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COMPARING TWO METHODS OF TEACHING INTER-PERSONAL
RELATIONSHIP SKILLS TO STUDENT NURSES
IN TRAINING PROGRAMS

by

Elizabeth Ann Bertoch

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Psychology

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

1980

ACKNOWLEDGMENTS

Sincere thanks to all those who assisted and encouraged the completion of this study.

Special thanks goes to Dr. Bill Dobson, my committee chairman, whose suggestions, guidance and continual support made the process less painful.

I would also like to express gratitude to Dr. Keith Checketts for his willingness to contribute time, statistical knowledge and encouragement to this research project.

To Dr. David Stone, I would like to sincerely thank him for the interest and support he has given throughout my training.

Finally, I would like to give special mention to my husband and children for their gentle prodding and steadfast support.

Elizabeth Ann Bertoch

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ABSTRACT

Comparing Two Methods of Teaching Inter-Personal
Relationship Skills to Student Nurses
in Training Programs

by

Elizabeth Ann Bertoch, Master of Science

1980

Major Professor: Dr. William Dobson
Department: Psychology

The purpose of this study was to determine which of two methods of teaching interpersonal relationship skills to student nurses was the most effective. The two methods compared were the traditional "established" method and a programmed group teaching method, the Basic Interpersonal Relations program.

Subjects were 45 sophomore associated degree nursing students in their psychiatric rotation.

Subjects were administered as pretests and posttests the Leary Interpersonal Checklist (ICL) and the Fundamental Interpersonal Relations Orientation-Behavior (FIRO-B).

Four groups were formed. Two groups (I and IV) were taught in the "established" way and in two groups (II and III), the Basic Interpersonal Relations program was taught.

The results showed that there was no significant difference in the amount of change in pre-post scores of any of the groups. This would indicate neither teaching method was superior to the other.

(68 pages)

CHAPTER I

INTRODUCTION

Historically, the registered nurse has been looked upon by the public as a caring, loving person, who is able to relate well with the patient. Many hours of a nurse's training and preparation are devoted to her technical skills, her knowledge of disease processes, and her administrative ability. But only in recent years have interpersonal and communication skills begun to receive more than superficial consideration (Sundeen, et al., 1976). That man needs more change and direction in this area has been argued by Carl Rogers. For example, he purports that rich interpersonal relationships will be possible in the year 2,000 if new skills are learned to make easier a rapid development of warm concern and empathy between two persons during short-term encounters (Rogers, 1958).

That the needs for these qualities exists is true, but unfortunately not all nurses tend to exhibit these qualifications (Peitchinis, 1972; Aiken & Aiken, 1973). It seems to be a general assumption that prospective nurses bring varying levels of interpersonal relationship skills to their initial study of nursing. Some seem to naturally have interpersonal skills, others learn these skills with some difficulty and unfortunately a few

never learn how to effectively relate on an interpersonal level with their patients.

The focus on the nurse-client relationship is a relatively recent development and has occurred in the context of the maturation of the nursing profession. As nursing theorists have become involved in developing philosophies and theories of nursing, the importance of the interpersonal relationship has become apparent. However recent research has indicated that, although nursing theory is placing greater emphasis on the need for the nurse to be able to relate to clients effectively, the average nursing practitioner demonstrates few of the characteristics that would facilitate this. In a thorough review of the literature, Peitchinis (1972) has cited several studies in which nurses and nursing students frequently were rated low on scales measuring characteristics associated with therapeutic effectiveness. In these studies nurses were generally compared to other occupational groups or to groups of college women. Nursing students who were involved in educational programs emphasizing the importance of the helping nurse-client relationship, tended to score higher in areas of therapeutic effectiveness.

One of the writer's responsibilities as an instructor of nursing is to teach prospective nurses how to relate effectively with clients. This is attempted during a psychiatric nursing course. The author's opinion is that effective interpersonal skills do not just happen, nor do they appear magically; they are learned. Experts in the field of interpersonal relations appear to agree (Carkuff, 1969; Rogers, 1961; Berenson & Carkuff, 1967; Benjamin, 1969; Travelbee, 1973).

Statement of Problem

In the process of the writers attempt to teach these skills to prospective nurses, she has been curious as to whether or not established methods of teaching interpersonal relationship skills have been effective, or, more pointedly, the writer has wondered if a different approach would be more useful. The effectiveness of programs teaching interpersonal skills has been tested in a variety of ways in other contexts (Truax & Carkhuff, 1967; Baldwin & Lee, 1965; Fredricks, 1971; Strupp & Bergin, 1969). This suggests that such applications may be feasible in teaching prospective nurses in the Weber State College Nursing Program.

The problem is that no data exists in the WSC nursing program to compare the relative effectiveness of two different teaching approaches in helping prospective nurses develop their interpersonal skills.

