing leads to a bonding relationship as identities begin to emerge. Empathy evolves when the nurse can understand the meaning of an experience to the person. The nurse is able to predict the response of the individual as a result of the empathic process. For example, the nurse empathizes with the person who is to have surgery and therefore predicts that he will feel anxious, and will need information about the surgery.

Nursing diagnoses are then formulated. Anxiety related to lack of knowledge of future surgery is

identified as a nursing diagnosis by the nurse. The desire of the nurse to eliminate this anxiety is characterized as sympathy. The beginning formulation of the nursing care plan evolves. Rapport and a human-to-human relationship follow which make it possible for therapeutic interventions to occur. The nurse and the person work together to identify interventions which will assist the person to achieve the goal of nursing. Interventions which focus on needs identified by the person and the nurse will in most cases lead to therapeutic outcomes (Giuffra, 1980). The phase of therapeutic interventions is where the major part of the therapeutic work is carried out. The person and nurse implement activities directed at meeting the person's needs. For example, the nurse tells the person what to expect with the surgery; allows the person to express his fear of pain, disfigurement and/or loss of body part.

Actual behavioral change is the focus of therapeutic interventions. The phase of adaptation and health is synonymous with the evaluation phase of the nursing process. The nurse and person evaluate the person's progress and need attainment. Adaptation is evaluated according to the persons physiological, psychological and behavioral acceptance of change or loss. For example, the nurse will ask the person how he/she feels and observe for signs of anxiety such as insomnia, headache, fatigue, and

jitteriness.

Health is the synthesis of how the person states he feels (subjective) and the absence of disease as indicated by physical and/or psychological exams (objective). If the person's subjective and objective health status differ, the person's health state is questionable. A questionable health state warrants reassessment and additional health teaching.

MH-RL was derived from Travelbee's (1971) interpersonal theory of nursing. The goal of MH-RL is to assist the person, family or community to prevent or cope with the experience of illness, and maintain or restore health. This model illustrates a process by which nurses can identify, and design a plan of care based on the needs of the person in any setting. The critical aspect necessary to facilitate the development of a relationship, and the implementation of therapeutic interventions enabling the person to adapt and progress to health is rapport. In MH-RL, the process for the development of rapport and human-to-human relationships is identified. The research question, can a formal educational program improve nurses ability to establish rapport, can be answered through utilization of this model. This model will serve as the conceptual framework for examining the development of rapport by nurses who participate in a

rapport facilitative training program.

Assumptions

For the purpose of this study, the following assumptions were identified:

1. Communication and therapeutic use of self is a process that enables the nurse to establish rapport (Travelbee, 1971).

2. The human-to-human relationship is the essence of the purpose of nursing (Travelbee, 1971).

3. The presence of rapport affect responses (client outcomes/compliance) (Travelbee, 1971).

4. An interpersonal relationship between the client and nurse requires that the nurse possess specific attributes of genuineness, competence, non-possessive warmth, caring, and respect for the client (Rogers, 1951).

5. Use of empathy facilitates an environment conducive to adaptation (LaMonica, 1983).

Hypotheses

The following research hypotheses were formulated to guide this research:

H_1. There will be significant differences in the nurses identification of rapport according to their age and length in practice.

H_2. There will be significant differences in the

clients identification of rapport according to their age.

H_3. There will be significant differences in the nurses identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_4. There will be significant differences in the clients identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_5. There will be significant differences in the identification of rapport among nurses who attended the facilitative training classes and those nurses who do not attend the classes.

H_6. There will be significant differences in the identification of rapport among clients cared for by nurses who attend the facilitative training classes and those clients cared for by nurses who do not attend the classes.

Definition of Terms

For the purpose of this study, the following definitions were used:

1. Rapport - An experience between nurse and client in which thoughts, feelings, interests or concerns are transmitted or communicated by one person to the other (Travelbee, 1971). It is characterized by mutual

understanding, positive body language, attentive listening/ facilitative communication and interpersonal closeness-warmth, honesty, trust and respect. In this study, rapport was the degree to which the nurse and person express or demonstrate that rapport exists as measured by scores obtained on the Mosley's Interpersonal Rapport Perception Questionnaire (MIRPQ) and Mosley's Behavioral Rapport Scale (MBRS).

2. Facilitative Training Program - A seminar training session which included the techniques of lecture, discussion, and experiential training. The facilitative program consisted of 6 hours of training in a one week period of time.

The first three hours of seminar were lecture/ discussion and addressed the identification of verbal and nonverbal responses, facilitative communication, attentive listening, mutual understanding, therapeutic use of self, and the development of interpersonal closeness-warmth, honesty, respect, trust. All are characteristics that the nurse must have in order to proceed to the development of rapport. The fourth hour of seminar training was based on Kalisch's (1971) experiential training. The method of training was similar to sensitivity training in that the participants were encouraged to discuss their personal feelings regarding the experience of sympathy and emotional

involvement when interacting with clients.

The fifth hour of seminar training consisted of role playing. Simulated nurse-client situations were assigned to paired participants. Persons role playing the client role were encouraged to express to the role playing nurse feelings about how he/she responds; to give feedback as to which responses would have been more effective in conveying genuine interest by the nurse. Each participant had the opportunity to role play the client and nurse. The sixth hour of seminar training was used to allow participants to discuss their feelings and problems experienced during the simulated interviews. Feedback was offered to participants as to the appropriateness of their responses.

Limitations

The following limitations of the study were identified:

1. The administration of Mosley's Communication Skills Questionnaire (MCSQ) as a pre and posttest to nurses during work hours may effect responses to the items on the questionnaires. Nurses could have been preoccupied with responsibilities thereby interrupting concentration on the test and resulting in greater errors of measurement.

2. Some clients were cared for by nurses in the experimental group and/or nurses in the control group.

3. Because the hospital was not randomly selected, generalizability of the study is limited to clients and nurses on long term care units in this state hospital.

4. The administration of MCSQ and MIRPQ as a pretest could have sensitized participants to the behaviors indicative of rapport.

5. Subjects were aware of why they were being observed and may have distorted the data collected if they changed their behavior as a result of being observed.

6. The researcher was aware of the group assignment of the participants and may have been influenced in the way behaviors were observed.

Summary

The body of nursing research concerning the development of rapport and its relationship to a nurse-client relationship and client compliance is non existent. In this chapter, the importance of rapport to the nurse-client relationship was discussed. The justification of the study was based on its therapeutic value in promoting health, cost containment and cost effectiveness for the client and health care industry. MH-RL, from which the study evolved, provided the background for identifying the process for developing rapport.

CHAPTER II

REVIEW OF LITERATURE

Rapport is widely accepted as important to the success of the professional/client relationship (Orlando, 1961; Peplau, 1952; Rogers et al., 1967; Travelbee, 1971). Included in this chapter of selected literature review are: the definitions of rapport as proposed by different theorists, the importance of rapport, how and when rapport should be established, and variables which may influence the development of rapport. Although research on the concept of rapport is not found in the nursing literature, the last portion of the review will present studies on the process of psychotherapy and compliance which validate the importance and need for rapport in the health professional/client relationship. This chapter will conclude with a discussion of these related research studies.

Definitions of Rapport

There does not appear to be any striking disagreement in the professional literature concerning the meaning of rapport. Although each definition is different, certain attributes which are similar could be inferred. Rapport

was considered by interaction theorist such as Hall (1964), Levine (1973), Peplau (1952), Travelbee (1971), and Watson (1979), to be a necessary prerequisite, component or ingredient to the establishment of a relationship (Torres, 1986). Peplau (1952) argued that rapport was established as a result of trust, respect, and shared satisfaction in an empathic atmosphere. Peplau (1952) maintained that all are essential components of a nurse-client relationship. According to Torres (1986), Lydia Hall did not specifically address rapport in her theory, but did say that the interaction between the nurse and client should result in a positive environment which is characterized by trust, shared feelings, verbal interaction and personal relationships.

Snipe (1979) defined rapport as a relationship of mutual trust or emotional affinity. Cheng (1973) confirmed the need for mutuality by defining rapport as the creation of a personal relationship and an atmosphere of mutual acceptance.

The nature of rapport was described by Rogers (1942) as a warmth and responsiveness on the part of the professional which gradually develops into a deeper emotional relationship. Rogers (1942) described the necessary conditions for rapport as genuineness of the professional, unconditional positive regard for the client,

and a desire to understand the client on an empathic level. The affective characteristic of rapport was maintained in definitions posed by others. Nahum (1965) described rapport as an emotional relationship established by emotional mechanisms such as trust, the feeling that the nurse understands, the feeling of communicating with the nurse.

Mittleman (1976) further validated the emotional characteristic of rapport and defined rapport as an emotional adjustment, a faith that the client places on the professional and the professional reciprocates. Mittleman further clarified that rapport occurs on a deeper emotional level whereas the professional relationship occurs on a rationale level. With rapport, the client can talk about himself and his problems in a more trusting way. The qualities which build this trust are empathy, non-possessive warmth and genuineness. A feeling is developed by the client that he is understood as an individual. With rapport, the client feels that the professional wants to help and can help.

Pope (1979) approached the definition of rapport from a social perspective. Pope described rapport as the beginning step of relationship formation. It is the sensitive interaction between two people who are beginning to move toward a relationship. The effect of this

relationship on communication and on the outcome of treatment is a consequent of the quality of the relationship. Pope emphasized that the formation of rapport, important to the success of the therapeutic relationship, rest with the health professional. It is necessary, therefore, to discuss the importance of rapport to the therapeutic process.

Importance of Rapport

According to Mittleman (1976), the more relaxed a client is and the more he is secure, the more he can cooperate. This behavior explains why rapport is important. Mittleman stated, if you want to teach any one about health, greater acceptance always comes with good rapport. People accept you first, then what you suggest. Mittleman also stated that in health care practices where prevention has failed, one can be sure that lack of good rapport was a large contributing factor. He stated that it is important to develop rapport with clients in order to gain their cooperation. Mittleman further emphasized that the most simple explanations and reassurances are more effective when rapport has been developed. Clients can be treated better when they loosen up voluntarily, and feel more secure in a psychological sense.

Rogers (1958) stated that the person who communicates

empathic understanding and unconditional positive regard for the client builds a relationship necessary to promote therapeutic change. For effective client care, teaching and education, the health professional must build a relationship that demonstrates an interest in the clients' well being. According to Rogers, people who are spontaneous, do and say what they mean, act without being defensive and without exhibiting a role or facade, are real and therefore portray the characteristics of genuineness. This climate is one which facilitates the development of rapport as described by Rogers.

The importance of rapport is further supported by other authors. Snipe (1979) reported that a lack of rapport may lead to incomplete or inaccurate reporting of symptoms and responses to treatment. Rakel (1977) attested that a lack of rapport can affect the outcome of treatment as seriously as can an error in treatment.

Bandler and Grinder (1979) reported that in order to help people change, it was necessary to first gain rapport. They noted that after rapport is gained, it is possible to influence the person to change current experiences and behavior. DiMatteo (1979), Kastelec, Kane, Olsen and Thetford (1976) simply stated that clients are more likely to be dissatisfied and not follow health recommendations when little rapport exists and good communication is not

established.

According to Nahum (1964), rapport must be thought of as a therapeutic mechanism. To establish rapport with the client is to exhibit an understanding of the client's suffering and to communicate sincerity so that the client can develop trust. Nahum maintained that rapport makes it possible for all other therapeutic mechanisms to function effectively. Professionals who establish rapport will be more effective than professionals who neglect or fail to establish rapport.

Strupp (1976) and Strupp (1980) reported that the major indicator of potential success of treatment lies in the therapist and clients ability to establish rapport. Harrison and Carek (1966) spoke of rapport as implying positive feelings combined with a spirit of cooperativeness. They viewed the development of rapport as therapeutic in that it had the tendency to decrease symptomology.

Marmor (1976) illustrated the importance of rapport when he stated that the basis of any therapeutic process consist of a good client/professional relationship. This relationship relies on the trust and rapport established by the professional as well as the genuine interest, respect and empathy for the client.

Console, Simons, and Rubenstein (1977) considered it

absolutely essential that rapport be established between the client and therapist. The information received, Console et al. stated, can only be meaningful and helpful if it is obtained in the context of a relationship of trust, confidence and care that always respects the client. Console et al. insisted that if the information is not obtained in a manner that inspires trust, hope and confidence on the part of the client, that it will not matter how much one knows about the client because he/she may never follow health recommendations.

This belief was supported by Wolberg (1977) and Warner (1981). Wolberg (1977) asserted that unless rapport was established with the client, the therapeutic process may come to naught. According to Warner (1981), rapport through empathy, respect and warmth is a means of influencing the attitudes of others.

In summary, rapport is an essential prerequisite for the effective use of all therapeutic mechanisms. It is important therefore to address when rapport should be established.

When to Establish Rapport

Although there is a lack of research relevant to when rapport should be established, health professionals generally agree that the initial contact with the client is

important. Singer (1965) supported that the initial interview sets the tone for what follows, and therefore represents a period more crucial than any other stage in the health professional relationship. Singer stressed the need to communicate interest in the client, while displacing information gathering and inquiry to a secondary position.

Further support of the need to establish rapport as early in the relationship as possible was offered by Console et al. (1977). They emphasized the importance of impressions formed during the first contact. Although it is important to obtain health information, Console et al. (1977) considered it absolutely essential that an "empathic alliance" between the client and health professional be established by the end of the initial interview (p. 13). Console et al. maintained that the information one gathers through active questioning can only be meaningful and helpful if it takes place in the context of a relationship of trust, confidence and one that respects the client.

This position was echoed by Wolberg (1977) who maintained that the therapeutic process with the client would not progress unless a "cooperative contact" was established with the client (p. 44). Wolberg stated that the development of this cooperative relationship should be the prime objective of the early phase of interaction.

Urban (1981), viewed the establishment of rapport as essential to initial phases of a relationship. Urban stated that rapport occurs when there is equality between the client and health professional. The professional is not viewed as special and separate from the client but relates in a natural and genuine manner. The professional is the expert, is accepting and supportive of the client and thus creates an environment for rapport to occur and subsequent successful treatment to follow.

Cheng (1973) concluded that it is important to form rapport with a client as soon as possible. Delay makes the formation of rapport more difficult because clients form opinions about health professionals from the beginning. Brook (1974) emphasized the importance of establishing rapport during the initial contact by stating:

> However long it takes and no matter how involved it gets, it does begin with the initial interview; what is experienced then and there may well determine the course of therapy. It may start auspiciously, with a promise of mutual rapport and understanding. Though many difficulties will arise as the treatment progress, this basic feeling of having been understood may well sustain the patient when the going gets rough (p. 1).

Brook (1974) described the initial session as a time of

mutual assessment, initiation of relationship formation and information gathering.

Thus, the review of the literature supports that establishing rapport early in the relationship is critical to the therapeutic process.

How to Establish Rapport

Rakel (1977) emphasized that a good first impression allows one to establish rapport more quickly. Rakel suggested approaching the client in an assured, confident manner and presenting a personal appearance acceptable to the client. He also advocates familiarizing oneself with the clients name and correct pronunciation prior to meeting the client.

Rakel also stressed the importance of communication when establishing rapport and said that the failure of communication between the health professional and client affects the outcome of treatment. Rakel maintained that effective interpersonal communication involves empathy, warmth, sincerity and respect. The communication of respect, according to Rakel, is the most essential of all in establishing rapport. Rakel insisted that the client should feel that his comments are being listened to, carefully considered and taken seriously.

The communication of respect also requires that the

client to be treated and viewed as an individual and not stereotyped according to illness, race or sex. Rakel identified the following as techniques for facilitating communication and the establishment of rapport: relaxed posture; consistent eye contact; forward lean with a comfortably close seating distance; natural gestures; formal expression indicating interest; verbal encouragement such as friendly voice tone; repetition of key words and phases and summarization to ensure clarity.

Possibly the greatest deterrent to establishing client rapport according to Rakel is an attitude of indifference, or lack of interest. Attitude, he felt, was the key to successful communication between two people. To illustrate this idea, Rakel quoted a statement made by Francis Peachy in 1923, "One of the essential qualities of the clinician is interest in humanity, for the secret of care of the patient is in caring for the patient, which could well serve as the maxim for establishing patient rapport" (p. 107).

Caring, according to Rakel, is synonymous with sympathy and the opposite of apathy. Sympathy implies the application of human tenderness and compassion to the caring of individual. Sympathy involves respect for the person as a human being and enables the professional to motivate the client to participate in his care, thereby

increasing the degree of compliance. Rakel acknowledged that educators felt that students should be taught to develop a detached concern for clients (to not experience sympathy). He argued that this would be difficult and undesirable, because the greater the detachment, the more unlikely it could be that the student would be concerned. The important element, Rakel emphasized, was for the student to remain sensitive to the needs of the client and have the understanding for a necessary involvement with the client.

Warner (1981) supported Rakel's (1977) view that rapport is established through empathy, respect and warmth. Warner identified empathy, respect and warmth as three essential elements in the rapport building phase.

As identified by Warner (1981), empathy could be communicated to the other person by a reflection of the person's feelings and a restatement of the content so that the other person obtains feedback. A reflection of feelings should include not only those expressed verbally but also the emotions indicated by nonverbal behaviors.

According to Warner, respect can be conveyed by willingness to hear the person without interruption. Respect is displayed by common courtesy, such as being on time for meetings, calling persons by name, and allowing no intrusions. An expression indicating genuine interest,

tone of voice, the distance between the speaker and the listener and the position of the listener can be perceived by the other person as indications of respect. Warner asserts that a position that indicates a "forwardness" rather than "away fromness" is extremely facilitating in establishing rapport.

Warmth, according to Warner, is included in communication of respect and empathy. Warmth conveys a personal kind of psychological closeness as opposed to professional distance.

Bourne (1983) identified several steps essential to establishing client rapport. Bourne believed that every effort should be made to communicate with closeness and empathy. The professional should meet the client, address the person by name and shake his hand. The professional should try not to hurry while in the relationship. Hurrying conveys to the client that you are not interested in him as a human being. Examine the nonverbal aspects of your behavior to determine whether they project closeness or distance. Bourne stresses the importance of listening. The professional should listen to the client and ask questions that require more than a yes/no answer.

Martin (1984) supported Bourne's (1983) ideas concerning the establishment of rapport. Martin stated that the professional could build rapport and trust with

the client by really listening to what the client had to say, showing understanding, providing information when necessary, maintaining a non-judgmental attitude and keeping the discussion relevant. Questions asked by the professional, Martin stated, should be open-ended, that is, they should not require a simple "yes" or "no" response.

Dillon (1971) felt that the professional needed to have a skill of observation in order to establish rapport. The professional must be able to observe and evaluate everything about the client in order to establish rapport. This included the client's dress, behavior, expression, gesture, manner, posture, speech, and especially the voice, which often tells more than words and has deeper meaning. Dillon also advocated listening as an important aspect of the establishment of rapport.

MacKinnon and Michels (1971) asserted that in order to establish rapport, the interviewer must communicate a feeling of understanding to the client. They suggest asking relevant questions, summarizing information received and demonstrating an interest in the client. The professional should also convey an accepting, respectful attitude.

Lambert (1983) validated the previous authors ideas concerning the development of rapport. Lambert stated that a general attitude of respect, acceptance and

understanding, are what is needed for rapport.

Marmor (1976) explicitly stated that the components of rapport and those conditions necessary for its formation include the therapist attitudes toward the client. In other words, the therapist must create and maintain a helping relationship characterized by respect, interest, understanding, tact and maturity.

Zucker (1967) took a separate stance related to the development of rapport. He identified rapport as being the variable directly related to the possibility of knowing the person. Although Zucker agreed that warmth, respect and acceptance of the client facilitates the development of rapport, he also maintained, in direct opposition to the views of others, that the quality of rapport is largely a function of what kind of person one is and is only trivially related to ones intention or technique.

Sterling (1974a) postulated that how you initially greet a person, the setting of the meeting and stating expectations of the meeting play a significant factor in establishing rapport. The professional should know the client's name. This information makes the client feel more comfortable and acknowledges his presence thus recognizing him as a human being. According to Sterling (1974b), eye contact is a valuable factor necessary throughout the interaction.

Snipe (1979) reported that the art of building rapport involved: an awareness of the clients feelings and emotional state; an attitude of interest and concern for the client; creating a climate in which the client may feel free to talk about his feelings and concerns and helping him to do so. It also includes knowledgeable and skillful interviewing and providing feedback so that the person knows that he has been heard and understood.

There are six characteristics essential in establishing rapport (Spink, 1987). According to Spink, essential in the development of rapport is the nurses comfort with their own humanness. To be comfortable with one's own humanness, one must learn to interact with clients on a person to person basis. Nurses must also develop self confidence and self assurance if rapport is to be established (Spink, 1987). Respect and acceptance of the client is also important.

Good rapport, according to Spink, demands that clients be treated with respect. Respect is shown by being interested in the client and using careful listening skills. The nurse must empathize with the client if rapport is to be established. That is, the nurse must be able to understand feelings and emotions the client is expressing. Spink related that nurses cannot establish true rapport without investing emotional energy. Last, the

nurse must demonstrate compassion. Spink emphasized that the nurse must sincerely want to alleviate client distress. Such sincerity goes beyond a willingness to invest oneself and beyond empathy. The absence of any of these characteristics, according to Spink, delays and even prevents the establishment of a true helping relationship. Without this relationship, nursing care cannot be complete.

In summary, the review of the literature revealed that authors agree that rapport occurs on an emotional level. Rapport development requires warmth, trust, respect, empathy, compassion, and facilitative communication. Rapport development requires that nurses are self confident, self assured and interact with clients on a person to person basis. One author, Zucker (1967), stated that rapport development was directly related to the possibility of knowing the person. Therefore, variables which may influence rapport development were examined.

Variables Which May Influence Rapport Development

Demographic Variables

Interest in the characteristics of race, sex, age, social class and educational level of the health professional has been stimulated by social criticism that has questioned the fairness and the adequacy of treatment provided for black people, members of lower socioeconomic

groups and women. There is also an assumption that demographic differences may impede the development and maintenance of therapeutic rapport (Davis & Weitz, 1981; LaFrance & Mayo, 1979). The question most frequently asked by researchers who included these variables in their study was: Does an absence of shared experiences and values interfere with the therapist's ability to establish rapport and to treat these clients effectively? Therefore a survey of the literature relevant to the issue of sex, age, race, social class, and educational level was conducted.

Researchers have varied in their views about the importance of the gender of the health professional. Some researchers expressed doubt that any male professional could be helpful to a woman (Chesler, 1971). Still others suggested that even though some male therapist may be helpful, it may be more advantageous for a female client to be treated by a female professional who may serve as a role model, facilitate expressions of feelings and communicate understanding and empathy (Brodsky, 1973; Kronsky, 1971).

The variable of gender had been investigated in several studies by Craig and Huffine (1976) and Koran and Costell (1973) with results showing no significant difference between males and females in terms of professional relationship. Craig and Huffine's (1976) study, occurred over a 2 year period with a psychiatric

clinic serving a predominantly black low income inner city population. The study addressed the association of continuance in treatment with the demographic and diagnostic attributes of clients and the race of the therapist.

In all, 140 clients, four blacks and four white therapists were participated in the study. Clients were divided into categories based on the number of therapy sessions attended and the length of time actively in therapy. The demographic variables compared to continuance in treatment were sex, race, age and education. The findings of this study indicated that there was no clear association between sex and education of the client and continuation in therapy. Analysis of the data also revealed no significant association between the race of the therapist and client and duration of therapy. However, the client's age and diagnosis were significantly related to the duration of the therapeutic relationship as indicated by the Chi Squares of $X^2(2, \underline{N} = 140) = 14.99$, $\underline{p}<.001$ and $X^2(4, \underline{N} = 140) = 24.21$, $\underline{p}<.001$ respectively.

