Nurse-patient relationships: the function of social support verbal immediacy and nonverbal immediacy with AIDS patients and hospice patients

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NURSE-PATIENT RELATIONSHIPS: THE FUNCTION OF SOCIAL SUPPORT, VERBAL IMMEDIACY, AND NONVERBAL IMMEDIACY WITH AIDS PATIENTS AND HOSPICE PATIENTS.

by

A. Dawn Adkins

B.S. Oral Roberts University, 1993

presented in partial fulfillment of the requirements

for the degree of

Master of Arts

The University of Montana

1997

Approved by:

[Signatures]

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Adkins, Alicia Dawn, M. A.  May 1997  Communication

Nurse-Patient Relationships: The Function of Social Support, Verbal Immediacy, and Nonverbal Immediacy with AIDS Patients and Hospice Patients (133 pp.)

Director: Dr. Sally Planalp

ABSTRACT

The nursing profession is changing into a more specialized field. Many nurses now have an area of expertise, such as hospice or gynecology. In this changing field it is important for the nurses to be happy where they are as well as for their patients to like and trust them. From the depth of this relationship comes the basis of their overall level of care. Considering a patient needs to be comfortable with his/her nurse, a level of liking is necessary.

A recent revival in the medical field has come in the form of both hospice care and home health care. These were used in the past and have been revived as chronic illnesses have risen in numbers. Both are used more and more in cities all across this country, thus becoming an area of specialty for nurses.

AIDS patients not only have the illness to deal with, they have society's disapproval. In the same manner, hospice patients must deal with their mortality as well as their illness. Both of these illness groups need medical care, social support, and the knowledge that their nurse cares (immediacy). The data collected in this study indicates that immediacy behaviors and social support are both very important in the care of these individuals as well as in a medical setting.
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Acknowledgments

No man, or woman, is an island. The truth of this statement has never been more real to me than it has become during this project. There are so many people who helped me in big and small ways during the time I’ve worked on this that there is not enough room for me to acknowledge all those who should be. However, there are a special few whom I feel I must place in the proverbial spotlight.

I owe the deepest and most heartfelt thanks to my advisor and mentor, Dr. Sally Planalp. Without her suggestions, time, and vast amounts of patience I would never have finished this with all my hair still on my head =). She was a source of tremendous help and encouragement, especially when I didn’t think completion was possible. Thank you. I also owe deep thanks to my other committee members, Dr. Wes Shellen and Dr. Jennifer Waltz. Their critiques and insights were always welcome as were their suggestions of new articles to review. Thank you for your help. From your suggestions my project not only improved, but I now have ideas for further work.

In this same line I must acknowledge my editors who spent great amounts of time invested in my efforts. Thanks to both Yudit Buirtago and Stacey De Witt for editing, thus making my work, easier to read and “get.” Additional thanks to Stacey De Witt for her assistance in data-gathering for Phase II.

I also would like to thank my informants and “subjects.” I greatly appreciate the amount of time and information they gave me. Without their cooperation this project would be both worthless and pointless. Thank you for letting me into your world and giving me a glimpse of the reality you live with everyday. I only hope more compassion is evident in me from my experiences with you.

Finally, a special thanks goes to my parents. Without their love, support, and encouragement I never could have made it this far. Thank you for always being there.
CHAPTER 1
RATIONALE AND LITERATURE REVIEW

RATIONALE

Diseases are sometimes more than ailments of the body; they can be blights on a society or culture. During biblical times the disease to fear was leprosy, while people in the 14th through 17th centuries feared the bubonic plague. In this century we have seen deadly diseases such as polio, measles, and smallpox virtually disappear, but now we have a rash of new diseases. The brief epidemics of the Ebola virus and the “flesh-eating” strain of strep in the 1980s and 1990s alarmed scientists and the public until the outbreaks ran their courses. But one deadly disease of the same time frame has not disappeared - Acquired Immune Deficiency Syndrome (AIDS) virus. AIDS is similar to the Ebola virus and the “flesh-eating” strain of strep because it is deadly, but it is different because people who live with it do not die immediately. These individuals can survive with AIDS for many years, and can still pass the virus on to others.

Although the first cases were reported in 1981, AIDS has rapidly become not only a household word, but a world-wide health concern. In 1995, HIV infection was the eighth leading cause of death in the United States, leaving 42,506 people dead (Famighetti, 1997). The Center for Disease Control estimates that by the year 2000, 30 to 110 million people will be infected with or dying of the virus that causes AIDS (Pogash, 1992). Another estimate is that by the year 2000, approximately 120 million people worldwide will be infected by the Human Immunodeficiency Virus (HIV), the virus that causes AIDS. In addition AIDS will become the leading cause of death among Americans 25-44 years old, one of the top three leading causes of death among teenagers, and one of the top five causes of death among children 1-4 years old by the year 2000. Currently,
there are over 1 million Americans infected with HIV (Doan-Johnson, 1993). Even with modern medical advances a cure has not been developed, and the spread of AIDS has reached epidemic proportions.

As the number of people with AIDS (PWAs) and carriers of the HIV virus rises, the need for nurses to care for them also increases. Throughout the different stages of care, nurses are able to see the physical and emotional types of assistance the patients need. As the amount of time needed to care for the patient increases, the opportunity to hear and see the varying levels of need also rises. In the case of AIDS, the person may only need drug therapy and minimal nursing attention at first. As the disease progresses and the patients cannot do as much as they could before, more continual medical supervision is required. This attention can be as minimal as taking vital signs to as extensive as round-the-clock care. As the disease reaches the final stages and the patient needs to be watched full time, the nursing staff become the primary, if not the only, people to care for physical and emotional needs of the patient.

Nurses are in an excellent position to assess and provide both medical care and a few types of social support for PWAs throughout the progression of the disease. First, nurses are the members of the medical profession who spend the most time with patients of any kind (Pluckhan, 1978) and therefore are more likely to communicate acceptance or rejection to a patient, regardless of the disease or condition. Secondly, nurses are also more likely to develop a deeper relationship with a PWA due to the time invested in care (Pluckhan, 1978). The longer patients need care, the greater the possibility of a connection developing between nurses and patients. Thirdly, nurses can help PWAs set social support/interaction goals as well as provide them with information concerning support groups (McGough, 1990). Doing this helps ensure the patient does not isolate him/herself from loved ones or people living through similar experiences. Finally, nurses
can discuss ethical and emotional aspects of survival with PWAs and their caretakers (Hall, 1994).

AIDS is not a new disease in our society and the way it has been viewed by the uninfected has changed. In the past people have treated PWAs cruelly for two reasons; the fact that AIDS was a "gay disease," and that people were not certain of how it was spread. In the early days of the disease some members of society were reluctant to touch, be close to, or even swim in the same pool as a PWA, and lashed out cruelly (Rushing, 1995; Pogash, 1992). The fear of some uninfected was so extreme that a few individuals pushed for quarantining or even killing anyone infected to stop the spread of the disease (Rushing, 1995), while others refused to be near a PWA. As a result many PWAs and homosexuals felt isolated and shunned from society. As time has gone by the harsh treatment has subsided some, yet it still remains on a smaller scale.

In the case of PWAs, patient care may be more important than care for people with a socially-accepted disease. This is because of the extra frustration these individuals carry around as the objects of others’ hatred and condemnation. As a result of the pain experienced by these individuals, nurses need to implement social support and immediacy behaviors in their care-giving. A nurse’s social support will assist the patients’ in their emotional adaptation to AIDS and it’s burdens. Social support also allows the PWA to see that s/he is not alone in the world and that someone cares for him/her.

While social support allows the PWA to feel emotionally supported by a nurse, immediacy actions are those which indicate the concern felt by the nurse. Immediacy is a communication theory in which specific behaviors, such as continual eye contact and open body-orientation, are viewed as "immediate" or highly interpersonal behaviors on the part of the sender. In theory when these behaviors are exhibited, the person is viewed as likable, kind, and cares about the person s/he is in contact with. When "immediate" behaviors are fewer or non-existent, the sender is viewed as less likable, pleasant, and
uninterested in the person s/he is communicating with. For example, a sender who has continual eye contact and an open body orientation towards a receiver is viewed as more interested in and friendlier than a sender with minimal eye contact and a closed body orientation. By implementing immediate behaviors the nurse shows the PWA s/he is interested and cares about what is going on in the life of the patient. This interest helps the PWA learn to trust the nurse as well as develop a relationship of respect and equality.

While it is important for nurses to exhibit immediacy behaviors with PWAs nurses should know how the disease is transmitted. By using immediacy behaviors when treated PWAs the nurse shows that s/he is interested in the PWA. This acceptance fosters the relationship between the two as well as shows the PWA that not all people in society hate people with AIDS. Knowing how AIDS is transmitted gives the nurse knowledge so that s/he will not do something which could endanger his/her life while attempting to be compassionate. Immediacy is important, so is safety and common sense.

Finally, gaining background knowledge in an area one is not familiar with is beneficial in that a researcher can consider the philosophy and perspective of those being researched. This is necessary in that this knowledge allows the researcher to change his/her own perspective and see the world through a different filter than what s/he is used to. In most medical settings the attitude is one of healing a body so that it may live and be healthier. This philosophy is somewhat different in the home health and hospice settings. The nurses in these settings may have a different view of medicine, one that is less goal-oriented. Realizing this helps a researcher to understand that there is more going on than simply medical care for the body. This realization helps to a researcher understand a nurse's point of view when studying immediacy and related behaviors, specifically the extent they are used.

Knowing the level of importance nurses and patients place on immediacy behaviors is significant in that if they do not feel behaviors are important then maybe they are not. If
neither party feels immediacy behaviors are meaningful in the nurse-patient relationship then emphasis on immediacy should be reexamined and possibly removed from this area of research. Conversely, if either nurses or patients place more importance on immediacy behaviors than the other group, the less interested group should be informed of the differences in opinions. If the nurses are the less interested party having this information could produce a behavior change on their part, resulting in their giving more “immediate” treatment and improving the overall relationship and care given/received.

Finally, rubber latex gloves are a necessity in the care of patients, yet could be seen as a boundary to touch, an integral part of immediacy. The attitudes of both parties are important as well as how quickly the nurse puts on the “barrier.” If done too early, it could be offensive; too late and it could be deadly. Considering the importance of health, rubber latex gloves are a necessity to have on during certain types of nursing duties.

HOSPICE AND HOME HEALTH CARE

This study was conducted with nurses working in a hospice or a home health care setting. The individuals working in these two settings have very different philosophies on patient care which may influence how patients are cared for. Traditional medicine focuses on finding the problem and providing a solution. In contrast, the Hospice philosophy recognizes that there are not always solutions. Some illnesses cannot be treated and will result in death. When a patient is terminally ill it is important to assist him/her through the final stages of life. Hospice views life as a journey in which those near the end need assistance in traveling through the last stages (Hayslip & Leon, 1992). The use of immediacy behaviors and social support are important in this setting. Hospice nurses are aware that the patients will invariably die and as a result are more inclined to touch or use other immediacy behaviors with patients in an effort to show affection. Additionally, the
patients are often letting go of their lives and coming to terms with past successes and failures, so they may need the support of nurses to work through their past experiences. From this basic difference in philosophy it seems that hospice nurses would be more inclined to use immediacy behaviors than home health care nurses. Hospice also considers the ongoing conflict between the quality of life and the extension of life (Hayslip & Leon, 1992). From the Hospice viewpoint an individual’s comfort levels during the last days are more important than the number of days. Keeping patients comfortable is accomplished by minimizing and/or controlling the patient’s levels of pain (Harkness-Hood, & Dincher, 1992) and by allowing the patient some input in the method of care (Hayslip & Leon, 1992; Harkness-Hood, & Dincher, 1992).

Hospice nurses need to learn to integrate their desire to assist and heal together with the Hospice philosophy in order to give a patient some say in how s/he lives and dies. While it is necessary for nurses to protect themselves by wearing gloves, it is also important to consider the patient and his/her feelings. In hospice settings patients are dying and may need assistance through the transition of being healthy to being near death. Hospice nurses often consider this reality and adjust their care accordingly.

The first hospice to take in a PWA was the Visiting Nurses and Hospice in San Francisco in 1981. The patient, like most PWAs at the time, died shortly after arrival. As AIDS spread and more and more hospices in major cities were inundated with patients, a patient profiles changed. No longer were they mostly elderly patients nor the diseases mostly cancer or “old age.” Instead, people in their prime with exotic and new diseases filled beds, resulting in a need to educate staff about HIV/AIDS (Lew-Napoleone, 1992).

The home health care philosophy is different from the Hospice philosophy because home health treats patients who are not yet at their death bed. Patients need to continue recommended treatment in order to get better. Immediacy behaviors are important in these settings because the patients need to know that someone is concerned with them so
that they will continue their treatments and maintain their health. Because home health care is a one-on-one nurse-patient setting and the nurse is focused on that one individual for that moment, it seems that they would use more immediacy behaviors than hospital nurses. Additionally, home health nurses treat their patient over a longer period of time than do hospital nurses, resulting in their getting to know the patient better and having more opportunity to express immediacy and social support. For different reasons immediacy and social support are important and used in both settings, even though the number and types of behaviors differ greatly.

HIV/AIDS

Because AIDS is a frightening disease and as of this writing there is no known cure, nurses and other members of the medical profession may not be as physically interactive with PWAs as they would with other patients. They may use fewer nonverbal immediacy behaviors, especially touch. An unrealistic fear of contracting AIDS has caused some nurses to wear latex rubber gloves when it is not necessary, such as when they are taking a patient’s blood pressure. While it is important to take precautions during the proper times, too much precaution may lead a PWA to view nurses as inaccessible and non-immediate. If nurses and other members of the medical profession are aware of how AIDS is transmitted, they may not be as likely to shy away from their AIDS patients because they know what precautions to take under different circumstances. Basic HIV/AIDS knowledge may help a nurse relax and treat the PWA with respect, while protecting him/herself from possible infection. This basic knowledge can help even those who are deeply afraid of infection by informing them about how to protect themselves, thus allowing them to touch their patients without the fear of becoming ill.
HIV has a limited range of transmittability. It can be passed to a healthy individual one of four ways: 1) through sexual contact with a HIV positive/PWA via an exchange of body fluids; 2) an injection with an unsterile needle that has been exposed to the virus (commonly occurring between IV-drug users); 3) exposure to infected blood or blood products (most often occurring during blood transfusions); 4) or by an infected mother to her unborn child (Harkness-Hood, & Dincher, 1992). HIV cannot be passed to another person by air, touch, or the handling of the same objects. One can safely live with a PWA and have little chance of getting the virus unless one engages in one of the aforementioned activities.

While the risk of infection is real when precautions are not properly taken, infection will not occur. It is important that nurses and other members of the medical profession are aware of this and react in such a way as to assist the person in moving past this emotional roadblock.

Although the methods of transmission of AIDS is common knowledge for most members of the medical profession, studies have shown that some doctors and nurses have reactions inconsistent with what their knowledge tells them. (Klonoff & Ewers, 1990; Norton, Schwartzbaum, & Wheat, 1990). Meyer (1991) discovered that in the past, members of the medical profession have avoided or even refused to treat a PWA due to fear or prejudice. Suczek and Fagerhaugh (1991) conclude that as a result, the public has developed a jaded view of PWAs, fearing that contact with them is the equivalent of a death sentence.

THE NEED TO BELONG

All human beings have an inherent need to be a part of something greater than themselves. Baumeister and Leary (1995) conclude that "belongingness" is not simply a
desire for human beings, but "is a fundamental human motivation." When people are lacking this sentiment they may suffer the loss of physical or emotional health, diminished happiness, or a decreased ability to adapt to the general or specific troubles of life (Baumeister and Leary, 1995). Conversely, when people are satisfied with the number and quality of intimate relationships they are a part of, they are more likely to be content and healthy, both physically and psychologically.

When people lack belongingness, such as individuals not accepted by others or by "main-stream society," they will be more likely to experience stress, isolation, fear, and illness. These individuals are prone to pull away from others, act out aggressively in their frustration, feel their importance is diminished, or become ill. Often it is when people are sick that they need the most assistance and reassurance from others.

When people are ill they view the world through a tainted lens darkened by emotion, especially if the illness is socially unacceptable or if a "private" area of their anatomy is damaged (Lederer, 1965). Sometimes these individuals experience anxiety or guilt about their illness, resulting in some level of emotional instability. It is important for nurses and other members of the medical profession to be aware of the emotions felt by the patient and not add to a patient’s emotional turmoil through comments, attitudes, or excessive treatment. In dealing with PWAs, nurses and other members of the medical profession should be aware of the underlying social ostracism possibly felt by these patients. By showing an extra level of care and interest in the individuals, medical professionals show PWAs that they are still valued as human beings. By giving support and using immediacy behaviors with PWAs, nurses make the patients to feel important and needed. The expressions of belongingness and immediacy also help the PWA to accept being touched with gloves when it is necessary. Additionally, being treated as "normal" can help a PWA see that s/he is not "different" and will make them more likely to open up and share their emotional turmoil with others.
SOCIAL AND EMOTIONAL CONSIDERATIONS OF AIDS

Poor treatment has potential for ostracizing PWAs from the very people and medical attention needed. Often PWAs need continual treatment, but if they are treated as outsiders, they may choose to not seek the medical attention they need, resulting in a more rapid deterioration. Moreover, they may develop a poor view of the medical profession, a so-called "helping" profession, and pass this opinion on to other PWAs. This could lead to PWAs to choose to neglect treatment until absolutely necessary, cutting their lives even shorter and raising the cost of care.

Other issues compounding the situation include the social stigmas associated with homosexuals and intravenous (IV) drug users, many of whom are African-American. The stigmas are compounded when dealing with Caucasian, middle-class individuals carrying prejudice against African-Americans and IV drug users. Some may believe that not only do the African-Americans deserve what they got, but we should just let them die with the minimal treatment. After all they has pickled their brains and deserves no extraordinary assistance. In a recent series of polls, people were asked if PWAs should be given sympathy because of their disease. The results were compared with other polls measuring the level of sympathy people felt for individuals who got AIDS due to homosexual activity or IV drug. These polls indicated that although more than 80% of the population were sympathetic to PWAs, the percentage dropped to 39% if a PWA got the disease from gay sex and 30% if gotten from drug use (Rogers, Singer, & Imperio, 1993).

Currently, AIDS is still considered a "gay man's disease," even though the disease is moving rapidly into other social circles. Le Poire (1994) concludes that this is because people's tolerance of PWA's is often correlated with their tolerance of gays and their knowledge of AIDS. In his summarization of acceptance of the gay movement in the United States, Gilder (1989) states that AIDS has given society an excuse to again attack
homosexuals on the basis of their sexual orientation. Considering nurses and other medical professionals are human and subject to the same societal opinions as anyone else (Gordon & Edwards, 1995), it is easy to see how they may allow their understanding of AIDS to be overridden by their intolerance of gays or IV drug users. Even so, nurses and others members of the medical profession are not supposed to allow their personal feelings to interfere with the care of a patient. As a result, disapproval of gay or drug using patients often comes out nonverbally in greater distances and less willingness to touch the individual (Le Poire, 1994).

Many PWAs have more than the opinions of people they do not know to contend with. Some PWAs report feeling rejected, singled out, and cut off from the world, family, and/or friends (Bennett, 1990). Others discuss their loneliness brought on by societal isolation and hatred of homosexuals, uncaring physicians, ignorance of others, change and loss of various relationships, and the reality of death (Cherry & Smith, 1993). Many homosexuals have lost a number of their friends to AIDS (Lloyd, 1992). Some IV drug users have no home or family to support them during this time. Additionally, PWAs must grapple with the realization that participation in sexual activity could potentially be deadly for their loved one. They may also have to contend with the guilt that they may have unwittingly passed the disease on to someone else. Another consideration is how and from whom they themselves got the disease as well as relational considerations resulting from that knowledge (Flaskerud, 1988). Other PWAs must grapple with the realization that they will die in their youth, and thus must let go of life-long dreams and ambitions. Young PWAs must also deal with issues of isolation and extreme pain that they are not prepared to handle in their prime (Sadovsky, 1991; Flaskerud, 1988), resulting in higher incidences of depression than in older individuals (Dobratz, 1993).

PWAs have more than interpersonal relationships to worry about. Many must consider the effects of public revelation on their job status and medical insurance.
gay men have a higher perceived notion of work-place discrimination due to the increase in AIDS-awareness. From this they may be reluctant to "come out" at work, yet may have no choice due to their HIV-status (Lloyd, 1992). In contrast, IV drug using PWAs need to get past their addiction otherwise their illness will progress more quickly due to a weakened body. Because of the mental effects of drugs these individuals often have more dramatic swings of emotion and are more likely to participate in self-destructive activities (Stein, 1992). How to financially cope with AIDS and treatment costs can also be a tremendous source of stress (Flaskerud, 1988).

In their treatment of PWAs, nurses have the potential to make their patients' remaining years easier or more difficult. By showing compassion and comfort to their patients, nurses can make a positive impact in the lives of the sick. In some cases nurses can also positively impact the family and friends of the PWA. By showing acceptance a nurse can be a positive model for those who have yet learned to accept the PWA's illness. Finally, a nurse often is a source of comfort for loved ones, particularly those who have issues they cannot yet accept.