Purpose of the Study

The purpose of this study is to determine which of two methods of teaching interpersonal relationship skills to student nurses is the most effective.

This study sought to answer the following specific questions:

1. Is the "established" method of teaching interpersonal relationship skills at Weber State College effective?
2. Would incorporation of the programmed group teaching method, the Basic Interpersonal Relations (B.I.R.) program, improve the effectiveness of interpersonal relationship skills of student nurses in the WCS nursing program.

Two groups (I and IV) were taught in the established way and in the two groups (II and III) the Basic Interpersonal Relations program was taught. The overall procedures will be detailed in the Methodology chapter.

Hypotheses

1. There is no difference in the amount of change in pre-post scores between Group I (established) and Group II (B.I.R.) on the Fundamental Interpersonal Relations Orientation Behavior (FIRO-B), the Interpersonal Checklist or the process recording; these instruments to be discussed later.
2. There is no difference in the amount of change in pre-post scores between Group III (B.I.R.) and Group IV (established) on the FIRO-B, the Interpersonal Checklist or the process recording.
3. There is no difference between the pre tests and the post tests scores on the FIRO-B, the Interpersonal Checklist, or the process recording after five weeks psychiatric training for either Group I, II, III or IV.
4. There is no difference in the amount of change in pre-post tests scores on the FIRO-B, the Interpersonal Checklist, or the process recording comparing Groups I and III to Groups II and IV.

Definitions

1. Nurse-client relationship. A one-to-one goal oriented relationship based on interactions between two unique.

- human beings; the nurse, and the client (Travelbee, 1973).
2. Nurse-patient relationship. Term used interchangeably with nurse-client relationship. The former is the traditional terminology. The nurse - "client" designation has come into accepted use as the result of consumer advocacy.
 3. Therapeutic relationship. That helping relationship "in which, at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning and improved coping with life of the other" (Rogers, 1961).
 4. Process recording. A written account of what transpired before, during and following a nurse-client interaction.

Limitations

1. The psychiatric nurse training course dealt only with associate degree student nurses of the WSC/USU Cooperative Nursing Program at Utah State University. Therefore, the reader should display caution in generalizing the results to students in other nursing programs.
2. It is likely that not all interpersonal relationship skills taught were aptly measured by the instruments.
3. The experimental groups were not randomly selected from their population, but, were selected as intact class units.

CHAPTER II

REVIEW OF LITERATURE

The literature reviewed for this study was divided into two areas of concern; 1) desirable characteristics and skills of the helping person, 2) methods of teaching interpersonal relationship skills, including (a) programmed instruction, (b) Basic Interpersonal Relationships Program, (c) traditional training of counselors and psychotherapists, and (d) some approaches to teaching interpersonal skills to nurses.

Desirable Characteristics and Skills of the Helping Person

When trying to determine how the field defines the helping person, one is confronted with hints suggested by slogans and professional cliché's. For example, on the walls of one collegiate school of nursing is a striking poster proclaiming "Helping is to care." For better or worse, to understand the concept of helping, the reality to be faced is that material available today is still highly subjective. Rosenhan (1973) states;

Helping is an elusive concept even for researchers of social behavior and human development. For example, the understanding of helping at even the most primitive level involves consideration of not only why someone becomes a helper but also how motive interacts with what a helping person considers to be the necessary payoff for actions.
(p. 293)

In reviewing the literature concerning the "helping person" the writer encountered a total of thirty-two characteristics and skills that were considered necessary for success. Many were similar and several synonymous. However there were five characteristics that were included in almost every source reviewed. It is to the primary core of these five that this study is directed. They include: 1) self understanding, 2) congruence, 3) acceptance, 4) empathy, and 5) communication skills.

Self Understanding

Grace, et al., (1977) stresses self understanding as being basic to effective functioning in psychiatric nursing. The nurse's feelings and reactions influence her interactions with patients and may interfere if she is not aware of them. They cite this example,

One nurse became anxious whenever her patient was silent and asked the woman question after question in an attempt to initiate conversation. After a few minutes of questioning, the patient's anxiety increased and she walked away from the nurse. The nurse repeated this pattern of asking persistent questions on a number of occasions, always with the same result, because she was not aware that her behavior was an attempt to relieve her own anxiety. Only with difficulty did she recognize her anxiety, and only then was she able to control her behavior. (p. 111)

Chapman, et al., (1975) stressed a conscious evaluation of where one stands (i.e., awareness of one's own frame of reference) as being a highly important part of becoming a helper. "This awareness is central to appreciation of what not imposing one's values on others sincerely means." The author's indicate that it is "appreciating" much about one's own behavior or others' behavior in the environment.

that greatly influences the way the patient acts in the helper's presence. Also that one's "conscious or unconscious values" on becoming a professional may be interfering with the effectiveness of therapy.