The purpose of Koran and Costell's (1973) study was to identify the demographic characteristic which would help to identify potential early terminators of therapy. Eighty-seven clients were studied, 41 men and 46 women. They were primarily from middle and upper socioeconomic classes.

Ages ranged from 19 to 52, with the majority between 20 and 40 years of age. Clients were divided into 11 groups. Each group was balanced according to sex and contained seven to nine members in addition to the two male co-therapists.

Following an initial interview, clients were given a packet of questionnaires containing the Fundamental Interpersonal Relations Orientation, Behavior (FIRO-B), and the Hill Interaction Matrix, Behavior (HIM-B) questionnaire. The FIRO-B was a 54 item questionnaire which measured an individual's orientation toward expressed and wanted inclusion, control and affection. The HIM-B was a 64 item questionnaire which asked an individual to describe how he behaved in and reacted to groups. Clients were told that the questionnaires were part of an on going effort to improve the effectiveness of therapy.

The findings indicated that clients in the study who terminated early did not differ in demographic characteristics from those remaining in therapy. The terminators included seven males with a mean age of 32.3 years and eight females, with a mean age of 31.8 years. Somewhat different findings were attributed to other studies.

Abramowitz, Roback, Schwartz, Yasuna, Abramowitz, and Gomes (1976) studied sex related bias in therapy. Male and

female practitioners were presented with written case materials of a bogus group therapy outpatient designated as male or female. The practitioners were then asked to indicate their clinical reactions to this person by completing a questionnaire. The questionnaire included six items which assessed the therapist's clinical impressions and degree of liking of the stimulus client. Although the subjects comprised a sex-stratified random sample of 600 members of the American Group Psychotherapy Association, data was returned by only 65 male and 57 female therapists. Abramowitz et al. (1976) generally found that male professionals preferred to treat women, especially white, middle class women.

Person, Person, and Newmark (1974) reported that females are more responsive to female therapists and males to male therapists in terms of helpful characteristics that were listed following therapy. Disputing this finding was research by Hackney (1974) who found that women reacted differently to attempts from female professionals to establish rapport than from attempts by male professionals.

Scher (1975) cited different results. Scher's study considered the relationship between verbal activity of the participants, sex of the participants, experience of the counselor and successful outcome in psychotherapy. Thirty-six university students and 23 counselors at a university

counselling service participated. The first, second, fifth and final counseling sessions were audiotape recorded. Verbal activity of both counselor and client was assessed from the tape. The mean percentage of time spoken was the measure of verbal activity used.

All counselors were rated for facilitative conditions of non possessive warmth and therapist genuineness. Data was analyzed using a multiple regression analysis. Scher (1975) found no significant interactions due to client and counselor gender on client and counselor ratings of symptom relief and satisfaction with treatment. Greer and Hurst's (1976) findings disputed both Scher (1975) and Person et al. (1974) findings. The purpose of their study was to determine if there were differential treatment effects due to the sex of the subject and sex of the counselor.

Subjects were 44 male and female undergraduates. The subjects were divided by sex and randomly assigned to either a male or female counselor. An equal number of males and females were assigned to each counselor. Subjects were asked to complete the Suinn Test Anxiety behavior Scale (STABS) and the Symptom Check List (SCL). The STABS was a 50 item self-report instrument designed to measure the extent to which subjective anxiety was experienced in a variety of test related situations. The SCL was a 32 item self-report instrument developed to

measure the extent to which a variety of anxiety symptoms were experienced.

An analysis of variance showed a significant treatment effect by both male and female counselors and a significant interaction effect by the male counselor with female subjects. Geer and Hurst (1976) reported that male counselors did better with female subjects than a female counselor did, and the female counselor seemed to do much better with males than females.

The existing research, with regard to gender and outcome, indicates that there is no clear relationship. A somewhat similar interpretation can be made for age of the client. In an extensive review of quantitative research of factors influencing the outcome of psychotherapy, Luborsky, Chendler, Auerbach, Cohen, and Bachrach (1971) discovered that although some therapist showed a preference for younger clients, age was not an important variable in relation to outcome.

Another variable investigated as relevant to the professional client relationship was that of race. Carkhuff and Pierce (1967) conducted a study to determine the effect of race of the therapist upon client depth of self-exploration, a critical index in the therapeutic involvement of the client. A Latin square design incorporating white and blacks and upper and lower classes

was replicated across four groups of four hospitalized mental clients by four trained counselors. All 16 clients were females. Randomly selected excerpts from the 64 recorded clinical interviews were rated on the depth of the client self-exploration in the interpersonal process by two experienced raters trained in rating client self-exploration. Pearson's Correlation yielded intrarater reliabilities of .80 and .88 and an interrater reliability of .78.

Carkhuff and Pierce (1967) found that the races of both the client and the health professional were significantly related to client self-exploration and the interaction between client and the health professional. Clients most similar to the race of the professional involved tended to explore themselves most while clients most dissimilar tended to explore themselves least.

A similar finding was reported in another study. Griffith (1977) conducted a literature review of the influence of racial differences between the client and therapist on the therapeutic relationship. Griffith's review suggested that more positive relationships resulted when clients and therapist were of the same race. Griffith (1977) also found that racial similarity led to greater self disclosure and higher ratings of rapport with the health professional. Sattler (1977) also conducted a

literature review of the effects of therapist-client racial similarity. Sattler (1977), on the other hand, disputed Griffith's finding and reported that the professional's race was not a significant variable in affecting performance and reactions.

In a study of pre-college counseling, Ewing (1974) addressed two research questions. First, does the client react to counseling interviews more favorably when the counselor is of the same rather than of a different background? Second, do counselors differ in their effectiveness in counseling students of a different ethical background as compared with their effectiveness in counseling students in general? Ewing employed three experienced black counselors and eight experienced white counselors who saw 13 black and 13 white students each. Following the interview, each student completed a one page evaluation form. Students responded on a 5-point scale ranging from 1 (not helpful) to 5 (extremely helpful). Although black students were more favorable to both groups of counselors than were white students, Ewing concluded that the racial similarity of the client and the professional was not important. Also, counselors were not shown to be differently effective with black or white students.

Ewing's finding was duplicated by Cimbolic (1972) who

studied black clients paired with white and black professionals. The study attempted to determine the effects of counselor race, experience level, and counselor-conditions upon black clients perceptions of these conditions. Seventeen subjects participated in initial interviews with four counselors, two black counselors, one experienced and one inexperienced, and two white counselors with the same experience differences as the black counselors.

Upon completion of four interviews, the subjects rated each of the counselors on empathy, genuineness, concreteness and positive regard. Subjects also indicated those counselors they would be willing to return to for future counseling. Findings indicated that there was no significant racial preference. Subjects did show a preference for counselors based on their level of experience.

In a study of preferences toward Mexican-American and Anglo-American professionals by Acosta and Sheehan (1976), the interactive effects of client ethnicity, therapist ethnicity and therapist expertise on client responses were examined. The subjects were 187 undergraduate college students; 94 were Mexican-Americans and 93 were Angelo-Americans. Subjects listened to one of two matched therapy audiotapes. Subjects then completed a therapist behavior

scale addressing the subjects perception of the therapist competence, trustworthiness and perceived similarity and attraction to the therapist. An analysis of variance revealed that the two groups of college students selected from these ethnic classifications both indicated a clear preference for the Anglo-American professional, $F(1,179) = 4.33$, $p<.05$.

There was no agreement as to the effect of social class on the professional/client relationship. Most studies, Lerner and Fiske, 1973; Lorion, 1973; and Lorion, 1974, dealing with social class of clients have reported that lower class individuals are less likely than those in the middle or upper classes to be accepted for treatment and are more likely to drop out of therapy early. Some researchers have suggested that middle and upper class professionals may not be able to gain rapport, to understand and empathize with lower class clients or to communicate effectively with them (Lorion, 1973).

Also suggested was that perhaps it is not the present social class of the therapist that is relevant but rather his or her social class of origin (Mitchell & Namenek, 1970). Here the assumption is made that therapists who have had backgrounds and experiences similar to those of their lower class clients would be more responsive to them, more able to understand them and thus more able to help

them in therapy. It was postulated that shared knowledge and experiences in comparable social classes facilitated communication and rapport and thereby facilitated therapeutic change. For example, Lorion (1974) stated that middle class therapist preferred to work with clients like themselves, who share their values and speak their language, with whom they are comfortable and feel they can communicate.

Lerner and Fiske (1973) supported Lorion's findings. Their study dealt with client attributes as related to outcome. Lerner and Fiske believed that two major groups of factors contributing to outcome in psychotherapy were client characteristics and therapist characteristics. The study population included 30 clients treated by 14 therapists. Each therapist filled out forms describing and evaluating each of his clients on 11 personality attributes at the beginning and end of therapy. Lerner and Fiske analyzed these attributes as related to therapeutic outcome and social class. Their findings did suggest that outcome is affected by the attitudes of the therapist. Lerner and Fiske (1973) found that professionals preferred and were more comfortable with upper class clients, that is with clients who talked their language and were more similar to them.

Still other studies focused on the socioeconomic

levels of the client. Imber, Nash, and Stone (1955) examined the relationship between a client's social class and the duration of psychiatric treatment. Sixty clients from the outpatient psychiatric department of John Hopkins Hospital were randomly assigned to a therapy group. The therapist were three senior residents with equivalent experience and training in individual and group therapy. Each therapist was assigned at least six clients per therapy group. None of the therapist had any choice in the clients assigned.

The findings in this study indicated that class position had a marked effect on duration of treatment although all therapists were equally experienced and beyond the minimum level. Imber et al. (1955) also found that middle class persons were more likely to establish a relationship with the health professional and therefore remain in therapy longer than lower class clients. Cole, Branch and Allison (1963) also found that the middle class and upper class clients remain in therapy longer than did lower class clients.

Albronda, Dean and Starkweather (1964) reported somewhat different findings. Their 5 year study also examined the relationship of social class and duration in psychotherapy. Three hundred and eighty-four clients, who were unable to afford private psychiatric treatment and who

were from a wide range of occupations, were included in the study. Clients were seen for a median of 14 sessions during the 5 year period. Treatment sessions were conducted by senior medical students from the Universities of California, San Francisco and Los Angeles, the University of Utah, Salt Lake City, Yale University in New Haven.

In comparing the relationship between social class, length of study and condition as improved or unimproved, an initial bias was found in favor of upper class clients but the margin narrowed between upper and lower class clients as treatment continued. The experience of upper and lower class clients was very similar. Albronda et al. (1964), therefore, concluded that there was no significant relationship between social class, professional relationship and termination from therapy.

One of the many characteristics usually considered as influencing the health professionals effectiveness is the amount of experience the professional has had. It is generally assumed that experience must and will enhance the effectiveness of the health professional. It is thought that with time, professionals become more at ease, more confident, and more flexible in their approach to clients.

Auerbach and Johnson (1977), in their thorough review of this area, concluded that therapist experience was

related to the quality of the therapeutic relationship. Scher (1975) also related significant findings. According to Scher (1975), in a study cited earlier on verbal activity, sex, counselor experience and success in counseling, clients of experienced therapists reported significantly greater symptom relief and greater satisfaction with therapy. Cheng (1973) commented that the health professional should be intellectually close to the client. Cheng suggested that being intellectually close to the client is helpful to rapport, and that professionals should remain aware that one of the consequences of their education is likely to be intellectual distance from many clients.

In summary, the review of the literature relevant to the issue of sex, age, race, social class and educational level, presented no firm conclusions about their influence on professional/client relationships.

Nonverbal Communication

Any of several behaviors, verbal and nonverbal can influence the establishment of rapport. This assertion was supported by Jackson (1975) who described rapport as being established by communication, which could be verbal and nonverbal. Cheng (1973) further supported this idea. He described the variables which contributed to the quality of rapport as: the professional's attitude of acceptance,

understanding, genuineness and interpersonal closeness. He stated that because rapport is affected by a wide range of variables, even a frown or a smile by the health professional could be interpreted by the client in different ways.

There is also considerable research evidence of a relationship between the occurrence of congruent postures and verbal indicators of feelings of rapport as identified by participants. For example, LaFrance and Broadbent (1976) used systematic observation and questionnaires to study the relationship between student-teacher congruent postures and student reported assessments of rapport in 12 college seminar classes. These researchers found significant positive correlations between the amount of individual student mirroring of the teacher's posture. In a later study, LaFrance (1979) measured the amounts of posture sharing and students reports of rapport between students and their teachers in 13 summer session college classes. Measures of posture sharing and rapport were taken once during the initial week and again during the final week of classes. Posture sharing and levels of rapport again were found to be positively related (LaFrance, 1979).

Mehrabion's (1968) study further validated the effects of nonverbal cues on the development of rapport. This

researcher manipulated body cues of touch, interpersonal distance, body trunk lean, eye contact and body orientation. Mehrabion concluded that postural forward lean increased for liked addresses and decreased, becoming backward lean, for disliked addresses. The study suggested that a forward lean may be indicative of conditions one might call "rapport" between two persons.

Postural congruence as an indicator of rapport was supported by Scheflen (1966). This researcher has proposed that an important nonverbal dimension for assessing rapport between two interactants is postural congruence/non-congruence. The postures of two interactants can be said to be congruent when the interactants hold their bodies, especially their extremities (head, arms, hands, legs and feet) in the same position as each other. These congruent body positions may be either carbon copies of each other or mirror images. Two postures are non-congruent when they are not direct or mirror imaged copies of each other.

According to Scheflen's (1966) theory, congruence indicates association between people and most often occurs among friends, colleagues, and people who know each other and are engaged in a common objective. Lack of postural congruence indicates non-association with the interaction and is often accompanied by other nonassociative behaviors such as lack of eye contact. Scheflen emphasized the

importance of mirroring since it indicates that people are open to one another.

These research findings validate the importance of the health professional building a relationship using verbal and nonverbal communication to demonstrate an interest in the client's well being and to facilitate the establishment of rapport.

Related Research

An extensive review of the literature revealed a lack of studies in nursing discussing the presence or development of rapport. Even so, one study in nursing on compliance has validated the importance of rapport to outcome. Warren (1985) examined factors associated with compliance and noncompliance in the taking of medicines by the chronically ill following hospital discharge.

Warren (1985) interviewed 42 subjects just prior to their discharge from the hospital. Thirty-four of these persons were re-interviewed again two weeks after discharge; eight subjects refused a second interview. The information obtained in the follow-up interview was used to divide the subjects into compliant and noncompliant groups.

Using two and three dimensional chi square to analyze the data, Warren (1985) reported that client health care provider communication and rapport were some of the factors

which proved to be significantly associated with compliance, $X^2(1, N = 42) = 6.0952$, $p<.02$.

In still another study, Wallace (1977) examined the effect of a systematic training program on responding skills of Dental Hygiene students. One of the purposes of the study was to determine if a systematic training program in communication skills could yield improved dental hygiene student/client rapport.

The experimental study involved two groups of dental hygiene student who had been randomly selected. Each group consisted of 12 juniors and 12 seniors. At the start of the study, all subjects were pretested using the Standard Communication Index and the Client's Responses Subjective Scales. Both were designed to measure the dental hygienist stimulus statements.

Subjects in one group received systematic response training while subjects in the other group received dental professionalism training. Immediately following their respective training programs, subjects were posttested using the Standard Communication Index and the Patient's Responses Subjective Scales. Two weeks after the program, the subjects were post-post tested again. The same was done for the clients who had been selected for each subject prior to the start of the experiment.

Each client was pre and posttested using the Patient

Questionnaire. Two raters evaluated the Patient Responses Subjective Scale for each subject. Scores were obtained for the Patient's Questionnaire as well. Analysis of variance was used to determine the results of the study. Statistically significant findings were evident in relation to dental hygiene student rapport formation. These subjects in the systematic training program were able to demonstrate increased ability to write responses and had higher client rapport scores then those subjects who received dental professionalism training. The results were also statistically significant two weeks following the training period. Wallace (1977) concluded therefore, that the systematic training program was an effective strategy for improving dental hygiene students client rapport formation.

Another study which validated the importance of rapport to client outcomes was one conducted by Peterson (1982). The purpose of the study was to determine the effectiveness of a chronic pain treatment program, to compare client, staff and physician ratings of outcome and to identify any factors associated with treatment response.

Forty-three subjects participated in a five week inpatient, multi-disciplinary pain program. Each subject completed questionnaires during the first, third and fifth weeks of treatment and at one month follow-up. The

instruments measured the clients perceived pain experience, psychological functioning and program related aspects. The physician and staff also assessed the client's pain experience. The study focused on assessing the relationship between treatment outcome, physician rapport, social support, prior pain adjustment and locus of control.

Comparisons of client, staff and physician ratings of outcome revealed that the physician and staff grossly overestimated the clients improvement. The clients and staff demonstrated a moderate agreement in the assignment of ratings while the clients and physicians showed almost no agreement. Analysis revealed that the client's rapport with the physician was associated with the client's rating of coping effectiveness.

The only other study found in the literature addressing rapport formation was one by Schroeder (1986) who conducted a phenomenological study which examined factors that inhibited or facilitated rapport during the initial stages of therapy. The purpose of Schroeder's study was to describe and define rapport as it is experienced by clients during the initial stages of psychotherapy and to increase knowledge regarding factors that inhibit or facilitate the formation of rapport.

Interviews were conducted with six clients who had completed no more than eight therapy sessions.

Phenomenological methodology was used to analyze the interviews. Clients defined rapport as trust and understanding that develops as the discomfort of a new relationship diminishes and the ease of communication increases. Rapport was viewed by clients as crucial to the success of therapy. Interviews indicated that the development of rapport is progressive, with the rapidity or ease of its development being influenced by the therapist. The study also indicated that rapport, in some cases, could be obtained with the client as early as the first or second session.

In summary, although none of the studies cited were actually conducted to examine the establishment of rapport, all validated the importance of rapport to client outcomes.

Summary

The review of the literature was used to examine and provide clarity about the concept of rapport. Although definitions of rapport differed from investigator to investigator, certain attributes were similar. All investigators thought that rapport was necessary in the professional/client relationship. Rapport was defined by most as an emotional relationship of mutual trust, warmth, and respect.

Other considerations described were the importance of

rapport and when to establish rapport. The success of treatment and compliance to care was related to the presence of rapport. Also establishing rapport early in the professional/client relationship was thought to be critical to the therapeutic process.

Further information was provided concerning how to establish rapport and the variables which may influence rapport development. The last portion of the literature review presented research studies which validated the importance of rapport and validated the importance of rapport to client outcomes.

The literature review provided a composite approach to understanding rapport as a concept and skill. Investigators validated that a relationship characterized by warmth, honesty, trust, respect, mutual understanding, positive body language and facilitative communication must exist if rapport is to be developed. The review of the literature supported the need for compassion and sympathy in order to relate to the person as a human being and to motivate the person to participate in their care.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

An explanatory, two group before and after, experimental design was used to study the effect of participation in a facilitative training program on the development of rapport. Clients and nurses meeting the criteria for inclusion in the study were randomly assigned to an experimental or control group. Nurses in both the experimental and control group were given Mosley's Communication Skills Questionnaire (MCSQ), Mosley's Interpersonal Rapport Perception Questionnaire-Nurse (MIRPQ-N) and Mosley's Behavioral Rapport Scale (MBRS) as pre and posttest.

Only the experimental group attended the training program which focused on the accurate identification of nonverbal and verbal responses, the therapeutic use of self, use of facilitative communication techniques, attentive listening, mutual understanding and the development of interpersonal closeness-warmth, honesty, respect, and trust. Clients cared for by nurses in the experimental and control groups were given the Mosley's Interpersonal Rapport Perception Questionnaire - Client (MIRPQ-C) and MBRS as pre and posttests.

The independent variable was the facilitative training program. The dependent variable was the development of rapport. Extraneous variables for the nurse included age, sex, length in practice, ethnic group, social class, educational preparation and assigned unit. Sex, age, ethnic group, social class, education and assigned unit were extraneous variables for the client group.

Setting

The setting for this experimental study was a state hospital located in a large metropolitan area of Southeastern United States. The hospital, the second largest of its kind in the United States, was a 650 open bed facility with greater than 1000 employees serving the indigent population of an urban city in the South. The inpatient nursing service of this hospital includes 70 units. All of the general nursing units ranged from a 22 to 40 bed capacity. The number of registered professional and licensed practical nurses assigned to each unit varied from 10 to 15. For the purposes of this study, only the units providing long term nursing care were utilized. The pediatric and intensive care units were not included. The nursing department in the hospital provided multiple services in the decentralized areas of operative, outpatient, emergency and inpatient services.

The hospital utilized team nursing in which nurse assistants, registered professional and licensed practical nurses provide care; however, only registered and licensed practical nurses were utilized for the study. Data was obtained in the clients' hospital rooms, and in hospital classrooms. Clients' rooms were well lighted and furnished with hospital bed(s) and chairs. Curtains were available between beds in all rooms to provide for privacy. Hospital classrooms were used for the training program. The classrooms were large enough to accommodate 35 persons and were furnished with student desks. The rooms were well lighted and equipped with a black board.

Population and Sample

Caring for the client is a responsibility shared with other health care professionals. However, according to Travelbee (1971), it is the nurse who is considered by the client and the client's family as the intercessor, teacher and advocate of the client. Therefore, the target population included only registered nurses and licensed practical nurses employed in the selected hospital. All long term nursing care units, to be included in the study, were written individually on a piece of paper and placed in a box or other facsimile. One unit, randomly selected from the box, was approached and nurses on rotating shifts,

permanent 7 am to 3 pm shifts, or permanent 3 pm to 11 pm shifts were asked to volunteer as participants in the study. Nurses on the 11 pm to 7 am shift were excluded because clients were usually asleep and there was minimal nurse-client interaction.

Those consenting to be participants in the study were randomly assigned to experimental or control groups. For example, if 10 nurses on the unit agreed to participate, their names were placed in a box and the first five names drawn were assigned to the experimental group. Remaining nurses were placed in the control group. Nurses were told that those in the control group would not attend the program but the materials used would be available to them after completion of the study. Persons attending the program were asked not to share any information outside of the seminar. Nurses were also told that they would be dropped from the study if the client with whom they were paired was discharged, refused to participate, transferred or died prior to the two week period. Nurses were also dropped from the study if they unexpectedly took a week of vacation or other types of leave during the two week period of the study.

Only alert, oriented and coherent adult clients cared for by nurses participating in the study, who had a hospitalized period of two weeks as suggested by their

diagnosis, DRG's and/or doctors' recommendations, were included in the study. The subjects cared for by nurses in the study were approached and asked to volunteer as participants. Subjects were told that they would be dropped from the study if they were discharged or transferred prior to the two week period. This process was repeated until all units had been approached and a minimum of 40 nurses and 40 clients was obtained. The nurse and client sample was not limited to 40.

Protection of Human Subjects

The following guidelines were followed to protect the rights of the subjects:

1. The study adhered to the guidelines of the Human Subjects Review Committee (HSRC) of Texas Woman's University and the selected hospital.

2. Agency approval and HSRC review and approval was obtained (See Appendix A).

3. A verbal and written explanation of the study including its benefits and drawbacks and an opportunity to ask questions was given to all subjects before participating in the study.

4. A written consent form was signed by all subjects prior to participation in the study (See Appendix B & C).

5. A disclaimer on the consent form stated that no

medical service or compensation would be provided to subjects by the university as a result of injury from participation in the research.