SOCIAL SUPPORT

Because PWAs have felt unloved or cast aside by the society they once were deeply a part of, it is important for nurses to do what they can to help bring emotional healing to their patients. By expressing care and concern through immediate behaviors, touch beyond medical-oriented ones, and treatment without wearing gloves when not needed nurses show PWAs that they are not as frightening as other parts of society believe. Expressions of care, even small ones, illustrate to the PWA that s/he is valuable. In many cases the mere knowledge that someone cares makes a difference in whether or not the person will fight to be healthy or lie back and wait for death. Considering the
lengthy fight many PWAs face, these expressions of care and support may make the difference in how long a PWA lives.

Social support is a "communication process" which helps people through the stresses and difficulties of life in several ways and different levels (Albrecht and Adelman, 1987). Aspects of social support include emotional, esteem, and network support in both tangible and psychological ways (DiMatto & Hays, 1981). Albrecht and Adelman (1984) state that caring and support are defining characteristics of social support. They also discuss the need for communication behaviors which express concern, although they do not give specific examples of them. McGough (1990) found several themes in social support. These include the belief that one is cared about by others, a sense of belonging, "mutual sharing," and sharing information and material objects. Finally, Dickson-Markman and Shern (1990) found that social support consists of any type of relationship or network which gives information, feedback, and assistance for a variety of physical and psychological needs. They found that among people of all ages high levels of both quality and quantity of social support make a difference in physiological and psychological health. Social support is also a factor in the reduction of stress and in allowing people to express their feelings and fears (Albrecht & Adelman, 1984).

From an extensive literature review DiMatto and Hays (1981) conclude that social support is a major factor in coping with serious illness or injury and in recovering physically, socially, and emotionally. White, Richter, and Fry (1992) found that positively perceived social support resulted in better adaptation to a chronic illness. In addition, they found that as a person became more ill, their perception was that their own social support system diminished, whether it actually had or had not.

It is likely that AIDS will become more of a chronic illness than a killer disease as new AIDS treatments extend the life expectancy of PWAs (Johnston, 1996). Strong social support is a primary way for PWAs to keep a positive outlook (Hall, 1994). Many
PWAs feel that life is worth living simply to have and benefit from the impact of loved ones' lives.

Overall social support is beneficial, yet there is also a downside. First, family members may be too supportive, to the point that they restrict the activity of the ill individual. This becomes a problem when the person needs to get up and move around in or outside the home and is not allowed to. Second, the demands of support may cause family members or friends to resent the ill individual, resulting in new problems such as the feeling that family members are being taken for granted and not appreciated enough for their hard work and the sacrifices made to care for the ill individual. Third, family members may not be supportive if they themselves have no external support and are burned out. Finally, too much support may undermine the ill person’s confidence causing him/her to take on the role of a sick person. When this occurs the individual loses confidence and acts like a “burden” or “impaired” person (DiMatto and Hays, 1981).

Social Support and Death and Dying Issues

As stated earlier, there currently is no known cure for AIDS so is often looked upon as a death sentence. Considering that it is not easy to accept one’s mortality, nurses should think about how they can assist PWAs through their acceptance process. Again, this can only help to improve the remaining quality of life for a PWA.

Considering the fact that many people treat dying individuals as though they are dying and not still in the “land of the living,” it is important for nurses to counteract this treatment. Rather than be serious around the PWA and wear rubber latex gloves to maintain a sterile environment, a nurse could consider being jovial and touching the PWA without gloves when not treating him/her. Additionally, the use of immediate behaviors allows the PWA to see the human side of the nurse and be alive again.
When treating a dying patient it is important for a nurse to be calm and act "normal." When a nurse or member of the medical profession treats a dying patient as though s/he has a fatal disease or with too much sympathy, the patient will often give up (Brauer, 1965). A patient's poor attitude is often the root of their decline in physical health.

Dobratz (1993) found that perceived social support, which includes nurses and physicians as well as friends and family, helps the afflicted individual's psychological adjustment to dying. Additionally, Albrecht and Adelman (1984) found that support from others assists "recovery from mental and physical trauma or illness." Conversely, Sullivan and Reardon (1986) found that when breast cancer patients were dissatisfied with their social support, they were less likely to fight the disease and viewed it with a sense of hopelessness.

When patients learn they are dying they tend to have strong reactions. As people near their deaths they have several fears (Klinzing & Klinzing, 1985). These may include the fear of being abandoned by those they care for or losing their independence, fear of excessive pain, and fear of what comes after death for them and the ones they leave behind. Kubler-Ross (1969) developed a series of stages dying individuals generally pass through as they near death. These five stages include denial, anger, bargaining, depression, and acceptance. While not all patients experience these fears or stages in the same order in the same manner, it is important for nurses to be aware of them. This awareness helps the nurse remember the importance of supporting the patient.

When caring for a dying person it is important to have as much physical and psychological contact as is possible and accepted (Gazda, Childers, & Walters, 1985). This allows the individual the knowledge of support and the dignity to refuse assistance and the ability to push others away when they feel the need. There are times when a person wants some form of support from those around him/her. A nurse showing support
in the past will help the patient believe the nurse will be there when the patient needs him/her. In contrast the patient also needs to freedom to refuse support and handle his/her own pain and fear on his/her own if needed.

**IMMEDIACY**

One of the most concrete ways for nurses to express their support and concern is through the use of immediacy behaviors. These behaviors are ones that are thought of as expressions of concern and can be seen and measured. Included in immediacy behaviors are continuous eye contact, open body position, high use of first person pronouns, and close proximity. Immediacy behaviors also relax patients and insure trust between them and their nurses.

The term “immediacy” first appeared in the mid 1960’s. It was originally used to describe psychologists’ clients’ attitudes and emotions (Correia, 1996). In their 1968 publication, Wiener and Mehrabian describe immediate and non-immediate behavior in general terms, giving specific examples for specific situations, yet not moving toward broader generalizations. These behaviors are described as “approach behaviors,” such as open body posture or increased amounts of time spent together (Andersen, 1985). These behaviors “signal availability for communication” via eye contact or close distance to the speaker (Andersen, 1985). Immediacy behaviors also “increase sensory stimulation” through many multi-channeled messages and “communicate interpersonal warmth and closeness” by reducing distances or any behaviors which could be threatening (Andersen, 1985). In contrast, any of these behaviors done out of context or done too often could be taken as a threat (Andersen, 1985). Simply put, one knows immediacy when one sees it.

There is no working definition of immediacy because it is not an easily definable concept, but its impact is obvious. The intent of immediacy is to show a closeness, liking,
and involvement between a sender and receiver (Infante, Rancer, & Womak, 1993). Buhr, Clifton, and Pryor (1994) found that immediacy behaviors increase the speaker's overall likability, competence, trustworthiness, and similarity with receivers. In addition, the receiver was left with a more positive impression of the speaker when immediacy behaviors were present.

Montgomery (1981) found that open communication, "the process of transmitting information about the self," is directly influenced by immediacy and vice versa. Both verbal and nonverbal behaviors are factored in to the "personalness" of the communication. She found that when these factors are present in interactions, the communication is more effective, deeper bonds are created, and trust levels are higher.

Immediacy has also been examined in teacher-student relationships. Effects of immediacy on effective learning environment (Thomas, Richmond, & McCroskey, 1994), teacher's personal communication style (Correia, 1996), instructional messages (Powell & Harville, 1990), and student race and learning style (Sanders & Wiseman, 1990) have been studied. The results of each was a recommendation of how to be viewed as more immediate. Recommendations include having a willingness to spend extra time with students (Correia, 1996), providing specific feedback or praise (Correia, 1996; Sanders & Wiseman, 1990), using humor (Correia, 1996; Sanders & Wiseman, 1990), smiling (Correia, 1996), eye contact (Correia, 1996; Sanders & Wiseman, 1990), and flexibility (Sanders & Wiseman, 1990). When these recommendations are implemented teachers are viewed not only as more immediate but also as more competent and effective (Thomas, Richmond, & McCroskey, 1994). While these recommendations are aimed specifically at teachers, it is likely that the above behaviors would be appreciated by people other than students.

The settings in which immediacy was studied with the most direct bearings on the current study were conducted in a medical environment. Patient's satisfaction with the
care they received from physicians showed that when physicians are perceived as distant and unfriendly, patients are less satisfied (Conlee, Olvera, & Vagim, 1993). Indirect studies of nursing and physician immediacy have focused on listening skills (Morse & Piland, 1981), interest and concern for others (Harrison, Stephen, & Pistolessi, 1987), “attending listening” behaviors; i.e. posture, eye levels, and “appropriate” distances (Gordon & Edwards, 1995), and empathy (Olson, 1995). According to the findings, listening and showing concern for a patient, having a relaxed posture, continual eye contact, and standing at an “appropriate” distance will make a patient more comfortable, and thus more pleased with the physician.

**Verbal and Nonverbal Immediacy**

As with any communication situation, the verbal and nonverbal parts work together to make a complete message (Stewart, 1995). The relationship of the communicators will be looked at in this study as well as the following areas of verbal immediacy: topics of discussion (Montgomery, 1981) and word usage (Cegala, 1989; Bradac, Bowers, & Courtright, 1979). The following nonverbal areas will also be studied: reduced proxemics, eye contact and body orientation to the individual, smiles and nods, relaxed body posture and dress, time spent together, levels of vocal expressiveness, and frequencies of touch.

**Nonverbal Immediacy**

Nonverbal immediacy dominates the research because it is easier to see. Body movements are easier to observe and record than are topics and wording. Additionally, self-reported research may not always be trusted. If verbal immediacy involves levels of trust and honesty, only the subjects themselves will know if they trust the sender, thus it cannot be directly observed by researchers. Furthermore, if someone wants to be viewed
as more immediate it is easier to describe behavior changes, (i. e. touch and hug more),

than it is to tell them to be more trustworthy and use more first-person pronouns.

According to Andersen, Andersen, and Jensen (1979), nonverbal immediacy

behaviors are ones that tend to communicate availability and interest, involve most of the

senses, and produce closeness between individuals. They reviewed examples of nonverbal

immediacy including reduced proxemics, more eye contact and body orientation to the

individual, more smiles and nods, relaxed body posture and dress, increased time spent

together, higher levels of vocal expressiveness, and greater frequencies of touch. They

also developed several immediacy rating scales, including the Trained Raters' Perceptions

of Immediacy Scale which has been used by other scholars studying immediacy. This scale

is a highly adaptable, practical, and appropriate to numerous settings and situations. In

this study the Trained Raters' Perceptions of Immediacy Scale was adapted for use in

observing proxemics, eye contact, body orientation, facial expression, body posture, time

spent with a patient, vocal expressiveness, and comforting touch.

Proxemics is the distance between people as they interact. This distance varies

with the setting and function of interactions (Stewart, 1995). While reduced distance can

be good, too much is uncomfortable (Pluckhan, 1978). While reduced proxemics can be

tolerated for brief periods of time or taken as a humorous situation, Americans tend to get

aggravated or upset if they feel someone has invaded their space (Dodd, 1991). In an

effort to return to their comfortable status-quo Americans will leave the situation, say

something to the offender, or even become hostile (Dodd, 1991).

Eye contact is the signal to start or end communication by showing one is open or

closed to another (Klinzing & Klinzing, 1985). Pluckhan (1978) states that through eye

contact people can know the amount of attention given to them by another person and

make judgments about the sender's attitudes. For example, if a person does not look at us

we think s/he does not like us or is ignoring us. In contrast, if a person we are
romantically interested in gazes steadily at us from across the room we take that as a sign of interest. Furthermore eye contact is associated with the amount of trust given to a person; the more eye contact the more trust to a point. Balzer-Riley (1996) states that too little or too much eye contact will inhibit communication. When there is too little eye contact we assume the person is not interested in what we have to say so we do not tell him/her any more than necessary. If a person gives us too much eye contact we assume s/he is strange and therefore are wary of him/her.

If one is interested in genuine interaction with another person one should encourage interaction through an open body orientation. In this position both individuals’ shoulders are parallel to the other person (Balzer-Riley, 1996). In contrast, the quickest way to end communication is by “turning away,” or changing body orientation away, from the person with which communication is occurring (Pluckhan, 1978).

The way people feel is often expressed on their faces. When people are happy or comfortable, these emotions are often expressed in smiles and nods (Klinzing & Klinzing, 1985; Gazda, Childers, & Walters, 1985; Blondis & Jackson, 1977). Additionally, smiles and nods indicate approval in some settings (Wiener & Mehrabian, 1968). Balzer-Riley (1996) believes smiles are appropriate and welcome in a nurse-patient setting because they put a patient at ease.

A relaxed body posture is another way someone can put others at ease. According to Balzer-Riley (1996) continual stress and tension builds up and evidentially leaks out to others, making them tense as well. In contrast a relaxed and attentive posture communicates warmth (Gazda, Childers, & Walters, 1985).

Giving a person a little extra time and attention than necessary expresses interest. When individuals are lying in a hospital bed with little or nothing to do but heal or die, a few moments of extra attention validates the patient as a human being (Blondis & Jackson, 1977). While it may be difficult to spend time with each patient in a busy medical setting,
the gesture of kindness does not have to be extended and the extra time makes a difference in the world of the patient (Blondis & Jackson, 1977).

**Vocal expressiveness** is also an important part of nonverbal immediacy. The tone, pitch, rate, and volume of a person's voice are only some of the aspects of vocal expressiveness which communicate beyond the actual spoken words (Klinzing & Klinzing, 1985). Wiener and Mehrabian (1968) believe tone is the strongest vocal indicator of immediacy. Tone communicates much regardless of content and tends to be taken more seriously than mere words. From the components of vocal expressiveness, a receiver makes a judgment as to what the speaker's emotions and personality may be.

**Touch**

Of the types of nonverbal behavior mentioned so far, touch tends to be the one that is the most consciously noticed. Klinzing and Klinzing (1985) compiled several studies of touch and concluded that the need for touch is extremely important in medical settings, in spite of the cultural norm which inhibits the amount of touch occurring between people in the United States. Touch is beneficial in that it can both calm and comfort patients who are in distress.

Touch is a basic need of all humans, something we need throughout our lives. Montagu (1978) found that the mortality rates of infants who have extensive contact with adults, being held or cuddled, are much lower than those who have little or no contact. This is partly due to the baby's perception of comfort and security from the adult. In addition, Montagu (1978) found that the physical development of infants is slowed or retarded when they are deprived of physical contact at the beginning of their lives. A sad illustration of this were babies in orphanages with marasmus during the 1800s and early part of the 1900s. This disease, primarily caused by a lack of ample stimulation,
particularly touch, causes the individual to become lethargic to the point of death. Far too many babies die because someone did not take the time to touch and stimulate them.

As people get older, the importance of touch does not diminish. Adolescents in particular need physical contact with other humans, especially significant people in their lives. Minimal or no touch by important people in a young individual's life may adversely affect his or her body image. As a result, teens will attempt to do something that they will make them more attractive and worthy of attention. If they go too far they may engage in self-destructive behaviors such as bulimia or anorexia (Gupta & Schork, 1995).

Perhaps the most common use of touch is to express fondness or attraction. Deliberate touch shows that one chooses to be close to another (Mehrabian, 1981). Most people can assume that when an individual intentionally touches them it is not because the person is repulsed by them, but rather is interested in their well-being.

Touch can be used in ways other than simply to show affection. It may also be used as a way to get others to do what one wants. Nannberg and Hansen (1994) conducted a study in which people were asked to fill out a short survey. Upon completion the subjects were asked to fill out as much of a second and more extensive survey as they had time to. Nannberg and Hansen (1994) found that those who were lightly touched not only filled out more of the survey, they gave more comprehensive answers. If wanting a patient to comply with recommended treatment or to take some medication a nurse can lightly touch the patient when explaining the treatment. This may encourage the patient to comply with medical orders and possibly get better.

Because touch is extremely important to patients, it is also important for nurses to consider of touch. They should follow the social norms of acceptability of touch on another person's body. The way a nurse touches a patient is just as important as where the touch occurs. Pluckhan (1978) found that touch is often taken as a more genuine way of
communicating than is verbal communication simply because it is usually more spontaneous.

When touching a patient it is essential that the nurse does so in a way that the patient knows it is heartfelt. If a nurse is not comfortable with touching patients s/he should not do so because his/her discomfort may be transmitted to the patient, passing along the uneasiness (Balzer-Riley, 1996). When a nurse is hesitant or stand-offish about touching, the patient will realize it and may be hurt worse than if the touch never occurred. Because of this a nurse should be decisive about whether or not to touch a patient. Nurses also should not fear the patient's condition (O'Brien, 1978), especially when patients are disfigured in some way. Johnson (1972) believes that a patient’s confidence will rise when nurses are willing to touch him/her in spite of his/her abnormal appearance.

When reassuring a patient the nurse may use comforting touches. Comforting is “communication which is intended to make others feel better” (Dolin & Booth-Butterfield, 1993). The purpose of this behavior is to support those who are experiencing stress or suffering (Dolin & Booth-Butterfield, 1993). There are distinct comforting touch behaviors: hugging, patting, and increased general touch, i.e.: holding a hand, rubbing an arm, or rubbing the head (Dolin & Booth-Butterfield, 1993). A nurse should only touch a patient in these ways if the patient initiates it, otherwise it could be misinterpreted (Blondis and Jackson, 1977). When dealing with a cancer patient who might have experienced potentially life-threatening side-effects from taking prescribed drugs, Heath (1992), used an unorthodox treatment. Upon the patient's suggestion Heath gave "pain hugs;" a hug any time the patient asked for as long as the patient needed, in place of the pain medication. Once the patient understood the risks involved with using the medication she accepted and was quite pleased with the alternative treatment.
While touch is important in daily life and in medical settings, one should note that there are marked differences between the two settings. Nurses deal with sick people who potentially have contagious diseases, some of which are transmitted via touch. Although it would be nice if nurses could touch anyone they wanted at any time with no fear of infection, they cannot. Nurses need to protect themselves when at all possible. This does not mean however, that all nurses should wear gloves at all times. It is important to note that there are different types of nurses, and each type deals with patients in a unique way. Nurses working in operating rooms, emergency rooms, and intensive-care units should wear gloves when touching any patient due to the instability of the patients' condition and the possibility of dealing with body fluids. Wearing gloves under these circumstances protects the nurse from possible infection and protects the patient from other diseases. In addition, there are some functions of nursing which should not be done without rubber latex gloves. When any nurse engages in cleaning medical instruments or lacerations, giving an injection, drawing blood, inserting a catheter, bathing a patient, or transporting specimens they should wear gloves for their own safety (De Vries, Burnette, & Redmon, 1991; Pratt, 1992). Wearing gloves under these circumstances protects the nurse from infection in the event something out of the ordinary were to happen. Except for the above nursing duties gloves are not necessary and may cause a patient to feel like a germ factory.

**Verbal Immediacy**

Verbal communication encompasses what is actually said between speakers. Verbal immediacy includes parts of verbal communication which express closeness between two individuals. It includes relationship of the communicators, topics of discussion (Montgomery, 1981), and word usage (Cegala, 1989; Bradac, Bowers, & Courtright, 1979).
Bradac, Bowers, and Courtright (1979) found that verbal immediacy is directly related to the receiver's assessment of the interaction. When a receiver views a sender in a positive light s/he is more likely to think highly of the interaction than if the receiver had a negative view of the sender. An example of this can be seen when a person receives a compliment. If the receiver likes the person giving the compliment, s/he is excited and expresses the emotion. If the sender is not viewed in such a positive light, the receiver's reaction is much less enthusiastic, possibly concerned over how to handle the awkwardness. Additionally, Bradac, Bowers, and Courtright (1979) found a direct correlation between verbal immediacy and the receiver's assessment of the speaker's competence and credibility. Immediacy also encompasses what is said beyond the literal meaning of words (Wiener & Mehrabian, 1968) and adds to the overall relationship. If the speaker's verbal communication matches the nonverbal communication the receiver will view the speaker as trustworthy (Balzer-Riley, 1996), increasing immediacy. If however the verbal communication does not match the sender's nonverbal cues, the receiver is not likely to trust what is being said. This breech or lack of trust can wear down not only the immediacy levels felt by the receiver, but the entire relationship as well.

In some medical settings a nurse or other medical professional may act as though s/he does not have time for either a patient or questions. Patients often interpret this as though the person does not care or is not disclosing the entire truth about his/her illness (Brauer, 1965). When this occurs the patient may lose confidence in those caring for him/her (Brauer, 1965).

Trust is an important aspect of immediacy in that if receiver does not trust the sender immediacy will not be perceived no matter how many “immediate behaviors” are exhibited. The amount of trust a receiver has in a speaker will have a direct effect on the interactions and how they are conducted. As a result it is important for medical professionals to be as clear and honest with patients as possible. Patients do not want the
fact that they are dying to be withheld from them (Klinzing & Klinzing, 1985). Eventually the patient will learn that s/he is dying and may lose trust in members of the medical profession if not informed sooner.