A further reason for emphasizing the helper portion of the interpersonal helping equation is that, "a fuller understanding of oneself seems to increase one's ability to appreciate more quickly who the patient realistically is." The authors' experience is that helpers who have a more realistic idea of where they stand with respect to themselves, their peers, their ideas about life and helping practice are ultimately more efficient at "getting with the patient in ways that result in help's being more quickly brought to bear."

The tradition of self awareness was established by Freud who recommended personal analysis to increase the therapist's understanding of himself and remove avoidance behaviors, which could distort his understanding of the patient.

Congruence

Synonyms used for congruence in the literature are genuineness and authenticity.

Roger's (1967) has long held that, unless a high degree of positive regard, "congruence" and empathetic understanding exists between helper and the patient, effective helping does not occur. Rogers explains that helpers are more congruent when they are what they are--genuine and without a front or facade. This is in contrast to the helpers who seem to be playing a role or to be operating behind a front. No one is totally congruent at all times, but there needs to be an element of

realness of oneself revealed to others before helping is perceived by them as effective.

Jourard (1968) clarifies congruence as he responds to students who know that they are faced in situations with being both "professional" and "real." "It is a difference between 'taking' a role and 'playing' a role. To take a role is a commitment to a task; to play a role is a charade."

Authenticity is how Arnold (1976) describes congruence.

True harmony exists between outer actions and inner feelings. Eliminated is the dissembling and role playing that can stifle a nurse's attempts to be therapeutic. If a nurse pretends to understand autistic or symbolic communication when she doesn't she reinforces the use of this kind of communication by the patient and he sees no need to change. If the nurse is truthful and consistent about letting the patient know when she doesn't understand she is sharing her real self. This can have a healing effect on the client. When she acknowledges her own failure to understand and her desire to do so, she is being authentic because she shows herself as a person. (p. 942)

Travelbee (1971) says the role of the nurse must be transcended because it is not possible to establish human-to-human relatedness if the barriers of role, title, status or position are present.

Acceptance

"The basis of all therapeutic interactions is acceptance," states Mereness, et al., (1978). They point out, "acceptance implies that the nurse treats the client as an important person who has inherent worth and not as a diagnostic entity or a set of psychiatric symptoms." They also maintain that acceptance implies that the nurse tries to understand the meaning the client is conveying through his behavior.

Topalis et al., (1978, p. 119), indicates acceptance is expressed in many ways: "relating with the patient in a nonjudgemental and nonpunitive

manner, expressing direct and indirect interest in the patient, recognizing and reflecting feelings, listening and permitting the patient to express strongly held feelings." She goes on to say, "in accepting patients through a nonjudgemental approach, we avoid all moral judgements and its expression--a patient's behavior is no more right or wrong, good or bad, than the pain that accompanies an ulcer is right or wrong."

Concerning the nonjudgmental attitude, Travelbee (1969, p. 53) however, emphasizes that this is an "unrealistic directive" and a "myth," that it does not exist, because a human being is always making judgements. "The nurse, as a human being, needs to know what judgements she has made about the patient in order to intervene effectively."

Wilson et al., (1979) makes a distinction between acceptance and approval:

Acceptance means refraining from judgements and rejecting a patient who may behave in a way the nurse dislikes. Therapeutic work requires that patients be able to examine, explore, and understand their coping mechanisms without feeling the need to cover up or disguise them in order to avoid negative judgements, or punitive sanctions from the therapist. (p. 56)

She goes on to explain that when nurses tell patients that they should say or do or feel a certain way they deny these patients the acceptance they need to explore their problems.

Empathy

Grace et al., (1977) emphasizes:

Empathy is the desire and attempt to understand another person and his or her perception of experience. It implies sensing the meaning and feeling in another's communications, even if he or she does not explicitly state them. While it is

not always possible to understand the patient's communication, the nurse's attempts to do so will be meaningful and encourage the person to continue communicating. (p. 203)

Kalisch (1973) states, "empathy is an essential part of the interpersonal process and forms the basis for the nurse-patient relationship." She clarifies that empathy is for the patients present, not his past, experience. The patient's feelings change from day to day, and the nurse must tune in to today's experiences. Kalisch further states that "the nurse must try to understand the patient's feelings during the interaction, when he or she can be helpful, not after the interaction is finished."

Del Campo (1978) indicates,

The humanistic nature of counseling relates to the therapeutic relationship which creates an empathetic bond stemming from the therapist's response to the inner distress of the patient and enabling him to adapt with the swift sensitivity to the signals of the dynamic and complex psychic apparatus of the individual. (p. 36)

Fromm-Reichmann (1950) considers this empathetic bond so significant that the success or failure of therapy is greatly dependent upon it.