6. Nurses were told that participation in the study was on a voluntary basis and that their participation or lack of participation would in no way influence their employment or promotional status at the hospital. The nurses were also told that they may refuse to participate or withdraw from the study at any time without penalty.

7. Subjects were told that their participation in the study would in no way influence care received during their hospital stay. The subjects were also told that participation was voluntary and that they may refuse to participate or withdraw at any time without penalty.

8. Assurance was given that confidentiality of records identifying the subjects would be maintained. Nurses and subjects were instructed to not place any signatures or identifying marks on the questionnaire. The questionnaires were coded to allow for comparison of pre and posttest scores. All coded lists were handled by the investigator only, kept in a locked file cabinet and destroyed after completion of the study.

9. Subjects were provided with the researchers' name and phone number as a contact person for answers to pertinent questions or concerns related to the research.

Instruments

All five instruments were developed by the investigator. The following instruments were used: Mosley's Demographic Data Sheet (MDDS), MCSQ, MIRPQ-C, MIRPQ-N, and MBRS. Mutual understanding, attentive listening/facilitative communication, positive body language, interpersonal closeness: warmth, honesty, respect and trust were the characteristics reflective of rapport utilized in the development of MIRPQ-N, MIRPQ-C, MCSQ, and MBRS.

Mosley's Demographic Data Sheet

The MDDS (see Appendix D) was used to collect descriptive information on the subjects. Variables included on the demographic data sheet for nurses included age, sex, length of practice, educational preparation, ethnic group, social class and assigned unit. The demographic data sheet for clients included age, sex, educational status, ethnic group, social class, and assigned unit. According to Forsyth (1979), Jarrett & Nord (1985) and Rakel (1977) all of these variables could either positively or negatively affect the ability of the nurse to establish a relationship. These investigators reported that a nurses' age, sex, ethnic group and social class may affect the way he/she relates to an individual with the same characteristics. A nurse who had been in the nursing

profession for a longer period may relate differently to persons than a nurse in the profession for a shorter period. A nurse may experience difficulty in establishing a relationship with someone with a self inflicted injury versus someone with Leukemia. Also, a registered nurse may establish a relationship more frequently than a licensed practical nurse based on her educational preparation or vice versa. Participants circled or completed the blank with the most appropriate response.

Mosley's Communication Skills Questionnaire

Existing knowledge of communication techniques, skills and the ability to interpret nonverbal behavior was assessed by administration of the MCSQ (see Appendix E). This test consisted of 60 multiple choice questions listing nurses' responses that followed a descriptive situation. A section depicting nonverbal facial expressions and body positions requiring interpretation of what was being communicated was included. Denova (1979) reported that objective tests were best because these tests: generally did not require much time for the subject to answer test items; were easier to grade; covered a greater scope of material than any other measure; were more reliable; and errors in personal judgment were eliminated. The measure was criterion-referenced. The purpose of a criterion-referenced test is to determine whether a person had a

minimum knowledge of the criterion being measured (Lord, 1980; Waltz, Strickland, & Lenz, 1984). Lyman (1978) stated that criterion referenced tests assessed present level of knowledge, skills and competence.

Approximately 45 to 60 minutes were needed to complete the MCSQ. The average acceptable completion time for each multiple choice item is 45 seconds according to Waltz et al. (1984).

A review of the literature was conducted to determine which minimum skills were necessary to develop rapport. A test blueprint, reflective of these skills was developed to indicate the content to be covered and to assign weights to each category or content area. The results of the development phase are noted in Table 2 and Appendix F.

Recommendations from Bloom's Taxonomy of Educational Objectives (1956) were used when determining the level of the questions. Bloom's Taxonomy is a comprehensive system which classifies objectives into three domains: cognitive, affective, and psychomotor. The cognitive domain, concerned with intellectual outcomes, is divided into knowledge and intellectual abilities and was the primary

Table 2

Test Blueprint

Content	Objective		
	Knowledge	Application Synthesis Analysis	Total
Communication	17	30	47
Paralanguage	0	4	4
Proxemic	1	4	5
Listening	1	1	2
Self-Awareness	0	2	2
Total	19	41	60

focus of question development. Bloom, Engelhart, Furst, Hill, and Krathwohl (1956) recommended that behavioral outcomes be arranged in order of increasing complexity beginning with the relatively simple recall of factual information, knowledge, and proceeding to increasing levels of complexity such as application, analysis and synthesis.

Bloom et al. (1956) stated that when measuring knowledge of facts, responses should be limited to either the recognition or recall of the answer, which is knowledge. However, when measuring complex learning outcomes, the answer is not achieved through mere recognition. Selecting an answer involves use of higher mental processes to arrive at a solution before the correct answer could be selected, which is application, analysis

and synthesis. Bloom et al. (1956) also stated that it was up to the person preparing the test to decide how much emphasis each outcome should receive. The number of items for each content area was determined by the weight/ emphasis given to each learning outcome and subject area in the review of the literature. An important question considered was: How important is each area in the development of rapport?

The following analysis resulted after administration of MCSQ to 14 nurses in a pilot study. Validity refers to the degree to which test scores serve their intended use (Ebel & Frisbie, 1986). Validity was obtained by following a systematic procedure during test development. This procedure included: identifying the learning outcomes to be measured, preparing a test plan that specified the sample of items to be used, and constructing a test that closely fit the set of test specifications. Content validity was obtained when the test blueprint and questionnaire was given to two masters prepared psychiatric nurse educators and one doctorally prepared nurse educator who were requested to assess the table and test for clarity and relevancy.

Content validity was further assessed following the pilot study with the utilization of an item analysis. Item analysis was used to evaluate the quality of individual

test items and the extent to which each item was a measure of the overall content domain (Waltz et al., 1984). The item analysis revealed information about four aspects of each item: item correlation or point biserial, item difficulty, discrimination, and overall evaluation.

The point biserial correlation coefficient described the relationship between the score on a single test item and the score on the total test for each examinee (Ebel & Frisbie, 1986). The idea was to determine whether or not the individual test item was consistent with the total test. The minimal acceptable point biserial correlation coefficient was .3 (Ebel & Frisbie, 1986). Those questions with less then a .3 point biserial correlation were reviewed and/or revised. Hulin, Drasgon, and Parsons (1983) and Lord (1980) recommended an overall evaluation of each item before discarding the question even though the point biserial was below .3. These authors stated that a poor correlation may be due to factors other than the item being a poor question. For example, one possible factor affecting the validity could be the motivation of the examinee at the time tested. If the examinee was not motivated and was tired, the resulting score could be affected and could be unreliable (Brown, 1981).

Discrimination is the ability of an item to differentiate between students who have greater or lesser

knowledge of the material tested. Lord (1980), Brown (1981) and Hulin et al. (1983) stated that there were situations in which discrimination was not crucial, such as when a test was used for mastery, pretest or assessment of minimum skills. The important consideration was, does the item measure whether students know an important concept or can demonstrate some intellectual skill. For this study, discrimination was not important. Items were selected not only on the basis of their discriminatory powers but because they measured some attainment of some important objective. Only 46 of the 60 questions received an evaluation of fair or above for discriminatory ability.

Item difficulty is defined as the proportion of students who answered an item correctly (Waltz et al., 1984). Item difficulty should match the difficulty of the task. If the task is easy, the test item should be easy. If the task is difficult, the test items should be difficult. No item should be eliminated simply because most students might be expected to answer it correctly or because it might be answered incorrectly by most students. Likewise, no attempt should be made to alter item difficulty to obtain a spread of score (Ebel & Frisbie, 1986). Of the 60 items, 50 questions received an overall evaluation of fair or above for item difficulty. Each item, therefore, was evaluated to determine whether the

item reflected a person's lack of knowledge or whether it was a poorly constructed question. The ten items with poor evaluations were revised and were retested.

Reliability refers to the consistency of measurement. This consistency of measurement would indicate that the score is relatively free from errors of measurement (Ebel & Frisbie, 1986). Internal consistency reliability is the most frequently used for cognitive measures. The alpha coefficient is the preferred index of internal consistency reliability because it measures the extent to which performance on any one item on an instrument is a good indicator of performance on any other item on the same instrument (Waltz et al., 1984). The Kuder-Richardson test for reliability, was reported as .70 for the test when administered to 44 nurses, .76 for the pretest when administered to 14 nurses and .81 for the posttest when administered to the same 14 nurses.

The pre and posttest scores of the control group were also used to yield test-retest reliability. The test-retest method is essentially a measure of examinee reliability and is an indication of how consistently examinees perform on the same set of tasks (Waltz et al., 1984). The same test was administered to the same group of subjects on two separate measurement occasions. The correlation between the scores obtained on the first

administration of the test and that obtained on the second administration yielded a test-retest Pearson product-moment reliability coefficient of $r = .96$, $p<.001$.

Mosley's Behavioral Rapport Scale

The MBRS (see Appendix G) was the observational tool used to assess the presence of rapport. The scale contained behaviors of the nurse and behaviors of the client reflective of rapport. Travelbee (1971) stated that the presence of rapport could be noted by observing the communication and behavioral patterns of persons involved in the interaction.

Burns and Grove (1993) attested that observation is the best way to ensure validity of the study's findings when trying to obtained substantive information about human behavior. Observation is also the best way to operationalize some variables of interest, particularly verbal and nonverbal communication behaviors (Burns & Grove, 1993). Observation is also important because a person may demonstrate knowledge as indicated through paper and pencil testing MCSQ but may not behaviorally/skillfully display this knowledge. LoBiondo-Wood and Haber (1990) aptly stated "what people say they do is often not what they really do" (p. 232). Observation is also necessary when asking clients about their perceptions of events because subjects may distort their responses to please the

researcher. Observing the subject may give a more accurate picture of the subjects behavior then asking. Nurses were observed by the investigator during the interaction process with clients and were given a score as identified by the tool.

The tool contained five scales which rated behavior as occurring: all the time (4); most of the time (3); some of the time (2); hardly ever (1); and never (0). Nurses were observed on four separate occasions for approximately 15 minutes per observation within a one week time period. The four observational times occurred on two separate days with 2 observations occurring per day.

The times of observation were randomly scheduled from the nurses regular duty time. If a nurse was scheduled to work Monday, Tuesday and Wednesday 7:00 am to 3:30 pm, these days were placed in a box and two days were randomly selected as observation days. These days were those on which observations occurred. Times of the day from 8:00 am - 2:00 pm with 15 minute increments were placed in a box and two times were drawn for Day 1. The times drawn were placed back into the box and two additional times were drawn for Day 2.

The nurse was then observed on these specified days and times. A total score for each behavior was given after the fourth period of observation.´ A nurse observed giving

information 3 times out of the 4 observed times received a score of most of the time for the statement "gives information." A nurse who was observed making direct eye contact for only 1 time out of 4 times received a score of hardly ever or 1 for "direct eye contact." Point values for negatively worded items were reversed for scoring purposes.

Validity and reliability analysis of the MBRS was conducted. Content validity of the MBRS was obtained when two masters prepared psychiatric experts and one doctorally prepared psychiatric expert reviewed the scale and test blue print for relevancy and clarity. Because of the small number of subjects, the point biserial correlation coefficient was completed to further establish validity. Questions with a negative value and a point biserial of below .3 were deleted. This analysis yielded 34 valid statements from an original total of 94 statements.

Interrater reliability for the MBRS was obtained when the instrument was tested in a pilot study with 14 clients and 14 nurses. Interrater reliability refers to the consistency of performance or the degree of agreement among different raters in assigning scores to the same subjects (Waltz et al., 1984). Therefore, interrater reliability is determined when two or more raters judge the performance of one group of subjects at the same point in time. The

investigator and three agency nurses, who did not participate in the research, assigned performance scores. Agency nurses were selected based on whether their schedules correlated with participating nurses in the study. Agency nurses observed their assigned nurse at the same time as the investigator on all four occasions. Each nurse participating in the study had only two raters (see Appendix H).

A Spearman correlation coefficient of r = .89, p<.007 was reported as an index of agreement between the raters. Internal consistency was reported with an alpha coefficient of .92 for the combined nurse and client sections, .91 for the nurse section identifying behaviors indicative of rapport and .78 for the client section identifying behaviors indicative of rapport. According to Fox (1976), the minimum acceptable level of reliability is .70. The pre and posttest scores on MBRS of nurses and clients in the control group were used to yield test-retest reliability. A Pearson product-moment correlation coefficient of r = .97 (p<.001) was reported for the control group for MBRS.

Mosley's Interpersonal Rapport Perception Questionnaire (Client and Nurse)

The MIRPQ (see Appendix I & J) contained 53 open ended statements assessing the nurse and client's intuitive feelings about each other using a four-point, forced choice Likert scale. Respondents had to choose either strongly agree, agree, strongly disagree or disagree in response to statements regarding their feelings about each other and the client's participation in care. The nurse and the client completed separate questionnaires.

Content validity was obtained for both the client and nurse instruments using a panel of experts who reviewed the questions for clarity and relevancy. The point biserial correlation coefficient was also completed to further establish validity. Statements with a negative value and a point biserial of below .3 were deleted. This analysis yielded 53 valid statements from an original total of 74 statements.

Reliability was established using the SPSSX computer program of reliability. Internal consistency was reported with an alpha coefficient of .87 on the nurse group and an alpha coefficient of .97 for the client group when pretested in a pilot study. Fourteen clients and fourteen nurses were in the pilot study. Test-retest reliability was also demonstrated with the control group. The same

test was administered to the same group of subjects on two separate occasions. The second testing occurred two weeks after the first. A test-retest Pearson product-moment reliability coefficient of r = .89, p<.007 was yielded for the nurse group and a coefficient of r = .96, p<.001 was yielded for the client group.

Procedure for Data Collection

After obtaining University approval, the hospital was approached for the purpose of obtaining agency approval. Nurses on all long term care units, excluding the pediatric and intensive care units, were asked to volunteer as participants in the study until a minimum of 40 nurses was obtained. Nurses who had not initially consented to participate in the study were approached a second or third time and were asked to participate when nurses in the original groups dropped out of the study. Nurses were randomly assigned to an experimental or a control group. The number of the nurses consenting to be participants was divided by two (the number of groups). This process identified the number of nurses for each group. When there was an odd number, the number remaining after division was assigned to a group based on the flip of a coin, heads = control, tails = experimental. For example when 41 nurses consented to be in the group, (41/2 = 20 R1) 20 nurses were

assigned randomly to the control group and 20 nurses were randomly assigned to the experimental group. The last person was assigned to either the experimental or control group based on the flip of the coin.

All of the nurse's names were placed in a box or other facsimile and the first 20 names drawn were in the experimental group. This process provided an opportunity for each person to have an equal chance to be in the experimental group. The last 20 nurses drawn were placed in the control group. The remaining name in the box was assigned to either the experimental or control group based on the flip of a coin. The nurses were told that those in the experimental group would not attend the program. Persons attending the training program were asked not to share any information outside of the class.

Nurses in the experimental and control groups completed the demographic data sheet. The MCSQ, and MIRPQ was administered to the experimental and control groups as a pretest. The MBRS was completed for the experimental and control groups by the investigator. The nurses were allotted 60 minutes to complete the MCSQ although 45-60 minutes was generally all that is required. Nurses were allowed to complete the MIRPQ on their own time. The instrument was collected 24 hours after distribution.

Each nurse was asked to select a person who would meet

the criteria for inclusion in the study. These subjects were then approached and asked to volunteer as participants. The subject was asked to complete the MDDS and MIRPQ for clients as a pretest. The subject was allowed to complete the questionnaire at their leisure. The instrument was collected 24 hours after distribution. Subjects received assistance with the questionnaire if they requested it or as need was assessed by the investigator.

The experimental group was required to participate in a six hour facilitative training seminar (see Table 3) on the development of rapport. The seminar was conducted by an individual with a master's degree and clinical experience in psychiatric nursing. Content focused on the accurate identification of nonverbal and verbal responses, therapeutic use of self, use of facilitative communication techniques, attentive listening, paralanguage and interpersonal closeness. These skills are needed to proceed through the phases leading to the development of rapport.

The content also focused on the importance of rapport to client outcomes. The program occurred one week after the administration of the MCSQ (second week). Nurses in the control group continued their nursing activities as before. Immediately following the completion of the facilitative training workshop by the experimental group,

Table 3

Implementation Schedule for Mosley's Facilitative Training Program

	Week 1	Week 2
Nurses Experimental Group	Mosley's Communication Skills Questionnaire	6 hours or seminar
	Mosley's Interpersonal Rapport Perception Questionnaire - Nurse	Mosley's Interpersonal Rapport Perception Questionnaire - Nurse
	Mosley's Behavioral Rapport Scale (completed by Investigator)	Mosley's Behavioral Rapport Scale (completed by investigator)
		Mosley's Communication Skills Questionnaire
Nurses Control Group	Mosley's Communication Skills Questionnaire	Regular Nursing Activity
	Mosley's Interpersonal Rapport Perception Questionnaire - Nurse	Mosley's Interpersonal Rapport Perception Questionnaire - Nurse
	Mosley's Behavioral Rapport Scale (completed by investigator)	Mosley's Behavioral Rapport Scale (completed by investigator)
		Mosley's Communication Skills Questionnaire

Table 3 (continued)

	Week 1	Week 2
Client Experimental and Control Groups	Mosley's Interpersonal Rapport Perception Questionnaire - Client	Mosley's Interpersonal Rapport Perception Questionnaire - Client

(second week), the experimental and control nurse groups were administered the same MCSQ as a posttest. Forty-eight hours following completion of the workshop, the same clients in the experimental and control groups were requested to complete the MIRPQ for clients as a posttest. The experimental and control group nurses were requested to complete MIRPQ for nurses. The investigator completed MBRS as a posttest.

Pacoe, Naar, Guyett, and Wells (1976); Rasche, Berstein, and VeenHuis (1974); Scott, Connelly, and Hess (1976); Secundy and Katz (1975) reported that medical students usually model interpersonal skills immediately after training. Forsyth (1977) supported this idea in the study of nurses and their empathic ability. Nurses demonstrated empathetic skills immediately following training sessions.

Pilot Study

A pilot study was conducted on two adult inpatient psychiatric units in a Veterans Administration Hospital to evaluate the adequacy of the study design and instrumentation. The hospital had a total bed capacity of 575 clients with an average daily census of 500 in 1987-1988 (September 1 through August 31).

Registered nurses and licensed practical nurses from all shifts were approached and asked to volunteer as participants. Those consenting to be participants were randomly assigned to the experimental and control groups. The nurses then selected a client who met the criteria for inclusion in the study. Clients identified by these nurses were approached and asked to volunteer as participants. Twenty nurses and 20 clients initially volunteered to participate in the study. However, six nurses and six clients were dropped from the study for the following reasons: two nurses did not take the posttest on communication; two nurses were on vacation and did not complete the study and two nurses initial clients were discharged.

The total number of participants retained in the study for purpose of data analysis was 14 nurses and 14 clients. Of the 14 clients, 100% were male. Their ages varied from 26 to 68 with a mean of 39.3 and a standard deviation of

10.3. They were predominately black (8; 57.1%). Fifty percent (7) reported that they had completed 1-2 years of college. Fifty percent (7) identified being in the lower class. There were 57.1% (8) of the client participants in the hospital because of a psychological disorder and 42.9% (6) were in for substance abuse.

Of the nurses volunteering to participate in the study, 73.6% (11) were female. The nurse's ages varied from 20 to 50 years with a mean age of 39.3. They were predominantly black, 71.4% (10). None of the nurses were currently enrolled in any educational program. Licensed practical nurses comprised 50% (7) of the population. Years of nursing practice varied from 2 to 30 years and 64.3% (9) reported being in the upper middle class.

There were seven nurses and seven clients in the experimental group and seven nurses and seven clients in the control groups. Nurses in the experimental and control groups completed MCSQ and MIRPQ as a pre and posttest. MBRS was completed by the investigator for the experimental and control groups as a pre and posttest. However, only the nurses in the experimental group participated in the three hour (time reduced by the VA Research Committee because it was a pilot study) facilitative training program. Clients in the experimental and control groups completed MIRPQ-C as a pre and posttest.

Reliability and validity analysis were conducted on all instruments. Content validity was established through the utilization of a test blueprint, objectives, panel of psychiatric nurses and an item analysis which included item selection and revision. An internal consistency estimate of reliability was obtained through use of Cronbach's alpha coefficient. The reliability of the instruments was further supported using a test-retest analysis.

There was no significant difference in the pretest scores of the experimental group of nurses and the pretest scores of the control group of nurses on MCSQ. However, after the nurses in the experimental group attended the facilitative training program, there was a significant difference in their communication scores and the communication scores of the nurses in the control group as reflected by their posttest scores ($t(12) = 2.2$, $p<.05$). The experimental group performed better.

The posttest scores of nurses on MIRPQ showed no significant changes from the pretest scores for the experimental and control group. Nurses who thought they had established rapport prior to exposure to the content again identified rapport after the training and vice versa. The posttest scores on MIRPQ for clients in the control group showed no significant changes from their pretest scores, i.e., their perceptions of the presence of rapport

did not change. However, a significant difference existed in the pre and posttest scores on MIRPQ for clients cared for by nurses attending the facilitative training classes ($t(6) = -1.82$, $p<.01$). There was a significant change in the perception of the presence of rapport for clients cared for by nurses attending the training program. Results indicated that although nurses attending the program did not report any significant changes in their perception of rapport, clients did think that nurses attending the classes were better at establishing rapport than they were prior to attending program (clients were not aware of which nurses attended the program).

The posttest scores on the observational tool, MBRS, used to observe the nurse-client interactions for the presence of rapport indicated that there was a significant difference in the performance of nurses in the experimental and control group ($t(12) = 3.96$, $p<.002$). Nurses in the experimental group displayed more of the behaviors characteristic of rapport when interacting with clients than did nurses in the control group. A significant difference existed between the pre and posttest scores of the experimental group on MBRS ($t(6) = -4.93$, $p<.003$).

The Pearson product-moment correlation coefficient computed to determine if there was a relationship between the MCSQ, MIRPQ-C, MIRPQ-N and MBRS indicated that although

there were relationships with all tools, the only significant relationship identified was the relationship between MIRPQ-C and MBRS (r = .93, p<.003). That is, client's perception of what constitutes rapport correlated significantly with behaviors observed in the experimental group by the investigator.

Results suggested that there were no significant differences in the identification of rapport as a result of the nurse's age, length of practice and highest educational preparation. There were no significant differences in the identification of rapport as a result of the client's age, diagnosis, and educational preparation.

Results from the pilot study demonstrated that all the tools were feasible for data collection. The small sample size and homogeneity of the client and nurse population may be responsible for the support of Hypothesis I, III and IV. The statistical t-test (utilized because of the small sample) and Pearson product-moment correlation coefficient were utilized in analysis of the hypotheses. The multivariate analysis of variance was used for the principal study because the sample size was larger and the test is the more powerful of the two analysis techniques (Kirk, 1982; Roscoe, 1975).

Treatment of Data

All data was organized, categorized and prepared for computerized statistical analysis. Although the tools MIRPQ and MBRS reflect ordinal level scales, statistical tests for interval/ratio level data were utilized. According to Glasnapp and Poggio (1985), Nunnally (1978), and Roscoe (1975), a statistical procedure designed for use with higher order data will ordinarily provide results superior to one designed for use with lower order data (Table 4). Descriptive statistics were used to summarize the characteristics of the subjects.

Sex, diagnosis, educational preparation, ethnic group and social class were described by measures of frequency, percent and mode. Age, length of practice and scores obtained on MCSQ were described using frequencies, percents, means and standard deviation. Additionally, the Pearson product-moment correlation coefficient was used to analyze the relationship between age and length of practice and MIRPQ, MBRS and communication scores. Differences in the scores according to sex, ethnic group, social class and educational preparation were analyzed in relationship to communication scores, MIRPQ and MBRS scores using a multifactor analysis of variance (MANOVA).