Trust, and often times immediacy, is built by the conversations between two people. First, people generally do not disclose sensitive information to others if they do not trust the person they are disclosing to. Second, topics of discussion are very important in any relationship, particularly if one of the individuals involved feels inferior in some way. Generally, people discuss things that interest them. When people discuss topics they are not concerned with it is usually because they care about the person they are conversing with. By talking about an uninteresting subject the individual expresses that s/he is willing to take time to honor something someone else finds important. This shows that the person is involved enough in the other individual to care about something the other individual is concerned with. In nursing relationships, particularly with dying patients, the patient often will express emotional turmoil or past regrets. Many times the information disclosed is of a sensitive nature and may even be uninteresting for the nurse. By listening to the patient and supporting him/her in whatever manner possible the nurse shows some level of immediacy.

Another indicator of immediacy is word usage. Word usage primarily involves terms which indicate detachment or concern for closeness, positive or negative affect, and the speaker's identification with the subject of communication. Wiener and Mehrabian (1968) state that the way an object is discussed illustrates the relationship between both the individuals involved and their relationship with the object in question. By expressing interest and concern for the topic at hand the people involved show some level of investment in the topic. In contrast, being negative and detached about something shows disinterest, if not out right dislike for that being discussed. Cegala (1989) found that first-person pronouns are a higher indicator of immediacy than third-person pronouns.
First-person pronouns indicate a level of involvement in the topic at hand, whereas third-person pronouns imply that the person is not as interested or directly involved. For example, if two people are discussing weekend plans using, “I’m going to...,” versus, “s/he’s going to...,” one can see that there is more investment involved in the first statement. Considering “I” shows personal involvement, it is acceptable that the person be involved more in what s/he is doing.

In medical settings, important aspects of verbal immediacy include showing interest, being clear, and showing respect. Compliments are a way of expressing the positive about a person as well as showing interest (Gazda, Childers, & Walters, 1985). Klinzing & Klinzing (1985) feel that when communicating with a dying patient it is important to explain things in terms the patient can understand. This helps the patient identify with his/her caregiver. Another way of showing respect to a patient is to ask for permission to enter his/her room (Blondis & Jackson, 1977).

Nurses caring for PWAs have a difficult task. They must take care not contract HIV or pass it on to someone else and at the same time treat PWAs with the respect they deserve. Finally, nurses should be aware of ways they can support their patients with AIDS. One of the more practical methods of support is through various immediacy behaviors. These behaviors communicate interest and concern, allowing the PWA to feel liked and cared for.

In this study I consider how immediacy, social support, and the need to belong are combined by nurses when they care for PWAs. I also consider how the wearing of rubber latex gloves affects the nurse-patient relationship. Finally the participants’ views on the relationship and quality of care and concern is taken into account.
CHAPTER 2
RESEARCH METHODS: PHASE I

RESEARCH QUESTIONS AND HYPOTHESIS

The goal of this study was to investigate the number and types of immediacy behaviors used by nurses treating patients and to learn if the patients were satisfied with the type of treatment they received. In Phase I of this study the use of specific immediacy behaviors by home health care nurses treating AIDS patients was observed. Observations were done in the living settings of the patients. The data were gathered through observations, surveys, and interviews.

The research questions were broken into two categories, observed behaviors and self-reported behaviors. This was done to look for inconsistencies between what was said and what actually occurred. There are times when people think they are doing things they are not or do things they do not realize they do. As a result the nurses and patients may not be aware of all of their behaviors. Looking at both observed and self-reported behaviors allows one to become aware of the inconsistencies. The observed data was analyzed in two ways, scaled and not scaled. In other words, some of the observed data was analyzed for an overall impression while others were only counted. The observed data was then compared with the participants' responses in an effort to find consistencies and inconsistencies.

In the observations I was able to see how immediacy was actually used in patient-nurse interactions, particularly behaviors used when caring for the PWAs. Specific immediacy behaviors, such as eye contact and body orientation, were observed for how much they were or were not used. Touch was also taken into account in the form of comforting touches. Another phenomenon observed was the use of rubber latex gloves and when the nurses put them on during treatment.
By asking nurses and patients their viewpoints we can obtain a more complete picture of immediacy, how touch is related to immediacy, and what both groups overall satisfaction with the nurse-patient interactions is. It is important to note that treatment and relationships will only be as positive, good, or beneficial as both sides allow. If one or both individuals involved closes him/herself off from the other individual the relationship may not be as good as it potentially could be. The heuristic value of this study is that there is room for feedback from both sides as well as from an objective observer. The research questions and hypotheses in this study address both patient and care-givers’ views of touch and other aspects of nonverbal immediacy, verbal immediacy. Additionally, possible differences in treatment based on the patient’s demographics is addressed.

**Observed Behaviors**

The focus of this study was the immediacy behaviors and comforting behaviors used by the nurses. There were several immediacy behaviors stressed as well as comfort touch. Immediacy is an vital aspect of the nurse-patient relationship. Without immediacy the PWA may not have a high level of trust for the nurse. While immediacy is important, an easily identifiable part of immediacy is touch. Comforting touch was specifically chosen for this study because of it’s practicality and easily identifiable behaviors.

The first set of research questions and hypothesis in this study are based on my observations of specific immediacy behaviors, how often, and when they are used by nurses when dealing with AIDS patients. In addition I ask questions which may not be specific examples of immediacy behaviors or comforting touches, yet they are indirectly related, such as the wearing of rubber latex gloves. These types of touch are important to PWAs because of the way they were treated by people both in and out of the medical field in the past. Looking at the use of gloves is important because many members of the medical field wore them unnecessarily in the past, and therefore ostracized the patients.
Furthermore if immediacy is based primarily on how many behaviors are enacted, it is important to see how many of those behaviors take place. I chose to narrow the number of immediacy behaviors to ones I thought would be evident and appropriate in a nurse-patient relationship. The behaviors include the use of touch, proxemics, eye contact, body orientation, relaxed smiles, relaxed nods, relaxed body posture, vocal expressiveness, first or third person pronouns, concern or detachment from the patient, and having a positive or negative outlook. All are both simple to observe and relevant in a "comforting" setting in the United States.

RQ1: To what extent do nurses use immediacy behaviors with their PWAs? These include touch? proxemics? eye contact? body orientation? relaxed smiles, nods, and body posture? being vocally expressive? use of first or third person pronouns? being concerned or detached from the patient? having a positive or negative outlook?

In the past touch has been a sensitive issue for PWAs. Before the methods of transmissions were discovered, AIDS patients were often quarantined or ostracized in some way. Many medical professionals did not want to touch a PWA for fear of having the virus passed on to them. While these fears have subsided for the most part, some people still are uneasy about touching someone with the modern-day plague. PWAs sense this uneasiness and struggle with the impact it brings. As a result it is important not only for nurses to be open and comfortable with touch, they should also be aware of the types of touch given.

Realizing that a nurse-patient setting is one in which comforting behaviors for both physical and psychological discomfort are likely to occur, I chose to look at specific forms of "comfort touch" from nursing literature. Thus I chose to look at the number of times several specific "comforting touches" were used. Comforting touches are an indicator of interest and compassion, and also for immediacy.
RQ2: To what extent do nurses use comforting touches with their PWAs? using gloves? using hugs? holding their hand? patting their arm or knee? rubbing their head?

In the past numerous health care workers, including nurses, have excessively worn rubber latex gloves unnecessarily when caring for their patients with AIDS. Some have worn gloves when they were not even going to touch the patient. This treatment unnecessarily ostracized the AIDS population and made them feel untouchable. Even after it was proven that these measures were extreme, some still continued to take excessive precautions. As a result many PWAs became angry and resentful when nurses were overly careful. Research question three was posited in order to explore how careful nurses were when touching or caring for patients. Are nurses too careful about glove wearing, within acceptable limits, or not careful enough in their precautions? The answer to this question comes in when rubber latex gloves are put on.

RQ3: When does the nurse put on rubber latex gloves?

*Self-reported Behaviors*

While a nurse may perform numerous immediate behaviors and give many comfort touches, it is important that the patient is satisfied as well. If the patient is not satisfied it will not matter how well the nurse treats the patient, s/he will not be happy, and this not view the nurse as immediate. As a result of this reality, I felt it important to look at the patients’ overall satisfaction and compare it to the overall immediate behaviors and comfort touches given.

The second set of research questions in this study are based on the results of patient and nurse surveys and interviews. In these questions I ask about their opinions, experiences with specific immediacy behaviors, how satisfied they are, and demographic characteristics.
Touch is especially important for PWAs due to the way they were stigmatized during the early development of the AIDS epidemic. Because of this I felt it was especially important to learn how important touch is to both nurses and PWAs, thus research question four and five:

RQ4: What do nurses feel are the benefits and drawbacks of touch?
RQ5: What do PWAs feel are the benefits and drawbacks of touch?

Just as nurses and patients are aware of the lack of touch with early AIDS patients, both groups are aware of the potential effects that wearing gloves has on the patient. While nurses wear gloves during some treatments for both nurses' and PWAs' protection, it is not necessary for gloves to be worn at all times. Nurses wear gloves for varying circumstances and amounts of time, however, the opinions of PWAs concerning the wearing of rubber latex gloves should also be taken into account when possible.

RQ6: How do PWAs feel about nurses wearing rubber latex gloves in non-medical situations?

PWAs' opinions on glove wearing is a small part of their opinion concerning their overall care is also important. If immediacy is present in the sender's behavior, the receiver should be satisfied and the reverse is also true. If either satisfaction or immediacy is not present and the other one is a part of the interactions then there must be more to satisfaction within a relationship besides immediacy and immediate behaviors. This being true, it is important to know if PWAs' are satisfied with the care they receive from nurses.

RQ7: Are the PWAs content with the present levels of care they receive from their nurses? If so, based on what reasons? If not, what do they feel they are missing?
There are other elements that play into how a nurse treats a patient. The demographics of the patient may be a factor in how a nurse treats a patient. This is especially true in dealing with patients who may have gotten their illness from participation in a socially unacceptable activity. If a nurse does not approve of a certain activity, such as homosexuality, and feels a PWA got the disease from participation in it, s/he may treat that patient differently than other patients. Additionally, a nurse may treat or feel differently about someone based on their gender or race, thus research questions eight and nine:

RQ8: Do nurses treat patients differently based on the nurses' perception of the patient's sexual orientation?
RQ9: Do nurses treat patients differently based on the patient's gender or race?

Finally, as with most relationships, the longer two people know each other the more information they have about each other. It is possible that the amount of time a nurse cares for a PWA is a factor in how s/he cares for the patient. Moreover, the closer a patient comes to their death, the more afraid of losing him/her the nurse may become, thus research question ten:

RQ10: Do nurses treat patients differently based on how long they have known each other, how sick the patient is, or the number of visits they have done with the patient?

First and third person pronouns have been become indicators of verbal immediacy. The use of first person pronouns, "I," "me," "we," and "us" expresses a level of interest and openness on the part of the sender. A closed and disinterested would not talk about him/herself and include the other party. In contrast the use of third person pronouns, "s/he," "him/her," "they," and "them" indicate a separateness from the speaker. When a
speaker uses these pronouns, s/he is not including him/herself in the group being addressed and thus indicating a level of detachment. Researchers believe first person pronouns are an indicator of greater immediacy and third person pronouns are an indicator of less immediacy.

Hypothesis 1: Patients will be more satisfied with nurses who use more first than third person pronouns.

Immediacy brings more than simply a label to a relationship it is an indicator of how an individual is viewed by others. Considering immediacy is viewed as a positive thing for a person to be, nurses should want to be seen as immediate by their patients. Immediacy is an indicator that the sender cares for and is concerned about the receiver. As a result, it is believed that the more immediate an individual is the more positive s/he will be viewed by others.

Hypothesis 2: Nurses who are more immediate will be viewed more positively than those who are viewed as less immediate.

METHODS

Subjects

The data for this study were gathered through observations of and surveys administered to twenty caregiver-PWA interactions. Caregiver and patient dyads were only observed together one time; however, some caregivers were observed with more than one patient and some patients were observed with more than one caregiver. The subjects included twelve caregivers, two Caucasian men and ten Caucasian women, and sixteen PWAs, twelve Caucasian men, one African-American man, one Hispanic man, one Caucasian woman, and one African-American woman. One of the Caucasian men cared
for a Caucasian man, and the other Caucasian male nurse cared for two other Caucasian men. All other patients were cared for by Caucasian women.

The observations occurred on different days, during different times in one of two settings: in patient's homes or in an AIDS-only hospice. Half of the observations occurred in patient homes through one of two home health care companies in a large, southern city. Typically home health care nurses travel to the homes of patients who are ill, but not necessarily "actively dying." When individuals near death, they are referred to as being in the stage of "active dying." The term "actively dying" refers to PWAs whom medical professionals expect to die within six months, but more often sooner than that.

The other half of the observations occurred in an AIDS-only hospice in a large southern city. Hospice caregivers care for patients who live at the hospice. In contrast to direct home care, hospice patients arrive no sooner than six months away from death and have no other place to go. Patients at the hospice are considered terminal and not likely to make a full recovery. It is important to note that while some PWAs may make small advances, such as being able to walk down the hall when they could not the day before, they will never be completely healthy again. These are the individuals who end up in a hospice.

In both settings nurses typically measure the patient's vital signs, assess the effectiveness of the patient's medication, and record responses to pre-set health questions. Nurses also perform special medical procedures as requested by doctors, such as drawing blood, changing medication lines, etc. Nurses and other caregivers at the hospice make sure the patients have had the opportunity to eat, use the bathroom, and other things important to daily living that they may not be capable of doing by themselves.
Procedure

The nurses were informed of my method and that I was there to study nurse-patient communication patterns. When entering the home of a patient, the nurses introduced me and explained my presence. At the hospice I was left to introduce myself and explain my purpose directly to the patients. I played the role of passive participant in both research settings, watching from an out-of-the-way area as the nurses cared for the patients (Spradley, 1980).

I understood the sensitive and confidential nature of issues around AIDS. This was clarified in the confidentiality form signed by patients and nurses. Consequently, I agreed not to record names of either party being observed. I also realized some situations could be sensitive or painful, both physically and/or emotionally. When the patients were given treatment in "private" areas of their body or if a patient or nurse requested I leave, I would have; however, this did not occur. Emotionally, issues surrounding AIDS as well as the dying process can be taxing or difficult to handle. Had any of the patients started disclosing highly personal information or broken down with a nurse I would have left the room to allow them privacy; however, this did not occur.

Data-gathering Techniques

The data were gathered through observation and surveys. When working with the home health companies I accompanied each of the nurses to the homes of their patients. I entered each home with the nurse and observed the types of interaction which occurred. During the visit I took notes using both the "During Visit Check Sheet" (see Figure 1) categories and unstructured field notes.

When working in the AIDS-only hospice I observed interactions in the living room, kitchen, or the staff office. Both check sheets were completed in the same manner as the home health care observations. The staff and patients were observed then

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interviewed using the same questions asked on the surveys. This was because the patients in the hospice were very near the end of their lives and lived there, resulting in a different experience from the home health patients. As the interviews progressed it became evident that some of the questions were not conducive to an interview setting. It seemed out of place to ask a nurse or PWA their opinion of touch because this is not a question asked in everyday conversation so I was somewhat uncomfortable and may have communicated my discomfort to the interviewee.

At the end of the visit the patient was given a survey (see Figure 4). The nurse was interviewed after the visit using the "After Visit Check Sheet" (see Figure 2) and was also given a survey (see Figure 3). Both nurse and patient were assured that their responses would remain anonymous. Ten of the twelve nurses/caregivers responded to the survey/interview for a response rate of 83%. Of the sixteen PWAs, eleven responded for a response rate of 69%. While the response rates were good, another potential problem was that some of the patients did not have full mental capacity, resulting in less accurate responses. From my identification on the surveys and my interactions and observations of the patients I believe that those who responded were mentally capable of doing so.

Due to confidentiality issues, audio or video recordings of interactions were not allowed. The patient interviews were difficult because some were physically and/or mentally unable to participate in an interview. Those who were able and consented were interviewed immediately following the request. The urgency to instantly conduct the interview existed because follow-up interviews could not be guaranteed due to illness, lack of opportunity to visit them again, or death. Interviews with patients were also restricted due to nurse proximity. At any time during the interview a caregiver could have stopped to listen, causing a patient to change an answer, not give full details, or end the interview all together. Additionally, one of the interviews was conducted with two patients at the
same time. As the interview progressed one of the patients became agitated that he was not the center of attention. At one point he said, "who's being interviewed here, me or him (the other patient)?" I explained that both men were and after the next question the other patient departed. During interviews with both patients and nurses, I took notes on survey sheets.

Data Analysis

The data were collected and categorized using a descriptive framework adapted from Andersen, Andersen, and Jensen's (1979) Trained Raters' Perceptions of Immediacy Scale. The descriptive framework incorporates aspects of verbal and nonverbal immediacy behaviors potentially used by nurses as they interact with patients. It contains a listing of specific nonverbal and verbal immediacy behaviors. Hugs, hand holding, arm or knee patting, and head rubbing are listed in terms of how often they occurred in one specific visit (see Chart 1). Overall nurse eye contact, body orientation to the patient, smile and nods, body posture, vocal expressiveness, use of first and third pronouns, concern for patient, and outlook are rated on a 5-point scale (see Chart 1). Both the point when the nurse put on the gloves and the nurse’s overall non-medical proximity are listed so that specifics of their glove wearing and proximity can be recorded.

Although much of the data fell into clear categories there were a few deviant cases. When coding a nurse's action of placing his/her arm around a patient's shoulder it was coded as a hug. This is because a hug is very similar in form to having one’s arm around someone’s shoulder and could be construed as a hug or arm around the shoulder. Another action that did not fit into a clear category was shaking hands. This occurrence was also coded as a hug because both actions occurred at the beginning of a visit and therefore was taken as a greeting.
Reliability

To insure internal reliability I conducted a pilot study with another individual. Ten segments from television medical shows were videotaped and observed. We rated the doctors' immediacy using the "During the Visit Check Sheet." The coding scale is defined in Chart 1.

<table>
<thead>
<tr>
<th>NURSE'S OVERALL EYE CONTACT:</th>
<th></th>
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<tbody>
<tr>
<td>1   none</td>
<td></td>
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<tr>
<td>2 only quick glances</td>
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<tr>
<td>3 mostly glances some gazes</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4 equal gazes &amp; glances</td>
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<td></td>
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<tr>
<td>5 mostly gazing</td>
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<table>
<thead>
<tr>
<th>NURSE'S BODY ORIENTATION TO THE PATIENT:</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>1 shoulders away</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 shoulders mostly &gt;45 degrees</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3 shoulders 45 degrees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 shoulders mostly &lt;45 degrees</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5 mostly turned in; 90 degrees</td>
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</table>

<table>
<thead>
<tr>
<th>NURSE'S RELAXED SMILES &amp; NODS:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 none</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 smile &amp; nod about 1/4 the time</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 smile &amp; nod about half</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 smile &amp; nod about 3/4 the time</td>
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<td></td>
</tr>
<tr>
<td>5 smile &amp; nod nearly all the time</td>
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</table>

<table>
<thead>
<tr>
<th>NURSE'S BODY POSTURE:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 very tense</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2 tense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 partially relaxed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 relaxed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 very relaxed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSE'S VOCAL EXPRESSION:</td>
<td></td>
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<tr>
<td>----------------------------------------</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1  very monotone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  monotone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3  somewhat expressive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  expressive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5  very expressive</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSE'S PRONOUN USE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  none</td>
</tr>
<tr>
<td>2  1-4</td>
</tr>
<tr>
<td>3  5-8</td>
</tr>
<tr>
<td>4  9-12</td>
</tr>
<tr>
<td>5  13+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSE'S CONCERN WITH THE PATIENT'S WELL BEING/HEALTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  very detached</td>
</tr>
<tr>
<td>2  detached</td>
</tr>
<tr>
<td>3  balanced</td>
</tr>
<tr>
<td>4  concerned</td>
</tr>
<tr>
<td>5  very concerned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSE'S OUTLOOK ON PATIENT'S CONDITION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  very negative</td>
</tr>
<tr>
<td>2  negative</td>
</tr>
<tr>
<td>3  balanced/neutral</td>
</tr>
<tr>
<td>4  positive</td>
</tr>
<tr>
<td>5  very positive</td>
</tr>
</tbody>
</table>

Chart 1: Code Definitions for the "During Visit Check Sheet"

When coding a nurse's actions in reference to the behaviors in Chart 1, an overall impression was recorded rather than an attempt to look at and record specific instances. The nurses would often change positions or would move around the room at least once during a visit. As a result it would have been too difficult to try and record every move the nurse made. I recorded the overall synthesis of the actions. For example, at the start of a visit a nurse may glance at the patient a few times, gaze at the patient continually during the procedure, and give both glances and gazes to the patient while packing the
equipment. The overall impression from these actions would be mostly glances and some gazes. It was believed an overall gestalt of the nurse’s behaviors would be a closer representation of the entire interaction and the relationship as a whole. Using Cohen's Kappa the overall reliability between the two coders was .78.

Validity

In an effort to ensure validity several things were done. First to ensure construct validity, "the degree to which a measure relates to other variables as expected within a system of theoretical relationships" (Babbie, 1995), the number and types of immediacy behaviors performed by nurses were compared to what their reported viewpoints on touch were.

Second, content validity, "the degree to which a measure covers the range of meanings included within the concept" (Babbie, 1995), was considered. In developing the research questions and hypothesis I included as many immediacy behaviors as were applicable to the nurse-patient relationship in this setting. This will help show how the range of immediacy behaviors can be taken into consideration in defining and finding immediacy. It is important to realize that not all immediacy behaviors may be important in all settings, this one included. This being the case seemingly irrelevant immediacy behaviors should not be considered here, such as sitting versus standing, being formal versus informal, and the use of gestures.