The response of the therapist is subject to his willingness and ability to become involved with the unique humanity of another being. This involvement allows the therapist to enter into the situation to see with the perspective of another, to experience with him, and then to react with openness and empathy toward the situation. (p. 57)

Communication Skills

The definition of communication is integrally related to the purpose of communication; both definition and purpose vary among sources. Ruesch and Bateson (1951) have defined communication as

"all of the procedures by which one mind may affect another."

Their definition of communication implies a purpose of influencing the behavior and ideas of another.

Stewart (1968) views communication as "a mental-physical process whose function is the elicitation of intended meaning." In this definition the conveyance of information is the primary purpose of communication.

Other theorists stress the social or interpersonal aspects of communication rather than primarily the means of transferring information. Satir (1967) has limited communication to "non-verbal as well as verbal behavior within a social context." Like Satir, Witzlowick et al., (1967) has elaborated on the social function of communication. They believe that "within communication are found the observable manifestations of a relationship."

Mereness (1978) says "communication refers to the reciprocal exchange of information, ideas, beliefs, feelings, and attitudes between two persons or among a group of persons." She goes on to state that it is basic to every phase of nursing and contributes to the development of any therapeutic relationship.

The three modes of communication are verbal, non-verbal and metacommunication.

Wilson et al., (1979) stresses that the spoken word is verbal language; the ability that makes people human and distinct from other animals. "Yet problems arise as humans discover that words do not 'mean' something, people do." Sundeen et al., (1976) points out the spoken word involves the physiological and cognitive mechanisms

required for speechproduction and reception. She goes on to say that "even though a person has progressed to the use of socialized communicative speech and desires to influence another or to enter into a relationship with another, these learned skills and rational purposes do not guarantee a successful interaction." She further explains that some of the problems that arise are because of a discrepancy in meaning of words in similar subgroups, but also numerous dialects and subdialects.

A mode of communication of which people are not always aware is non-verbal communication. Mereness et al., (1978) explain "non-verbal communication refers to the messages sent and received through such means as facial expression, voice quality, physical posture, and gestures. Non-verbal communication is often referred to as body language."

Birdwhistell (1960), has said that "studying non-verbal communication is like studying non-cardiac physiology. There is no true dichotomy between verbal and non-verbal behavior, a study of one will include many elements of the other." F. E. X. Dance (1967) takes the question a step further by claiming that "non-verbal vocal sounds become verbal when they are heard and interpreted by someone." According to his theory, a scream is vocal sound, but becomes verbal when a passerby hears it and interprets it as a cry for help. Wilson et al., (1979) indicates "numerous non-verbal communication channels exist. Most researchers seem to agree that non-verbal channels carry more social meaning than verbal channels. Nonverbal cues help us to judge the reliability of verbal messages more readily."

Another mode of communication, which is rarely recognized on a conscious level is metacommunication. Mereness et al., (1978, p.) stated, "metacommunication refers to the role expectation individuals have of each other in the context in which verbal and non-verbal communication takes place." She goes on to site examples such as, salesperson-customer and nurse-client. Satir (1967) has defined metacommunication as "a comment on the literal content as well as on the nature of the relationship between the persons involved." Sundeen et al., (1976) calls metacommunication "essentially communication about communication." Ruesch (1961, p. 139) explains, "It conveys the sender's attitude toward himself, the message, and the listener. Therefore, there are two parts to all communication, the literal message, or what is being said, and instructions on how to interpret or decode what is being said."

Skills That Foster Effective Communication

Concerning the "how-to" aspects of communications, Wilson et al., (1979) states that, a set of communication skills employed rigidly as a sort of relationship "magic" is antihumanistic in many ways.

Relationships and the people within them, are much too complex and unique for a set of directions to be facilitative. It is essential to remember that a holistic approach essentially militates against the rigid, inflexible application of communication techniques. (p. 111)

However in reviewing numerous writings on communication skills two specific ones were mentioned in every case. These are listening and reflecting.

Listening

According to Sundeen et al., (1976) listening is probably the most effective communication technique available. She indicates "although it is usually considered a passive process of receiving information, therapeutic listening is an active process that requires the nurse's complete attention and a great deal of energy." Van Dersal (1974) indicates most people seem to have the greatest trouble with listening. He explains "they assume that listening is the same as hearing, and that anyone who can hear can therefore listen. But listening, as we are using the word here, requires not only that you hear, but also that you understand what you hear" (p. 160). Active listening requires concentration, since you must listen for the meaning of words states Blondis et al., (1977). She explains,

Attentive listening is another way of saying active listening. It refers to the attitude of the nurse; it means that she is ready to hear what the patient wants to say and will endeavor to understand his situation without argument, interruption, or judgement. Active listening requires concentration, since you must listen for the meaning of the words. (p. 189)

Reflecting

Brammer (1973), indicates "reflecting is one way of expressing to the helpee that we are in his internal frame of reference and that we recognize his deep concerns." He continues, "The main purpose of using reflection from the helper's viewpoint is to understand the helper's experience, and to tell him that he is trying to perceive the world the way the helpee is viewing it" (p. 134).