A multifactor analysis of variance with repeated measures (MANOVA) was also used to determine if there were

Table 4

Statistical Analysis Procedures

Hypothesis	Level of Dependent Variable	Statistical Test
H_1. There will be significant differences in the nurses identification of rapport according to their age and length in practice.	Interval	MANOVA, Pearsons product-moment correlation, frequency, percent, mean, mode, standard deviation
H_2. There will be significant differences in the clients identification of rapport according to their age.	Interval	MANOVA, Pearsons product-moment correlation, frequency, percent, mean, mode, standard deviation
H_3. There will be significant differences in the nurses identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.	Interval	MANOVA, frequency, percent, mode, mean, standard deviation
H_4. There will be significant differences in the client's identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.	Interval	MANOVA, frequency, percent, mode, mean, standard deviation

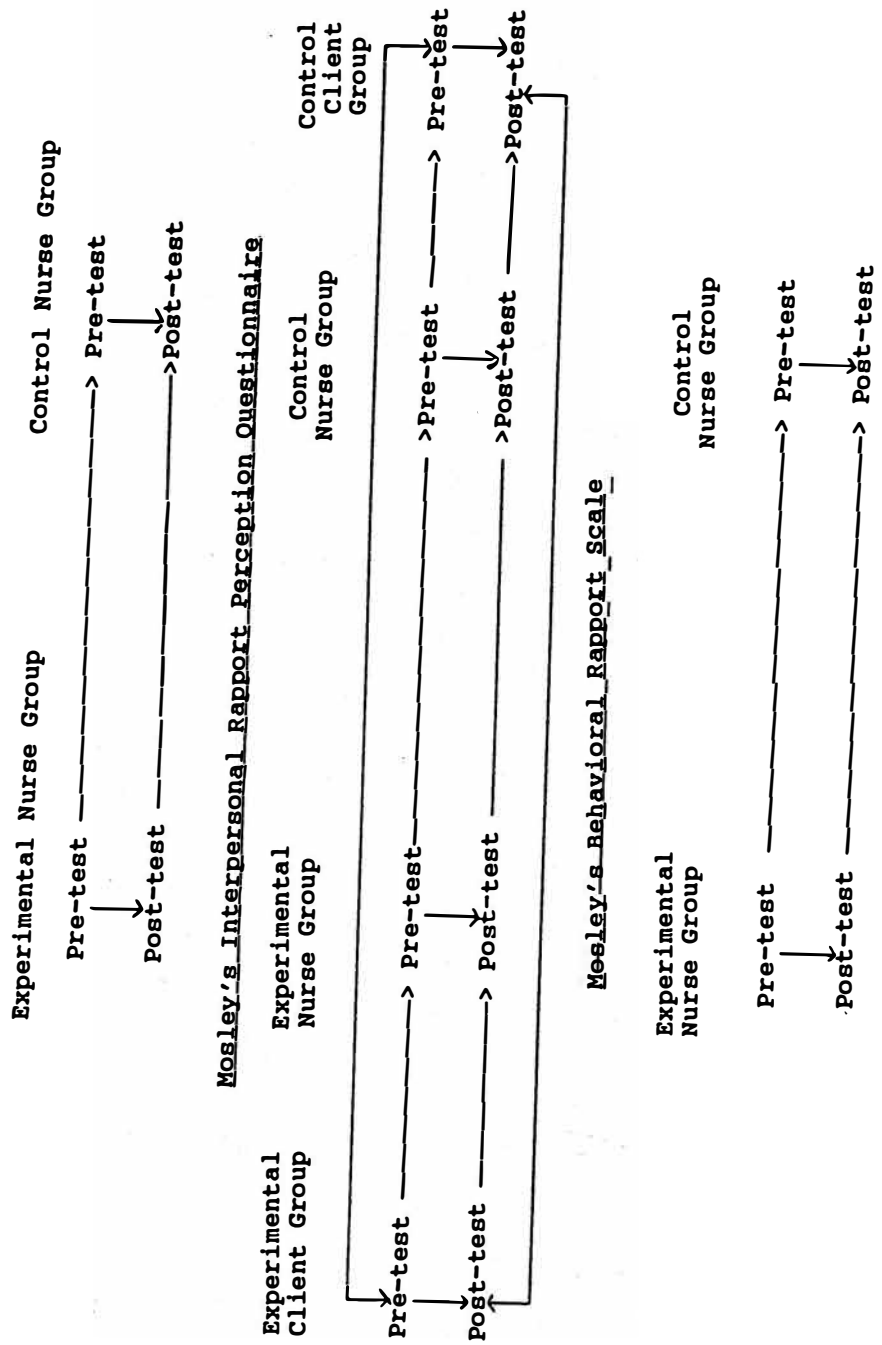
Table 4 (continued)

Hypothesis	Level of Dependent Variable	Statistical Test
H_5. There will be significant differences in the identification of rapport among nurses who attended the facilitative training program and those nurses who do not attend the program.	Interval	MANOVA
H_6. There will be significant differences in the identification of rapport among clients cared for by nurses who attended the facilitative training program and those clients cared for by nurses who do not attend the program.	Interval	MANOVA

any differences between and within the experimental and control groups on their pre and posttest scores (Figure 2). A multifactor analysis of variance is an inferential statistical procedure that has about the same purpose of a t-test. The difference, however, is that the multifactor analysis of variance can be used to compare two or more groups and is the statistical method that analyzes the independent and interactive effects of two or more independent variables on a dependent variable. The MANOVA enabled the investigator to control variables which are not

Figure 2

Between and Within Group Comparisons of MCSQ, MIRPQ, and MBRS



manipulated; and was more precise then the one way analysis of variance and the t-test (Kerlinger, 1973).

The Pearson product-moment correlation coefficient was used to determine if there were any significant relationships between scores obtained on the MCSQ, MIRPQ and MBRS. The Pearson product-moment correlation coefficient identified the magnitude or degree of relationship between the scores on each parameter (Wilson, 1985). The significance level for all data analysis was .05.

Summary

In this chapter, the procedure for collecting, summarizing and analyzing the data for this experimental study was delineated. For the collection of data, the MDDS, MCSQ, MIRPQ and MBRS was used for the nurse population. The MDDS, MIRPQ and MBRS was used for the clients.

The study was conducted in a large hospital using all available long term inpatient units except the pediatric and intensive care units. A two group pre and posttest design was used. The experimental group attended the facilitative program.

Differences in pre and posttest scores were evaluated using a MANOVA statistical test. The Pearson product-

moment correlation coefficient was used to assess the degree of the relationship between nurses' and clients' age, the nurse's length in practice and their perception of the presence of rapport.

CHAPTER IV

ANALYSIS OF DATA

This experimental study was conducted to investigate the effectiveness of a facilitative training program on the development of rapport. The purpose of the study was to ascertain whether this program would indeed enhance the development of rapport between nurse and client. The following hypotheses were addressed:

H_1. There will be significant differences in the nurses identification of rapport according to their age and length in practice.

H_2. There will be significant differences in the clients identification of rapport according to their age.

H_3. There will be significant differences in the nurses identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_4. There will be significant differences in the clients identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_5. There will be significant differences in the identification of rapport among nurses who attended the

facilitative training program and those nurses who do not attend the program.

H_6. There will be significant differences in the identification of rapport among clients cared for by nurses who attended the facilitative training program and those clients cared for by nurses who do not attend the program.

The data obtained from the 40 nurses who agreed to participate and completed the study are summarized and described using frequencies, means and standard deviations. For nurses, the presence of rapport was measured by using Mosley's Communication Skills Questionnaire (MCSQ), Mosley's Interpersonal Rapport Perception Questionnaire - Nurses (MIRPQ-N) and Mosley's Behavioral Rapport Scale (MBRS). The combined samples of nurses is discussed first, then the experimental and control groups are described individually. A description of the client sample occurs next. For clients, the presence of rapport was measured by using Mosley's Interpersonal Rapport Perception Questionnaire - Clients (MIRPQ-C) and MBRS. The combined client sample is discussed first and is followed with a description of each client group, experimental and control. The chapter concludes with the presentation of the inferential data analysis.

Description of Sample

The sample of nurses consisted of an experimental group and a control group. The experimental group received the facilitative training program and the control group received no training. The 40 registered professional and licensed practical nurses who comprised both groups received the MCSQ, MIRPQ and MBRS as pre and posttests.

The experimental nurse group initially consisted of a total of 30 nurses and the control group consisted of 31 nurses. However, only 20 (67%) of the experimental nurses actually completed the study. Ten nurses (33%) were dropped from the study at various points for the following reasons: three subjects (10%) called in sick for either one or more days of the study; one subject (3%) did not complete the study secondary to an inability to leave the unit; four subjects (13%) were activated by a military Persian Gulf War assignment; and two subjects (7%) decided to withdraw.

Only 20 of the control nurses (65%) completed the study. Eleven (35%) did not complete the study for the following reasons: two (6%) called in sick at some time during the study; three (10%) had clients who were discharged prior to the completion of the study; six (19%) did not complete posttesting secondary to an inability to leave the unit due to poor staffing. Consequently, the

sample consisted of a total of 40 nurses - 20 in the experimental group and 20 in the control group.

The nurses in the experimental and control group selected a client on their unit for whom they provided nursing care. Clients were then assigned to a group, experimental or control, which corresponded to their paired nurse. The 40 clients who comprised both groups were administered MIRPQ as pre and posttest.

Demographic Characteristics of Nurse Sample

The variables of age, sex, ethnicity, length of practice, educational level, socioeconomic class and assigned unit are used to describe the sample of 40 nurses (see Table 5 and Table 6). Nurse ages for the total nurse sample (N = 40) varied from 25 to 56 years with a mean of 38.53 years and a standard deviation of 7.36. The mean age of the 20 experimental nurses was 39.2 years with a standard deviation of 7.49 years. The mean age of the 20 control nurses was 37.85 years with a standard deviation of 7.23 years.

Of the 40 nurses participating in the study 37 (92.5%) were female and 3 (7.5%) were male. Nineteen (95%) of the experimental nurses were female and one subject (5%) was male. The control group of nurses was comprised primarily of females, 18 (90%). Ethnicity varied within the total nurse sample as was indicated by the 12 (30%) who were

Caucasian; 25 (62.5%) were Black Americans and 3 (7.5%) were Hispanic. Ethnicity was described by nurses in the experimental group as: Caucasian, 8 (40%); Blacks, 11 (55%) and Hispanic, 1 (5%). Subjects in the control nurse group described their ethnicity as: Black 14 (70%); Caucasian 4 (20%) and Hispanic 2 (10%).

The mean length of time in nursing practice for the total nurse group was 11.43 years and varied from 1 to 23 years. Within the experimental group, the length in nursing practice ranged from two to 23 years and the mean length of time in nursing was 11.10 years. Of the 20 control group nurses, 11 (55%) had practiced nursing 13 or more years. The majority of the nurses were from the upper middle class 24 (60%). Ten of the nurses (50%) in the experimental group described themselves as upper middle class. The majority of the nurses 14 (70%) in the control reported being in the upper middle class.

The level of education for the total nurse group varied as follows: 17 (42.5%) were licensed practical nurses; 5 (12.5%) had diplomas; 2 (5%) were associate degree graduates and 16 (40%) had earned bachelor's degrees. The educational levels of the experimental nurse subjects were: 7 (35%) licensed practical nurses; 1 (5%) diploma in nursing; 1 (5%) associate degree in nursing; and 11 (55%) baccalaureate in nursing. Only 4 (20%) of the 20

nurses reported being enrolled in nursing school. The level of education for the control nurse group included 10 (50%) nurses with licensed practical nursing certificates; four (20%) with diplomas; one (5%) with an associate degree; and five (25%) with bachelor of science degree (see Table 5). Only three (15%) nurses in the control group reported that they were currently enrolled in nursing school.

Nurses participating in the study staffed the following units: Psychiatric, Medical-Surgical, Nephrology, Neurology/Neurosurgery, Rehabilitation and Acquired Immunodeficiency Unit (AIDS) (see Table 5 and Table 6). Nurses in the experimental group were employed on various units within the facility. The majority, five (25%), worked on medical-surgical units. The remaining nurses worked on the following units: Psychiatry, four (20%); AIDS's, four (20%); Rehabilitation, three (15%); Neurology/Neurosurgery, two (10%); and Nephrology, two (10%). The majority of the nurses in the control group, five (25%), worked on the medical-surgical unit.

Table 5

Frequency Distribution and Percentages of Nurses Demographic Data (N = 40)

Variables	Experimental Group		Control Group		Total Group	
	n	%	n	%	N	%
Age (years)						
25 - 34	6	30	6	30	12	30
35 - 42	7	35	10	50	17	42.5
43 - 50	6	30	4	20	10	25
51 - 56	1	5	0	0	1	2.5
Total	20	100	20	100	40	100
Sex						
Female	19	47.5	18	45	37	92.5
Male	1	2.5	2	5	3	7.5
Total	20	50	20	50	40	100
Ethnic Group						
Black	11	55	14	70	25	62.5
Caucasian	8	40	4	20	12	30
Hispanic	1	5	2	10	3	7.5
Total	20	100	20	100	40	100
Length of Practice (years)						
1 - 6	4	20	5	25	9	22.5
7 - 12	9	45	4	20	13	32.5
13 - 18	4	20	7	35	11	27.5
19 - 23	3	15	4	20	7	17.5
Total	20	100	20	100	40	100

Table 5 (continued)

Variables	Experimental Group		Control Group		Total Group	
	n	%	n	%	N	%
Educational Level						
Licensed Practical Nurse	7	35	10	50	17	42.5
Diploma in Nursing	1	5	4	20	5	12.5
Associate Degree	1	5	1	5	2	5
Bachelor of Science in Nursing	11	55	5	25	16	40
Total	20	100	20	100	40	100

Table 6

Frequency Distribution and Percentages
of Nurses Demographic Data
Social Class and Assigned Unit
(N = 40)

Variables	Experimental Group		Control Group		Total Group	
	n	%	n	%	N	%
Socioeconomic Class						
Upper Class	2	10	2	10	4	10
Upper Middle Class	10	50	14	70	24	60
Lower Middle Class	8	40	4	20	12	30
Total	20	100	20	100	40	100

Table 6 (continued)

Variables	Experimental Group		Control Group		Total Group	
Assigned Unit						
Psychiatry	4	20	4	20	8	20
Medical-Surgical	5	25	5	25	10	25
AIDS	4	20	4	20	8	20
Rehabilitation	3	15	3	15	6	15
Neurology/Neuro Surgery	2	10	2	10	4	10
Nephrology	2	10	2	10	4	10
Total	20	100	20	100	40	100

Demographic Characteristics of Clients

The attribute variables of age, sex, ethnicity, educational level, socioeconomic status and assigned unit are presented to describe the total sample of 40 clients (see Table 7). Age varied for the total client group from 22 to 90 years with a mean of 42.03 years and a standard deviation of 13.19. The mean age of the 20 subjects in the experimental group was 41.05 years with a standard deviation of 11.73 years. The mean age of the 20 clients in the control group was 43.0 years with a standard deviation of 14.65 years.

There were 30 (75%) males and 10 (25%) females in the total client group. The majority of the participants in the experimental client group were male, 14 (70%). The control group client population was comprised of 16 (80%) males. Within the total client sample, 10 (25%) clients

were Caucasian; 28 (70%) clients were Black Americans; and two (5%) were Hispanic and American Indians. Fourteen (70%) of the participants in experimental group reported their ethnicity as Black. The control group client population represented the following ethnic groups: Blacks, 14 (70%); Caucasian, 4 (20%); Asians, 2 (10%).

Level of education for the total client sample varied as follows: four (10%) reported completing elementary school; five (12.5%) completed junior high; eight (20%) attended high school but did not graduate; nine (22.5%) graduated from high school; nine (22.5%) attended college for 1-2 years and five (12.5%) reported having more than 3 years in college. The majority of the clients, 5 (25%) in the experimental group had completed one or two years of college. The majority, 6 (30%), of the participants in the control client group had completed 12 years in school (see Table 7).

Clients participating in the study were from the following units: Psychiatry, eight (20%); Medical-Surgical, 10 (25%); AIDS, eight (20%); Rehabilitation, six (15%); Neurology/Neurosurgery, four (10%) and Nephrology, four (10%). The experimental group of clients were on the following units: Psychiatry, Medical-Surgical, AIDS's, Rehabilitation, Neurology/Neurosurgery and Nephrology (see Table 8). Clients in the control group were from the

following units: Psychiatry, Medical-Surgical, AIDS's Rehabilitation, Neurology/Neurosurgery and Nephrology (see Table 8).

Most clients, 31 (77.5%), identified their socioeconomic status as lower class. Fifteen clients (75%) in the experimental group identified the lower class as their socioeconomic status. Sixteen clients (80%) in the control group identified their socioeconomic level as lower class.

Instrument Scores

MCSQ was a 60 item multiple choice test which assessed nurses knowledge of skills needed to develop rapport. MIRPQ for nurses and clients measured perceptions of the presence of rapport. Subjects were required to rate 53 open ended statement using either strongly agree, agree, strongly disagree or disagree. MBRS was the observational tool used to assess behaviors of the nurse and client reflective of rapport.

The highest possible score on MCSQ was 100%; the lowest possible score was 0%. The highest possible raw scores on MIRPQ was 212 points and the lowest score was 53. These scores were converted to ratio scores with the maximum possible point equaling 100 and the lowest score equaling 0. The highest possible raw score on MBRS was 136 before conversion. One hundred was the highest ratio score

Table 7

Frequency Distribution and Percentages of Client's Demographic Data
(N = 40)

Variables	Experimental Group		Control Group		Combined Group	
	n	%	n	%	N	%
Age (years)						
22 - 35	7	35	5	25	12	30
36 - 49	8	40	12	60	20	50
50 - 63	4	20	1	5	5	12.5
64 - 90	1	5	2	10	3	7.5
Total	20	100	20	100	40	100
Sex						
Male	14	70	16	80	30	75
Female	6	30	4	20	10	25
Total	20	100	20	100	40	100
Ethnic Group						
Black	14	70	14	70	28	70
Caucasian	6	30	4	20	10	25
Asian	0	0	2	10	2	5
Total	20	100	20	100	40	100
Educational Level						
Elementary	1	5	3	15	4	10
Junior High	3	15	2	10	5	12.5
High School (did not graduate)	4	20	4	20	8	20
High School (Graduated)	3	15	6	30	9	22.5
College 1-2 years	5	25	4	20	9	22.5
College > 3 years	4	20	1	5	5	12.5
Total	20	100	20	100	40	100

Table 8

Frequency Distribution and Percentages of Client's Demographic Data Assigned Unit and Social Class (N = 40)

Variables	Experimental Group		Control Group		Total Group	
	n	%	n	%	n	%
Assigned Unit						
Psychiatry	4	20	4	20	8	20
Medical-Surgical	5	25	5	25	10	25
AIDS	4	20	4	20	8	20
Rehabilitation	3	15	3	15	6	15
Neurology/Neuro Surgery	2	10	2	10	4	10
Nephrology	2	10	2	10	4	10
Total	20	100	20	100	40	100
Socioeconomic Class						
Upper Middle Class	0	0	1	5	1	2.5
Lower Middle Class	5	25	3	15	8	20
Lower Class	15	75	16	80	31	77.5
Total	20	100	20	100	40	100

possible after conversion.

Communication Scores (MCSQ). The pretest communication scores for the total nurse group varied from 22% to 70%. The mean pretest score was 45.53 and the standard deviation was 11.56. Posttest communication scores for the total nurse group fell between 33% and 87%. The mean posttest score was 57.68 and the standard deviation was 11.34.

The mean pretest score for the experimental nurse group was 46.65%. The standard deviation was 15.26 as shown in Table 9. Scores ranged from 22% to 70%. The posttest mean communication score of the experimental group was 69.30%. The standard deviation was 14.27 and scores varied from 42% to 87%.

The mean pretest score for MCSQ for the control nurse group was 44.40% with a standard deviation of 8.04 (see Table 9). Scores varied from 28% to 57%. The posttest mean score for the control group on MCSQ test was 46.05%. The standard deviation was 8.41. Scores ranged from a low of 33% to a high of 58% (see Table 9).

Nurses Rapport Perception Scores (MIRPQ). Pretest rapport perception scores for the total nurse group ranged from 56% to 87%. The mean pretest score was 70.68 with a standard deviation of 5.79. The posttest scores for this nurse group varied from 65% to 94%. The mean posttest score was 77.58% and standard deviation was 5.87.

The mean pretest rapport perception score for the experimental nurse group was 69.05%. The standard deviation was 6.53 and scores ranged from 56% to 77% (see Table 9). The posttest mean rapport perception score for this group was 82.75 and the standard deviation was 7.29. There was a variation in the scores from 69% to 94% as depicted in Table 9.

Table 9

Pre and Posttest Scores of Total Samples of Experimental and Control Nurse Groups (N = 40)

Variables	Experimental Group n = 20		Control Group n = 20		Total Group N = 40	
	M	SD	M	SD	M	SD
MCSQ						
Pretest	46.65	15.26	44.40	8.04	45.53	11.56
Posttest	69.30	14.27	46.05	8.41	57.68	11.34
MIRPQ						
Pretest	69.05	6.53	72.30	5.04	70.68	5.79
Posttest	82.75	7.29	72.40	4.45	77.58	5.87
MBRS						
Pretest	51.70	2.68	51.70	2.59	51.70	2.64
Posttest	75.00	6.25	52.05	4.09	63.93	5.17

The mean pretest rapport perception score for the control nurse group on the MIRPQ test was 72.30% and the standard deviation was 5.04 (see Table 9). Scores fell between 65% and 87%. For this group, the mean posttest score was 72.4% with a standard deviation of 4.45. The range of scores was from 65% to 86%.

Behavioral Rapport Scores (MBRS). Scores obtained for the pretest on the MBRS for the total nurse group ranged from 46% to 56% with a mean of 51.70 and a standard deviation of 2.64. The posttest scores for the MBRS ranged from 46% to 85% and had a mean of 63.93% with a standard deviation of 5.17.

For the experimental nurse group, the mean pretest MBRS score was 51.70 with a standard deviation of 2.68 as illustrated in Table 9. Scores ranged from 46% to 56%. The mean posttest score for this experimental nurse group was 75%. The standard deviation was 6.25 and scores varied from 65% to 85%.

The mean pretest score for the control nurse group was 51.70%. The standard deviation was 2.59. Scores varied from a low of 46% to a high of 56% (see Table 9). For this control nurse group, the mean posttest score was 52.05% for MBRS. The standard deviation was 4.09. There was a variation in the scores from 46% to 60%.

Client Rapport Perception Scores (MIRPQ). The highest possible score on MIRPQ was 212 points and the lowest score was 53. The scores were converted to ratio scores with the maximum possible score equaling 100 and the lowest possible score equaling 0. The total sample of 40 clients scored between 50% and 74% on the pretest. The mean pretest score was 62.25% with a standard deviation of 7.08. The total sample of 40 clients scored 50% to 95% on the posttest. The mean posttest score was 72.28 with a standard deviation of 8.62. These scores are presented in Table 10.

The mean pretest score on MIRPQ for clients in the experimental group was 62.35 with a standard deviation of 6.41 as illustrated in Table 10. The range of scores was

from 50% to 74%. For this group, the mean posttest score was 82.35% with a standard deviation of 9.01. Scores varied from 50% to 75%.