Finally, internal validity of qualitative research can be met in four ways: 1) data collection of a long period of time, 2) interviewing informants, 3) participation and observations conducted in the field, 4) and continual questioning and reevaluation should be done (LeCompte & Goetz, 1982). In this study twenty observations were done over a period of two months. This time frame allowed me to see consistently similar results. All of the nurses and patients were given surveys and/or interviewed when possible. This
allowed both informant types the opportunity to share their experiences and perceptions. All of the observations and interviews were conducted in the field. Finally, the findings were questioned and reevaluated. The result of this process was the development of new questions asked in Phase II.

The construction and development of research questions and hypothesis are an important part of any data-based study. When considering what to look at and focus on I considered immediacy, social support, and the need to belong in a AIDS-oriented setting. I considered the nurses’ and patients’ comfort levels as well as what would be allowed during observations. As I developed my data gathering tools I used quantitative and qualitative techniques to obtain a more rounded view. After I finished gathering my data I moved on to the analysis and reporting stages.
CHECK SHEET: DURING VISIT

gloves put on when:

COMFORTING TOUCHES

hugs:
holding hand:
patting arm:
patting knee:
rubbing head:

non-medical proximity: 6-18" 18"-3' 3-7'

overall eye contact  1  2  3  4  5

body orientation to patient:  1  2  3  4  5

relaxed smiles & nods 1  2  3  4  5

relaxed body posture  1  2  3  4  5

vocally expressive  1  2  3  4  5

VERBAL

1st person pronouns: 1  2  3  4  5

2nd & 3rd person pronouns: 1  2  3  4  5

concerned or detached from patient:  1  2  3  4  5

positive or negative outlook  1  2  3  4  5

Figure 1: During the Visit Check Sheet
CHECK SHEET: AFTER VISIT

NURSE
race: white___ black___ Hispanic___ Asian___
sex: F___ M___

PATIENT
race: white___ black___ Hispanic___ Asian___
sex: F___ M___
perceived sexual orientation: ho___ he___
length of time known:
# of previous visits:
how sick is the patient:

Figure 2: After the Visit Check Sheet
Nurses' Questionnaire

The purpose of this survey is to find out how nurses view touching patients. The touches discussed are not meant to be sexual in nature. "Non-medical" touches refer to any touch given or received beyond what is required during a medical procedure. Please do not identify yourself in any way as it is important to keep anonymity. Thank you for your assistance.

1. Nurses should not touch any patient in a non-medically oriented fashion.
   1  2  3  4  5
   strongly agree mildly agree neutral mildly disagree strongly disagree

2. Touching a PWA in a way other than medically-oriented is beneficial to the patient.
   1  2  3  4  5
   strongly agree mildly agree neutral mildly disagree strongly disagree

3. Is there any situation during the time a nurse is with a PWA that it is acceptable not to wear gloves? If so, under what circumstances?

4. In your opinion, what are the benefits of touching PWAs in a non-medical way, if any?

5. In your opinion, what are the drawbacks of touching a PWA in a non-medical way, if any?

6. How do you decide when to touch PWAs?

7. Is there anything else you feel is important in nurse-PWA interaction that you want to tell us?

Figure 3: Nurse’s Questionnaire
Patient's questionnaire

The purpose of this survey is to find out how patients feel about their interaction with their nurse. The touches discussed are not meant to be sexual in nature. "Non-medical" touches refer to any touch given or received beyond what is required during a medical procedure. Please do not identify yourself in any way as it is important to keep anonymity. Thank you for your assistance.

1. **Nurses should not touch any patient in a non-medically oriented fashion.**
   - 1 2 3 4 5
   - strongly agree    mildly agree    neutral    mildly disagree    strongly disagree

2. **Being touched by a nurse in a way other than medically-oriented is important.**
   - 1 2 3 4 5
   - strongly agree    mildly agree    neutral    mildly disagree    strongly disagree

3. **Does the wearing of rubber latex gloves by nurses make you uncomfortable?**
   - Yes    No    Why?

4. Under non-medical circumstances, would you prefer that your nurse not wear gloves? If so, what situations?

5. In your opinion, what are the benefits of nurses touching patients in a non-medical way?

6. In your opinion, what are the drawbacks of nurses touching a patient in a non-medical way?

7. **How pleased are you with the way your nurse cares for you?**
   - 1 2 3 4 5
   - very pleased    mildly pleased    neutral    mildly displeased    strongly displeased

8. What are the two most important reasons for the answer you gave above?

9. **Have you ever felt a nurse’s touch was intrusive?** Yes    No    If yes, why?

10. **Do you feel your nurse is concerned with you as a person?** Yes    No    Why or why not?

11. **Do you want a copy of the results?** Y    N    If so, please write your address on the back of this page and refer to yourself as "J. Doe."

12. Is there anything else you feel is important in nurse-PWA interaction that you want to tell us?

Figure 4: Patient's Questionnaire
CHAPTER 3
RESULTS: PHASE I

FINDINGS

Survey Results

Of the sixteen patients observed eleven responded to the survey. Three of the patients were too ill or demented to respond to the survey. I gave them a survey anyway, not expecting those patients to respond. The other two who did not respond may have chosen not to because of not wanting to put forth the effort or forgetting. Ten of the twelve caregivers responded to the survey. One of the caregivers said she would not respond to my survey but gave no reasons. I do not know why the other caregiver chose not to respond.

Patient opinion of care received

The vast majority of medical care for patients with permanent illness comes from nurses, not doctors. As a result, patients are more likely to develop a relationship with the nurses. Patients will also be exposed to different styles of care by different nurses. From this background patients know when they believe their nurse is concerned about them. When asked if they believed their nurse was concerned with them as an individual all eleven patients responded "yes" (see Table 1). None of the patients felt their nurse was not concerned with them as an unique individual. Almost all of the patients who responded to question number seven, how pleased are you with the way your nurse cares for you, were pleased with the way their nurse cared for them (see Table 2). Nine of the eleven respondents were "very pleased", one was "mildly pleased", and one responded "neutral."
Table 1: Do you feel your nurse is concerned with you as a person?

While none of the patients felt their care was poor, there are safeguards against mediocre care. Most of the patients had family members or assistants from the agency who were concerned with the patient's welfare. If a nurse were to become abusive or negligent with a patient in any way, the assistant was supposed to report the problem. If an assistant was not assigned to a patient and a family member was around it was assumed the family member would not tolerate abuse or neglect either.

Assistants and family members are not the only ones who stand up for the patients. Many of them take responsibility for their care as well. One of the patients said that he would not tolerate a poor nurse and that if he did not like the nurse or the nurse's actions he would and did inform the agency he wanted a different one. Another patient said that once he had a nurse who did not listen to his request of how he wanted his IV medication administered to him. As a result the medication was incorrectly mixed and burned as it entered his veins. The patient asked the nurse to leave and informed the agency she was not allowed into his home again.

When asked what the main reasons of why they were pleased or displeased with the way the nurse cares for them, four patients mentioned "care." One patient said his
nurse was "very gentle and very caring." Another patient responded, "they care." A third patient said her nurse was "helpful, caring, and knew her needs." The last patient to mention "care" felt "the patients were treated like people and the nurses cared."

Although "care" was an important aspect of approval of the way nurses treated the patients, it was not the only factor. One patient was pleased with the way he was cared for because his nurse "talks to patients and listens to patients." A second patient responded, "I feel as if she (the nurse) understands my suffering. She shows me kindness." Another patient alluded to the treatment of PWAs in his response of "the nurse shows concern for how I am feeling and this makes me feel good. I am treated with respect and not like I have a contagious illness."

![Pleased With Nurse's Care](image)

**Table 2: How pleased are you with the way your nurse cares for you?**

The primary results, from three different nurse-PWA settings, (see Tables 1 and 2) show that overall the patients were satisfied with the care they received. Of the eleven patients who responded to the survey, nine said they were "very pleased" with the care they received from their nurses. Of the two remaining respondents, one was "mildly
pleased" and the other "neutral." None of the patients said they "displeased" or "strongly displeased" with the type of care they get from their nurses.

Assuming this pattern held up, a much larger sampling would not hold any "displeased" patients, few "neutrals," and numerous "very pleased" individuals. I felt the majority of patients would continue to respond "very pleased," and therefore would be redundant to continue surveying additional PWAs in hopes of finding a greater range of responses. Because of the overall consistency of results I felt the patients were satisfied and that it would be unlikely different results would be found. Due to the small sampling size, research questions eight, nine, and ten could not be answered with statistical tests.

I also felt more accurate results would come out of the qualitative data because I had first-hand observations. It is highly likely I saw things that participants did not realize occurred or found important because their interactions are a part of their "normal" routines. Additionally, I was able to see discrepancies between what the nurses said and did during treatment. Finally, looking at the richer aspects and minor innuendos of the interactions was possible with a smaller sample size, yet would have not have been so with a larger sample size due to time constraints.

Wearing gloves

While patients felt good about their nurses and the way the nurses cared for them, there is more besides their interpersonal relationship involved in their interactions. The health and safety of both people is considered and protected. In many instances nurses wear gloves to protect themselves and their patients from infection. It is important for nurses to wear gloves while performing certain procedures on their patients. While this is necessary, in the past nurses and other members of the medical profession were excessively cautious about wearing gloves. PWAs have some awareness of this and may be sensitive to the wearing of gloves. If a PWA feels a nurse is overly cautious it could
affect the view of immediacy and care. When caring for patients who carry infectious
disease, nurses usually wear rubber latex gloves to prevent the spread of infection. While
wearing the gloves is a necessity, it may not be very physically or emotionally comforting
to a patient.

In response to question number three, *does the wearing of rubber latex gloves by
nurses make you uncomfortable*, three of the patients responded that the wearing of
rubber latex gloves made them uncomfortable. Eight said it did not (see Table 3). When
commenting further on the issue, patients said that the wearing of latex rubber gloves by a
nurse was not a problem when it was necessary. One patient reported not liking the
gloves because “they itch and stick to his skin.” All other patients reported they felt
wearing gloves was "necessary" and "protects both the nurse and patient." Several of the
respondents felt the nurse wearing gloves was a good thing because they "did not want to
make anyone sick." Moreover, a patient responded that he would be offended if a nurse
wore gloves when s/he would not be in contact with body fluids or with open abrasions.
This patient felt this action would show a nurse's ignorance of HIV/AIDS, resulting in a
loss of confidence by the patient. Another patient reported dissatisfaction with any nurse
who wore gloves when it was not necessary. Finally, one patient reported being highly
offended when nurses wore plastic breathing masks around him. He felt this action "says
the nurse is not educated enough to know how they can and cannot become infected with
HIV." The patient also felt that the wearing of a mask showed the nurse "is not confident
in their abilities as a nurse if they are that cautious."
Not only were the patients sensitive to the issue of wearing gloves, the nurses were as well. The nurses who responded were aware of the impact gloves may have on a patient. Although they were aware of the patient's feelings, they also were aware of possible dangers involved in treatment. One nurse responded that she does not wear gloves, "at all times when not handling body fluids." Another nurse answered "patients (PWAs) should be treated like anyone else as much as possible. The only danger to nurses is blood and body fluids. Touching and hugging should be without gloves unless they have open sores."

Harkness-Hood, & Dincher (1992) state that HIV can only be transmitted to a healthy individual one of four ways; through sexual contact with an HIV positive/PWA, an injection with an unsterile needle that has been exposed to the virus, exposure to infected blood or blood products, or by an infected mother to her unborn child. PWAs know how HIV is transmitted and expect their nurses to have that knowledge as well. If a nurse is overly cautious, it is quite understandable that the patient may be concerned about the nurse's abilities and frame of mind.
**Touch**

Even though the nurses are in a potentially dangerous situation by caring for individuals with a transmittable disease, they are not concerned about transmittability via touch. The nurses studied here realize that there is no possibility of them contracting the HIV virus through touch. In response to question number three, *is there any situation during the time a nurse is with a PWA that it is acceptable not to wear gloves? If so, under what circumstances*, the nurses overwhelmingly indicated the importance of touching patients without gloves. Five of the nurses indicated it was inappropriate to wear gloves during "normal" times or when they "did not need to." More specific instances of when touch without gloves was important included times of "holding a patient's hand in a comforting way," "talking with a patient," and "touching and hugging should be done without gloves unless they have open sores." One nurse even wrote enthusiastically, "you do not hurt anyone by hugs and touches. It feels good to nurse too!"

Overall, touch is something the nurses feel is important. In response to question number one, *nurses should not touch any patient in a non-medically oriented fashion*, only two of the nurses responded "neutral" or "mildly agreed" that non-medical touch should not occur. Of the other eight respondents, four said they "mildly disagreed" and four said they "strongly disagreed" that nurses should not touch patients in a non-medically oriented fashion (see Table 4). In addition all ten of the nurses "mildly" or "strongly agreed" that touching a patient non-medically was beneficial to the patient (see Table 5). When asked what those benefits were one of the nurses answered "nurses heal with their hands." Six of the respondents pointed out the need to treat PWAs as individuals. They feel that touching PWAs shows "acceptance of the patient as an individual." Touching today's PWAs contrasts the way PWAs in the "early 1980s" were treated because it helps them not "feel like lepers" but "cared for and appreciated like
normal people." One of the nurses felt touch helped to "establish comfort and relationship." Touch by a nurse helps the patient relax and accept treatment in contrast to "stigmatizing" them and making them even more conscious of their disease.

Table 4: Nurses should not touch any patient in a non-medically oriented fashion.

Table 5: Touching a PWA in a way other than medically-oriented is beneficial to the patient. (Patients' opinion)

Nurses are not the only ones who feel non-medical touch is important. Patients have strong feelings about touch as well. In response to question number one, nurses should not touch any patient in a non-medically oriented fashion, only one patient of
eleven felt nurses should not touch a nurse in a non-medical fashion, and that was only a mild agreement (see Table 6). Of the other ten responses, seven strongly disagreed that nurses should not touch a patient in a non-medical way.

<table>
<thead>
<tr>
<th>Nurses Should Not Touch Patients</th>
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<tbody>
<tr>
<td><strong># of respondents</strong></td>
</tr>
<tr>
<td>strongly agree</td>
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<tr>
<td>7</td>
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Table 6: Nurses should not touch any patient in a non-medically oriented fashion. (Nurses’ opinion)

In contrast with question number one, all eleven patients "mildly" or "strongly agreed" that being touched by a nurse in a way other than medically-oriented is important, five and six respectively (see Table 7). When asked what the benefits of non-medical touch were, three of the respondents specifically discussed how comforting it is to have nurses who are not afraid to touch them. Another respondent wrote that touch helps him "feel closer to the nurses and feel good (about) himself." Finally, a patient answered that he was glad his "friends and family do not have a fear of touching me," yet for "AIDS patients who aren't as lucky...the touch of a nurse would be very comforting."

Although both patients and nurses feel that benefits come from nurses touching PWAs, they also realize there are potential problems. When asked what some of the drawbacks could be most of the nurses replied, "none." One of the nurses pointed out the need to "be careful" so as not "to offend them." Another nurse felt that touch would not
benefit the patient if s/he is uncomfortable with it. Finally, one nurse commented that if a nurse could "sense the patient would not be comfortable or would not feel comfortable, then don't touch them non-medically." She then reported that she had never been in a situation where the patient was not comfortable, yet felt that "hugging sometimes does not feel comfortable" and therefore does not give hugs.

Just as the nurses understood the potential drawbacks from touch, the patients did as well. When asked about the potential drawbacks of nurse non-medical touch, five of the patients said none or did not respond to the question. Another patient answered, "none, to be touched is comforting and relaxes you." One of the patients felt that the decision for a nurse to touch a patient "depended on a lot of things," therefore the drawbacks do as well. Two of the respondents considered how others could feel by mentioning that "some people don't want a soothing, reassuring touch of a hand," or that touch may "bother the patient." Another respondent felt that touch is "sometimes not needed." One patient felt that some nurses, in touching patients "seem to (be) fake sometimes."

Knowing that there are both benefits and drawbacks to touching their AIDS patients, nurses have many things to consider when deciding if and when they should touch them. In response to how they decide when to touch a PWA, two nurses felt AIDS was not a factor. One nurse responded "nurses use their hands to touch all types of patients, regardless of their illness." The second nurse explained "the tasks you do on patients determines when to touch any patient." This nurse also felt that touching in a non-medical way "depends on how comfortable" the nurse is "with a patient on a personal level." The nurse continued her response by answering non-medical touch should only occur if the nurse thinks the patient "would be receptive and not take it in a negative way." Another nurse backed this up by saying that patients "let you know...you can 'feel' it from them." A third nurse added in her answer that nurses know because "when you've been
with them (patients) for awhile and know them, you know what they prefer. That's what you follow."

Table 7: Being touched by a nurse in a way other than medically-oriented is important.

In response to the question of a nurse's touch ever being intrusive, two people responded that they felt a nurse's touch had been intrusive (see Table 8). One felt the nurse "did not mean to be intrusive," while the other said that he wanted to be alone sometimes. An important note is that the person who wanted to be alone was also a resident of a hospice and had lost a certain level of privacy he had once had. The other nine respondents did not report an experience of feeling intruded upon by a nurse's touch.

Table 8: Have you ever felt a nurse's touch was intrusive?
Other results

There were several factors other than immediacy that influenced the closeness of the nurse-patient relationship. When asked what other aspects of nurse-patient interaction were important in their opinion both nurses and patients had quite a bit to say. A number of the nurses said that they enjoyed working with PWAs and wanted to work primarily with them. Nurses realize the importance of being part of the PWAs' lives, yet also consider the consequences of their patients' deaths and what the consequences mean for them. One nurse mentioned the importance of "being a part of their lives, but not too involved." Another hospice worker mentioned that working in the hospice was "hard." She felt that the time working in the hospice was a very serious period in her life and that because of her work 'she couldn't even date." She also felt that "working with these people has really changed me."

Nurses also mentioned the importance of viewing the patients as people. One hospice worker mentioned "it is important to let the patients be people but sometimes you have to make them take help. These are really powerful people." Another nurse commented on how the demographics of the patients may affect if and how she touches them. According to this nurse, most homosexual men are accepting of hugs and touch, yet care should be taken with drug users who could be demented from the drugs. She also stated that some heterosexual men like hugs and some do not, and that race is sometimes a factor in choosing to or not to touch a patient. This nurse feels that overall one "can sense who will be accepting" of touch "and who will not."

Patients also consider the personal aspects of the nurse-patient relationship and feel those things are significant as well. One patient pointed out the extreme importance of being treated the same as anyone else. The patient went on to say that if "a nurse is not able to treat a PWA as an equal, s/he should find another job. It is very important that we are not treated like we have AIDS. A nurse that is concerned, caring, and supportive is
what makes a good nurse." Another patient explained he was happy at the hospice because "they make time (for him). It is safe, good, and sterile care...a dream at work." The final comment made by this individual was that he "wanted to be a productive part of society like" he "used to be."

**Observation Results**

**Gloves**

While wearing rubber latex gloves is important to the safety of both patient and nurse, it is not always needed. Only two of the ten nurses who were observed used rubber latex gloves while treating their patient. One the nurses wore them when she was changing the patient's IV line. Throughout this procedure she used three pairs of gloves, changed them each time she opened a new package of IV equipment. Doing this minimized the possibility of spreading germs or causing an infection. The other nurse who wore gloves did so when he was cleaning out a wound in a patient's leg. Both of these nurses could have been in direct contact with the patient's body fluid. During the other eighteen episodes the nurse was not in contact with the patient's body fluids, therefore did not put gloves on. In the two instances where gloves were used, both nurses put them on immediately before treating the patient, not earlier.

**Comforting touches**

Very few of the nurses utilized comforting touches; hugs, patting an arm or knee, holding a hand, or rubbing a head (Dolin & Booth-Butterfield, 1993), during the time I observed. Of the twenty episodes, nurses and patients hugged in only two. Both hugs were given by the same nurse when she was leaving. This particular nurse was also the only one to shake a patient's hand. The handshake occurred upon arrival in the home.
Another comforting touch used by nurses was patting the patient's arm. Two different nurses used this with one patient each. One nurse patted her patient's arm just before giving him his shot. The second nurse patted the patient's arm while he was telling her about a positive trip to the doctor.

The last of the comforting touched that was used by any nurse was patting the patient's knee. One nurse did this while attempting to get a patient who was watching TV involved in "pet therapy." "Pet therapy" is when volunteers from animal shelters bring animals to sick people with the hopes of cheering them up. In this case the patient was not completely coherent and the nurse was attempting to get his attention.

Although some of the nurses used some of the comforting touches, not all of the comforting touches were used. In the twenty episodes observed none of the nurses held a patient's hand or rubbed a patient's head.