Reflecting is described by Hays (1966) as, "directing back questions, feelings, and ideas to the person; thus encouraging him to accept

his own feelings and ideas as part of himself." When he asks what he should believe or feel or do, the nurse can encourage him to express his viewpoint. How Sundeen et al., (1976) explains Berne's game (Berne, 1964) "Yes, But" is a good example of how reflecting can be used by a helper (p. 116). The protagonist in "Yes, But" asks for advice ("What can I do about this problem?") When suggestions are given, the response is "Yes I could do that, but..." To focus on the thoughts and feelings of the client, the receiver of the message "What can I do?" can reflect back the question, "What do you think would be helpful?" The reflecting technique enables the client to explore his own ideas and feelings regarding the situation. The listener then takes on the role of facilitator rather than that of advice giver.

Methods of Teaching Interpersonal

Relationship Skills

Programmed instruction. A review of the literature that dealt with programmed instruction in an educational setting by Jameson et al., (1974) reported that programmed teaching is as effective as other methods of instruction then in use. The instructional techniques compared were (a) traditional class, (b) instructional radio, (c) instructional TV, (d) programmed instruction, and (3) computer-assisted instruction. It was concluded by the authors that relatively few studies indicate that one medium is significantly different from another. This review also concluded; upon comparing programmed instruction and traditional instruction that programmed instruction is generally as effective as traditional instruction and the amount of

time required for achieving specific educational objectives may be decreased. In similar aspects Nash et al., (1971) concluded after a literature review regarding the relative practical effectiveness of programmed instruction that it was clear from the data reviewed that programmed materials most always reduce teaching-learning time to a practically significant extent as compared with traditional methods of instruction. They also concluded that programmed materials have an advantage over conventional instructional methods with both low and high ability groups.

Solomon et al., (1968) tested the effectiveness of a programmed approach to group psychotherapy. A control group and a directed group, conducted by a professionally trained group leader and conducted as a therapeutically oriented group, were used to differentiate the effectiveness of the self-directed structured groups, in which the subjects met without a professionally trained leader and utilized programmed instruction as a guide to their interaction. The results generally indicated a change in the self-concept (Self Concept Rating Scale), in the direction of a more positive evaluation, by both the professionally directed and self directed subjects as compared to the control subjects. In addition, the results revealed a significant increase (.05 level of significance) in "self-disclosure" from early sessions to late sessions for both the professionally directed and self-directed conditions as determined by the Self-Disclosure Index. In both cases, improved self-concept and increased self-disclosure were achieved in the self-directed condition to the extent as was possible under the direction of a professionally trained group leader. Judged

therapeutic climate, however, was somewhat lower for the self-directed condition as compared to the professionally directed condition as judged by the subjects. Also using vocational rehabilitation subjects as clients, Robinault et al., (1973) reported gains in the areas of decision making, insightfulness, and general interpersonal advancement for their clients after use of a 10 session self-directed program designed for vocational education. There were no standardized tests used and no control group. The results reported were based on self and others reports.

The programmed instruction method has also been utilized in facilitating interpersonal growth in the area of cultural assimilation. A programmed self-instructional approach to culture training called the Culture Assimilator has been used to decrease some of the stress experienced when one works with people from different cultures. Dssett et al., (1971) reported improvement in personal adjustment and interpersonal relationships among members of heterocultural groups after the use of the Culture Assimilator. In a study published following the above mentioned review also using the Culture Assimilator, Mitchell et al., (1972) obtained the same results to those obtained in the review.

Even though this section of the review of literature on the use of programmed instruction techniques does not lend unanimous support to their positive results in increasing interpersonal skills or other psychologically related goals, it has been pointed out that programmed instruction has been and continues to be a valuable and helpful tool in these areas and as such, an aid to psychologists and health care educators.

Basic Interpersonal Relations Program

The Basic Interpersonal Relations Program is briefly described as to purposes and procedures under the Chapter on Methodology. The predecessor of the B.I.R., the Relationship Improvement Program, is also discussed. This section of the review of literature will be directed to those studies directly involving the Relationship Improvement Program and the Basic Interpersonal Relations program used in this study.

Research concerning the effectiveness of the Basic Interpersonal Relations program and the R.I.P. is comparatively sparse. Statistical support has, however, been obtained verifying favorable outcomes after the use of these programs.