The mean pretest MIRPQ score for the control group was 62.15% with a standard deviation of 7.74 as indicated in Table 10. Scores fell between 50% to 74%. The posttest score mean for the control client group was 62.20. The standard deviation was 8.22. Scores varied from 50% to 75%.

Table 10

Pre and Posttest Scores
Experimental and Control
Client Groups
(N = 40)

MIRPQ	Experimental Group n = 20		Control Group n = 20		Total Group N = 40	
	M	SD	M	SD	M	SD
Pretest	62.35	6.41	62.15	7.74	62.25	7.08
Posttest	82.35	9.01	62.20	8.22	72.28	8.62

Data for the nurse and client samples have been described and summarized according to descriptive statistics, first for combined samples and then for each separate group. The data from nurses were described according to the variables of age, sex, length of practice, ethnicity, educational level, socioeconomic class and assigned unit. Data from the client groups were described

according to age, sex, ethnicity, educational level, socioeconomic class and assigned unit. The next section of this chapter will include the findings of the study.

Findings

This study was conducted to investigate if facilitative training would improve nurses ability to establish rapport. Further analysis of data is explained according to the hypotheses. Each hypothesis is discussed separately.

Hypothesis One

H_1: There will be significant differences in the nurses identification of rapport according to their age and length in nursing practice.

A Pearson product-moment correlation coefficient was used to determine the relationship between nurse's age and length in practice and posttest rapport scores. There were no significant relationships between age and posttest communication scores, age and posttest rapport perception scores, and age and posttest behavioral scores (see Table 11). No significant relationship was reported for the nurses length in practice and communication scores, length in practice and perception scores, and length in practice and behavioral scores. This hypothesis was not supported.

Table 11

Correlation of Rapport Scores of Total Sample With Age and Length in Nursing Practice

Rapport Scale	Variable Age	Variable Length in Practice
Communication (MCSQ)	.032 p>.847	.206 p>.203
Rapport Perception (MIRPQ)	.101 p>.538	.086 p>.596
Behavioral Rapport (MBRS)	.083 p>.610	.113 p>.489

Hypothesis Two

H_2: There will be significant differences in the clients identification of rapport according to their age.

The Pearson's product-moment correlation coefficient, $r = -.267$, $p>.096$, indicated that there was no significant relationship between the client's identification of rapport and their age. Therefore, this hypothesis was not supported.

Hypothesis Three

H_3: There will be significant differences in the nurse's identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

The MANOVA statistic Pillai indicated that there were no significant differences in the reporting of rapport

according to the sex of the nurse, $F(3,34) = .6484$, $p>.5893$. A MANOVA was done to assess if differences existed in the MCSQ, MIRPQ and MBRS scores and levels of ethnicity. Ethnicity of the nurses was categorized by participants into three groups and included Caucasian, Hispanics, and Black Americans. The MANOVA statistic Pillai, $F(3,33) = 2.5914$, $p<.0257$, indicated that there was a significant difference in rapport scores and nurses ethnicity.

When a significant effect was found in MANOVA, the Univariate F test on the dependent measures were examined. The interpretation of the univariate values indicate that rapport scores on MCSQ did not vary significantly according to ethnic group. However, a significant difference was noted in the nurses perception of the presence of rapport according to ethnicity (see Table 12). In order to determine exactly which means were different, Duncan's post hoc comparison test was completed. Caucasian nurses reported having more rapport (MIRPQ) than did Black or Hispanic nurses (M = 11.68 for Caucasian; M = 7.33 for Hispanic; M = 4.75 for Blacks). Results also indicated that Caucasian nurses displayed more of the behaviors characteristic of rapport (MBRS) than did Black or Hispanic nurses (M = 17.33 for Caucasian; M = 12.0 for Hispanic; M = 10.67 for Black).

Table 12

Univariate Analysis of Rapport Scores of Total Sample by Ethnic Group
(N = 40)

Variable Ethnic Group[a]	SS	MS	F	p
Rapport Scale				
Communication (MCSQ)	236.35	78.783	.54	.660
Rapport Perception (MIRPQ)	431.77	143.92	3.77	.019*
Behavioral Rapport (MBRS)	368.98	128.99	4.25	.012*

[a]df = (3) for each scale
* p<.05 (significant)

Nurses identification of rapport was also examined according to their educational level. The educational variable was reported in four levels. These levels were as follows: licensed practical, n = 17; diploma, n = 5; associate degree, n = 2; and bachelor's degree nurses, n = 16.

The MANOVA Pillai criterion, F(3,34) = 5.555, p<.0033 indicated that a significant difference in mean rapport scores (MCSQ, MIRPQ, MBRS) and the educational preparation of the nurse did exist. Univariate F scores specifically indicated a significant difference in mean rapport scores for MIRPQ and MBRS and educational preparation of the nurse. Results further indicated that a significant difference did not exist in the nurses knowledge of the

skills (MCSQ) necessary to develop rapport and their educational preparation (see Table 13).

Table 13

Univariate Analysis of Rapport Scores of Total Sample With Level of Education Preparation (N = 40)

Variable Educational Level[a]	SS	MS	F	p
Rapport Scale				
Communication (MCSQ)	597.83	149.46	1.12	.363
Rapport Perception (MIRPQ)	982.43	245.61	6.78	.0004*
Behavioral Rapport (MBRS)	1102.7	275.69	9.65	.0001*

[a]df = (4) for each scale
* p<.05 (significant)

Duncan's post hoc comparisons test indicated that nurses with bachelor's degrees in nursing reported having more rapport (MIRPQ) than diploma or licensed practical nurses (M = 14.89, bachelors degree; M = 1.40, diploma; and M = 3.22, licensed practical nurses). Results further indicated that nurses with a bachelors degree in nursing demonstrated more of the behaviors characteristic of rapport (MBRS) than did other nurses (M = 22.54, bachelors degree; M = 12.0, associate degree; M = 8.80, diploma; M = 7.83, licensed practical nurses).

Differences in rapport scores were also examined

according to whether nurses were currently enrolled in a nursing program. Scores resulting from the MANOVA Pillai's criterion, $F(3,34) = 1.7139$, $p>.1826$, indicated that there were no significant differences in rapport scores of nurses and their current enrollment environment (enrolled, $n = 7$; not enrolled, $n = 33$).

A MANOVA was used to examine the difference between rapport scores of nurses grouped according to socioeconomic classes. Pillai's criterion, $F(3,34) = .08438$, $p>.4795$, indicated that there were no significant differences between rapport scores obtained on MCSQ, MIRPQ and MBRS and the nurses socioeconomic class.

Also assessed were differences in rapport scores according to the units the nurses were assigned. Scores generated from the MANOVA Pillai's criterion, $F(5,28) = .9813$, $p>.4819$, indicated that there were no significant differences in rapport scores, MCSQ, MIRPQ and MBRS, and the nurse's assigned unit.

Summarization of the statistical findings of hypothesis three is that there were no significant differences in the nurses identification of rapport according to sex, the nurses current educational enrollment, assigned unit and socioeconomic class. This part of the hypothesis was not supported. There were significant differences in nurses identification of rapport

according to ethnicity and educational preparation. Therefore, with regard to ethnicity and educational preparation, the hypothesis was supported. Nurses with bachelors degree reported more rapport and demonstrated more rapport behaviors than other nurses. Caucasian nurses reported greater rapport and exhibited more rapport behaviors than nurses in other ethnic groups.

Hypothesis Four

H_4: There will be significant differences in the client's identification of rapport according to their sex, ethnicity, educational preparation, social class, and assigned unit.

Pillai's criterion $F(1,36) = .5730$, $p>.4540$ indicated that there were no significant differences in the clients perception of rapport (MIRPQ-C) according to sex. A MANOVA was also done for clients rapport scores (MIRPQ-P) and levels of ethnicity. Clients reported their ethnicity as: Caucasian, $n = 10$; Black, $n = 28$; Asian, $n = 2$. There were no significant differences in the identification of rapport by clients according to their ethnicity as indicated by Pillai's criterion $F(3,34) = .0992$, $p>.9599$.

Clients rapport scores were further analyzed according to educational preparation (see Table 14). Pillai's criterion, $F(5,28) = 3.1536$, $p<.0221$ indicated that a significant difference did exist with clients perception of

Table 14

Univariate Analysis of Rapport Scores of Total Client Sample With Educational Preparation
(N = 40)

Variable Educational Preparation[a]	SS	MS	F	p
Rapport Scale (MIRP)	330.49	66.098	3.15	.022*

[a] df = (5)
* p<.05 (significant)

rapport (MIRPQ-C) and their educational preparation. Duncan's post hoc comparison test indicated that persons who reported that they had attended college perceived that they had more rapport than those persons who had not attended college (M = 17.80, > 3 years college; M = 13.67, 1-2 years college; M = 10.50, high school but did not graduate; M = 6.22, graduate high school; M = 6.00, junior high; M = 4.75, elementary school). The means were not significantly different for persons attending college for 1-2 years or for persons attending college more than 3 years.

A MANOVA was also used to determine if there would be any significant differences in the client's perception of the presence of rapport (MIRPQ-C) according to their socioeconomic class. Subjects classified themselves into the following three groups: lower class, lower middle

class, and upper middle class. There were no significant differences in the perception of rapport and the client's socioeconomic class as indicated by Pillai's criterion $F(2,35) = .3754$, $p>.6897$.

Rapport scores were also assessed according to clients assigned unit. Pillai's criterion, $F(5,28) = 1.0562$, $p>.4052$ indicated that there were no significant differences in the client's perception of rapport according to assigned unit.

In summary, statistical findings for hypothesis four indicated that there were no significant differences in the client's identification of rapport according to sex, ethnic group, social class and assigned unit. There were, however, significant differences in client's identification of rapport according to their educational preparation. This part of the hypothesis was supported.

Hypothesis Five

H_5: There will be significant differences in the identification of rapport (posttest scores) among nurses who attended the facilitative training program and those nurses who do not attend the program.

There were no significant differences in the pretest mean rapport scores of the experimental group of nurses and the pretest mean rapport scores of the control group of nurses (see Table 15). A MANOVA indicated, however, that

there were significant differences in the pre and posttest rapport scores (MCSQ, MIRPQ, MBRS) for the experimental nurse group as compared to the control nurse group. The Pillai's criterion, $\underline{F}(3,36) = 107.62$ was significant at the .0001 level. The univariate test also indicated significant differences in the posttest scores (MCSQ, MIRPQ, MBRS), (see Table 16). The experimental group of nurses performed better in all posttest rapport scores than the control group of nurses (see Table 15).

After nurses in the experimental group attended the facilitative training program, there were significant differences in their posttest rapport scores and the posttest rapport scores of nurses in the control group (see Table 15). Also after attending the facilitative program, nurses in the experimental group demonstrated increased knowledge of how to develop rapport; perceived that they had more rapport; and demonstrated more behaviors reflective of rapport. Nurses who had not attended the facilitative program had no significant changes in their mean scores from pretest to posttest (see Table 15). The hypothesis was supported.

Hypothesis Six

H_6: There will be significant differences in the identification of rapport among clients cared for by nurses who attended the facilitative training program and those

Table 15

Mean Pre and Posttest Rapport Scores of Nurse Sample (N = 40)

Rapport Scale	Pretest Experimental[a]	Pretest Control[b]	Posttest Experimental[a]	Posttest Control[b]
Communication (MCSQ)	46.65	44.40	69.30	46.05
Rapport Perception (MIRPQ)	69.05	72.30	82.75	72.40
Behavioral Rapport (MBRS)	51.70	51.70	75.80	52.05

[a] n = 20; [b] n = 20

Table 16

Univariate Analysis of Pre and Posttest Differences for Rapport Scores of Total Nurse Sample (N = 40)

Rapport Scale[a]	SS	MS	F	p
Communication (MCSQ)	4410.0	4410.0	30.84	.0001*
Rapport Perception (MIRPQ)	1849.60	1849.60	46.98	.0001*
Behavioral Rapport (MBRS)	5640.63	5640.63	192.69	.0001*

[a]df = (1) for each scale
* p<.05 (significant)

clients cared for by nurses who did not attend the program.

There were no significant differences in the pretest mean rapport scores of the clients in experimental group (M = 62.35) and the pretest mean rapport scores of clients in

the control group (M = 62.15). The MANOVA Pillai's criterion, F(1,38) = 128.50, demonstrated that the difference between the posttest scores of the experimental and control groups was significant at p<.0001.

Univariate analysis also indicated a significant difference in posttest rapport scores of clients (see Table 17). There was a significant difference in the identification of rapport by clients cared for by nurses who attended the facilitative training program (M = 82.35) and clients cared for by nurses who did not attend the program (M = 62.20). This finding indicated that clients did perceive that nurses attending the program were better at establishing rapport than they were prior to attending the program. Clients were not aware of which nurses attended the program. This hypothesis was supported.

The data was examined additionally to determine if the nurses perception of rapport (MIRPQ-N) differed significantly from clients perception of rapport (MIRPQ-C). Statistical analysis (see Table 18) indicated that there were significant differences in the clients identification of rapport when compared to the nurses identification of rapport. Duncan's post hoc comparison test indicated that clients perceived that they had rapport more often than did nurses (M = 10.03 for clients; M = 6.90 for nurses).

Table 17

Univariate Analysis of Pre and Posttest Differences for Rapport Scores for Clients (N = 40)

Rapport Scale[a]	SS	MS	F	p
Perception (MIRPQ)	3980.03	3980.03	128.50	.0001*

[a] df = (1)
* p<.05 (significant)

Table 18

Univariate Analysis of Differences for Rapport Perception Scores for Nurses and Clients (N = 80)

Rapport Scale[a]	SS	MS	F	p
Perception (MIRPQ)	195.31	195.31	5.55	.02*

[a] df = (3)
* p<.05 (significant)

Instrument reliability was supported using a test-retest analysis (see Table 19). A Pearson's product-moment correlation coefficient was obtained for pre and posttest scores for the control group of nurses and the control group of clients.

The same test was administered to the same group of subjects on two separate measurement occasions. The significant alpha levels indicated how consistently the

subject performed on the same set of task. Although the alpha level was significant for MBRS, the Pearson's value of .55 was much lower than values for MCSQ and MIRPQ.

An internal consistency estimate of reliability was obtained through use of Cronbach's alpha coefficient. Internal consistency for MIRPQ-N was reported with an alpha coefficient of .80. The alpha coefficient for MIRPQ-C was .96. The internal consistency alpha coefficient for MBRS combined nurse and client sections, was .67; .45 for the nurse section identifying behaviors indicative of rapport; and .61 for the client section identifying behaviors indicative of rapport. The nurses were least reliable in demonstrating behaviors indicative of rapport. The Kuder-Richardson estimate for reliability for MCSQ pretest was .76; the posttest Kuder-Richardson reliability was .87.

Point biserials were used to assess content validity for all instruments. Those questions with less than a 0.3 point biserial correlation were reviewed.

Summary of Findings

Descriptive and inferential statistics were used to describe the data obtained for nurse and client groups. There were 40 nurses who consented to participate and actually completed the study. Descriptive statistics revealed that nurses in the experimental group performed

Table 19

Test-Retest Pearson's Product-Moment Correlation Coefficient of Rapport Scores for Control Nurse and Client Group (N = 40)

Rapport Scale	Pretest MCSQ	Pretest MIRPQ-N	Pretest MBRS	Pretest MIRPQ-C
Posttest				
MCSQ				
r	.91	———	———	———
p	.0001*			
MIRPQ-N				
r	———	.96	———	———
p		.0001*		
MBRS				
r	———	———	.55	———
p			.012*	
MIRPQ-C				
r	———	———	———	.95
p				.0001*

* $p<.05$

better in terms of rapport behaviors and perception than nurses in the control group from pretest to posttest. There were 40 clients who participated in the pretesting and posttesting to determine if they perceived that they had rapport with their assigned nurses. Descriptively, the clients with nurses in the experimental group perceived that they had more rapport as compared to the clients with nurses in the control group. The experimental client group's mean score increased after the nurses attended the facilitative training program.

Age and length of nursing practice was found to be unrelated to rapport perception or behaviors. The client's age was not found to affect the identification of rapport. There were significant differences in nurses identification of rapport according to their ethnicity and educational preparation. Nurses identification of rapport according to the nurses' sex, current educational status, social class and assigned unit was also unrelated to rapport perception or behaviors.

Clients who had attended college perceived that they had rapport moreso than persons who had not attended college. The rapport scores of nurses attending the facilitative training program were statistically higher than the nurses who did not attend the program. Clients cared for by nurses attending the facilitative training program had statistically significant differences in their identification of rapport as compared to clients cared for by nurses not attending training program.

CHAPTER V

SUMMARY OF THE STUDY

The purpose of this study was to determine if a formal educational program could improve nurse's ability to establish rapport. Mosley's Humanistic-Rapport Ladder (MH-RL) was the conceptual framework for the study. The problem of this study was: Can a formal educational program improve nurse's ability to establish rapport? Six hypotheses were tested to determine the relationship between facilitative training and rapport development.

H_1. There will be significant differences in the nurses identification of rapport according to their age and length in practice.

H_2. There will be significant differences in the clients identification of rapport according to their age.

H_3. There will be significant differences in the nurses identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_4. There will be significant differences in the clients identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit.

H_5. There will be significant differences in the identification of rapport among nurses who attended the facilitative training program and those nurses who do not attend the program.

H_6. There will be significant differences in the identification of rapport among clients cared for by nurses who attended the facilitative training program and those clients cared for by nurses who do not attend the program.

This chapter includes a summary, a discussion of findings, conclusions, and implications. Recommendations for further study are discussed.

Summary

Forty nurses and 40 clients, who agreed to participate in the nurse-client rapport study, were randomly assigned to either an experimental or control group. There were 20 nurses and 20 clients in the experimental group and 20 nurses and 20 clients in the control group. Following agency approval, data were collected using four instruments, (a) Mosley's Demographic data Sheet (MDDS), (b) Mosley's Communication Skills Questionnaire (MCSQ), (c) Mosley's Interpersonal Rapport Perception Questionnaire - Nurse (MIRPQ-N), Mosley's Interpersonal Rapport Perception Questionnaire - Client (MIRPQ-C) and Mosley's Behavioral Scale (MBRS).

Nurses, who comprised both experimental and control groups, completed the MDDS, MCSQ and MIRPQ-N as pre and posttest. MBRS was completed by the investigator. Following pretesting, the experimental group attended a facilitative training program on rapport development. Clients in the experimental and control groups were administered the MDDS and completed the MIRPQ-C as a pre and a posttest. Data were analyzed using the MANOVA statistical test.

Discussion of Findings

One dependent variable, the development of rapport, was the focus of the study. The independent variable, the facilitative training program, was administered to nurses in the experimental group. Findings of the study are discussed according to the six hypotheses.

Research Hypotheses

Hypothesis One and Two

The first hypothesis was related to whether nurses identification of rapport would vary significantly according to their age or length in nursing practice. The second hypothesis was related to whether the client's identification of rapport would vary significantly according to their age.

The mean age of the total nurse population was 38.53

years with the standard deviation of 7.36. The mean age of the total client population was 42.03 years with a standard deviation of 13.19. A Pearsons correlation coefficient indicated that there was no significant change in rapport score according to the age of the nurse or the age of the client.

This finding is similar to Luborsky's et al. (1971) and Craig and Huffine's (1976) report which found no significant relationship between age of the health professional or client and rapport development. Their findings are different, however, from hypothesis posed by Rakel (1977). Rakel believed that a person's age would influence rapport development. He thought that an older person would be better at establishing rapport than younger persons.

The mean length in nursing practice was 11.43 years. Results indicated that the number of years in practice did not significantly affect rapport development. This finding is in direct contrast to research reported by Auerbach and Johnson (1977). They concluded that the therapist's experience was related to the quality of the therapeutic relationship. Similarly, Scher (1975) found a difference in the presence of rapport according to the professional's length in practice. Scher (1975) documented that clients of experienced therapist reported significantly greater

relief and satisfaction with therapy.

An explanation for these contradictory findings may be that the development of rapport cannot be judged by experience alone. For example, when the development of rapport was examined according to the ethnicity and educational preparation of the nurse, significant results were obtained. Significant results were also obtained for the client when related to educational preparation. Rapport development is therefore related to many factors other than experience.

Hypothesis Three and Four

Hypothesis three stated that identification of rapport would vary significantly according to the nurses sex, ethnic group, educational preparation, social class and assigned unit. Hypothesis four was related to the client's identification of rapport according to their sex, ethnic group, educational preparation, social class and assigned unit. The investigation of the difference between sex of the nurse and client and rapport revealed no significant findings. The sex of the nurse or client did not significantly affect their identification of rapport even though the nurse group was primarily female (92.5%) and the client group primarily male (75%).

The variable of sex of the health professional and its effect on a therapeutic relationship has been examined by

several authors each reporting different findings. In the present study, differences were difficult to investigate because of the high number of female nurses in the sample. Craig and Huffine (1976) and Koran and Costell (1973) reported results similar to this study. They found no significant differences between males and females in terms of professional relationships. Scher (1975) cited similar results. Scher (1975) found no significant interactions due to client and counselor sex on client and counselor ratings of satisfaction with treatment.

Offering contradictory findings was Chesler (1971) who expressed doubt that male professionals were helpful to female clients. Brodsky (1973) and Kronsky (1971) supported these results with their findings. Both concluded that even though some male therapist may be helpful, it was more advantageous for a woman client to be treated by a female professional who could than act as a role model and facilitate the open expression of feelings. Person et al. (1974) also reported that females are more responsive to female therapist and males to male therapist.

There were more studies disputing the finding of this study. Hackney (1974) found that women reacted differently to attempts from female professionals to establish rapport than from attempts by male professionals. Abramowitz (1976) reported that male professionals preferred to treat

women. The existing research therefore validates the contradictory findings as it relates to sex and rapport development.

The investigation of the difference between ethnicity of the nurse and skills needed to develop rapport as measured by MCSQ revealed no significant findings. Ethnicity was not an intervening variable in the nurses knowledge of rapport development. Results did indicate significant differences in the nurses perception of rapport (MIRPQ-N) and behaviors exhibited by the nurse characteristic of rapport (MBRS) according to ethnicity. Three ethnic groups represented nurses in this study: (a) Caucasians (30%), (b) Hispanics (7.5%), and (c) African Blacks (62.5%). Caucasians nurses reported having significantly more rapport than did Black and Hispanic nurses. Results also indicated that Caucasian nurses displayed more of the behaviors characteristic of rapport than did Black or Hispanic nurses. Therefore, although Caucasian nurses exhibited no more knowledge of rapport development than Black or Hispanic nurses, they exhibited more behaviors characteristic of rapport and perceived that they had rapport more often then did the other nurses.

Clients reported their ethnicity as: (a) Caucasian (25%), (b) Black (70%), and (c) Asian (5%). Results indicated that there was no significant difference in the

client's identification of rapport according to their ethnicity. Although cultural differences exist within the clients groups, ethnicity was not an intervening variable in rapport identification.

The variable of race has been explored extensively and offers contradictory findings. None of the studies clearly supported the finding of this study. For example, Carkhuff and Pierce (1967) found that the race of both the client and the health professional were significantly related to client self exploration and the interaction between the client and health professional. A similar finding was reported in another study. Griffith (1977) reported that racial similarity led to greater self disclosure and higher ratings of rapport with the health professional. Sattler (1977) stated that the professional's race was not significant in affecting performance and reactions. Ewing (1974) likewise concluded that racial similarity of the client and health professional was not important.

An explanation of why Caucasian nurses perceived that they had rapport more often than Black or Hispanic nurses and demonstrated the behaviors characteristic of rapport may be related to the race of the persons in the professional journals who identify the variables indicative of rapport. The behavior/variables reflected in the instruments used in this study as indicative of rapport

were obtained from journals probably written by the majority population or Caucasian individuals.