Nonverbal immediacy

The nurses' proximity from the patients varied considerably (see Table 9). During two of the episodes observed the nurse was "within eighteen inches" of the patient. In one of these cases the proximity was beyond the control of the nurse. The patient was in a wheelchair and when the nurse sat down he wheeled over to her. The other eighteen episodes were evenly distributed with nine nurses overall "one-and-a-half feet to three feet" away from the patient and the other nine being "three to seven feet" away from the patient. In five of the cases when the nurse and patient were three to seven feet apart they were sitting on two different chairs or couches. In three of the other four cases the nurse was moving around preparing something when the patient entered the room. In five of the cases when the nurse and patient were one-and-a-half to three feet away, the nurse and patient were sitting on the same couch. Of the other four cases, three of them occurred
while the nurse and patient were sitting at a table. The final instance happened when a nurse was walking past a patient in a hallway.

The nurses' eye contact and body orientation toward the patients varied considerably between different episodes. All of the nurses used eye contact to some degree (see Table 10). In seven episodes the nurse primarily used "quick glances", in two "mostly glances and some gazes" were used, in seven instances the nurse used an "equal number of glancing and gazing", and during the other four the nurse "mostly gazed" at the patient.

Table 9: Nurse-patient non-medical proximity.

Table 10: Nurse-patient overall eye contact.
The nurses' use of overall body orientation towards the patient was a little more equally distributed (see Table 11). None of the nurses were ever "completely turned away" from their patients at all times. In five of the episodes the nurse kept his/her shoulders "greater than forty-five degrees" from the patient, in four cases the nurse generally had his/her shoulders "forty-five degrees" from the patient, during five episodes the nurse kept his/her shoulders "less than forty-five degrees" from the patient, and in the other six episodes the nurse had his/her shoulders "mostly parallel" with the patient.

![Nurses' Body Orientation](image)

**Table 11: Nurse body orientation to the patient.**

In addition to eye contact and body orientation, a relaxed atmosphere is also an important aspect of nonverbal immediacy. The use of smiles, nods, and a relaxed body posture adds to the overall ambiance. The use of relaxed smiles and nods often puts others at ease. Nurses tend to use both techniques when caring for patients (see Table 12). None of the nurses "did not smile or nod," six smiled and/or nodded "about a fourth of the time", seven did so "about half the time", five "about three-fourths of the time," and two nurses "used relaxed smiles and nods "the majority of the time."
A nurse's overall body posture is just as important as smiling and nodding during conversation. The nurses seemed to realize this. None of the nurses had a "very tense" body posture (see Table 13). Two of the nurses were "slightly tense," however both of these nurses were caring for people who were very ill or who were not following the nurse's previous instructions. During fifteen of the nurse-patient episodes the nurses were "partially relaxed" and both cared for and conversed with the patient. In three of the episodes the nurse's posture was "relaxed." In each of these cases the patient was not terribly ill and the nurse and patient were primarily talking. None of the nurses observed were "very relaxed."

Table 12: Nurses' relaxed smiles and nods towards patients.

Table 13: Nurses' overall body posture.
Finally, vocal expressiveness is another aspect of nonverbal immediacy used by nurses. Overall the nurses were expressive in their speech (see Table 14). None of the nurses were "very monotone," "monotone," or "very expressive." In thirteen of the episodes the nurses were "somewhat expressive" while during the other seven the nurses were "expressive." In five of the expressive episodes the nurse had known the patient for over four months and spent extra time talking to the patient. Of the other two episodes which were expressive one occurred when a nurse was changing the dressing on the leg of an unresponsive patient, and the other occurred while a hospice worker was preparing something and the patient interrupted what she was doing.

![Nurses' Vocal Expressiveness](image)

Table 14: Nurses' vocal expressiveness.

**Verbal immediacy**

While nurses used various aspects of nonverbal immediacy, they used aspects of verbal immediacy as well. Although touch and other nonverbal immediacy behaviors were looked at in depth, I attempted to look at verbal immediacy as well. The most specific aspects of verbal immediacy hypothesized dealt with the use of pronouns by nurses. Pronoun usage is considered a key point of verbal immediacy. Because recording devices could not be used an accurate count of the number of pronouns used was impossible. This
inaccuracy would have affected both the number counted and the ratio found. Rather than obtain inaccurate data I chose to focus on other areas. Moreover, taking into consideration that the amount of time spent at each home varied from less than fifteen minutes to over an hour, hypothesis one, nurses who use more first than third person pronouns will be viewed as more immediate, and the first and third pronoun section of research question one, to what extent do nurses use first or third person pronouns with their PWAs, were eliminated. This was because the difference in time spent at different patients' home would have factored into the number of pronouns counted; the less time spent at a home, the fewer number of pronouns likely spoken. While the use of first and third person pronouns was impossible to obtain, other areas of verbal immediacy used became evident throughout the study.

Nurses often expressed some level of concern for the patient. While expression of concern is not listed as a direct link to immediacy, Gazda, Childers, and Walters (1985) believe that showing interest is. Concern is a more involved form of showing interest and a consistent theme in the observed episodes (see Table 15). None of the nurses were found to be "very detached" from the patient. During three of the episodes the nurse was "detached" from the patient. In two of these episodes the patient was in an unresponsive state, saying nothing to the nurse and not looking at him/her. In the third episode the patient had interrupted what the hospice worker was doing, resulting in her desire to get back to her task. During four of the episodes the nurse was "balanced" in concern and detachment for the patient. In nine of the episodes the nurse was "concerned" about the patient, and in the other four occurrences the nurse was "very concerned" about the patient.

Concern for the patient was manifested in several ways. A large part of the nurses' concern for their patient came in the form of asking about how their overall health had been from the last time they had seen the patient. The home health care nurses not only
asked about the patient's health, they also told the patient what their vital signs were as they checked each one. Most of the these nurses also remembered different problems the patient had during recent visits and asked about them. The nurses also knew and asked about family members or romantic partners. When the patients had pets, the nurses greeted the animal and gave it attention upon entering when it seemed to want it. One final theme that emerged in the home setting is the watching of soap operas. All the visits occurred in the early part of the day and, with the exception of two, all the patients were watching soap operas. The nurses asked about the plots and discussed who were the villains that week and what they were doing. On a couple of occasions the nurse and patient discussed which characters they felt were physically attractive.

In contrast the hospice workers saw the patients at various times during the day. Many of the workers ate with the patients or sat outside with them and talked about things other than the patient's health. Because of this the workers were able to get involved in more than just the patients' health. They were able to see the patients in the more realistic settings of daily life, i.e. eating, cooking, napping.

![Nurse's Concern For Patient](image)

Table 15: Nurses' concern or detachment from patient.
The topics discussed by nurses and patients are not the only aspect of verbal immediacy used by nurses. Nurses also must think about the patient's condition when caring for them. When speaking with their patients, nurses must consider the patient's overall physical condition. Often patients will ask nurses about their health. Of the twenty episodes, none of the nurses had a "very negative outlook" on the patient's health (see Table 16). During two of the episodes the nurses had a "negative outlook" on the patient's health. In both of these cases the patient was in an unresponsive state and had been steadily declining in health for some time. During eleven of the episodes the nurse was either "balanced" about the patient's condition or said nothing about it. In five of the episodes the nurse had a "positive outlook" on the patient's condition, while in the other two episodes the nurse had a "very positive outlook." Often the positive expressions came after the nurse took a vital sign and noticed that it was the same or better than the previous visit. At other times the patient would mention that s/he was better and gave an example of progress. During these times the nurse would express pleasure and encouragement.

![Nurses' Outlook](image)

Table 16: Nurses' overall outlook, positive or negative.
From the results we can see that there is a great deal of communication going on between nurses and their AIDS patients. Their relationship and interactions make for an interesting look into a “normal,” yet different form of daily interaction. Both sides have strong feelings about the way nurses should treat PWAs, however their actions do not always coincide with their words. It is interesting to note that both sides feel being treated normally and with respect is valued. Because of nurses’ beliefs and subsequent actions in treating PWAs the same as they would other patients, PWAs appreciate their nurses and like how they are treated, when they are treated “normally.”
One of the more satisfying findings of the study was the fact that overall the patients were pleased with the care they received from their nurses and caregivers. PWAs were asked, "Are you content with the present levels of care you receive from your nurse? If so, based on what reasons? If not, what do you feel is missing?" All of the patients felt their nurse was concerned with them as an individual and eighty-two percent were very pleased with the care they receive. From this it is obvious the patients are content with the type of care received.

While it was easy to find that the patients liked their nurses and level of care, getting their reasons was more difficult. Most of the patients mentioned words such as "care," and "respect," but concrete behaviors were not mentioned. It seems that while it is easy to say someone has an interest or is concerned, it is difficult to explain why. From observing interactions some specific behaviors were present. Most of the nurses took time to ask about the patient and his/her family or living situation, interests, or health. In other cases the nurses also took time to "blend into" the PWAs surroundings by joining into the activity the patient was engaged in at the time of the nurse's arrival, such as watching TV. The nurses also frequently asked their patients if they needed any supplies, medication, or other type of assistance. While some of the things the nurses could do nothing about, some knew of other individuals or places that did. It is believed that these actions, as well as the following behaviors, contributed significantly to the patients use of and definition of "care."

None of the patients felt there was anything missing from their care which could be corrected. The only thing mentioned came from one patient at the hospice. He said he
wished he could have more privacy. While it would be nice to grant his wish, the reality is living in a home with seven other patients and a minimum of five staff members/volunteers diminishes anyone's level of privacy. One must also remember this is not a direct fault of a caregiver's poor abilities but of several people living or working in an enclosed area.

Verbal immediacy

Verbal immediacy was an important part of the nurses' care and something all of the nurses and caregivers used to some extent. Verbal immediacy was important in that it was used to express care and concern for patients as well as for keeping up with the patients' lives. Through verbal immediacy a connection was made which allowed the nurse-patient relationship to grow and expand.

According to Gazda, Childers, and Walters (1985) showing interest in a person, as through giving compliments, is an expression of verbal immediacy. In this study the nurses did not compliment the patients, however, they did show interest and concern for their patients (see Table 15). The results ranged from three instances of nurses being detached to four instances of nurses who were very concerned for the patient. The nurses who were detached were so because the patient was unresponsive. The nurses did their jobs as sensitively as possible and moved on realizing the patient would simply lie there and do nothing. In the other cases the nurses were concerned about the patient, yet did not want to smother the patient with concern and interest. As with the other types of immediacy behaviors, there is a point at which too much concern would be uncomfortable or would communicate the patient is worse off than s/he seems. None of the nurses reached this extreme.

While a nurse's outlook is not a direct form of immediacy, it is related to immediacy in medical settings. Considering the nurses are dealing with dying individuals
to whom the nurse's medical assessment means a great deal, it is important for them to remain somewhat positive about the patient's condition. If a nurse tells a patient s/he is not doing well a spiral of depression could begin, pulling with patient down. In most of the episodes the nurse either did not mention the patient's condition or said both positive and negative about it (see Table 16). This was because the nurses realize the patients are sick and do not want to give them a false sense of hope. It is important to be honest with a patient lest they begin to hope they are "cured." Honesty helps patients accept the reality of the situation. In other instances discussion of the patient's medical condition did not come up.

In the remaining nine episodes the nurse's outlook was either more positive or more negative. The nurses were honest, yet not brutality so, in their comments on the patients' vital signs. Positive expressions often came when a patient's vital signs were better than they had been on the previous visit. By expressing excitement the nurse lifts a patient's spirits without making them feel they have been cured. During times when a patient's vital signs were worse than the time before, the nurse tended to find something else to comment on. This helps a patient not feel s/he is sliding into a never-ending hole of sickness. In the cases when the nurse was somewhat negative it was because the patient was unresponsive and either had given up or would not get better regardless. In one of these cases the mother refused to believe her son was very ill. The nurse was less than positive so the mother would begin to accept her son's coming death.

Another important aspect of verbal immediacy investigated in this study was the nurses' truthfulness. Klinzing and Klinzing (1985) believe that telling a patient the truth about his/her condition will only improve the medical professional-patient relationship. Not telling the truth causes a patient to distrust the medical professional and therefore possibly not listen to medical orders.
Other areas of verbal communication occurred in many of the observed episodes as well. First of all the nurses told the patients their vital signs after taking them. In most cases one or both of the individuals would comment on the results, discussing whether they were better or worse than the previous visit. Additionally the nurse would express pleasure when a vital sign improved over the previous visit. This shows the nurse was aware of the patient and his/her health from the previous visit.

Secondly the nurses asked patients about family members or other important events which had occurred since the last visit, thus expressing concern. The nurses briefly discussed how family members were and even asked about specific events or occurrences. Remembering events and details about things important to patients expresses true concern on the nurses' part because people generally do not remember things they consider unimportant. This indicates the nurse uses previous knowledge learned from prior visits and as well as allows the patient the choice of topics for discussion. These small concessions are important factors in their relationship.

Finally, many of the nurses arrived while the patient was watching TV. Since most of the visits occurred during the day the patients often were watching soap operas. With the exception of one episode, in all the patients' home where the TV was on, the nurses asked what show was on and what was happening. They would then discuss who on the show was good and the latest things the bad guys did. In one case a nurse arranged all visits at the home of a patient during the time a specific soap opera was on. Since the treatment required by the patient took about an hour they were able to watch the entire show and discuss what had occurred. Usually people who arrange to share this kind of time together have some bond developed. Brauer (1965) feels that time spent with a patient is an important factor in relationship building. By sharing this time together the nurses and patients were able to build rapport and trust in the relationship. In the
nurse-patient setting this shows the nurse is aware of what is important to the patient and attempts to become involved as well.

**Gloves**

The answer to research question three, "*When does the nurse put on rubber latex gloves?*" was very straightforward and the same for all nurses who used gloves. The nurses put rubber latex gloves on immediately before performing a medical procedure in which they could potentially be in contact with a patient's blood or body fluids. In instances when a nurse would not be handling blood or body fluids, the nurses and caregivers did not wear gloves at all. This is important because patients understand the need for nurses to use gloves when necessary.

Research question six, "*How do PWAs feel about nurses wearing rubber latex gloves in non-medical situations?*" covers PWAs attitudes on nurses wearing gloves in non-medical settings. PWAs do not like this and tend to distrust nurses who wear gloves for no specific purpose. This is important to note because distrust could build a barrier between patient and nurse resulting in a less-than-desirable situation for both parties. From this one can see that nurses realize patients should be touched without gloves when possible.

**Nonverbal immediacy**

Using nonverbal immediacy was found to be an important part of a nurses' care of PWAs. As the nurses gave treatment to their patients they engaged in several forms of nonverbal immediacy behaviors.

Research question one had to do with the extent immediacy behaviors are used. The findings indicate immediacy behaviors are not used much by some nurses and used quite a bit by other nurses, with varying degrees of use in between by still other nurses.
While proxemics are an indicator of immediacy, it was not always possible for a nurse or caretaker to remain within a close area to a patient. Overall, most of the nurses stayed between one-and-a-half and seven feet from their patients. This allowed the nurses to be close to their patients, yet not at a distance that was stifling or uncomfortable for the patients. Generally in American culture, particularly Caucasian culture, it is not desirable to continually remain at a close distance (Dodd, 1989). While this behavior may not be construed as "immediate" in the sense that the nurses remained at a constant close distance, it was "comfortable" as defined by Pluckhan (1978) and accepted by the patients.

Eye contact is also an important part of communication in that it helps the partner know if the individual(s) s/he is attempting to communicate with is open or closed (Klinzing & Klinzing, 1985). In this study the nurses ranged from using mostly quick glances to using mostly gazes (see Table 10). Considering that too little or too much eye contact inhibits communication (Balzer-Riley, 1996), it is important to find a balance. It is hard to maintain continuous eye contact in any setting. Being involved in a care-giving situation makes continuous eye contact that much more tricky. Patients realize the nurse's main concern is their health and accurate measurements of it, therefore do not become offended if the nurses look at their equipment more than the patient. While Pluckhan (1978) states that eye contact is a demonstration of the amount of attention given by another person, in this setting it is not wholly accurate. Eye contact is not as much of an indicator of attention as is staying in a conversation or giving verbal feedback when a nurse performs medical procedures or checks vital signs.

Just as the nurses had different levels of eye contact towards the patients, they also exhibited different levels of body orientation. It was fairly equally distributed from shoulders generally less than forty-five degrees from the patient to shoulders mostly turned in to the patient (see Table 11). While an open body posture is a sign of interest in a person (Balzer-Riley, 1996) and "turning away" is the quickest way to end communication
(Pluckhan, 1978), this setting is different. Just as giving care affects a nurse’s eye contact with a patient it affects body orientation as well. It is very difficult to have one’s shoulders turned in to a person if they are sitting beside one on a couch. Moreover it is difficult to remain completely “turned in” if one is standing while the other is sitting or is doing a medical procedure and needs to be focused on the equipment. Patients understand this reality as well.

The majority of the time the nurses had some relaxed smiles and nods. These also varied from having them one fourth of the time to nearly all the time (see Table 12). In this study the nurses were in their patient’s homes, either in ones they owned or in a hospice. As a result it was important for them to help the patient feel relaxed and not too intruded upon. Smiles and nods help to relax the person one communicates with (Balzer-Riley, 1996) and indicate comfort or approval (Klinzing & Klinzing, 1985; Gazda, Childers, & Walters, 1985; Blondis & Jackson, 1977; Wiener & Mehrabian, 1968). Nevertheless we should not forget that the nurses are caring for very sick and dying individuals. Overall the nurses who cared for the healthier patients used more smiles and nods than those caring for the actively dying individuals. In the cases of actively dying or impassive patients, very few smiles and nods occurred. This was because the patients were unresponsive and the nurses were intent on what their job was. The patients who gave feedback to the nurses overall received more smiles and nods. The patients responded to the nurses who in turn responded back, creating a cycle of communication.

In this study the majority of the nurses had a partially relaxed body posture (see Table 13). A few of the nurses were tense. The two who were tense were that way because their patient was actively dying. As a result it could not be expected that the nurse would be relaxed when treating a very ill individual. In contrast, the times when a nurse was relaxed came when the patient was not terribly sick and was joking with the nurse or when hospice caregivers interacted with them over matters other than medical
ones. In these cases both parties were not stressed and were in a more "natural" situation than a medically-oriented one. In many medical situations a patient may be hurt in some way, therefore is tense. When medicine is not discussed it is easier for a patient to relax.

Vocal expressiveness was indicated in this study as well. The nurses were either somewhat expressive or expressive (see Table 14). Wiener and Mehrabian's (1968) claim that vocal tone is the strongest vocal indicator of immediacy received some support in the findings. None of the nurses were monotone and none of the patients felt their nurses was uninterested in them. While some of the nurses were more expressive than others, this is possibly due to their personalities. The episodes in which the nurses were more expressive were dominated by the same two nurses. These nurses also tended to be more expressive physically in hugging the patients and in expressing affection. Regardless, none of the nurses showed disinterest in their patients from their expressiveness.

While touch communicates a liking or attraction to another person and an interest in their well-being (Mehrabian, 1981), there are some boundaries which when crossed cause the "touchee" to feel uncomfortable. The overall responses from the patients suggest they are comfortable with touch inside "normal" parameters. PWAs are very aware that they have a deadly disease and do not wish to be continually reminded of it by a nurse who is afraid to touch them with his/her bare hands. At the same time it also seems they do not want to be overly touched and pampered. PWAs want to be treated as though they were like any other patient. PWAs, like any human being, want to feel accepted and touchable, yet do not want to be smothered with affection. It seems that there is a area of toleration between the two extremes. A nurse who treats PWAs as though they are like any other patients will be appreciated and respected by the patients. A nurse who is very touchy and makes too much of an effort to make patients feel accepted will be disliked as well as a nurse who refuses to touch patients at all or only while wearing gloves. In the words of a nurse; it is best to touch a patient "when it feels right."
Looking at all the nonverbal immediacy behaviors there is a minimum amount of immediacy that is necessary to make a person comfortable. All of the nurses used some form of the nonverbal immediacy behaviors. While some of the nurses used a wider variety of behaviors and/or a greater number of behaviors, this difference did not influence how the patients rated their care. Nonverbal immediacy in a medical setting is somewhat distinct from immediacy in other settings. This is because the nurse is not only seen as an authority and expert, but also has some power and knowledge concerning the patient's health. It is different from a classroom setting because a student has a choice of whether or not to stay in the classroom, but the patient does not have a choice concerning whether or not to leave his/her unhealthy body for a healthier one. Because of this it is possible that the nurse need not be as nonverbally expressive as in social settings. While this is the case there are a minimum number of behaviors the nurse must do. If the nurse performs no or very few nonverbal immediacy behaviors then s/he will be viewed as cold and uninterested. After the minimum level any amount over that is acceptable to a point. At some stage too much nonverbal behavior becomes excessive and viewed by others as "odd." While it is likely there is a maximum limit, none of the nurses seemed to cross it with any of their patients.

Comforting touches

"Comforting touches" is a medical term used to describe touch given by medical personnel to patients for the purpose of comfort (Dolin & Booth-Butterfield, 1993). Because touch is such an important part of immediacy (Klinzing & Klinzing, 1985; Mehrabian, 1981; Pluckhan, 1978; Johnson; 1972) comforting touches are a form of nonverbal immediacy that is especially relevant in medical settings. In answer to research question two: "To what extent do nurses use comforting touches with their PWAs? using hugs? patting their arm or knee? holding their hand? rubbing their head," hugs were
rarely used. Out of twenty observed episodes only two hugs occurred. Both of these hugs were given by the same nurse. Hugs were probably not used much because they are an expression of a closer personal relationship. While the patients and nurses may consider themselves "close," they may not have reached a point where hugs are acceptable. Many people save hugs for family members or their closest friends. Others are not sure how a hug would be received, therefore do not offer hugs out to people with whom they are not completely comfortable.