In several studies attempting to validate the R.I.P., counseling students have been used as subjects. In one such study Saltzman (1966) utilized a pre-test, posttest, control group design. The assessment instrument used was a modification of the Barrett-Lennard Relationship Inventory. Results showed that compared to the control group the experimental group made positive growth as measured by the Barrett-Lennard Relationship Inventory that was significant at the .05 level. A follow-up posttest 3 months after indicated that although experimental group results were still more positive than control group results, the two groups did not differ significantly. The author concluded that the changes registered by the experimental group were enough to justify further consideration of the use of R.I.P. Hurst (1966) also used counseling students to test the effectiveness of R.I.P. He combined R.I.P. with weekly T-group sessions as one experimental

treatment based on readings and didactic instruction in counseling theory and methodology. A third group, serving as a control group, received no training. His findings confirmed the prediction that the training program using R.I.P. would increase self and other acceptance of the trainees more than the other training program or the control group. The R.I.P. group was the only one of the three to show consistent increases in mean scores on instruments designed to measure self and other acceptance. The Minnesota Multiphasic Personality Inventory scales on the acceptance of self and the acceptance of others yielded group differences significant at the .05 and .001 levels respectively favoring the R.I.P. group. Perkins (1967) used R.I.P. with first quarter counseling students in an effort to improve their counseling skills. Three experimental and one control group were formed. All experimental groups used R.I.P. One experimental group was made up of pairs of beginning counselors using R.I.P. together. Subjects in the second experimental group were paired with experienced counselors for R.I.P. sessions while those in the third experimental group were each paired with the experimenter. The control group received no training. Results reported by the author indicate that the students in the R.I.P. groups were not evaluated as significantly more effective counselors than students in the control group as shown by practicum supervisor's ratings. It should be noted, however, that no pre-testing of the student counselor's counseling effectiveness was made.

Only one study (Fredricks, 1971) reported in the literature has been found by the author after an extensive search reporting effectiveness of the Basic Interpersonal Relations program. This may be

because the Basic Interpersonal Relations material was adapted from the RIP material and the research validating RIP has been, perhaps erroneously, accepted as also validating the Basic Interpersonal Relations program. The author noted, however, in a selection of promotional literature published by the Human Development Institute, the publisher of the Basic Interpersonal Relations program, that it was stated:

All Institute materials have been thoroughly validated and reviewed by professionals in the particular specialties involved. As such, every Institute program carries with it an absolute guarantee of complete satisfaction. Assessments of any Institute program, as published in professional journals as well as other reference materials, are available upon request. (Human Development Institute, 1976, p. 6)

The author requested said assessments of both RIP and the Basic Interpersonal Relations program. The reply to the request included the following:

The Human Development Institute was moved from Atlanta to Chicago in 1970, and unfortunately in the process, much of the research data on development of the programs was at that time lost or discarded. So, we are unable to help you with any information about either Basic Interpersonal Relations or the General Relationship Improvement Program. (Wilkinson, 1976)

Hence, the study by Fredricks remains the only one currently available testing the effectiveness of the Basic Interpersonal Relations Program.

Fredricks (1971) attempted to determine the effects of the Basic Interpersonal Relations program on the interpersonal functioning of college student volunteers. The effects of the Basic Interpersonal Relations treatment were contrasted with a professionally directed group therapy treatment and two control groups. Both treatment groups met five times over a two week period. Each session was for two hours. The control groups received no treatment. All subjects were

pre- and posttested on: (a) the Fundamental Interpersonal Relations Orientation-Behavior Scale, (b) the California Psychological Inventory, and a semantic differential designed to measure subject changes in interpersonal relations attitudes. The results are not clear as to whether the Basic Interpersonal Relations program is or is not as effective as the counselor led group in terms of training subjects in interpersonal skills. Neither group achieved pre-post significance on any measure except for a .05 level of significance on one of the 18 variables of the California Psychological Inventory (variable 5, Self-Acceptance) favoring the professionally directed group. Frederick's study, however, contained a potentially serious flaw regarding Basic Interpersonal Relations training. The subject completed the course in a two week period rather than the five weeks it is designed to involve. By this, Fredricks subjects may not have had enough time to practice the principles they were learning. This point is supported by the near total lack of statistical significance on the assessment instruments that was also shown by the professionally directed group. A better test of the Basic Interpersonal Relations program would have included a regularly scheduled weekly group meeting over a five week period.

The results of the review of literature concerning R.I.P. and the Basic Interpersonal Relations program are tentative. The majority of the studies utilizing R.I.P. however, provide positive support for the program. The Basic Interpersonal Relations program lacks adequate testing. The brochure which is included with each Basic Interpersonal Relations program, however, notes that the program is for both adults

and students (Human Development Institute, 1969). Therefore, the use of the Basic Interpersonal Relations program was felt warranted and represented a potentially productive area of research.