In other words, cultural differences may exist in how rapport is expressed. The norm group was probably Caucasian and the variables identified in the professional journals may have reflected how this culture (Caucasian) established rapport. Spector (1991) and Branch and Paxton (1976) have documented that various cultural groups related and/or communicated differently from the norm culture. For example, direct eye contact was identified in this study as a criteria for rapport establishment. Spector (1991) reported that Mexicans, Puerto Ricans, Asians, Africans-Americans and other cultures believe that glaring or staring (direct eye contact) is associated with "evil eye" which explains sickness and misfortune (p. 122-126). Other criteria identified as indicative of rapport were the initiation of interaction and touch other than through treatment. According to Spector (1991), Asian Americans are usually quiet and say very little, giving the health professional the impression that all is well. The Asian person would not then initiate interactions.

Black Americans believe in prayer for healing rather than personal touch and therefore are not likely to readily use touch to establish rapport (Spector, 1991). When touch is employed by Black Americans, touch is utilized in the

treatment of disease such as laying clay wrapped in a dark leaf on a sprained ankle. Blacks would not necessarily reach out to touch anyone other than during treatment. Because of cultural beliefs, Black and Hispanic nurses may not exhibit the behaviors identified in this study as indicative of rapport.

The relationship between education and rapport was also explored. Educational levels of the nurses were reported as: (a) licensed practical, (b) diploma, (c) associate degree and (d) bachelors degree nurses. Although there was no significant difference in the nurses knowledge of the skills needed to develop rapport, as measured by MCSQ, nurses with bachelors degrees reported having more rapport than licensed practical, diploma or associate degree nurses. Nurses with bachelors degrees also demonstrated behaviors characteristic of rapport moreso than the licensed practical, diploma or associate degree nurse.

An explanation for this significant difference may be the length of Bachelor of Science (BSN) degree nursing programs. The length of the BSN program may allow emphasis on relationship formations moreso than other programs in nursing. The length of the BSN degree nursing programs may also facilitate students engagement in more nurse-client interactions than other programs. This increased time

spent interacting with clients may allow the skill of establishing rapport to become internalized and routine.

Educational levels of clients varied and were reported as: (10%) completed elementary school; (12.5) completed junior high; (20%) attended high school but did not graduate; (22.5%) graduated from high school; (22.5%) attended college for 1-2 years and (12.5%) reported having more than 3 years of college. Significant differences in rapport perception were identified for clients according to their educational preparation. Clients reporting that they had attended college perceived that they had more rapport than those persons who had not attended college. Rapport perception did not vary significantly for those clients who had 1-2 years of college and clients with greater than 3 years of college. Attendance at college, regardless of the number of years, was the only criteria for the increased perception of rapport when compared to clients not attending college.

This significant difference may be related to emotional maturity and/or experiences associated with collegiate life. Persons attending college may have experienced broader exposure to many groups of people and are therefore used to developing rapport. A person who has attended college may have experienced broader exposure to many groups facilitating their ability to develop rapport.

Additionally, course work could be a factor. College programs usually require sociology, psychology and English courses as degree requirements for graduation. All these courses are usually taken at the introductory level during the first year in college. This could explain why a client with only one year of college would perceive that they had the same level of rapport as the person with 4 years of college.

There were no available studies in the literature where researchers had investigated the relationship of rapport and educational preparation. However, Cheng (1973) commented in an article that the health professional should be intellectually close to the client. This suggestion indicates that being intellectually close to the client is helpful to rapport and that professionals should remain aware that one of the consequences of their education could be intellectual distance from the clients.

The variable of social class or socioeconomic level has also been explored by several authors. There was no agreement in the literature as to the effect of social class on the professional-client relationship. In this study, nurses identified their social class as: upper class (10%), upper middle class (60%) and lower middle class (30%). Findings of this study indicated that there were no significant differences in the nurses knowledge of rapport

development, the nurses perception of rapport and behaviors indicative of rapport according to their socioeconomic level.

A similar finding was evident for clients who also classified themselves as: upper middle class (2.5%), lower middle class (20%) and lower class (77.5%). There were no significant differences in the perception of rapport for clients.

The results of this rapport study were validated by Albronda et al. (1964) who concluded that there was no significant relationship between social class and professional relationship. Although significant differences in rapport scores and socioeconomic classes were not indicated by the MANOVA statistic, significant differences in the means scores did exist for nurses and clients, as determined by the Duncan's hoc comparison test.

Nurses in the lower middle class ($\underline{M}$ = 17.08) demonstrated more behaviors indicative of rapport than did nurses in the upper middle class ($\underline{M}$ = 9.92). A similar finding was evident for clients. Clients in the lower middle class ($\underline{M}$ = 14.38) perceived that they had more rapport than clients in the upper middle class ($\underline{M}$ = 0.00). These significant means validate Lorion's (1974) conclusions that professionals preferred to work with clients like themselves, who share their values, speech,

their language and with whom they feel more comfortable. Nurses probably felt more comfortable and found it easier to communicate with clients "like themselves." Clients may have likewise felt better able to relate to persons who were "like themselves."

Lorion (1973) reported that middle and upper class professionals were not able to gain rapport, to understand or communicate effectively with lower class clients. Mitchell and Namenek (1970) concluded that therapist with similar socioeconomic backgrounds to those lower class clients would be more responsive to them and better able to understand them, thus being more able to help them. In other words, according to Mitchell and Namenek (1970), knowledge and experience in comparable social classes facilitates rapport and therapeutic change. Imber et al. (1955) found that middle class persons were more likely to establish a relationship with the health professional moreso than the lower class client.

The investigation of the difference between rapport identification and assigned unit of the nurse and client revealed no significant findings. The client or nurse's assigned unit was not an intervening variable in rapport development. Clients and nurses participating in the study were from the following units: Psychiatry (20%), Medical-Surgical (25%), AIDS (20%), Rehabilitative (15%),

Neurology/Neurosurgery (10%) and Nephrology (10%).

The lack of any significant difference in perceptions and behaviors indicative of rapport on various units was suprising. Clients on Psychiatric, AID's and Rehabilitative units characteristically are hospitalized for longer periods than clients on the other units and therefore were expected to demonstrate higher rapport scores than other clients. Additionally, clients on these units, because of the chronicity of their illness, may have repeated hospitalizations allowing them to become familiar with the nurses and the nurses to become more familiar with the client. This familiarity was expected to perhaps increase the rapport scores.

Also, communication has been identified as being central to rapport development. Communication is frequently an intervention used with psychiatric clients (Stuart & Sundeen, 1991). Thus, a higher rapport score was expected from the clients and nurses on this unit. There were no available studies in the literature which examined the relationship of rapport and assigned units.

Hypothesis Five

Hypothesis five was related to whether identification of rapport among nurses who attended facilitative training program was significantly different from nurses not attending the program. Results indicated that posttest

rapport scores increased significantly in the experimental group of nurses. The facilitative training program consisted of six hours of training occurring in one day. Information such as the importance of rapport, when and how to establish rapport and variables most likely to influence rapport development were included in the training program.

The first three hours of class was lecture/discussion. The lecture addressed the identification of verbal and nonverbal responses, facilitative communication, attentive listening, positive body language, mutual understanding, therapeutic use of self, and the development of interpersonal closeness - warmth, honesty, respect and trust. All are characteristics, identified in the literature review, that the nurse must have in order to develop rapport.

The fourth hour of class was based on Kalisch's (1971) method of experiential training. Participants were encouraged to discuss their personal feelings regarding the experience of sympathy and emotional involvement when interacting with clients. The fifth hour of class consisted of role playing. Participants were allowed to discuss their feelings and problems experienced with the role playing during the sixth hour.

The facilitative training program resulted in improved rapport scores of the experimental group which was

significantly higher than rapport scores of the control group. The control group of nurses in this study received no training. There were no significant changes in rapport scores from pretest to posttest for the control group. Significantly higher rapport scores indicated that the facilitative training program was effective in addressing the variables of verbal and nonverbal responses, facilitative communication, attentive listening, mutual understanding, therapeutic use of self, and the development of warmth, honesty respect and trust.

After participating in the program nurses were more knowledgeable of skills needed to develop rapport, perceived that they had more rapport and subsequently demonstrated more behaviors characteristic of rapport. Low rapport scores, as in the control group, indicated that nurses did not have the knowledge necessary to establish rapport, did not perceive that they had more rapport and failed to demonstrate behaviors indicative of rapport. Control group nurses were probably not as sensitive to the verbal and nonverbal responses of the client. They were probably not as sensitive to the feelings of the clients and therefore unable to demonstrate attentive listening and interpersonal closeness. The experimental group of nurses, because of the facilitative training classes, were more sensitive to the interpersonal behaviors of their clients.

The results of this study supported research findings of Wallace (1977). Wallace concluded that a systematic training program on responding skills of dental hygiene students did increase the student's ability to establish rapport. In Wallace's (1977) study, although hygiene students in the control group received dental professionalism training, they were not as successful in establishing rapport as hygiene students in the systematic training program or experimental group.

Hypothesis Six

Hypothesis six examined the differences in the identification of rapport among clients cared for by nurses attending the facilitative training program and these clients cared for by nurses who did not attend the program. Results indicated that there was a significant difference in the identification of rapport by clients cared for by nurses who attended facilitative training program when compared to clients cared for by nurses who did not attend the program. Clients perceived that nurses attending the program were better at establishing rapport than they had been prior to the program. Clients also perceived that they had rapport more often then nurses. The training intervention had an effect on the nurses ability to establish rapport and in turn enhanced the client's perception of the presence of rapport.

The clients reporting of rapport more often than nurses may be related to the clients increased satisfaction with nursing care as a result of the nurses increased sensitivity secondary to the facilitative training program. The finding in this study correlates with a study by Warren (1985) who validated the importance of rapport to outcome. Warren's study looked at factors associated with compliance and noncompliance in taking medicines. Health care provider rapport was one of the factors significantly associated with compliance.

Another study which validated the importance of rapport to client outcomes was one by Peterson (1982). The purpose of this study was to determine the effectiveness of a chronic pain treatment program. The study assessed the relationship between treatment outcome, physician rapport, social support, prior pain adjustment and locus of control. Analysis revealed that the client's rapport with the physician was associated with the clients rating of coping effectiveness.

Schroeder (1986) in a phenomenological study, defined rapport as trust and understanding as the ease of communication increases. Schroeder's (1986) finding further supports the finding of this study. Clients cared for by nurses attending the facilitative training program may have perceived that they had more rapport because of

the nurse's ability to establish trust, the nurses increased understanding and ability to communicate as result of facilitative training.

Conclusions and Implications

Several conclusions and implications regarding the research problem can be made. Conclusions and implications are as follows:

1. A formal educational program can improve nurses ability to establish rapport. Nurses in this study, prior to any intervention, were functioning without sufficient knowledge of rapport development. The nurses did not perceive that they had rapport nor demonstrated behaviors indicative of rapport.

2. The importance of rapport to therapeutic outcomes has been documented in the literature review. Nurses, therefore, need more formalized facilitative training in order to increase their ability to establish rapport and effect outcomes.

3. The importance of rapport to therapeutic outcomes has been documented in the literature review. Future research studies should focus on examining the relationship of rapport and improved client outcomes.

4. Educational programs on the establishment of nurse-client relationships should be formalized and focus

on nonverbal and verbal communication, therapeutic use of self, facilitative communication, attentive listening, positive body language, mutual understanding and interpersonal closeness.

5. Facilitative training should be a part of nurses continuing education in order to maintain their ability to establish rapport.

6. Nurses who attended a formal educational program had significant increases in all posttest scores as related to knowledge, perception, and behaviors indicative of rapport. Clients cared for by nurses attending the formal classes had higher rapport scores than clients not cared for by these nurses.

7. The nurses ability to establish rapport was influenced by their ethnicity. Caucasian nurses had significantly higher perception and behavioral rapport scores than Black or Hispanic nurses. This result could be indicative that the variables identified as representative of rapport are not sensitive to minority populations.

8. The nurses ability to establish rapport was influenced by their educational preparation. BSN degree nurses had significantly higher rapport perception and behavioral scores than licensed practical, diploma or associate degree nurses. Programs of nursing other than BSN programs therefore need to increase their emphasis on

nurse-client relationships and rapport development.

9. Clients who had attended college had significantly higher perception rapport scores then those clients who had not attended college.

10. Significant differences in the mean rapport scores did exist for nurses and clients according to their socioeconomic level. Both lower middle class nurses and clients had significantly higher rapport scores.

11. The information that clients and nurses tend to relate better to persons of similar background should be included in curriculums of nursing when teaching formation of nurse-client relationships. Increased awareness of the discomfort experienced by clients when interacting with persons of different socioeconomic background should further increase a nurses sensitivity during interactions.

12. Nurses should be encouraged to exert every effort to get to know, understand and communicate with the client who is not from the same socioeconomic background.

Recommendations for Further Study

The existence of nursing research on rapport development and the effect of rapport on outcomes is nonexistent. The following recommendations are suggested.

1. This study should be replicated using nurses and clients and the same research design. Nonsignificant

variables such as age, length in practice, sex, and assigned unit should be omitted.

2. A follow up knowledge posttest (MCSQ) should be administered to nurses to determine if they still possess the knowledge to develop rapport one month after attendance at the program.

3. A follow up behavioral (MBRS) posttest should be administered to nurses to determine if they still demonstrate behaviors indicative of rapport one month after the study.

4. Future studies should investigate the relationship of knowledge of rapport development and performance.

5. The instruments used in this study should be retested to obtain additional reliability and validity information.

6. Minority populations should be studied to collect information regarding behaviors reflective of rapport.

7. This study should be repeated using new instruments which incorporate the behaviors identified during the assessment of minority populations.

8. Future research should focus on investigating the relationship of rapport and client outcomes.

REFERENCES

Abramowitz, S., Roback, H., Schwartz, J., Yasuna, A., Abramowitz, C., & Gomes, B. (1976). Sex bias in psychotherapy: A failure to confirm. American Journal of Psychiatry, 133, 706-709.

Acosta, F., & Sheehan, J. (1976). Preferences toward Mexican-American and Angelo-American psychotherapist. Journal of Consulting and Clinical Psychology, 44, 272-279.

Albronda, H., Dean, R., & Starkweather, J. (1964). Social class and psychotherapy. Archives of General Psychiatry, 10, 276-283.

Auerbach, A., & Johnson, M. (1977). Research on the therapist's level of experience. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy: A handbook of research. New York: Pergmon Press.

Bandler, R., & Grinder, J. (1979). Frogs into princes. Utah: Real People.

Becker, M., Drachman, R., & Kirscht, J. (1972). Motivations as predictors of health behavior. Health Services Reports, 87, 852-862.

Bloom, B. S., Engelhart, M., Furst, E., Hill, W., & Krathwohl, D. (1956). Taxonomy of educational objectives. New York: David McKay.

Bourne, T. (1983, September). How to establish and maintain rapport with your clients. Dental Management, 18-20.

Branch, M., & Paxton, P. (1976). Providing safe nursing care for ethnic people of color. New York: Appleton-Century-Crofts.

Brodsky, A. (1973). The consciousness raising group as a model for therapy with women. Psychotherapy: Theory, Research and Practice, 10, 24-29.

Brook, L. (1974). Interactive effects of sex and status on self disclosure. Journal of Counseling Psychology, 21, 469-474.

Brown, F. (1981). Measuring classroom achievement. New York: Holt.

Burns, N., & Grove, S. (1993). The practice of nursing research, conduct; critique and utilization. Philadelphia: Saunders.

Carkhuff, R., & Pierce, R. (1967). Differential effects of therapist race and social class upon client depth of self exploration in the initial clinical interview. Journal of Consulting Psychology, 31(6), 632-634.

Cheng, A. (1973). Rapport in initial counseling interview and its impact on effectiveness. Acta Psychologica Taiwanica, 15, 31-40.

Chesler, P. (1971). Marriage and psychotherapy. In J. Agel (Ed.), The radical therapist: The radical therapist collective. New York: Ballantine Books.

Cimbolic P. (1972). Counselor race and experience effects on black clients. Journal of Consulting and Clinical Psychology, 39, 328-332.

Cole, N., Branch, C., & Allison, R. (1962). Some relationships between social class and the practice of dynamic psychotherapy. American Journal of Psychiatry, 118, 1004-1012.

Console, W., Simons, R. C., & Rubenstein, M. (1977). The first encounter: The beginnings of psychotherapy. New York: Aronson.

Craig, T., & Huffine, C. (1976). Correlates of client attendance in an inner-city mental health clinic. The American Journal of Psychiatry, 133, 61-64.

Davis, M., & Weitz, S. (1981). Sex differences in body movement and positions. In C. Mayo & N. Henley (Eds.), Gender and nonverbal behavior (pp. 81-92). New York: Springer-Vertag.

Denova, C. (1979). Test construction for training evaluation. New York: Van Nostrand & Reinhold.

Dillon, L. (1971, July). Rapport. Journal of Alabama Dental Association, 55, 26-29.

DiMatteo, M. (1979). Nonverbal skill and the physician-client relationship. In R. Rosenthal (Ed.), Skill in nonverbal communication: Individual differences. Cambridge, MA: Oelgeschlager, Gunn and Hain.

Ewing, T. (1974). Racial similarity of client and counselor and client satisfaction with counseling. Journal of Counseling Psychology, 21(5), 444-449.

Ebel, R. & Frisbie, D. (1986). Essentials of educational measurement (4th ed.). Englewood Cliffs, New Jersey: Prentice-Hall.

Fawcett, J. (1984). Analysis and evaluation of conceptual models of nursing. Philadelphia: Davis.

Flemming, G. (1979). Using consumer evaluations of health care. Hospital Progress, 60(8), 54-60, 68.

Flemming, J. (1983). Consumerism and the nursing profession. In N. L. Chaska (Ed.). The nursing profession: A time to speak (pp. 471-478). New York: McGraw-Hill.

Forsyth, G. (1977). Exploration of empathy in nurse-client interaction. Unpublished.

Forsyth, G. (1979). Explanation of empathy in nurse-client interaction. Advances in Nursing Science, 1(2), 53-61.

Geer, C., & Hurst, J. (1976). Counselor-subject sex variables in systematic desensitization. Journal of Counseling Psychology, 23(4), 296-301.

Griffith, M. (1977). The influence of race on the psychotherapeutic relationship. Psychiatry, 40, 27-40.

Fox, D. (1976). Fundamentals of research in nursing (3rd ed.). New York: Appleton-Century-Crofts.

Gerrard, B. (1978). Interpersonal skills for health professionals: A review of the literature. Unpublished manuscript, Department of Medicine, McMaster University.

Giuffra, M. (1980). Humanistic nursing technological society. Journal of New York State Nurses' Association, 11(1), 17-22.

Glasnapp, D., & Poggio, J. (1985). Essentials of statistical analysis for the behavioral sciences. Columbus, OH: Charles E. Murril.

Hackney, H. (1974). Facial gestures and subject expression of feelings. Journal of Counseling Psychology, 21, 173-178.

Hall, L. (1964). Can nursing care hasten recovery? American Journal of Nursing, 64(6).

Harrison, S., & Carek, D. (1966). A guide to psychotherapy. Boston: Little Brown.

Hays, R., & Dimatto, M. (1987). Key issues and suggestions for client compliance assessment: Issues of information, focus of measures, and nature of response options. The Journal of Compliance in Health Care, 2(1), 37-53.

Heiby, E., & Carlson, J. (1986). The health compliance model. Journal of Compliance in Health Care, 1(2), 135-152.

Hulin, C., Drasgon, F., & Parsons, C. (1983). Item response theory: Application to psychological measurements. Homewood, IL: Dorsey.

Imber, S., Nash, E., & Stone, A. (1955). Social class and duration of psychotherapy. Journal of Clinical Psychology, 11, 281-284.

Jackson, E. (1975). Establishing rapport: Verbal interaction. Journal of Oral Medicine, 30(4), 105-111.

Jarrett, L., & Nord, W. (1985, January). Establishing client rapport and communication. South Dakota Journal of Medicine, 19-23.

Kalisch, B. (1971). An experiment in the development of empathy in nursing students. Nursing Research, 20(3), 202-211.

Kasch, C., & Knulson, K. (1985). Client compliance and interpersonal style: Implications for practice and research. Nurse Practitioner, 52-56.

Kastelec, J., Kane, R., Olsen, D., & Thetford, C. (1976). Issues underlying prevalence of doctor-shopping behavior. Journal of Health and Social Behavior, 17, 328-339.

Kerlinger, F. N. (1973). Foundations of behavioral research (2nd ed.). New York: Holt, Rinehart & Winston.

Kincey, J., Bradshaw, P., & Ley, P. (1975). Clients satisfaction and reported acceptance of advice in general practice. Journal of the Royal College of General Practitioners, 25, 558-566.

Kirk, R. (1982). Experimental design: Procedures for the behavioral sciences (2nd ed.). Brooks Cole Publishing.

Koran, L., & Costell, R. (1973). Early termination from group psychotherapy. International Journal of Group Psychotherapy, 23, 346-359.

Kronsky, B. (1971). Feminism and psychotherapy. Journal of Contemporary Psychotherapy, 3, 89-98.

LaFrance, M. (1979, March). Nonverbal synchrony and rapport: Analysis by the cross-lag panel techniques. Social Psychology Quarterly, 42(1), 66-70.

LaFrance, M., & Broadbent, M. (1976). Group rapport: Positive sharing as a nonverbal indicator. Group and Organization Studies, 1, 328-333.

LaFrance, M., & Mayo, C. (1979). A review of nonverbal behavior in women and men. Western Journal of Speech Communication, 43, 96-107.

Lambert, M. (1983). The client-therapist relationship as a factor in psychotherapy outcome: An introduction. In Lambert (Ed.), A guide to psychotherapy and client relationships. Illinois: Dow-Jones & Irwin.

LaMonica, E. (1983). The nurse as helper: Today and tomorrow. In N. L. Chaska (Ed.), The nursing profession: A time to speak (pp. 489-499). New York: McGraw-Hill.

Lerner, B., & Fiske, D. (1973). Client attributes and the eye of the beholder. Journal of Consulting and Clinical Psychology, 40(2), 272-277.

Levine, M. (1973). Introduction to clinical nursing. Philadelphia: Davis.

LoBiondo-Wood, G., & Haber, J. (1990). Nursing research. St. Louis: Mosby.

Lord, F. (1980). Applications of item response theory to practical testing problems. New Jersey: Lawrence Erbium Publishers.

Lorion, R. (1973). Socioeconomic status and traditional treatment approaches reconsidered. Psychological Bulletin, 79, 263-270.

Lorion, R. (1974). Client and therapist variables in the treatment of low-income clients. Psychological Bulletin, 81, 344-354.

Luborsky, L., Chendler, M., Auerbach, A., Cohen, J., & Bachrach, H. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. Psychological Bulletin, 75, 145-185.

Lyman, H. (1978). Test scores and what they mean. Englewood Cliffs, New Jersey: Prentice-Hall.

MacKinnon, R., & Michels, R. (1971). The psychiatric interview in clinical practice. Philadelphia: Saunders.

Marmor, J. (1976). Common operational factors in diverse approaches to behavior change. In a Burton (Ed.), What makes behavior change possible. New York: Bruner/Mazel.

Martin, B. (1984, April). Establishing rapport in first appointments. Dental Student, 44, 45, 55.

Mehrabian, A. (1968). Inference of attitudes from posture, orientation and distance of a communicator. Journal of Consulting and Clinical Psychology, 32, 296-308.

Meleis, A. (1991). Theoretical nursing development and progress (2nd ed.). Philadelphia: Lippincott.