In two episodes a nurse patted a patient's arm. One of these came as a patient described a positive visit to a doctor. The other one occurred just before a shot. This indicates that, again, comforting touches do not occur often. The pat before the shot reinforces the notion that patting a person's arm indicates sympathy. The patient did not want the shot and disclosed previous experiences of discomfort due to his lack of body fat. The nurse patted his arm and told him she would try to do it quickly, thus expressing sympathy. In the case of the patient describing the doctor's visit, the nurse showed her approval and happiness for the patient by patting his arm. It also showed her investment in him as a human being.

Patting a person's knee fits better in a setting of verbal interaction rather than in comfort. Most comfort touch occurs above the waist, i.e. holding hands, patting arms, hugs. Patting someone's knee occurs more often when two people are speaking and one is reassuring or agreeing with the other. In this study only one caregiver patted a patient's knee. This occurred while attempting to get a non-responsive patient involved in "pet therapy." While this action could not be construed as one of comfort, it was done to obtain interest or participation from a non-responsive patient. This action was a subtle attempt to reassure the patient he was not alone. It was also a way to show that even though the caregiver wanted the patient to participate in therapy, it was acceptable for him not to as well.
In no episode did a nurse rub a patient's head or hold their hand. Considering both of these behaviors generally occur when one is attempting to comfort another who is suffering it was understandable that these did not occur. None of the patient's were in a great deal of physical or emotional pain. Under these circumstances a nurse rubbing a patient's head could be construed as treating him/her like a child. While holding a patient's hand might be more accepted, it could also be viewed as a romantic gesture or as odd.

It is possible that the majority of the nurses save comfort touching for occasions when a patient is in need of comforting. Considering in most of the observed episodes the patient was not suffering or no painful procedures were performed the nurses may not have felt the need to perform any of the behaviors I was looking for. Moreover, the nurses may not have felt it necessary to do these things in front of me. Another factor to consider is the appropriateness of using comforting touch. If a nurse feels a patient could misinterpret his/her intentions it may be better not to touch the patient (Blondis and Jackson, 1977). Unfortunately in today's society people are sued for or accused of almost anything. With this current state of affairs some nurses may not be as willing to unnecessarily interact physically with patients for fear of legal recourse, warranted or not.

In answer to research question four: "What level of importance do nurses place on comforting touches?,” all the nurses except one placed a high level of importance on touch. In contrast, the nurses did not actually touch their patients very much. This is likely due to the fact that the nurses realize AIDS patients need to be touched like all people, and therefore give touch much vocal praise; however, in actuality the nurses say they touch PWAs no more or less than any other patient. Nurses are also likely to be aware of the leprosy-type treatment PWAs of the 1980s received. As a result it is likely they believe and say that PWAs should be treated as all other patients and that touch is an important part of treatment. The reality in this study is that non-medical touch between
nurses and PWAs is minimal. While this inconsistency may seem peculiar, it actually is not. The nurses in this study did not go out of their way to treat their AIDS patients differently by giving them a great amount of touch. The nurses made an effort to act "normal" with the patients, thus treating them the same as any other patient. This is important because the patients do not feel "different." Instead they feel normal and trust the nurse, an indicator of immediacy.

Just as nurses place high value on non-medical touch, so do PWAs. In answering research question five, "What level of importance do PWAs place on comforting touches?" I found similar results as in research question four. While the patients say non-medical touch is important to them it does not show in care episodes. In some instances the nurse did not touch the patient at all, yet the patient was pleased with the care given to him/her. As with the nurses inconsistent answer and action, it is possible that the patients feel their answer was the "right" thing to say. However, as long as the patients feel they are being treated as "normal" individuals and not different from other patients they trust the nurse and are happy with the relationship. If the nurse expresses interest in, spends time listening to, and is honest with patient then the patient feels things are fine, thus immediacy is accepted.

Social Support

In this study social support came from verbal immediacy behaviors. Caring and support are defining characteristics of social support (Albrecht and Adelman, 1984). Nurses showed this by their willingness to join into the patient’s activity, ask about family members, and show enthusiasm when vital signs had improved. Dickson-Markman and Shern (1990) discuss how social support provides information, feedback, and assistance for a variety of physical and psychological needs. Again the verbal immediacy behaviors
support this. Additionally the nurses utilized comfort touches when appropriate as well as looked into the answers for patient questions.

The results of this study indicate verbal immediacy, i.e. topic selection, previous knowledge, and awareness of what is important to the other individual is just as important as nonverbal immediacy. Although this is true here, it may not be in other medical settings. While non-medical touch between nurses and PWAs in this study is minimal, one cannot conclude AIDS is or is not a factor. Further research of the same kind is needed with non-PWAs to make this speculation.
CHAPTER 5
RESEARCH METHODS AND RESULTS: PHASE II

RATIONALE AND RESEARCH QUESTIONS

Upon completion of Phase I, the differences in what nurses actually said versus what they actually did in relation to touch and other areas of immediacy was evident. The nurses gave a great deal of lip service to touch and its importance, yet did not touch the patients much at all. Additionally, verbal immediacy behaviors were apparent in the majority of nurse-patient interactions, such as expressing concern, being positive, and giving information to the patient about his/her condition. Each of these behaviors were important in that they allowed the nurse to express interest in the patient. The expression of concern shows the patient that the nurse cares and is involved in the life of the patient. This action allows the patient to hear from the nurse how s/he feels about the patient or his/her condition.

If the nurse did not care about the patient it is likely that the nurse would not be interested in how the patient felt. By being positive the nurse helps the patient to understand that even though s/he is not completely healthy, there are some good things going on. Through expressing the positive side the nurse helps the patient keep his/her spirits up, which is an important part of remaining healthy.

By telling the patient what his/her vital signs are the nurse allows the patient to be a part of his/her health maintenance. This is in contrast with the stereotype of the health care professional who does not tell the patient about his/her health. By giving the

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knowledge of how s/he is doing to the patient, the nurse allows the patient to keep track of his/her progress for him/herself. Many of the patients commented on their own progress to the nurse as well, giving the two something both to talk about and to get excited over when improvements were discovered.

The topics discussed by the nurses and patient seemed important as well. This is because they discussed some personal topics, such as the patient’s relationship with family members, as well as not so personal subjects, such as who on any given soap opera is a “hunk.” The ease of transition between topics was an indicator of relationship and commitment on both sides Montgomery (1981). There are some topics, such as family difficulties, which one would not discuss with an individual s/he does not trust or have a relationship with. Additionally, some of the findings in Phase I differed from what the literature reports about immediacy. For example, all of the patients felt their nurses were interested in them as people, even nurses who used little touch or other forms of immediate behavior. I was not sure if these discrepancies were because the patients were PWAs or if all nurses unwittingly acted in this manner. As a result I chose to do a follow-up study to see if nurses treated patients without AIDS differently.

I decided to look at hospice patients in Phase II. While hospice patients do not have the social stigmas of AIDS patients, both populations are in the process of dying, therefore a comparison could be made in the ways nurses treat them. There should be similarities in the way nurses treat any dying patient. From this assumption new research questions were developed in addition to research questions two, three, four, five, and seven from Phase I:

RQ2: To what extent do nurses use comforting touches with their PWAs? using gloves? using hugs? holding their hand? patting their arm or knee? rubbing their head?

RQ3: When does the nurse put on rubber latex gloves?
RQ4: What do nurses feel are the benefits and drawbacks of touch?

RQ5: What do PWAs feel are the benefits and drawbacks of touch?

RQ7: Are the PWAs content with the present levels of care they receive from their nurses? If so, based on what reasons? If not, what do they feel they are missing?

Considering that the patient populations were different, it is important to consider if there were differences in the way the populations were treated by nurses. If nurses treat PWAs and hospice patients similarly then the fact that AIDS is involved may not be a strong factor in treatment, thus research question eleven:

RQ11: What are the differences in the ways nurses treat PWAs and hospice patients?

Verbal immediacy has not been studied as much as nonverbal immediacy and does not appear as much in the Communication literature. In Phase I, I discovered that verbal immediacy was used to keep the nurse and patient informed and involved in each other’s lives and to create bonds between the two. Considering the importance of verbal immediacy in Phase I, I decided to look closer at aspects of verbal immediacy in Phase II. I wanted to study how nurses and patients used topic selection in their relationship and the types of things they discussed. I also wondered if they discussed topics of personal nature, impersonal nature, or both. As discovered in Phase I, paying attention to something not of personal interest or giving extra time to an individual is an expression of immediacy. I was also curious about whether nurses discussed things they had learned about in previous visits with the patients. Showing the initiative to remember something important to another person is an expression of concern and unnecessary effort, and a form of immediacy. Finally, I was curious as to whether or not the nurse would segue into the patient’s activity when they arrived to treat them as the AIDS nurses did with the soap
operas, again allowing themselves to be involved in something deemed important by the patient and thus, expressing care. The results of these questions became research question twelve:

RQ12: What are the roles of topic selection, prior knowledge, and nurse involvement with the patient’s activity before arrival?

METHODS

In this phase a modified form of the original descriptive framework was used. In the modified version, observation of pronoun usage was dropped because it was impossible to accurately record pronouns during naturalistic observations. Whether or not gloves were worn by the nurses was not recorded because the nurses in Phase I used them only when necessary and it was felt the same would be true in a hospice setting. Additionally, the patients in Phase I were aware of the need for glove use to minimize the risk of contamination.

Under the verbal section three areas were added relating to topic selection. These included nurse comments concerning the patient’s vital signs, comments from previous visits, and whether or not the nurse involved him/herself in the patient’s activities upon arrival at the home. These topics were placed on the sheet in such a manner that specifics of the behavior could be recorded by the researchers in the form of open-ended field notes. Doing this allowed the researchers the freedom to write exactly what was said.

In this phase a second researcher gathered data as well. The second researcher was trained to use of the coding form and numerical scale. Additionally the two researchers developed an interview form for use with both nurses and patients.
**Data-gathering Techniques**

The data for this study were gathered through sixteen observations of nurse-patient interactions and ten interviews. A total of five nurses and eleven patients were observed. As in Phase I, no nurse-patient pair was observed more than once. The observations occurred on different days at different times in patient homes or in the "Hospice House" in a small northwestern town.

The nurses who care for all the patients are a part of "Hospice." These nurses are involved in caring for very ill and dying patients. Typically hospice nurses travel to the homes of home care patients who are terminally ill or care for patients who live at the "Hospice House." In contrast to home care, patients living at the Hospice House arrive no sooner than 6 months away from death and have no other place to go. As these individuals near death they are referred to as being in the stage of "active dying."

In both home care and at the Hospice House, nurses typically measure the patient's vital signs, assess the effectiveness of the patient's medication, and record responses to pre-set health questions. Nurses also perform special medical procedures as requested by doctors, such as drawing blood, changing medication lines, etc. In addition, nurses at the Hospice House make sure the patients have had the opportunity to eat, use the bathroom, and other things important to daily living.

The nurses were informed of our method and purpose. When entering the homes of the patients, the nurses introduced us to the patients and explained why we were there. There were also occasions where we introduced ourselves and explained our purpose to patients directly. These instances occurred primarily in the Hospice House when nurses were not present. After introductions we moved to an unobtrusive area and watched as the nurses cared for the patients, without participating in the interaction. Thus we played the role of passive participants in this research setting (Spradley, 1980).
In order to maintain the confidentiality of the patients in the hospice setting we agreed not to record names while gathering data. We also realized some of the care-oriented situations could be sensitive or painful to a patient, both physically and/or emotionally. Consequently when patients were given treatment in "private" areas of their body or if the patient requested that we leave, we did so. In addition, if any of the patients had begun disclosing highly personal information or had become emotional with the nurse, we would have left the room to allow them privacy, but this did not occur.

In the patients' homes, we sat out of the way and observed, writing notes on observation sheets (see Figure 7). At the Hospice House we remained either in a patient's room or in the common area to observe. Interviews were conducted in the field and we took notes on interview sheets. All five of the nurses were interviewed (see Figure 5). These interactions were informal and extemporaneous, conducted while waiting for supplies or driving from one home to another.

The patient interviews were more difficult to obtain (see Figure 6). Of the eleven patients only four were interviewed. Some patients were physically and/or mentally unable to participate in an interview. Those who were able were interviewed immediately upon receiving permission. This was because follow-up interviews could not be guaranteed due to illness, lack of opportunity to visit them again, or death. Other difficulties with patient interviews mirrored those of Phase I. Nurse proximity and the possibility of their over-hearing patient answers remained a complication. Moreover, both researchers were uncomfortable conducting the interviews using the pre-developed questions. Both researchers felt some of the questions were about subjects not found in "normal" conversation, therefore felt strange asking. In addition some of the nurses and/or patients seemed uncomfortable or irritated by our questions. This contributed to a somewhat uncomfortable atmosphere which may have made all parties involved feel uneasy. As a result the patient interviews were shorter and less informative than desired.
Perhaps the best illustration of this was when a patient informed one of us, after answering two questions, the “questions were stupid and I won’t answer any more” just before requesting she leave.

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. What do you think about nurses touching patients in a non-medically oriented fashion?</td>
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<tr>
<td>2. Do you think touching a patient in a way other than medically-oriented is beneficial to the patient?</td>
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<tr>
<td>3. In your opinion, what are the benefits of touching patients in a non-medical way, if any?</td>
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<tr>
<td>4. In your opinion, what are the drawbacks of touching a patient in a non-medical way, if any?</td>
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<tr>
<td>5. How do you decide when to touch patients?</td>
<td></td>
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<tr>
<td>6. Is there any situation during the time a nurse is with a patient that it is acceptable not to wear gloves? If so, under what circumstances?</td>
<td></td>
</tr>
<tr>
<td>7. Other comments they made or subjects they brought up on their own.</td>
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Figure 5: Nurses’ Interview Guide
1a. How do you feel about the way your nurse cares for you? Why?

1b. Is your nurse concerned with you as a person? Yes No
   How you know?

2. What do you think about nurses touching patients in a non-medically oriented fashion?

3. Do you think a nurse touching a patient in a non-medically-oriented way is beneficial to the patient?

4. In your opinion, what are the benefits of nurses touching patients in a non-medical way?

5. In your opinion, what are the drawbacks of nurses touching a patient in a non-medical way?

6. Under non-medical circumstances, would you prefer that your nurse not wear gloves? yes no If so, what situations?

7. Does the wearing of rubber latex gloves by nurses make you uncomfortable? yes no Why?

8. Have you ever felt a nurse's touch was uncomfortable? Yes No
   If yes, why?

Figure 6: Patients' Interview Guide

Data Analysis

Before we began observing, we developed pre-set categories and used them to record data. This establishes "synchronic reliability," similarity of observations over the same time period (Kirk & Miller, 1986). While observing, we recorded behaviors listed on the form and took detailed notes of the visits. When coding, we went back to the notes from the pre-set categories as well as to our unstructured field notes and compared the findings. In using consistent categories we were able to identify behavior patterns as well

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as use the field notes as a reliability check to our personal insights (Kirk & Miller, 1986). Furthermore, we evaluated the consistency between interviews and observed data.

The data were collected using the modified “During the Visit Check Sheet” (see Figure 7) and were coded within the listed categories (see Chart 2). Although much of the data fell neatly into the categories, there were a few deviant cases. When coding a nurse’s action of placing his/her arm around a patient’s shoulder it was coded as a hug. This is because the two actions are very similar in form and could be defined as a hug or an arm around the shoulder. Another action that did not easily fit into a category was back rubbing. Therefore, these occurrences were placed within the head rubbing category. This is because both actions involved touch and the movement of the hand across the area of the body named. Additionally, the two body parts are anatomically near each other and from certain angles it may be difficult to surmise whether or not someone is touching the back or the head.

**Summary**

The construction and development of research questions and hypothesis are an important part of any data-based study. When considering what to focus on I considered the results of Phase I and how immediacy, social support, and the need to belong in an AIDS-oriented setting were a part of the nurse-patient interaction. From the findings I adapted the first “During the Visit Check Sheet,” removing parts that could not be studied for practical reasons or that did not apply. I also added new things to study, such as topic selection and expressions of concern, based on my new research questions. I also considered the nurses’ and patients’ comfort levels as well as what would be allowed during observations. After gathering my data I began the analysis and reporting stages of this study.
CHECK SHEET: DURING VISIT

COMFORTING TOUCHES

hugs:
holding hand:
patting arm:
patting knee:
rubbing head:
non-medical proximity: 6-18" 18"-3' 3-7'
overall eye contact 1 2 3 4 5
body orientation to patient 1 2 3 4 5
relaxed smiles & nods 1 2 3 4 5
relaxed body posture 1 2 3 4 5
vocally expressive 1 2 3 4 5

VERBAL

cconcerned or detached from patient 1 2 3 4 5
positive or negative outlook 1 2 3 4 5
topics:
vitals/comments on improvement/deterioration:
comments on knowledge from previous visits:
involvement in patient’s activity at time of visit:

Figure 7: During the Visit Check Sheet
### Nurse's Overall Eye Contact:
- 1. None
- 2. Only quick glances
- 3. Mostly glances some gazes
- 4. Equal gazes & glances
- 5. Mostly gazing

### Nurse's Body Orientation to the Patient:
- 1. Shoulders away
- 2. Shoulders mostly >45 degrees
- 3. Shoulders 45 degrees
- 4. Shoulders mostly <45 degrees
- 5. Mostly turned in; 90 degrees

### Nurse's Relaxed Smiles & Nods:
- 1. None
- 2. Smile & nod about 1/4 the time
- 3. Smile & nod about half
- 4. Smile & nod about 3/4 the time
- 5. Smile & nod nearly all the time

### Nurse's Body Posture:
- 1. Very tense
- 2. Tense
- 3. Partially relaxed
- 4. Relaxed
- 5. Very relaxed

### Nurse's Vocal Expression:
- 1. Very monotone
- 2. Monotone
- 3. Somewhat expressive
- 4. Expressive
- 5. Very expressive

### Nurse's Concern with the Patient's Well Being/Health:
- 1. Very detached
- 2. Detached
- 3. Balanced
- 4. Concerned
- 5. Very concerned
NURSE’S OUTLOOK ON PATIENT’S CONDITION:

- 1 very negative
- 2 negative
- 3 balanced/neutral
- 4 positive
- 5 very positive

OPEN-ENDED FIELD NOTES:

- comments on patient’s vital signs and improvement/deterioration
- comments on knowledge from previous visits
- nurse’s involvement with the patient’s activity at the time of the visit

Chart 2: Code Definitions for the "During Visit Check Sheet"

RESULTS

Interview Results

Patient opinion of care received

All individuals, whether sick or healthy, have a sense as of whether others are interested in them. When asked if their nurses were concerned with them as a person all four of the respondents answered, “yes.” None of the patients felt their nurse was not interested in them as more than a patient. When asked how they knew their nurse was interested one patient said, “you can sense people’s attitudes.”

The main reasons for the patients’ answers focused on the actions of the nurses. For example one patient said, “they (the nurses) are willing to go out of their way to get us stuff like ice water. They don’t mind doing the simple things for us.” Another patient mentioned a nurse will call a doctor for him when he needs help or has a question. A third patient commented on how the nurses would let him go outside to smoke and sometimes would join him for conversation and to observe the beauty of the mountains.

When asked their opinion of their nurse’s care and why they felt that way positive comments continued. One patient felt the nurses at the Hospice House were “incredible”
and he could not "comprehend how they do it (care for patients) and deal with death all the time. The nurses are very caring, comforting, and give care to the patient before they do anything else." A second patient expressed his amazement of the nurses as well. He said, "not everybody can work in a place like this. It takes a very special kind of person." A third Hospice House resident expressed appreciation of the nurses' humanity by saying, "the nurses admit when they're wrong. Not many people admit to mistakes. They know they're human and just try to be helpful and not give orders." A home care patient expressed her relief at having someone to take her vital sign and keep her informed about her condition.

Table 17: Do you feel your nurse is concerned with you as a person?

Wearing gloves

Only one of the patients was asked if his nurse wearing rubber latex gloves made him uncomfortable. He responded "no. It's a good precaution and it should be done." When asked if there was a time when it is not acceptable to wear gloves with a patient, nurses had strong things to say. One nurse said, "(nurses should not wear gloves) at all times when they aren't needed for a procedure." A second nurse commented, "(nurses should not wear gloves) anytime you are not working with body fluids, particularly with
AIDS patients. Some nurses will put on more than one pair of gloves when working with these patients. It seems a bit excessive but people are afraid and want to protect themselves. You have to be careful not to hurt the patient’s feelings by putting gloves on at the wrong times.” A third nurse eloquently expressed the struggle for balance between nurse safety and patient feelings through, “what do you do when you have someone with an oozing skin rash reach out to you wanting to be held? Do you tell them to wait ‘till you put gloves on? You have to balance humanity and quality of life with safety. In these cases sometimes it's best to go wash your hands quickly and thoroughly. You don't do anything stupid, just humane."