Traditional Training of Counselors and Therapists

Truax et al., (1967) point out the field of counseling and psychotherapy has too often appeared reluctant to make scientific inquiries into the process and outcome of training.

Very few researchers have made even an attempt to assess dimensions of training that are related to the patient's therapeutic outcome. In the instances where rigorous attempts have been made to assess traditional training programs and their relation to client outcomes, the results have sometimes been equivocal if not negative. (p. 182)

Bergin and Solomen (1963) sought to assess the therapeutic level of functioning of final-year, post-internship graduate students in a traditional program. They found the student's level of empathic understanding in this well-established and traditional program to be positively correlated with the outcome assessments of the trainees' patients. The levels were extremely low however and it would suggest a benign or possibly detrimental consequences of traditional graduate programs.

A prescription for the training of psychotherapy was offered by Whitaker (1953):

Teaching psychotherapy differs specifically from every other type of medical teaching. One teaches attitudes rather than facts and that which is intuitive, abstract and personal becomes more significant than the factual or historical. Part of the confusion in the present day teaching of psychiatry arises from the effort to teach psychopathology and dynamics concurrently with teaching the process of a therapeutic doctor-patient relationship. (p. 167)

An excellent description of training at an important psychoanalytic center is given by Ekstein et al., (1958). The method of teaching is closely tied to psychanalytic theory, "with the therapist's primary use of personal analysis and controlled observation of himself while attempting analysis of a patient." The approach to training is well documented, but thus far no effort has been made to validate any aspects of the program's approach through research.

Rogers (1957) very explicitly points out an approach to therapist training, including 1) listening to taped recordings of experienced therapists, 2) role-playing between trainees, 3) observation of live demonstrations of technique and approach by teachers, 4) involvement in personal therapy, and 5) recording and critiques of interviews conducted by trainees.

A study of student teachers by Berenson (1971) compared a human relations training group, a didactic training control group, a Hawthorne Effect control group, and a non participating control group on their levels of interpersonal functioning. Following training, the human relations training group demonstrated the highest level of interpersonal functioning. Berenson continues to explain that although there are usually a number of courses teaching human relationship training, these are commonly taught in a didactic manner. The emphasis is placed on theory rather than direct application to the clinical setting. In other words, "the focus is on the discrimination of desirable teaching behaviors rather than the communication of these behaviors. Thus, the deliberate modeling and other experiential sources of learning are largely neglected

and, as a result, the attitudinal, emotional, physical, and behavioral changes are not maximized."

The "didactic-intellectual" and "relationship-oriented" or experientially based approaches to training counselors and therapists have been traditionally separated. Truax et al., (1967) have made an attempt to combine the two in their training counselors and psychotherapists. They attempt to explain the process this way,

Recent developments in training practices have led to the emphasis upon more realistic and meaningful integrative programs in which the teacher actively 'shapes' trainee behavior in accordance with the best available evidence on effective practices in the context of a free and open relationship. The trainee-products, then, have an opportunity to come to know themselves more fully in interaction with the learning practices which are currently most effective. In addition, the trainees have a model of a genuine human who shares his belief system in a therapeutic context. (p. 301)

In summary, few scientific inquiries as to process and outcomes of training programs in the field of counseling and psychology have been made. Some that have been done show a benign and possibly a negative effect of counselor training.

A variety of methods have been and are still being employed. These are the psychoanalytic theory following the medical model, some exclusively didactic, others experiential, and still more using integrative approaches.

Some Approaches to Teaching

Interpersonal Skills to Nurses

In reviewing the current literature on methods of teaching interpersonal skills most of it centered on communication skills and empathy training.

Farrell et al., (1977) reported a systematic approach to developing and evaluating a course in basic communication skills for beginning student nurses. The skills that they considered basic to communication and listed as student learning objectives were, 1) communicate at a beginning effective level, 2) view oneself as having the capacity to be a helping person, and 3) recognize one's own feelings and reactions to situations.

The course was offered to two small groups of sophomore undergraduate nursing students (N-21) - one the experimental group, the other a control group. Each group met for two hours each week for 16 weeks. The control group was given the routine course consisting of lecture and assigned readings. There was no supervised practice of actual interviewing. On the other hand, the experimental course was taught partially through intensive role-playing exercises and the use of self-pacing, self instructional videotape vignettes. In addition critiques were given to students of audiotaped student interviews with clients. Two standardized tests were administered as a pre and posttest to both groups of students. These were the Carkhuff 16 Helpee Stimulus Expression Test and the (POI) Personality Orientation Inventory.

To evaluate objectives one and two, the students ability to communicate effectively and to view themselves as helping persons, the Carkhuff test was used. Ratings of student's responses were made on a five point scale with three (3.0) constituting the minimum level.

To establish that the groups did not differ initially in their communication skills, a t-test was computed on the pre-test.