Mitchell, K., & Namenek, T. (1970). A comparison of therapist and client social class. Professional Psychology, 1, 225-230.

Mittleman, J. (1976, January). Client rapport, the answer to third party intrusion. Dental Survey, 20-22.

Mittleman, J. (1976, July). Reaching the client with rapport. Dental Management, 19-22.

Nahum, L. (1964, November). Rapport: It's nature, rapport can be an important therapeutic mechanism. Connecticut Medicine, 783.

Nahum, L. (1965, January). The formation of rapport. Connecticut Medicine, 29(1), 10, 13-14.

Nunnally, J. (1978). Psychometric theory (2nd ed.). New York: McGraw Hill.

O'Hari, D., O'Hari, M., Southward, G., & Krayer, K. (1987). Physician communication and client compliance. The Journal of Compliance in Health Care, 3(2), 125-129.

Orlando, I. (1961). The dynamic nurse-client relationship: Function, process and principles. New York: Putnam.

Pacoe, L., Naar, R., Guyett, I., & Wells, R. (1976). Training medical students in interpersonal relationship skills. Journal of Medical Education, 51, 743.

Peplau, H. (1952). Interpersonal relations in nursing. New York: Putnam.

Person, R., Person, M., & Newmark, I. (1974). Perceived helpful therapists characteristics, client improvement, and sex of therapist and client. Psychotherapy, Theory, Research and Practice, 11, 63-65.

Peterson, L. (1982, April). Variables defining treatment outcome in a chronic pain program: Client and program related factors. Dissertation Abstracts International, 42(10), 4205-B-4206-B

Pope, B. (1979). The mental health interview: Research and application. New York: Pergamon Press.

Rakel, R. (1977). Establishing client rapport. In Principles of Family Medicine. Philadelphia: Saunders.

Rasche, L., Berstein, L., & VeenHuis, P. (1974). Evaluation of a systematic approach to teaching interviewing. Journal of Medical Education, 49, 589.

Ricks, D. (1987, September 18). Study shows link between emotions and immune system. United Press International.

Rogers, C. (1942). Counseling and psychotherapy: Newer concepts in practice. Boston: Haughton.

Rogers, C. (1951). Client-centered therapy. Boston: Honghton Mifflin.

Rogers, C. (1958). The characteristics of a helping relationship. In D. Avila, A. Combs, & W. Parkey (Eds.), The helping relationships source book. Boston: Allyn & Bacon.

Rogers, C., Gendlin, G., Kiesler, D., & Traux, C. (1967). The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics. Madison: University of Wisconsin Press.

Roscoe, J. (1975). Fundamental research statistics for the behavioral sciences. New York: Holt, Rinehart & Winston.

Sachett, D. L., & Hayes, R. B. (Eds.). (1976). Compliance with therapeutic regimens. Baltimore: Johns Hopkins Press.

Sattler, J. (1977). The effects of therapist-client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy: A handbook of research. New York: Perqamon Press.

Scheflen, A. (1966). An introduction to psychosomatic manifestations of rapport in psychotherapy. Psychosomatic Medicine, 28(4), 297-303.

Scher, M. (1975). Verbal activity, sex, counselor experience and success in counseling. Journal of Counseling Psychology, 22(2), 97-101.

Schroeder, I. (1986). Factors that inhibit or facilitate rapport during the initial stages of therapy: A phenomenological study. Dissertation Abstracts International, 47(3), 1286B.

Scott, N., Connelly, M., & Hess, T. (1976). Longitudinal investigation of changes in interviewing performance of medical students. Journal of Clinical Psychology, 32(2), 424-431.

Secundy, M., & Katz, V. (1975). Factors in client-doctor communication: A communication skills elective. Journal of Medical Education, 50, 689.

Singer, E. (1965). Key concepts in psychotherapy. New York: Random House.

Snipe, R. (1979). Rapport as a factor in the diagnosis and treatment of physical illness. Journal of the National Medical Association, 71(11), 1142-1144.

Spector, R. (1991). Cultural diversity in health and illness (3rd ed.). Englewood Cliffs, New Jersey: Appleton and Lange.

Spink, L. (1987, March-April). Six steps to client rapport. AD Nurse, 2(2), 21-23.

Sterling, E. (1974a). Establishing rapport: Phase I, the first four minutes. The Canadian Dental Hygienist, 24-25.

Sterling, E. (1974b). Establishing rapport: Phase II, the client's role as "client." The Canadian Dental Hygienist, 21-23.

Strupp, H. (1976). The nature of the therapeutic relationship. In A. Burton (Ed.), What makes behavior change possible. New York: Brunner/Mazel.

Strupp, H. (1980). Success and failure in time limited psychotherapy. A systematic comparison of two cases: Comparison two. Archives of General Psychiatry, 37, 708-716.

Stuart, G., & Sundeen, S. (1991). Principles and practice of psychiatric nursing (4th ed.). St. Louis: Mosby.

Torres, G. (1986). Theoretical foundations of nursing. Norwalk, Connecticut: Appleton-Century-Crofts.

Travelbee, J. (1971). Interpersonal aspects of nursing. Philadelphia: Davis.

Ulmer, R. (1986). Editorial: Client noncompliance and health care cost. Journal of Compliance in Health Care, 3-5.

Urban, W. (1981). Integrative therapy. In R. Corsini (Ed.), Handbook of innovative psychotherapies. New York: John Wiley.

Wallace, D. (1977). The effects of a systematic training program in responding skills on dental hygiene students at Texas Woman's University. Dissertation Abstracts International, 1237A.

Waltz, C., Strickland, O., & Lenz, E. (1984). Measurement in nursing research. Philadelphia: Davis.

Warner, S. (1981). Supportive leadership via rapport. Radiologic Technology, 52(4), 415-420.

Warren, S. (1984). Determination of factors associated with compliance and noncompliance in the taking of medications by the chronically ill. Ann Arbor, MI: University Microfilms International.

Warren, S. (1985). Determination of factors associated with compliance and noncompliance in the taking of medications by the chronically ill. Dissertation Abstracts International, 45(7), 2107-2813.

Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little Brown.

Watterson, R. (1971). Public relations: Determining public attitudes. Hospitals, 45(9), 57-59.

Wilson, H. (1985). Research in nursing. Menlo Park, California: Addison-Wesley.

Wolberg, L. (1977). The technigues of psychotherapy. New York: Grune and Stratton.

Yoos, L. (1981). Compliance: Philosophical and ethical complications. The nurse practitioner. The American Journal of Primary Health Care, 6(4), 27-34.

Zucker, H. (1967). Problems of psychotherapy. New York: The Free Press.

APPENDIX A

HUMAN SUBJECTS REVIEW COMMITTEE

APPROVAL TO CONDUCT STUDY

LSUMC
Campus Correspondence

LOUISIANA STATE UNIVERSITY
MEDICAL CENTER

date: July 24, 1989

from: Ron E. Gardner, M.P.H., Chairman
LSUMC Institutional Review Board

to: Principal Investigator
Carolyn W. Mosley, Nursing

Re: Exempted Study

Name of Study:

Relationship of Facilitative Training, Development of Rapport and the Establishment of a Human-to-Human Relationship

Federal Regulations as published in Federal Register of January 26, 1981 - Part 46 of 45 CFR 46.101 lists exemptions to regulations of Department of Health and Human Services governing research on human subjects.

It is the opinion of the Chairman that your study is exempt since it falls into one of the categories listed, specifically 46.101 B-3 & B-5. You do not need IRB approval to conduct the study identified above.

D-22 Adm
Revised 1/87

APPENDIX B

GENERAL INFORMED CONSENT - Client

GENERAL INFORMED CONSENT - Client

Title: Relationship of Facilitative Training on the Development of Rapport.

Institution: Texas Woman's University, Houston/Charity Hospital, New Orleans.

Investigator: Carolyn W. Mosley
(504) 822-5886

OBJECTIVES

Accurately following doctors and nurses recommendations for how to take care of myself has been identified as a major problem in the health care system and is thought to be directly related to high health care expenditures. Interpersonal communication between the nurse and client is directly related to adherence and positive client outcomes. The critical aspect of this relationship is called rapport. The clients satisfaction and compliance with instructions depend upon the ability of the nurse to convey a feeling of understanding, compassion and genuine interest in the client. Good communication between nurses and clients results in a compliant client whereas poor communication results in noncompliant clients. **Therefore, the objective of this study is to examine the effects of a facilitative training (communication) program on the development of rapport.** The results of this study could have profound implications for identifying a method to improve the health of clients and to decrease non compliance which leads to cost effectiveness and cost containment for both the client and hospital.

Client INCLUSION CRITERIA

In order to be included in this study I must be an alert, oriented, verbally coherent adult client who has an expected hospital stay of two weeks prior to discharge and who has care provided by a nurse also participating in the study.

Client EXCLUSION CRITERIA

I will be excluded/dropped from the study if I am discharged or transferred prior to the two week period.

PROCEDURES

I understand that I will be requested to complete a personal data sheet which will assist in obtaining background information such as sex, race, education, etc. I also understand that at the beginning of the first week (pretest) and the conclusion of the second week (posttest) I will complete Mosley's Interpersonal Rapport Perception Questionnaire - Client which looks at how I view my relationship with an identified nurse. I am also aware that a questionnaire will also be completed by the same nurse in which she/he identifies how she/he views our relationship. I fully understand that although I may complete the questionnaire at my leisure, it will be collected within 24 hours after being administered. In order to assist in collecting accurate data, I agree to not share any responses with the nurse and to place the questionnaire in a brown envelop for its protection. I am aware that my responses will in no way affect the care I receive or the identified the nurse and agree to answer all questions honestly. I understand that assistance will be provided at my request in the reading and completion of the questionnaire. I understand that Mosley's Behavioral Rapport Scale, an observational questionnaire containing behaviors indicative of a close, open relationship (rapport) will be completed by the investigator while observing me interacting with this nurse.

ALTERNATIVES

If I do not wish to participate in this study, I can go on as usual with no changes in routine or questionnaires to complete.

POSSIBLE RISK AND DISCOMFORTS FROM THE STUDY

The potential discomfort associated with participation in the study include possible anxiety during completion of the questionnaire and/or during the observational period. I understand that in the event of physical injury resulting from this research, Texas Woman's University is not able to offer financial compensation nor to absorb the cost of medical treatment. However, I understand that in the unlikely event of physical injury first aid will be provided as necessary.

BENEFITS FROM THE STUDY

Although I will not receive any direct benefit, my participation will be helpful to other clients. By participating, I will assist in the identification of useful
data for the study of rapport as a nursing intervention for increasing client responsibility and participation in care, promoting positive client behaviors and decreasing the percentages of clients who experience a relapse after discharge from the hospital. This could lead directly to cost effectiveness and cost containment for the hospital and decreased health care cost for clients.

FINANCIAL DISCLAIMER

Participation in this study will not result in any extra charges above and beyond those routinely incurred by clients with my illness if any. The cost of unforeseen complications must be met by me.

ASSURANCE OF RIGHT TO PRIVACY

I understand that all data obtained will be confidential, handled by the investigator only and will be maintained in a secure, locked location and destroyed after completion of the study. I will not place my name or any identifying marks on the questionnaire. I am fully aware that each questionnaire will be coded with an identifying number for the purpose of analyzing data. I also understand that the results of this study may be published. However, my privacy will be protected and my name will not be used in any manner whatsoever.

ASSURANCE OF RIGHT TO WITHDRAW WITHOUT PREJUDICE

I understand that I may withdraw from this study at any time without jeopardizing, in any way, my medical treatment in this institution in the present or future.

ASSURANCE THAT QUESTIONS HAVE BEEN ANSWERED

All my questions concerning this study have been answered. I understand that I have the right to be provided with answers to questions which may arise during the course of this study. I also understand that I may phone the investigator Carolyn Mosley at 822-5886 if I have

any concerns and/or questions.

I acknowledge that I have been given a copy of the consent form for my own personal use.

_____ _____

Signature Date

_____ _____

Witness Date

I am unable to read/write but this consent form has been read to me and explained to me by _____ (name of reader). I understand the information stated above and I willingly sign this consent form.

_____ _____

Signature Date

_____ _____

Witness Date

APPENDIX C

GENERAL INFORMED CONSENT - NURSE

GENERAL INFORMATION CONSENT – NURSE

Title: Relationship of Facilitative Training on the Development of Rapport.

Institution: Texas Woman's University, Houston/Charity Hospital, New Orleans.

Investigator: Carolyn W. Mosley
(504) 822-5886

OBJECTIVES

Adherence to medical and/or nursing recommendations has been identified as a major recurrent problem in the health care system and is thought to be directly related to high health care expenditures. It has also been documented that the interpersonal interaction between the nurse and client is directly related to adherence and positive client outcomes. The critical aspect of this relationship is called rapport. Some authors, however, state that rapport is an intuitive skill and cannot be taught. Therefore, a precise definition of what constitutes such skills and how these skills are developed remain undefined. Travelbee (1971) suggested, however, that a nurse's ability to establish rapport is dependent on communication skills that instill in clients a sense of confidence and trust by conveying sincerity and an interest in their care and well being. The clients satisfaction and compliance with instructions depend upon the ability of the nurse to convey a feeling of understanding, compassion and genuine interest in the client. Good communication between nurses and clients results in compliant client whereas poor communication results in noncompliant clients. **Therefore, the objective of this study is to examine the effects of a facilitative training (communication) program on the development of rapport.** The results of this study could have profound implications for identifying a method to improve the health of clients and to decrease non compliance which leads to cost effectiveness and cost containment for both the client and health care industry.

NURSE INCLUSION CRITERIA

In order to be included in this study, I must be a Registered Nurse or a Licensed Practical Nurse who will not be on vacation or on any other leave for the next three weeks.

NURSE EXCLUSION CRITERIA

I will be excluded/dropped from the study if the client with whom I am paired is discharged or transferred prior to the two week period. I also understand that if I unexpectedly choose to take a week of vacation or other types of leave during this period that I will be excluded from completion of the study.

PROCEDURES

I understand that I will be requested to complete a demographic data sheet which will assist in obtaining background information such as sex, race, education etc. I also understand that at the beginning of the first week (pretest) and the conclusion of the second week (posttest) I will complete Mosley's Communication Skills Questionnaire which will take approximately 30-40 minutes of my time. I am aware that I will be required to complete this questionnaire at a specific time and place with others who have also consented to be participants. Additionally, at the beginning of the first week (pretest) and conclusion of the second week (posttest), I will complete Mosley's Interpersonal Rapport Perception Questionnaire - Nurse which assesses how I view my relationship with a client for whom I provide care that I will identify. I fully understand that although I may complete the questionnaire at my leisure, it will be collected within 24 hours after being administered. I am also aware that the client I identify will be requested to complete Mosley's Interpersonal Rapport Perception Questionnaire - Client which identifies how he/she views the relationship he/she has with me. Mosley's Behavioral Rapport Scale, an observational questionnaire, containing behaviors indicative of a close open relationship (rapport) will be completed by the investigator while observing me interacting with this client. I will be randomly assigned to an experimental or control group. If I am in the experimental group, I will participate during week 2 in six hours of facilitative training (communication) classes. If I am in the control group, I will go on as usual with my nursing activities.

ALTERNATIVES

If I do not wish to participate in this study, I can go on as usual with no changes in routine or questionnaires to complete.

POSSIBLE RISK AND DISCOMFORTS FROM THE STUDY

The potential discomfort associated with participation in the study include anxiety during the training seminar and/or while completing the questionnaires and during the observation period. I understand that in the event of physical injury resulting from this research, Texas Woman's University is not able to offer financial compensation nor to absorb the cost of medical treatment. However, I understand that in the unlikely event of physical injury first aid will be provided as necessary.

BENEFITS FROM THE STUDY

Although I will not receive any direct benefits, my participation will be helpful to other clients. By participating, I will assist in the identification of useful data for the study of rapport as a nursing intervention for increasing client responsibility and participation in care, promoting positive client behaviors and decreasing the percentages of clients who experience a relapse after discharged from the hospital. This could lead directly to cost effectiveness and cost containment for the hospital and decrease health care cost for clients.

FINANCIAL DISCLAIMER

Participation in the study will be at no expense to me. The cost of unforeseen complications must be met by me.

ASSURANCE OF RIGHT TO PRIVACY

I understand that all data obtained will be confidential, handled by the investigator only and will be maintained in a secure, locked location and destroyed after completion of the study. I will not place my name or any identifying marks on the questionnaire. I am fully aware that each questionnaire will be coded with an identifying number for the purpose of analyzing data. I also understand that the results of this study may be published. However, my privacy will be protected and my name will not be used in any manner whatsoever.

ASSURANCE OF RIGHT TO WITHDRAW WITHOUT PREJUDICE

I understand that I may withdraw from this study at any time without jeopardizing in any way my employment or promotional status in this institution in the present or the future. I also understand that I may phone the investigator, Carolyn Mosley at 822-5886 if I have any concerns and/or questions.

Page 4 of 4 pages

ASSURANCE THAT QUESTIONS HAVE BEEN ANSWERED

All my questions concerning this study have been answered. I understand that I have the right to be provided with answers to questions which may arise during the course of this study.

I acknowledge that I have been given a copy of the consent form for my own personal use.

_____ _____

Signature Date

_____ _____

Witness Date

I am unable to read/write but this consent form has been read to me and explained to me by _____ (name of reader). I understand the information stated above and I willingly sign this consent form.

_____ _____

Signature Date

_____ _____

Witness Date

APPENDIX D

MOSLEY'S DEMOGRAPHIC DATA SHEET

PARTICIPANT BACKGROUND INFORMATION (NURSE)

INSTRUCTIONS: Please circle the letter that correctly answers the following statement; complete the statements requiring additional information.

1. Sex
   A. Female
   B. Male

2. Age: _____years

3. Ethnicity
   A. Black
   B. Hispanic
   C. Caucasian
   D. American Indian
   E. Oriental
   F. Other _____

4. Highest Education Completed
   A. Licensed Practical Nurse
   B. Diploma in Nursing
   C. Associate Degree in Nursing
   D. Bachelor of Science in Nursing
   E. Non-Nursing Baccalaureate Degree
      (Please specify major) _____
   F. Master's degree (Please specify major) _____
   G. Earned Doctoral Degree (Please specify major) ___

5. Present Educational Level
   A. Not in school
   B. Enrolled in nursing school (Please specify level, i.e., sophomore, junior, etc._____

6. Length of Nursing Practice: _____ years

7. Socioeconomic Class
   A. Upper class - greater than $41,000.00
   B. Upper middle class - $26,000.00 - $40,000.00
   C. Lower middle class - $13,000.00 - $25,000.00
   D. Lower class - $0.00 - $12,000.00

8. Floor/unit assigned
   _____

PARTICIPANT BACKGROUND INFORMATION (Client)

INSTRUCTIONS: Please circle the letter that correctly answers the following statement(s); complete the statements requiring additional information.

1. Sex
   A. Female
   B. Male

2. Age: _____years

3. Ethnicity
   A. Black
   B. Hispanic
   C. Caucasian
   D. American Indian
   E. Oriental
   F. Other _____

4. Highest Education Completed
   A. Elementary - grades 1-6
   B. Junior High - grades 7-8
   C. High school but did not graduate - grades 9-12
   D. High school - graduated
   E. College - 1-2 years
   F. College - 3 years or more

5. Socioeconomic Class
   A. Upper class - greater than $41,000.00
   B. Upper middle class - $26,000.00 - $40,000.00
   C. Lower middle class - $13,000.00 - $25,000.00
   D. Lower class - $0.00 - $12,000.00

6. Reason for hospitalization

_____

_____

APPENDIX E

MOSLEY'S COMMUNICATION SKILLS QUESTIONNAIRE AND ANSWER SHEET

MOSLEY'S COMMUNICATION SKILLS TEST

DIRECTIONS: Darken the circle on the answer sheet with the letter which corresponds to the answer you've selected. Choose the best response. There is only one answer for each question.

1. Ms. S. States that she is short of breath. Which of the following would be the most therapeutic response from you?

   A. "Short of breath?"
   B. "Everyone feels that way sometimes."
   C. "Don't worry, I'll get you something for it."
   D. "Are you telling me you're short of breath?"
   E. "It'll get better once we start the oxygen."

2. Mr. J. states he has pain. Which of the following represents a supportive statement?

   A. "I'll hold your hand if it helps."
   B. "You said you have a lot of pain."
   C. "It must be hard to always have pain."
   D. "I'll go and get your pain medicine."
   E. "Take your mind off it by deep breathing."

3. Which of the following is the most empathetic statement to Mr. J.'s statement that he has pain?

   A. "I've had pain myself."
   B. "I'm sorry you feel so bad."
   C. "Perhaps a back rub would help."
   D. "I can appreciate it's difficult to have pain."
   E. "Everyone has to have some pain sometime in life."

4. Ms. T. says, "I'd like to go home soon." Which of the following responses would probably not be a therapeutic communication?

   A. "Go on."
   B. "I'm listening."
   C. "You'd like to go home?"
   D. "Sounds like you miss your family."
   E. "Why would you like to be home?"

5. You ask C., a 10-year-old, how he is doing in school and he doesn't answer. You most therapeutic response might be to:

   A. Repeat the question.
   B. Allow a space of silence.
   C. Change to a more comfortable subject.
   D. Ask if there is something bothering him.
   E. Assume school is an emotional topic for him.

MATCHING

A client asks you if you have ever cared for anyone with his disease who is now "gone." Match the communication technique in the right column with an example of it in the left column. (Each technique may only be used once.)

6.	"Who is gone?"	A. Reflecting
7.	"You're asking me if I've ever cared for anyone who has died?"	B. Paraphrasing C. Offering hope
8.	"Are you asking me if I you will die?"	D. Perception checking E. Requesting an explanation

9. In addition to the above, the statement, "Are you asking me if I think you will die?" could be an example of which communication technique(s)?

   A. Focusing
   B. Clarification
   C. Validating the implied
   D. B & C
   E. A & C

10. Select the following statement which best identifies the purpose of reflection.

    A. To signify agreement of the nurse with certain elements of the clients communication.
    B. To increase the clients' awareness of what he is saying and how it is being said.
    C. To go over what the nurse and client have talked about in order to regain the focus of the meeting.
    D. To emphasize the nurse's ability to recognize the verbal and nonverbal patterns of the clients immediate behaviors and levels of tension.

11. "What are you thinking about?" is an example of which communication technique?

    A. Exploring
    B. Sharing observations
    C. Giving a broad opening
    D. Offering a general lead
    E. Acknowledging clients feelings.

12. Allowing the client to take the initiative in introducing a topic is an example of which of the following techniques?

    A. Using silence
    B. Active listening
    C. Giving broad openings
    D. Offering general leads
    E. Encouraging description of perception

13. "Everyone gets down in the dumps sometimes; I've felt that way occasionally." is an example of which non therapeutic technique?