**Touch**

Touch is a potentially dangerous activity in a hospice setting. In hospice, nurses take care of people dying from many different illnesses, some of which are communicable. As a result, it is very important for nurses to be aware of who they touch and how they touch them. Nevertheless, there are times and places on the body in which touch can occur without harming a nurse. For example, if patient does not have a disease which can be transmitted via touch it is acceptable for the nurse to touch the patient. Another example is if a patient has a skin rash on one area of the body the nurse could safely touch an area of the body that is free of the rash.

Both patients and nurses are interested in touch and have definite opinions about it. When asked their opinion of non-medical touch by nurses one patient said, "they touch me and I love it!" This particular patient seemed to be a touch-oriented person. Many times during the visit she and the nurse were touching. Additionally, the patient insisted on hugging both the nurse and researcher upon arrival and departure. The same patient felt touch is beneficial and, “shows a nurse is willing to take time with me. They are very careful with me.”
While touch is good, it is not for everyone. When asked about the benefits and drawbacks to non-medical touch another patient responded, "the nurses here (at the Hospice House) do it a lot (touch)...Me I'm not too touchy, huggy. I think it's good for others though. It makes them feel respected and happy."

Patients were not the only ones with opinions about touch. Nurses had quite a bit to say as well. When asked their general opinion of touch two of the nurses said it was important. Another nurse added to this through, "it is critical to the well-being of the patient, especially hospice patients. They need a lot of comfort and support and it helps them handle the fact that they are dying." Two nurses felt a nurse should only touch a patient if touch is "accepted" and "both (the nurse and patient) are comfortable with it."

When asked how they decide when to touch a patient "feel" and instinct were important factors. One nurse said touch, "is an instinct. You just know. Some people you touch and some you don't." For another nurse touch, "is almost an automatic thing unless you feel they don't want to be touched...Touch is a natural sharing of a person. It just happens and you try and make it as authentic as possible." For a third nurse when it comes to touch, "you follow the patient's lead. The only time I make a conscious decision about touch is when I first meet the person. Then I have to decide if the person is receptive or not...With different people you do different types of touching but most is just instinct and gut feeling."

The nurses felt there were benefits of touching a patient in a non-medical way. One nurse stated, "touch shows the patients that his/her life is still valued and that the patient is important as a person. It makes a difference in how they respond. I've seen patients who were not doing well suddenly get better an hour after someone sits and holds their hand." Another nurse said the benefits of touch, "depend on the person. It's different with different people."
While touch is beneficial in a hospice setting, there are drawbacks as well. Two nurses commented on the importance of being aware of what the patient wants because not all patients like to be touched. One of these nurses commented on the emotions involved in touch. She said, “if a lot of people are in the room holding their hand and stroking them they may feel guilty about leaving (dying) or may enjoy the attention and hold on longer than they should. When that happens you have to tell them it’s OK to go. They always look relieved when I give them permission to go.” Another nurse agreed with that statement through, “the stimulation that touch produces prolongs their life when they are often ready to die.”

**Social Support**

Social support is also important in the nurse-patient relationship. Social support is beneficial to patients because it reduces stress and allows them to express their feelings and fears (Albrecht & Adelman, 1984).

It is very important for the hospice nurses to know that their patients are not suffering. An important part of the Hospice philosophy is for patients not to suffer when they do not have to. One of the nurses commented several times her desire to keep her patients from pain when possible. Another nurse stated, “there is no reason for the patient to be in pain. There is no place for it. We try to get rid of the pain so the patients can make the journey they need to. How can a person work out the love and forgiveness and beliefs about death that they need to when they are suffering? We try to help them.”

Another part of the Hospice philosophy is allowing the patient some say in the way s/he is cared for, lives, and dies. Hospice nurses are aware that their patients are dying and try to give them dignity through decision-making. One nurse summed it up by saying, “We don’t force the patients to take their medication. It’s their choice. This sounds bad but so what if they don’t take their meds. They’re dying so what’s the difference? It’s not
like the medication won't heal them if they don't take it. We just want to keep them pain-free so they can concentrate on other things.”

Perhaps the most important part of social support was assisting patients in their adjustment to death. One nurse commented, “we feel humor is important. How would you like it if everyone around you was serious all the time? We like to have fun. We’re sarcastic with each other and make fun of each other. You have to keep the atmosphere light or you’ll go crazy.”

Another way of assisting hospice patients in their adjustment to death was through the nurses’ acceptance of mortality. All of the nurses felt that not only was it important for patients to accept their death, it was also important for nurses to be accepting of patients’ feelings regarding their death. One of the nurses said, "I'm not a religious person or anything, but I've learned to talk with my patients about Heaven. They ask what I think or they just want to talk about it." Thus, the nurse expresses social support through actively listening to the patient and sharing her thoughts about death.

Not only do the nurses talk with the patients about after-life viewpoints, they also accept patient reports regarding their experiences. One nurse told a story of when an actively-dying patient saw his long dead brother outside waiting for him. The patient told the nurse the brother wanted him to go so they could play basketball, but he was not ready to go. The nurse said he could go or wait until he was ready. The patient lived a few days longer and each day said his brother was waiting for him outside. This was helpful to the patient because his family was not completely convinced that what he saw was real. The nurse's belief reduced some of his fears of "losing his mind," in that the nurse told him others had had similar experiences.

While some members of the medical profession view stories such as the one above as medicinally-induced, the hospice nurses do not. A nurse said, "About 90% of our patients see angels. It's not always a dramatic sighting. Sometimes it's a dream or just
something they haven't thought about in years. Often it is the breakthrough they needed...I often think about when I worked in the hospital and the patients would talk about strange things and angels. We (the staff) always thought it was from the medication and told the patients they were hallucinating. Now I'm not so sure we were right."

Another nurse said, "I have never seen a patient die who didn't say that they saw angels around their bed."

Nurses also assist patients in the actual dying process. Some patients are ready to die, yet are afraid to do so. One nurse said, "A man was just hanging on and I told him it was OK to let go. A tear fell down his cheek and then he died." Thus, the nurse expressed personal support for the patient through acknowledging the patient's stress and emotion and also by helping him to let go.

While the nurses realize the need to be a part of patients' lives and assist the patients, they also know they must consider themselves as well. One nurse spoke of the, "importance of savoring experiences. You also need to take time out to grieve and to be with your family, otherwise you get rowdy." Another nurse said "it's important to make a difference in the lives of the patients, but it is also important not to get too attached. While it's easy for me to say that I don't always take my own advice." All of the nurses agreed getting too close to patients was not good, yet each told of at least one patient who touched them very deeply on a personal level.

Observation Results

Gloves

While the frequency of glove-wearing was not recorded, the visits during which gloves were used were noted. The only time nurses were observed wearing gloves was when blood was drawn or when another medical procedure requiring protection was performed. It should be noted that there were instances where we left the room prior to
or during a procedure to give the patient some privacy. As a result, it was not possible to consistently report glove-wearing behaviors accurately.

**Comforting touches**

The comforting touches (Dolin & Booth-Butterfield, 1993) targeted in this study were hugs, holding hands, patting arms or knees, and head rubbing. At least one type of comfort touch was used in all but three of the sixteen episodes observed.

Of the sixteen observed episodes patients and nurses hugged in six of them. In three of these more than one hug occurred. As in Phase I, all of the hugs occurred at the start or end of the visit. For example, at the beginning of one home visit the patient got up from her bed and tightly embraced the nurse for approximately 15 seconds. In another instance as a nurse was leaving the patient gave the nurse an extended and firm embrace. While still embracing each other, they told one another they loved each other. Sometimes the hug took the form of placing the arm around the patient's shoulders. In one instance a nurse at the Hospice House entered a patient's room, sat on the bed next to him, placed her arm around him while she told him, "Good morning," and discussed how he had slept.

Another comforting touch used by nurses was holding the patient's hand. This occurred in four episodes with one nurse doing it twice during one visit. Nurses held their patient's hand most often when they were discussing something very meaningful or emotional. One patient was discussing his fear of dying when the nurse grabbed his hand and allowed the patient to express his fear. In a different instance a patient told a nurse how important she was to him when they grasped hands. The other times hand-holding occurred was while a nurse performed a procedure on a patient. In one case while a nurse conducted an unpleasant treatment on a patient, the patient expressed her discomfort. After verbal encouragement did not lessen the patient's expressions of discomfort the
nurse grabbed the patient’s hand and told her it would be OK. They held hands until the patient loosened her grip.

During eight of the episodes the nurse patted the patient’s arm. This action was similar to holding the patient’s hand in that it was most often used when the nurse first arrived or was about to leave. For example, a nurse entered a patient’s home, went to her bedside, knelt down and patted the patient’s arm while asking how she (the patient) felt. Arm patting was also similar in that a nurse patted a patient’s arm during an uncomfortable procedure in an effort to offer comfort. An example of this occurred during the same procedure discussed earlier. Before the nurse held the patient’s hand, she patted her arm a few times in an effort to ease the discomfort.

Patting the patient’s knee occurred in five of the episodes. These instances occurred when the nurse asked the patient how s/he felt or questions concerning organizational paperwork. For example, after entering the patient's home a nurse sat next to the patient on her bed and asked how she felt while her hand was on the patient's knee.

The last category of comforting touches, head rubbing, was used in only two of the nurse-patient episodes. While there were no observed instances of actual head rubbing, back rubbing was observed. In one instance a patient began coughing harshly. The nurse rubbed the patient’s back until she stopped coughing.

Nonverbal immediacy

In addition to comfort touches, other areas of nonverbal behavior were observed as well. These behaviors included non-medical proximity, eye contact, body orientation, relaxed smiles and nods, and vocal expressiveness. In the hospice setting twelve of the nurses spent the majority of their time within 18 inches of the patient, while the other four were between one-and-a-half and three feet away (see Table 18). In most cases the nurses sat next to the patient on his/her bed. Nurses were more than one-and-a-half feet away.
from the patient when the patient was seated in a chair. Often this was the patient’s choice to have that extra room between him/herself and the nurse.

![Nurses' Nonmedical Proximity](image)

Table 18: Nurse-patient non-medical proximity.

Eye contact was also an important part of the nurse-patient relationship. Eye contact was used by all of the nurses in each of the visits (see Table 19). None of the nurses gave “no eye contact.” One of the nurses used “only quick glances” with the patient. In four of the episodes the nurses used “mostly glances,” brief eye contact, and “some gazes,” and eye contact for at least a few seconds. Ten episodes, by far the largest number, “contained equal gazes and glances” by nurses when caring for their patients. Finally, in only one episode was the nurse involved in “mostly gazing behaviors.”

![Nurses' Overall Eye Contact](image)

Table 19: Nurse-patient overall eye contact.
While eye contact behaviors were generally similar, the nurse’s body orientation towards the patients was highly variable (see Table 20). Of all the episodes, only one nurse had her shoulders “turned away” from the patient the majority of the time. In four of the episodes, the nurses’ shoulders were “generally less than forty-five degrees” from the patient. In two of the episodes, nurses kept their shoulders “around forty-five degrees” from their patient. Six of the episodes had nurses who generally positioned their shoulders “mostly greater than forty-five degrees” from their patient. Finally, only three of the episodes had nurses who kept their shoulders “mostly turned in” toward the patient.

![Nurses' Body Orientation](image)

Table 20: Nurse body orientation to the patient.

In nurse-patient settings a comfortable ambiance is important in the relationship development. The use of smiles, nods, and a relaxed body posture add to the ease of the interactions. Nurses expressed relaxedness in smiles and nods (see Table 21). In all sixteen episodes observed, all the nurses smiled and/or nodded. Two of the episodes found the nurses smiling and nodding “about a forth of the time”, in five of the episodes the nurses smiled and nodded “about half the time,” in seven episodes the nurses smiled and nodded “about three-fourths of the time,” and in two episodes the nurses smiled and nodded “nearly all the time.” Most often smiles occurred while a nurse spoke informally.
with a patient about non-medical subjects. In contrast, both nurse and patient became more serious when discussing medical procedures. During these times the nurses tended to nod more frequently.

A nurse’s overall body posture also expressed ease to patients. In the sixteen episodes observed, none of the nurses were “very tense” or “tense,” eight of the nurses were “partially relaxed,” seven were “relaxed,” and only one was “very relaxed” (see Table 22). Most of the nurses had relaxed postures because they tended to sit on a patient’s bed while talking with them. In these instances, nurses tended to slouch forward more than when they would had they sat in a chair.
In the hospice setting the nurses tended to be expressive in their conservational pitch, tone, and volume when they conversed with patients (see Table 23). None of the nurses were "very monotone," "monotone," or "very expressive." In eight of the episodes the nurses were "somewhat vocally expressive." In the other eight episodes the nurses were "vocally expressive." In the episodes when the nurse was somewhat expressive s/he spoke with the same manner to both researcher and patient. Nurses were expressive when dealing with patients who were hard of hearing or who seemed to need a little more encouragement than normal. Additionally, one nurse’s speaking rate was slower, and she used more conversational fillers, such as "yeah," "um," and "right" when she spoke with patients than when she spoke with either of the researchers or family members.

Nurses' Vocal Expressiveness

<table>
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<th>NUMBER OF EPISODES</th>
<th>very monotone</th>
<th>monotone</th>
<th>somewhat expressive</th>
<th>expressive</th>
<th>very expressive</th>
</tr>
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<tr>
<td># of episodes</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 23: Nurses' vocal expressiveness.

Verbal immediacy

Hospice nurses used verbal immediacy in addition to nonverbal immediacy. One of the more obvious aspects of verbal immediacy were the nurses’ expressions of concern. The hospice nurses all expressed some level of concern and interest for their patients (see Table 24). None of the nurses were "very detached" or "detached" from the patient at all times. In two of the episodes the nurses maintained a "balance" between being concerned
or detached from the patient. During these times the patient was neither improving or deteriorating noticeably. Eight episodes contained nurses who expressed "concern" for their patients. Expressions of concern generally occurred when a patient was not doing as well as in previous visits or had expressed discomfort on some level. Finally, six of the nursing episodes had nurses who were "very concerned" about the patient. These expressions occurred when the patient was noticeably worse off than the previous visit or if s/he complained of pain or discomfort.

Nurses expressed concern for the patient in a variety of ways. Most often a nurse asked how the patient was doing and probed for an overall sense of health. Based on the patient's response, the nurse exhibited an interest in the areas of the patient's body which were not doing as well as in the previous visit or had been problems for some time. The nurses did this by asking more probing questions or by physically interacting with the patient. Nurses also compared the response with the way the patient had answered the question or had been feeling during the previous visit.

Another expression of concern occurred when the nurses checked vital signs. As the hospice nurses checked each vital sign they told the patient what the vital sign was. By doing this they showed the patient they wanted the patient to be aware of his/her condition. In most cases the nurse also commented on vital signs in comparison with previous visits showing they remembered the patient's previous condition. In one case a nurse conducted an "admit" of the patient. An "admit" is the first time a patient is a part of hospice care. When a nurse "admits" a patient the nurse takes all the patient's important medical information, i.e. past medical history, medication currently being taken, and other questions listed on the admit from. The nurse then returns this information, along with his/her assessment of the services needed by the patient, and to the hospice organization for the official assigning of nurses and aides. Even though the nurse was
unfamiliar with the patient, she still commented on the patient’s vital signs in relation to
the patient being out of the hospital for a matter of hours.

A final expression of concern for the patient as an individual came in the form of
asking the patient about his/her family. Many of the nurses knew of patients’ family
members by name and inquired about their well-being. In some cases family members
were present during visits and the nurse spoke with them directly.

Another aspect of verbal immediacy used by nurses concerned honesty. Hospice
nurses care for people who are terminally ill and will not ever be healthy again. As a
result, it is important for the nurse to be honest about the patient’s condition, yet not too
negative in the patient’s presence. Hospice nurses realize their patient’s are dealing with
death and dying issues. Often the nurses talk with the patients about their physical
condition if they are asked specifically. Even when talking with the most terminal patient
in the worst health, the nurses try to describe circumstances in as positive a light as
possible (see Table 25).

None of the nurses were “very negative” or “very positive.” Only one of the
nurses was “negative” throughout an episode. In this case the patient was in a state of
deterioration for several days. The nurse offered to call his doctor to have his medication changed for the third time in a week. She told him the medicine might help him, but continued to warn him that his condition would most likely continue to worsen. In seven of the episodes the nurse either maintained a "balance" between the positive and negative aspects of the patient's condition or did not mention it at all. A balance was maintained by the nurse commenting on a good part of the patient's health with every bad comment. Often this was done by stating that the patient had not ___ (vomited, had lower blood pressure, had a fever, etc.) in several days. Finally, in eight of the episodes the nurse was "positive overall" about the patient's condition. This often came when the patient told the nurse s/he felt better or had a positive change in a vital sign. In these cases the nurse expressed as much pleasure as the patient over the improvement.

![Nurses' Outlook](image)

Table 25: Nurses' overall outlook.

Topic selection was another area of verbal immediacy observed. It was divided into three areas: comments on patient condition, knowledge from previous visits, and involvement in patient activity. When the patient's vital signs were taken, the nurse related the information to the patient and commented on them. Other ways of commenting on a
patient's condition included saying they looked better or worse from the previous visit or noting how little or how much a patient could do for him/herself.

Regarding information from previous visits, all nurses referred to topics previously discussed with patients. In one instance, a nurse had recommended a change of medication for the patient. The patient's doctor agreed and the change was implemented. The nurse asked the patient how the new medication was working and the patient reported feeling much better. In another case a nurse asked a woman how her family had been. The nurse listened with apparent understanding as the patient discussed several individuals in great detail using their names as references. Obviously the nurse had prior knowledge concerning these people.

Nurse involvement in patient activity was apparent during every visit. Every patient ceased his/her activity when the nurse arrived thus facilitating focus on nurse-patient interaction. Because the patients ceased their activity the nurses did not directly involve themselves in what the patients had been doing as the nurses in Phase I did.

From the results we can see that there is a great deal of communication going on between hospice nurses patients. The patients involved in this part of the study all believed the nurses were concerned about them. Additionally, touch and nonverbal immediacy behaviors are frequently used and an important part of the nurse-patient relationship. Immediacy behaviors are not the only part of relationship that is important. Social support, particularly in areas of spirituality, are also important in the Hospice setting. This importance is strongly indicated and will be further discussed.
CHAPTER 6
DISCUSSION: PHASE II

In looking at research question seven, are the patients content with the present levels of care they receive from their nurses? If so, based on what reasons, it was discovered that hospice patients are pleased with the care they receive. All of the patients who participated in this study felt that their nurse was concerned with them as individuals. Patients were also very concrete in their reasoning, citing events and small favors the nurses performed for them. It seems that the patients believe a nurse cares about them based primarily on the nurses' actions, specifically the personal things done for the patient. For example, getting a drink of water or calling a doctor for a medical reason is not viewed as the nurse's job, but as an expression of care and concern. Additionally, the nurses take the time to speak informally with patients about things other than their health. None of the patients felt anything was missing from the direct care they receive.

Verbal immediacy

Nurses expressed their concern for patients by asking how they were in relation to the previous visit. When this was not relevant, a nurse asked how the patient felt in relation to when she was first released from the hospital. This small action supports Brauer's (1965) belief that giving unnecessary time to patients indicates interest. This gift of time allows the nurse and patient to establish trust and build rapport with each other. This is because when a person does not like another individual s/he often does not go out of his/her way to spend extra time with that individual.

Research question twelve is concerned with how nurses use verbal immediacy when they treat hospice patients? Specifically what are the roles of topic selection, prior knowledge, and nurse involvement with the patient's activity before arrival. Nurses use
verbal immediacy to show interest as well as to give the patients the belief they have someone they can trust. In answering part of research question one, *to what extent are nurses concerned or detached from the patient? have a positive or negative outlook*, over half of the episodes the nurses did not comment on the patient’s condition. In some instances the comment would not have been relevant or might have caused the patient to think about something s/he did not want to. Most of the comments concerning a patient’s condition were given in a positive light (see Table 25). This was done in order to keep their patients’ spirits up as much as possible. While the nurses felt it "very important to be positive, yet realistic with the patients," they did not “want to give them a false sense of getting completely better when they won't." In being realistic with the patients the nurses showed they would not lie about small details. This is important because it builds trust (Buhr, Clifton, and Pryor, 1994; Balzer-Riley, 1996) and rapport with patients. Trust is needed between patients and nurses, particularly when patients are near death. If there is no trust between the two the patient is likely not to believe the nurse when s/he says they will be there for the patient’s death or will try to minimize pain. Building trust gives the patients something solid to hold on to near the end.

Hospice nurses also showed immediacy in comments on vital signs and in comments concerning previous visits. By telling the patient what his/her vital signs are the nurse displays the desire for the patient to know what his/her condition is. When a nurse gives an additional comment of pleasure that the vital sign has stayed the same or improved, s/he shows specific interest in the patient. In these instances the nurse remembers something particular about that patient, making him/her feel cared about.

In reference to research question twelve, *how do nurses use verbal immediacy when they treat hospice patients? Specifically what are the roles of topic selection, prior knowledge, and nurse involvement with the patient’s activity before arrival, knowledge from previous visits was used to express involvement and interest in the patient’s life.*
When a nurse remembers a vital sign from a previous visit or something specific about a patient that is important to him/her, the patient feels cared about and that the nurse is interested in him/her as much than just a body to treat.

The patients exhibited interest in the nurses by ending the activity they were involved in before the nurse’s arrival. This indicated they were willing to give the nurse their full and complete attention. As a result, this part of research question twelve was irrelevant.

Nonverbal immediacy

Nonverbal immediacy was also a part of interactions between nurses and patients. Buhr, Clifton, and Pryor (1994) reported that immediacy behaviors increase competence, trustworthiness, and similarity with receivers. All of the responding patients reported being pleased with their care because the nurses did small things for them that were not necessarily in their job description. While not all small actions can be described as immediacy behaviors, they do help increase perceived trustworthiness and similarity.

In research question one, to what extent do nurses use immediacy behaviors with their PWAs? using touch? using proxemics? using eye contact? using body orientation? using relaxed smiles, nods, and body posture? being vocally expressive? using first or third person pronouns, the extent of the listed behaviors used by nurses while caring for hospice patients was studied. Proxemics are very important in hospice settings. Considering the nurses are caring for individuals who are near death, it is important for them to have close contact. Close contact gives the feeling that someone is near and available. In the majority of hospice episodes the nurse and patient were no farther than eighteen inches apart the majority of the time (see Table 18). Considering most people do not allow others with whom they are uncomfortable within eighteen inches it is safe to assume that there are strong connections between hospice nurses and patients.
It should also be noted that none of the patients expressed discomfort over the close proximity.

The overall **eye contact** in the observed episodes expressed a general openness to communication by the nurses. The majority used equal numbers of gazes and glances (see Table 19), thereby expressing an interest in communication (Klinzing & Klinzing, 1985). By gazing at the patients the nurses showed they were interested and followed the conversation of the patient. However none of the nurses gave too much eye contact to a patient, making him/her uncomfortable (Balzer-Riley, 1996).

The overall **body orientation** of the nurses varied a great deal (see Table 20). Some were mostly oriented toward the patient while others were generally turned away. While Balzer-Riley (1996) feels an open body orientation encourages communication and Pluckhan (1978) believes turning away will discourage communication, it was not true in this setting. The primary reason was that the nurses tended to sit next to a patient approximately six to ten inches apart. In this position it is difficult to position one’s body directly toward the other. In addition, the nurses moved around in order to get supplies or perform vital sign checks. In these actions it is difficult to keep one’s body oriented towards the person with which one is communicating. Patients understand this reality and do not take it personally.

Hospice nurses use **relaxed smiles and nods** quite a bit (see Table 21). In only two of the episodes did the nurses use relaxed smiles and nods less than half the time. Overall, the patients seemed content and relaxed during the interactions. Many of the patients responded to the nurses “laid-back” style with smiles and humor of their own. Perhaps the best was to summarize the need for smiles came from a nurse in, “they (patients) need humor. It’s important for them and for us to laugh sometimes. how would you like it if everyone had a serious expression on their face all the time?”
Just as smiles and nods were often used, so were relaxed body postures. While some of the nurses were only partially relaxed, the others were more so (see Table 22). Again the majority of the reason for being relaxed was so that the patients would have the ability to relax themselves. Stress and tension felt by an individual leaks out to others, making them tense as well (Balzer-Riley, 1996) while a relaxed and attentive posture communicates warmth (Gazda, Childers, & Walters, 1985). Another reason for the high rate of relaxedness was that many of the nurses sat on the patient's bed. It is hard to be tense when one is sitting without a back to the seat. Considering all of the patients felt that the nurses cared about them, Gazda, Childers, & Walters' (1985) assessment that a relaxed posture communicates warmth was true in this setting.

The nurses all had some level of expression in their vocal quality (see Table 23). This is important because monotone voices tend to be boring or communicate disinterest. In contrast, too much expression can be frightening or unnerving. According to Wiener and Mehrabian (1968) tone is the strongest indicator of immediacy. Considering the patients' contentment and the medium levels of the nurses' vocal expressions, immediacy was communicated. None of the nurses were completely monotone or highly expressive. This sensitivity to vocal tone helped to relax and soothe the patients, particularly those who spoke of their impending death.

Touch is vital in the hospice setting. Both patients and nurses reported the importance of touch in the hospice environment. Most patients said they felt comforted by nurse's touch. In one particular instance a patient and nurse carried on a conversation while they embraced. This is an excellent example of being comfortable touching another. Even when personally uncomfortable with touch, patients recognize the benefit of touch for others. This supports the finding that touch is extremely important in medical settings (Klinzing and Klinzing, 1985).
Mehrabian (1981) found that touch communicates a liking or attraction to another person and an interest in their well-being. This was observed in the hospice nurses' care for their patients. One of the nurses specifically described the struggle between personal safety and causing a patient to feel rejected. In their daily care routines most of the nurses touched their patients. Nurses displayed all types of comforting touches in one form or another.

Touch also lessens a patient's physical pain and emotional anxiety. This was illustrated when a nurse described how some patients suddenly get better an hour after someone sits and holds their hand. In other cases a nurse touched a patient while performing a painful procedure. When the nurse touched the patient while verbally comforting her the patient whimpered less. This supports Heath's (1992) assertion that touch can be as an effective form of treatment as medicine in some situations. In other instances touch was used to alleviate emotional stress. For example, while expressing concern over his upcoming death a nurse touched, then held a patient's hand. After a few minutes the patient's anxiety lessened.

**Comforting touches**

Overall, comforting touches proved to be an important part of the hospice setting. Research question two concerned extent of use of comforting touches via hugs, hand holding, patting an arm or knee, and head rubbing. Hugs were found to be an important and purposeful part of some, but not all of the nurse-patient relationships. Nurses and patients hugged in only six of the observed episodes. In three of the episodes more than one hug was given. In these cases either the patient was very expressive and enjoyed showing affection or the patient was experiencing high levels of stress and needed some form of comfort. The nurses and patients who hugged expressed genuine concern and desire to hug, thereby showing the closeness of the relationship.
Hand holding was done to show support through emotional or physical pain. Nurses held patients' hands when the patient was in some form of pain. It is uncomfortable to hold someone's hand for no reason and in American society it is an expression of romantic involvement. As a result, hand holding generally does not occur without a legitimate reason; in this case the easing of pain.

In eight of the episodes the nurse patted a patient’s arm. These actions were for a variety of reasons. In some cases arm patting occurred while talking; in other instances they occurred while the nurse performed a procedure. Generally the arm is a “safe” place to touch and communicates no romantic interest. As a result it is considered acceptable to touch someone’s arm. If the patient and nurse are not totally comfortable in their relationship but the nurse still wants to communicate concern, arm patting is a safe way to do so.

In five of the observed episodes the nurse patted the patient’s knee while they were talking. In several of the cases it happened right at the end of the visit when the nurse wrapped up her comments. In these cases patting the patient’s knee served as a nonverbal demonstration of ending the interaction. Patting the knee also expressed interest and awareness of the other individual.

In no cases did head rubbing occur. This is positive in that many people take head rubbing as an insult or as a derogatory gesture. In its place, back rubbing occurred to comfort a patient and to let them know the nurse was aware of them and their discomfort.

In response to research question four, what level of importance do nurses place on comforting touches, hospice nurses place a great deal of importance on comforting touch. Nurses expressed the belief that touch shows a patient that s/he is “accepted” and “valued,” even though the patient is no longer a “productive” part of society. Considering the Hospice philosophy focuses on assisting the patient through the final stages of life, acceptance of a patient via touch can be helpful and rewarding for both patient and nurse.
The nurses not only verbalized this belief, they acted on it numerous times, touching their patients in the ways they felt their patients needed at the time.

In response to research question five, what level of importance do patients place on comforting touches, it was discovered that patients give less importance to comforting touch, yet generally enjoy the contact. Some of the patients wanted to be touched more than others and even initiated touch of different sorts with their nurse. In contrast, other patient did not want to be touched at all, yet felt that touch could be good for other patients. It should be noted that none of the patients turned away a comforting touch in any form.

**Social support**

Social support was evident in hospice nurse-patient relationships. According to Albrecht and Adelman (1984) caring and support are defining characteristics of social support. Dickson-Markman and Shern (1990) further define social support as any type of relationship or network which provides information, feedback, and assistance for a variety of physical and psychological needs. The hospice nurses fit this description in that they informed patients of their current health status, offered their opinions about vital signs, performed procedures that lessen discomfort (enemas, changing medication lines, etc.), and by assisting patients in their adjustment to the dying process. In helping patients accept their death, the nurses displayed Albrecht & Adelman's (1984) findings that social support is a factor in stress reduction and in expressions of feelings and fears.

Perhaps one of the more interesting findings is the acceptance of spirituality issues and sightings of apparitions. Currently in the United States it is not fully acceptable to discuss or accept the notion of other-worldly beings. Many of those who do are considered delusional or religious fanatics. One of the nurses said it best, "I often think about when I worked in the hospital and the patients would talk about strange things and
angels. We (the staff) always thought it was from the medication and told the patients they were hallucinating. Now I'm not so sure we were right." While Americans may not believe the sightings or experience them until death, can it truly be said that the experience does not occur? If someone is afraid to die, the "sighting" could be their way of handling their emotions. By telling dying individuals they do not see what they think they see, social support is not being expressed. Perhaps nurses at medical facilities other than hospices should assess their views regarding these issues.

Comparisons

In answering research question eleven, what are the differences in the ways nurses treat PWAs and hospice patients, definite differences were found. More touch was observed more often in the hospice setting than with PWAs. Considering the level of awareness expressed by the AIDS, nurses the reason is not fear of contracting the disease. The AIDS nurses are aware of how the disease is spread. Perhaps the main reason is that the hospice patients are near death. Because of this reality hospice nurses want the patient to know they are not alone. Most of the PWAs were not as close to their death as the hospice patients, resulting in more independence and desire for autonomy.

Another reason for the difference in amount of touch is the difference in Hospice philosophy and home health care philosophy. In Hospice the focus is on preparing people for death. Touch is viewed as a way to relax and comfort people who are suffering. In home health the focus is on helping people get better or maintain their health. Many of the patients are somewhat healthy, therefore the "normal" rules of touch in society are still active.

With the exception of the amount of observed touch, there is little difference in the way nurses care for PWAs and hospice patients. There are several possibilities as to why this is true. First, the nurses in this study who worked with AIDS patients wanted to work
with that population, as did the hospice nurses. If both nurse groups were where they wanted to be they would do their job well because they wanted to. Had any of the nurses not truly wanted to be working with either population they probably would not have put in as much effort.

Second, both patient populations are groups of people who are in the process of dying, although not necessarily “actively dying.” In most nursing schools and some nursing texts there is a section on how to care for dying individuals and considerations for those specific individuals. It is likely that the nurses in both groups had “dying patient” training in nursing school. Therefore they are likely to treat the patients the same.

Finally, it is possible that nurses no longer feel threatened by the HIV/AIDS virus. While it would be wonderful to say this is the complete reason, it is unlikely that it holds true for all individuals in the nursing profession. It is more likely that both the hospice nurses and AIDS nurses are comfortable with their respective patients and take infection-preventing measures when appropriate. This comfort level leads to treating the patients like any other individual.
CHAPTER 7
CONCLUSIONS

As one can see from the results of Phase I and Phase II, there is not much difference in the way nurses treat hospice patients and AIDS patients. Not only is the overall treatment the same, but the overall levels of immediacy used with the two populations is the same as well. This same approach to caring for patients indicates, at least in the two groups studied, that AIDS is not as big an issue in the way patients are treated as it once was. Immediacy is important in both settings and both populations responded positively to the nurses' use of immediacy.

The main difference in the way the hospice patients and AIDS patients were treated was in the levels of touch given to the two groups. Nurses tended to touch hospice patients much more than AIDS patients. This is primarily due because the hospice patient were dying and needed closer attention than did the PWAs. PWAs also had family and friends who either lived with them or visited regularly and were healthy enough to live on their own. In contrast, the hospice patients were within six months of their death and had fewer family or friends around. As a result of this the hospice nurses were available to assist the hospice patients in their adjustment and acceptance of their mortality. Hospice nurses were also the hospice patients primary source of social support, and thus gave more physical attention.

In the immediacy literature there is no single, specific definition of immediacy. However, specific behaviors involved in the expression of immediacy are suggested within the literature. While no specific definition of immediacy emerged from the results of Phase I and Phase II, this study indicated that there is more to immediacy than simply behavior. Immediacy is seen through expressions of interest, topics of discussion, comments on previous encounters, nonverbal behaviors, and just the desire to show
kindness to a vulnerable individual. The result of this is that immediacy cannot be found or defined on the basis of actions only. Immediacy is a felt and expressed part of a relationship as well which is expressed both in and beyond the behaviors of the two individuals involved.

Nonverbal immediacy is defined and discussed much more than verbal immediacy. It is researched more because nonverbal behaviors are easier both to define and to observe than are verbal behaviors. An outsider can look at two individuals hugging or making eye contact and define it as such. Additionally, when attempting to "teach" or explain what to do to be viewed as "more immediate" it is easier to tell someone to what to do with their proxemetics and body posture than it is to consider the topics of discussion. In contrast, much of the meaning and importance placed on verbal communication is heard, not seen. While it is easy to tell someone to put their arm around a person who is crying, it is difficult to tell them what to say. This is the primary reason verbal immediacy is so elusive; it is much more situation-oriented. The difficulty with self-reporting comes with not knowing if the person is being honest with him/herself or the researcher in answering, knows how to describe the answer accurately, or even is aware of the hidden meanings in communication. If the respondent misinterprets the question and answers a question other than the one intended by the researcher the data is not accurate and the results may be skewed or inaccurate in some way.

While more emphasis has been placed on the nonverbal aspect of immediacy, verbal immediacy seems to be just as important in medical settings. It means a great deal to patients to know that nurses are interested and aware of the problems they face. When a nurse asks about a family member or verbally comforts a patient during a painful medical procedure it is important to the patient. These actions are not a necessary part of the nurse's job yet show the nurse is interested in more than the patient's physical health.
The individual relationship between two parties indicates immediacy much more than a display of specific types of behavior of a tally of those “immediate behaviors.” There are things which could be said or done which would not be viewed as immediacy yet are within the confines of that specific relationship. For example, referring to someone as “dumb-head,” and punching their arm would not fall into the standard categories of immediacy, yet may be an expression of affection between two people.

Additionally an individual may perform the “immediate” actions and still be viewed as non-immediate. For example, if a nurse sincerely hugs his/her patients, has mostly gazing eye contact, and has his/her shoulders turned in to the patients most of the time, yet comes across as insincere to one or more patients can that nurse be described as immediate? In some cases the answer is “yes,” and in some, “no.” When a patient views a nurse as untrustworthy for whatever reason the nurse will not be immediate to that patient. This is because the patient will not allow it. The same nurse may get along well and be viewed as immediate by all his/her other patients, however, the one patient who is uncomfortable with the nurse’s actions and does not view the nurse as “immediate” cannot be overlooked. Thus, it is important to realize that immediacy is highly personal and situational and cannot be defined with strong parameters. One should realize that much more is going on than simply actions.

Just as the patients defined care as “something they know,” immediacy is similar. It is more a feeling of being comfortable with a person and the relationship one has with him/her. In contrast, irritation and annoyance develop when expectations of the relationship and the way one acts within it are violated (Pluckhan, 1978; Balzer-Riley, 1996). Immediacy is something one “knows,” both when it is there and when lines have been crossed.

There is no simple way to define immediacy or immediacy behaviors. While some behaviors are indicators of immediacy, there are no strict guidelines. Instead, immediacy
should be viewed as a continuum, similar to a bell curve. There are a minimum number of behaviors necessary to be “immediate,” yet the number and types of immediacy behaviors seem to differ within different relationships. Some of the nurses in this study displayed numerous immediacy behaviors, while others did not. In spite of the differences, all the patients viewed the nurses in a positive light. Along the continuum an increase in immediacy behaviors are associated with an increase in perceived immediacy until immediacy peaks. Perceived immediacy will then decrease until the maximum boundary is reached. At this point immediacy behaviors become excessive and uncomfortable. These boundaries vary with each person, each relationship, and within the relationship itself.

Immediacy is an operational theory and exists because certain reactions consistently result from the actions of people. In situations such as interpersonal interactions, teaching, and medical settings individuals consistently react to the same types of behavior. For example, eye contact is a sign of interest and acknowledgment. Few, if any, individuals feel that no eye contact means the other person is interested.

The definition of immediacy needs to be expanded to include differences in relationship types and the fact that displayed immediacy behaviors are only the tip of the iceberg of the relationship. The reality that relationships change over both short and long passages of time should be taken into consideration when attempting to tag something as immediacy. The longer a relationship endures, the more likely it is that the people involved know how to act around each other as well as which behaviors they can or cannot do. As time passes immediacy behaviors may become more or less frequent, yet the intensity of the meaning is likely to increase. This is especially true in medical settings where a patient is dying. As the patient approaches death the nurse s/he has had from several months and who knows him/her well will put more meaning into a hug than would a brand new nurse. Again, the reason for this is the passage of time and the depth of the relationship.
Another thing to consider in defining immediacy is that the behaviors are different with each person in different settings. One cannot say that a specific set number and type of behavior will be a factor in the immediacy levels within a given relationship. Some people just do not display these types of behaviors very often. For some individuals, the most immediate and caring thing another person could do for him/her when s/he is upset is to leave him/her alone and not hug or attempt to console him/her. Therefore the setting and the relationship should be considered as well as the behavior.

There are some physical restraints on immediacy in the nurse-patient setting. Nurse are required to touch patients to some degree when treating them. For the most part the nurses did their jobs to the best of their abilities. However, the nurses did express some care for the patient as they treated them. It would be difficult to imagine a nurse who would not treat a patient with respect and dignity. As a result of the nurses' actions some level of immediacy was expressed. In the setting studied the patients decided, although not consciously, if the nurses were immediate. An extremely important part of this decision and outlook on the nurse was whether or not the nurses listened to them and their concerns. Again, this shows that there is more than just actions that factor into immediacy. The fact that nurses would take time to listen and talk with patients made a huge impression on the patients. Thus they felt the nurses were interested and concerned.

While the assumption has been made that there is a direct connection between immediacy and liking, it seems this is not completely accurate. Both the PWAs and the hospice patients were content with the present levels of care they received from their nurses. They felt this way because of the "care," the little things the nurses did to assist the patients. This care given to the patients was not viewed as part of the job, but as genuine affection. None of the patients felt something was missing. The fact that these results were consistent from nurses who displayed a number of immediate behaviors to nurses who displayed almost no immediate behaviors indicates, in this setting, that
immediacy may be a factor in liking, but not the main factor. It seems that more research should be done in this area to ascertain the role of liking in immediacy. There are other links to immediacy which should be studied as well. Future research suggestions include:

- Reviewing immediacy-type research in the Communication, Psychology, and Medical disciplines for the purpose of consolidating terminologies and solidifying the practical use of immediacy. Considering the amount of literature available in these areas it would constitute an extensive literature review, far beyond the scope of this study.

  By reviewing the literature from the above academic areas one could not only consolidate the terminologies used for the same behaviors, but also review the combined literature. One could see what has and has not be studied and choose to develop future research based on those findings. Additionally, consolidating terminologies would make it easier for members of all those disciplines to talk about their research and their findings.

- A focus on verbal immediacy in medical settings. Is immediacy the same in hospitals, doctors offices, or clinics as it is in home care or hospice? What are the expectations of the patients in the different settings?

  As the way medicine is performed changes over time it will be important to realize that the treatment of patients will be different. No longer is the hospital setting the traditional setting for all medicine. As a result it is important to know and study the differences in settings. Knowing whether or not immediacy changes, as well as if people expect different types of treatment will help members of the medical profession know what patients want and how they can be better served.
• Considering the role of relationships on immediacy.

Just as immediacy behaviors are slightly different from medical settings to classroom settings, it is important to know why. By knowing how the relationship affects immediacy we can begin to understand the nature of immediacy itself. From this understanding we may be able to develop a clear definition of immediacy.

• Immediacy research with patients who are not dying to see if the behaviors are the same or altered in some way.

No two medical settings are alike and neither are any two patients. By knowing if patients are treated differently based on whether or not they are dying we can learn a great deal about the purpose of immediacy. Additionally, we can see how patients who are not dying are treated. This will become more and more important as HMOs and moving patients in and out of the hospital as quickly as possible becomes a more common event.

• Immediacy research with medical personal beyond physicians and nurses.

When discussing medical personal most people think of doctors and nurses. However, there are numerous individuals who work with patients that are not doctors or nurses. Nurses’ aides, technicians, and volunteers are just a few medical personnel who fall into this category. The way these individuals treat patient can make just as much if not a greater impact on the patients’ care. Additionally, these individuals have the capacity to develop relationships with patients just as doctors and nurses do. These outside relationships may greatly impact the patient beyond what we already know.
• The effects of job experience of a medical worker, amount of time patient is known, race, sex, and how sick a patient is on immediacy levels and behavior.

As a medical worker gains experience s/he may or may not allow him/herself to become more or less attached and concerned with his/her patients. As the patient and nurse get to know each other their immediacy level should rise, however, the reality that one is dying may or may not change how the nurse responds to the patient. Nurses have the same societal influences as any one else in the areas of they treat people of the same or different race and gender. All of these things could be factors in immediacy and the amounts that are expressed. Further research in these areas will show whether or not they are factors.
BIBLIOGRAPHY


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