    A. Defending
    B. Rejecting
    C. Disapproving
    D. Stereotyping
    E. Belittling feelings

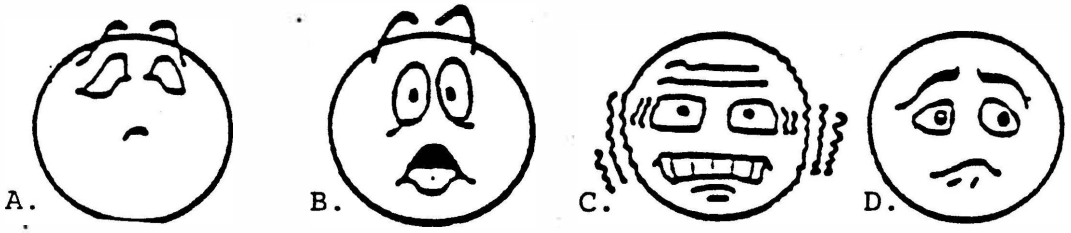
14. Using one's personality as an advantage to working with persons is referred to as:

A. rapport.
B. self-efficacy.
C. therapeutic use of self.
D. psychological expertise.

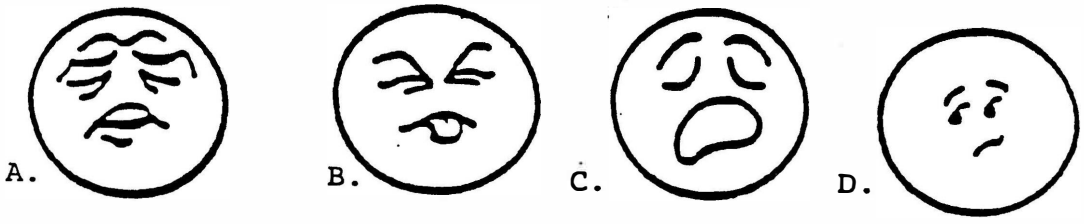
15. _____ is the key ingredient of the therapeutic relationship.

A. Wisdom
B. Rapport
C. Insight
D. Patience

16. Select the facial expressions which depicts the affect of anxiousness.



17. Select the facial expression which depicts the affect of grieving.



18. The following position assumed by the nurse may communicate what idea to the client?

A. The nurses' power
B. The clients' dependency
C. The nurses' lack of interest
D. A & B
E. A, B, & C

19. When you stand by the side of a clients' bed, you are within his _____ space.

A. social
B. public
C. intimate
D. personal

20. Select the statement which <u>best</u> communicates the idea depicted in this picture.

A. Communication is a primary way to establish rapport.
B. Touch is the best way to communicate with the visually impaired.
C. A person's culture or ethnic background may interfere with communication.
D. Touch can be as effective as spoken words in establishing a nurse-client relationship.
E. Warmth is an innate quality, and some people manifest it more spontaneously than others.

21. Select the statement which best illustrates whether a communication process is present.

A. Two persons yelling angrily across the room to each other.
B. Two persons sitting side by side on a plane who neither speak or look at one another.
C. Two persons sitting side by side who do not speak but occasionally look at one another and smile.
D. A & C
E. A, B, & C

22. The picture below depicts which emotion?

A. Defensive
B. Agreeable
C. Thoughtful
D. Uncertainty
E. Domineerence

23. The following picture reflects the _____ position.

A. Attentive
B. Defensive
C. Agreeable
D. Submissive

24. The <u>most important</u> thing the nurse should do to improve her listening skills is to:

A. listen for meaning.
B. learn to stop talking.
C. practice active listening.
D. be objective about what is seen.

25. What type of silence is indicated when the clients' facial expression (frowning and pouting) and posture both show that the persons is aware of your presence but refuses to say anything?

    A. Ignoring silence
    B. Stubborn silence
    C. Thoughtful silence
    D. Ambivalent silence

26. Identify what the role of the nurse would be in the above silence.

    A. Ask what the person is thinking about.
    B. Do not interrupt unless silence is prolonged.
    C. Initiate speech and structure the interchange.
    D. Sit out the anger, being undemanding but interested.

27. Which type of question is more easily answered by the highly stressed person?

    A. Open
    B. Closed
    C. Leading
    D. Probing

MATCHING

A persons' eyes may be used as a major source of communication. Match the use of ones eyes in the column on the right with the message one wants to convey in the column on the left.

28. Feelings of discontent	A. Direct eye contact
29. Feelings of aggression	B. Avoidance of eye contact
30. Feelings of trust	C. Increased eye contact
	D.

Prolonged eye contact

31. The face depicts a blend of varying emotions. Tight pursed lips are indicative of which emotion?

    A. Shock
    B. Sadness
    C. Anxiety
    D. Frustration

32. An "open mouth" without speaking indicates which emotion?

    A. Shock
    B. Anger
    C. Stress
    D. Surprise
    E. Happiness

33. Select the statement below which best describes the sequential process of observation and decision making.

    A. Collect data, observe, develop inferences about the observations.
    B. Collect data, develop inferences, decide to act or not based on these observations.
    C. Observe, develop inferences, decide to act or not to act based on observations.
    D. Observe, develop inferences, collect data.

34. Select the statement(s) which best describe the relationship between communication and observation.

    A. An individual observes as he communicates, and depending on what he observes and his interpretations, may say or do certain things.
    B. An individual communicates on the basis of what he observes and what he interprets to be going on in a situation.
    C. Skill in observation is the result of deliberate concentration on developing the act of seeing perceptively.
    D. A & B
    E. B & C

35. Which of the following statements best characterize social communication?

    A. Social communication focuses on the client's needs.
    B. In social communication, there is no need to like the individual.
    C. There is an obligation to meet the needs of the client in social communication.
    D. Social communication is characterized by superficiality and its lack of a goal.

36. "Do you have problems with burning before urinating or afterward?" is an example of which type of question.

    A. Leading
    B. Indirect
    C. Ambiguous
    D. Double-barreled

37. Ms. S. asks you, "What should I do?" What would be your most therapeutic response?

    A. "Perhaps you should discuss this with your physician."
    B. "Ms. S., you'll resent it later if I told you what to do."
    C. "It must be difficult for you having to make a decision."
    D. "I can appreciate that it must be hard, but you are the only one who should decide."
    E. "I wish I could give you the answer, but it's unprofessional of me to do so."

38. Which one of the following is an example of nonverbal communication?

    A. Screaming
    B. Profuse sweating
    C. Writing a letter
    D. Saying, "I am anxious."

39. Assessment of a clients' communication includes which of the following?

    A. Presence of stereotypes
    B. Congruency of the message
    C. How the words are constructed
    D. Knowledge about the structure of language.

40. Consensual validation is <u>best</u> defined as the:

A. study of language and its structure.
B. process of exploration of possible meanings of the behavior.
C. examination of the intention of a person to interact and communicate a message.
D. mutual agreement between two or more persons about the meaning attributed to behavior.

41. Which statement(s) or phrase(s) reflect sharing (disclosure) of information?

A. Jaywalking
B. Painting a picture
C. "Its good to wake up feeling ready for the day."
D. B & C
E. A, B, & C

Self-awareness is an important pre-requisite to effective communication and the establishment of any relationship. Questions <u>5</u> and <u>6</u> refer to the Johari Window.

1 Known to self and others	2 Known to others and not known to self
3 Known to self and not known to others	4 Not known to self or others

* self = client

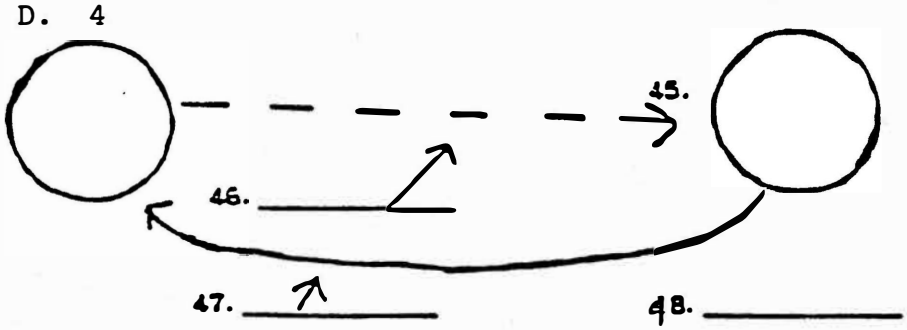
42. As the nurse develops greater intimacy with the client, more information can be added to which category(s)?

A. 3
B. 4
C. 1 & 2
D. 3 & 4

43. As the clients' self-awareness increases, more information is added to which category(s)?

A. 1 & 3
B. 2
C. 1 & 2
D. 4

44.



The above illustration depicts the five structural components of communication. Darken the appropriate letter for each number which correctly identifies the components. Each response may only be used once.

Responses for questions 44 - 48.

A. Context
B. Sender
C. Message
D. Feedback
E. Receiver

49. The above structural process indicates that communication is:

A. dynamic.
B. arbitrary.
C. reciprocal.
D. A & B
E. A & C

50. Interactions and relationships are most often controlled by which of the following?

A. Verbal cues
B. Nonverbal cues
C. Voice qualities
D. Body positioning

51. Leaning forward, showing the palm of the hand, and fussing with the other person's collar are behaviors conveying which emotion?

    A. Closeness
    B. Aggression
    C. Uncertainty
    D. Ambivalence
    E. Nervousness

52. Which non verbal behavior has the <u>most</u> frequent variation between different cultures and ethnic groups.

    A. Gestures
    B. Eye contact
    C. Tone of voice
    D. Body positioning

53. Which of the following statements correctly list the different zones of space in human interactions?

    A. social, public, personal, intimate
    B. personal, social, proxemic, kinesic
    C. intimate, social public, affectionate
    D. point distance, affiliation, personal, social

54. Warmth is conveyed by which of the following behaviors?

    A. Offering advice
    B. Using eye contact
    C. Responding spontaneously
    D. Refraining from touching

55. The response "I can imagine how you feel," is an example of an attempt to show which feeling?

    A. Empathy
    B. Respect
    C. Sympathy
    D. Validation
    E. Ambivalence

56. _____ is the most basic facilitative characteristic a nurse should possess.

A. Genuineness
B. Respectfulness
C. Trustworthiness
D. Unconditional regard
E. Non possessive warmth

57. Respect is conveyed in which of the following manner(s)?

A. Addressing every person with "Mr." or "Ms.".
B. Asking permission for access to personal belongings.
C. Communicating with the person for as much time as was agreed upon.
D. A, B & C

58. Active listening is demonstrated in verbal and nonverbal ways. In which of the following does the nurse <u>best</u> convey active listening nonverbally?

A. Waving the hand
B. Tapping the foot
C. Leaning forward in the chair
D. Asking questions at intervals

59. Which type of question is best used when initiating relationships?

A. Open
B. Closed
C. Direct
D. Probing

60. Which of the following is the <u>best</u> statement(s) to use if seeking a description of how an event took place.

A. "How did you fight?"
B. "Why did you do that?"
C. "Tell me about the argument."
D. A & B
E. B & C

APPENDIX F

MOSLEY'S COMMUNICATION SKILLS TEST

OBJECTIVES AND RELATED QUESTIONS

Mosley's Communication Skills Test
Objectives and Related Questions

CONTENT & OBJECTIVES TEST	TEST QUESTIONS
Communication: 79%	
Differentiates nonverbal and verbal communication.	38
When given a set of terms related to communication, selects the best definition.	10, 12, 14, 40
Identifies relationship between observation and communication.	33, 34
Identifies the structural components of communication.	44, 45, 46, 47, 48
Identifies characteristics of the communication process.	49
Differentiates between social and therapeutic communication.	35
Applies principles of communication when assessing client interactions.	16, 17, 21, 22, 23, 25, 27, 28, 29, 30, 31, 32, 39, 41, 50, 51, 52
Applies principles of communication when interacting with clients.	11, 13, 15, 20, 36, 55, 56, 59
Analyzes client interactions to determine the best response needed to facilitate communication.	1, 2, 3, 4, 5, 6, 7, 8, 9, 26, 37, 54, 57, 60

CONTENT & OBJECTIVES TEST	TEST QUESTIONS
Self-Awareness: 3%	
Applies principles from Johari's window to self and client.	42, 43
Proxemics: 8%	
Applies knowledge of proxemics when assessing client interactions.	18, 19, 22, 23, 53
Paralanguage: 7%	
Applies knowledge of paralanguage when assessing client interactions.	28, 29, 30, 54
Listening: 3%	
Identifies methods to convey listening.	24, 58

APPENDIX G

MOSLEY'S BEHAVIORAL RAPPORT SCALE

MOSLEY'S BEHAVIORAL RAPPORT SCALE

Section I--Nurse	4 ALWAYS	3 MOST OF THE TIME	2 SOME-TIMES	1 HARDLY EVER	0 NEVER
1. Gives information					
2. Initiates interaction with open-ended statements					
3. Acknowledges client's presence					
4. Uses broad opening statements					
5. Uses stereotyped statements					
6. Challenges the client					
7. Probes (persistent questions)					
8. Varies pitch of voice					
9. Uses appropriate rate of speech					
10. Uses voice that is congruent with message					
11. Uses voice that is incongruent with message					
12. Hesitates					
13. Speaks gently					
14. Makes direct eye contact					
15. Stands approximately 3 to 4 feet from the client					

Section I--Nurse	4 ALWAYS	3 MOST OF THE TIME	2 SOME-TIMES	1 HARDLY EVER	0 NEVER
16. Hands or arms touching in front and at or above the waistline					
17. Taps feet or shuffles feet					
18. Hands are tightly clasped or fists are tightly clenched, or hands are in motion					
19. Fingers extended but not stiff					
20. Symmetrical stance of legs with insteps touching					
21. Head held erect					
22. Torso leans backward					
23. Shoulders are raised and erect, causing the chest to be expanded					

Section II--Client	4 ALWAYS	3 MOST OF THE TIME	2 SOME-TIMES	1 HARDLY EVER	0 NEVER
24. Acknowledges nurses presence verbally or nonverbally					
25. Greets nurse by name					
26. Gives information readily					
27. Seeks clarification of nurses instructions					
28. Does not volunteer information					
29. Uses appropriate rate of speech					
30. Uses monotone tone of voice					
31. Uses voice incongruent with message					
32. Pulls back or flinches when touched					
33. Rotates body away from nurse					
34. Initiates termination of the interaction					

APPENDIX H

INTERRATER RELIABILITY FOR MOSLEY'S BEHAVIORAL RAPPORT SCALE

Interrater Reliability for Mosley's Behavioral Rapport Scale

Subject	Raters			
	Principle Investigator	Nurse A	Nurse B	Nurse C
1	X			X
2	X	X		
3	X	X		
4	X	X		
5	X			X
6	X		X	
7	X	X		
8	X			X
9	X			X
10	X		X	
11	X	X		
12	X	X		
13	X		X	
14	X		X	

APPENDIX I

MOSLEY'S INTERPERSONAL RAPPORT PERCEPTION QUESTIONNAIRE - Client

MOSLEY'S INTERPERSONAL RAPPORT
PERCEPTION QUESTIONNAIRE
(Client)

DIRECTIONS: This questionnaire explores your feelings about your nurse and the way you view your nurses' interactions with you. There are no right or wrong answers.

Some items may seem similar to others. However, each item is different, so please answer each one without regard to the others. There is no time limit.

Place an X in the box which best expresses your feelings about each statement.

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
1. I feel I should be cautious in dealing with my nurse until I have reason to believe that she/he is trustworthy.				
2. My nurse often goes out of the way to be helpful to other clients.				
3. I think my nurse understands my condition.				
4. I feel better after talking with my nurse.				
5. I feel like I'm intruding when I ask questions of my nurse.				
6. The nurse talked to me about my condition as soon as she met me.				
7. My nurse always has time to talk with me.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
8. My nurse doesn't understand how sick I am.				
9. My nurse keeps me informed of all activities pertaining to my hospitalization.				
10. My nurse can tell when I'm upset.				
11. My nurse usually looks away while talking to me.				
12. My nurse listens to me whenever I talk.				
13. My nurse says she cares about me, but her actions say otherwise.				
14. My nurse is cool and distant.				
15. My nurse avoids getting close and personal with me.				
16. I'm taking an active part in my recovery because of my nurse.				
17. The nurse and I have a platonic relation-ship --- she gives care and has no interest in me as a person.				
18. I am the dominant person in our interaction.				
19. My nurse is in a hurry most of the time.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
20. My nurse has a friendly attitude.				
21. My nurse keeps me from expressing my feelings.				
22. My nurse anticipates my needs.				
23. My nurse encourages my participation in my care.				
24. My nurse acts impersonal.				
25. My nurse stands four feet away when talking to me.				
26. My nurse uses a soft understanding voice when talking with me.				
27. My nurse encourages me to talk, to express my thoughts, feelings and concerns.				
28. I like having my nurse around me.				
29. My nurse checks with me concerning the things she/he thinks I want or need.				
30. My nurse never tries to be anything but herself/himself.				
31. My nurse encourages me to make my own choices.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
32. My nurse and I have achieved a rapport (mutual understanding).				
33. I feel good when the nurse touches me in support.				
34. My nurse hurries to fill in periods of silence.				
35. My nurse gives me time to think about what has been said in our interactions.				
36. My nurse addresses me by my name.				
37. My nurse understands my feelings.				
38. My nurse doesn't appear rushed when interacting with me.				
39. My nurse is not really sincere about her/his wish to help me.				
40. I'm able to better cope with my problems/illness because of my nurse.				
41. My nurse has a negative attitude.				
42. My nurse is not really dependable.				
43. While communicating, my nurse's posture is strained and unnatural.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
44. Although I talk easily with friends, I'm at a loss for words when talking with my nurse.				
45. My nurse is very supportive.				
46. My nurse makes me feel as if she'd/he'd rather be elsewhere.				
47. My nurse forgets to do things or bring items I request.				
48. I prefer talking to the doctor instead of the nurse.				
49. I feel comfortable talking of personal concerns with my nurse.				
50. My nurse pays more attention to my verbal message than to my non-verbal messages.				
51. My nurse finds it difficult to be empathic (understand my feelings) because my values are different from hers/ his.				
52. My nurse gets so excited that she/he interrupts without even intending to.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
53. My nurse can hardly wait until another person finishes speaking so that she/ he can state their own ideas.				

APPENDIX J

MOSLEY'S INTERPERSONAL RAPPORT PERCEPTION QUESTIONNAIRE - NURSE

MOSLEY'S INTERPERSONAL RAPPORT
PERCEPTION QUESTIONNAIRE
(Nurse)

DIRECTIONS: This questionnaire explores your feelings about yourself, your client and the way you view your client's interactions with you. There are no right or wrong answers.

Some items may seem similar to others. However, each item is different, so please answer each one without regard to the others. There is no time limit.

Place an X in the box which <u>best expresses</u> your feelings about each statement.

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
1. I feel I should be cautious in dealing with my client until I have evidence that she/he is trust-worthy.				
2. My client goes out of the way to be helpful to me and others.				
3. My client knows I understand his condition/feelings.				
4. My client feels better after talking with me.				
5. I feel that my client is intruding when he/she asks questions of me.				
6. I talked to my client about his/her condition as soon as we met.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
7. I always have time to talk with my client.				
8. My client feels that I don't understand how sick he/she is.				
9. I keep my client informed of all activities pertaining to his/her hospitalization.				
10. I can tell when my client is upset.				
11. My client usually looks away when talking to me.				
12. My client listens to me whenever I talk.				
13. Although I say I care about my client, my actions sometimes say otherwise.				
14. My client is cool and distant.				
15. My client avoids getting close and personal with me.				
16. My client takes an active part in his/her recovery because of me.				
17. My client and I have a platonic relationship --- I give care and have no further interest in him/her as a person.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
18. My client is the dominant person in our interaction.				
19. I'm in a hurry most of the time.				
20. My client has a friendly attitude.				
21. I sometimes stifle my client's expression of feelings.				
22. I anticipate my client's needs.				
23. I encourage my client's participation in his/her own care.				
24. My client acts impersonal.				
25. I stand 4 feet away when talking with my client.				
26. I use a soft understanding voice when talking to my client.				
27. I encourage my client to talk, to express his/her thoughts, feelings, and concerns.				
28. I like being around my client.				
29. I check with my client concerning the things I think she/he may want or need.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
30. I never try to be anything but myself.				
31. I encourage my client to make his/ her own choices.				
32. My client and I have achieved a rapport.				
33. I feel good when I touch my client in support.				
34. I hurry to fill in periods of silence.				
35. I give my client time to think about what has been said in our interactions.				
36. My client addresses me by name.				
37. I understand my client's feelings.				
38. I try not to appear rushed when interacting with my client.				
39. My client feels I'm not really sincere about my wish to help her/him.				
40. My client is better able to cope with his/her problems/ illness because of me.				
41. My client has a negative attitude.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
42. My client believes I'm not dependable.				
43. While communicating, my posture is strained and unnatural.				
44. Although I talk fluently with friends and colleagues, I'm at a loss for words when talking with my client.				
45. I'm very supportive with my client.				
46. My client makes me feel as if I'd rather be elsewhere.				
47. I forget to bring items my client requests.				
48. My client prefers talking to the doctor than to me.				
49. I feel comfortable talking with my client about his/her personal concerns.				
50. I tend to pay more attention to my client's verbal message than to his/her nonverbal message.				

	STRONGLY AGREE	AGREE	STRONGLY DISAGREE	DISAGREE
51. I find it difficult to be empathetic with my client because his/her values are different from mine.				
52. I get so excited, I interrupt my client without even intending to do so.				
53. I can hardly wait until a person finishes speaking so that I can state my own ideas.				

APPENDIX K

FACILITATIVE TRAINING PROGRAM

PROGRAM OUTLINE

FACILITATIVE TRAINING PROGRAM

Program Outline

1 - 3 Hour Seminar

I. Introduction and presentation of objectives
   - A. Nursing
     1. Definition
     2. Nurse-client relationship vs human-to-human relationship
     3. Rapport and nursing

II. Phases preceding development of rapport
   - A. Original encounters
   - B. Emerging identifies
   - C. Empathy
   - D. Sympathy

III. Tools for the development of rapport and human-to-human relationships
   - A. Communication
   - B. Therapeutic use of self

IV. Establishing rapport and human-to-human relationships
   - A. Communication & therapeutic use of self
     1. Verbal/nonverbal
        - a. Kinesics
        - b. Paralanguage

c. Proxemics

2. Structural components

3. Characteristics of communication

4. Most common nonverbal cues

a. Tone of voice

b. Facial expression

c. Body position

d. Gestures

5. Communication and observation

6. Activities 1 & 2

V. Facilitative attributes of communication

A. Attending

1. Listening

2. Eye contact

3. Observing

4. Positioning

B. Human attributes

1. Interest

2. Honesty

3. Dependability

4. Acceptance

5. Patience

6. Empathy

7. Sympathy

VI. Effective responding skills

A. Giving information

B. Reflecting

C. Verbalizing implied thoughts and feelings

D. Acknowledge clients feelings

E. Clarifying

F. Sharing observations

G. Validating

H. General leads

I. Broad openings

VII. Common ways of hindering communication

A. Advice giving

B. Changing topics

C. Defensiveness

D. Leading statements

E. Multiple questions

F. Overuse of closed questions

G. Giving approval

H. Expressing disapproval

I. Requesting an explanation

J. Belittling clients feelings

K. Reassuring cliche

L. Agreeing

VIII. Questioning skills

4th hour

IX. Discussing of feelings, reactions, and problems with content presented.

5th hour

X. Role playing of a simulated encounter with a client.

6th hour

XI. Discussion of feelings and role playing activities.

ACTIVITIES

Activity 1

A photocopy of a cartoon that contained numerous details was made available. One minute was allowed to observe the cartoon. Participants were asked to write a concise description of what they saw. Volunteers shared their description. The seminar focused on the identification of differences in perception.

Activity 2

A videotape of an interaction was provided. Participants were allowed to watch the TV for 10 minutes without sound. After 10 minutes, the TV was turned off and participants were asked to share what they observed, i.e., the general theme of the interaction and how each determined the theme. The TV was turned on, and the picture covered allowing participants only to hear the sound. After 10 minutes, participants again shared their understanding of the theme.

Participants identified the nonverbal behaviors used to help them understand the TV characters' message when they could only hear the character. Participants shared personal observations of verbal and nonverbal cues used and evaluated the strength of their listening skills.