Posttest scores were then compared and a significant difference was found. The experimental group gained about two levels of competence on the Carkhuff scale, falling slightly below the minimum level of (2.8), whereas the control group mean was 1.0 - slightly lower than this group's pre-test mean of 1.04 and the experimental group's mean of 1.03. There was no significant difference between the two groups on either the pre-test or post-test, nor within the groups respectively, on pretesting or posttesting on the second instrument the POI. This instrument depicts the extent to which attitudes and values are considered to be self-actualized and whether the individual is self oriented or other oriented.

The consensus of the authors was that the systematic teaching method for communication skills could enhance the student's ability to respond to a variety of clients in an effective, satisfying way.

In order to compare two teaching methods Carpenter et al., (1976) devised and administered a therapeutic behavior questionnaire to 36 nurses. The test instrument that was used as a pretest and posttest concerned perceived therapeutic and nontherapeutic communication behavior on the part of the nurse.

Three groups of 12 Subjects each were studied in a control group design. The first took a communication class using videotaped role plays; the second, the controls, took a pharmacology class; the third, a posttest only took a class similar to the first but without a role play experience. Findings included: (a) the subjects taking communication scored significantly higher in therapeutic behaviors than controls, (b) subjects having videotaped role plays scored

significantly higher in therapeutic behaviors than those not having such experience, (c) results were supported by higher overall class means and more favorable student evaluations in the videotape role play group. It was the conclusion that videotaped role plays show promise for effective therapeutic behavior change in nurses from a wide variety of backgrounds.

LaMonica et al., (1977) developed a program to assist nurses who scored low in empathy to improve their abilities to perceive and respond more empathetically. The course consisted of seven sessions of didactic and experiential components. The student design consisted of 39 volunteers who were registered nurses. Twenty four were pretested and scored less than 2.0 on Carkhuff's Index of Communication. These 24 nurses were then divided into two groups. Group I, the experimental group, received the pretest, the staff development program, and the post-test. Group II received only the pretest and the posttest. The remaining 15 were in Group 3 which controlled test-retest variable and time effect in the investigation. Group III received only the posttest. Carkhuff's Index of Communication and Carkhuff's Empathy Scale were the instruments used in the study. The analysis of variance of the post-test helping scores from groups I, II and III showed a variance in the scores. Further statistical analysis revealed that the only essential variance was between groups I and II and I and III. This suggested that: 1) the experimental program was effective in increasing subject's abilities to perceive and respond with empathy, 2) pre-testing had little effect on post-testing scores, and 3) the time lapse between onset and conclusion of the experiment was not a significant variable.

The data also documented the effectiveness of the staff development program in raising a helper's ability to perceive and respond with empathy. In the study, helper growth was defined as the difference between the pre- and the post-test scores. The growth observed in the participants scores varied from an increase of .43 to 1.68, with the mean at 1.11; that 8 of the 12 participants raised their levels of empathy by at least one point may be seen.

Data obtained in the study clearly brought out that the nurses tested had extremely low levels of empathy. While the population studies might not have been a representation of registered nurses throughout the United States, they were similar in education and experience to practicing nurses, and the implications are that a training program would be most beneficial in raising nurses' level of empathy.

The studies reviewed on approaches to teaching interpersonal skills to nurses showed, 1) a systematic approach to teaching communication skills improves the subject's ability to respond therapeutically, 2) a videotaped role playing program does effect a behavior change in therapeutic behavior, 3) an empathy training program would be beneficial to most nurses.

In the review of literature the author has: 1) described the most beneficial skills of the helping person as being self understanding, congruence, acceptance, empathy and the two communication skills of listening and reflecting, 2) concluded that programmed instruction is as effective as other means of teaching interpersonal skills and perhaps faster and remains an invaluable tool, 3) research

on the Relationship Improvement Program shows favorable support, however, the Basic Interpersonal Relations program lacked adequate testing, 4) that varied didactic and experiential models are presently employed in training counselors and psychotherapists and the research as to which method is the most beneficial is scanty and inconclusive, 5) training programs for nurses in communication skills and empathy are needed and when employed are effective.

CHAPTER III

METHODOLOGY

Population and Sample

The accessible population for this study were second year nursing students in training at Weber State College/Utah State University Cooperative Associate Degree Nursing Program on the U.S.U. Campus.

The psychiatric nursing course at Weber State College was designed by the Weber State College Nursing faculty and has been in effect since the inception of the associate degree nursing program in 1952. It was designed and patterned after various other psychiatric nursing programs already established in the United States. Since Weber College was one of the original six associate degree (two year) programs in nursing, considerable alteration was needed in existing psychiatric nursing courses to fit an associate degree programs' needs. Faculty also brought their special knowledge derived from their experience in communication with the ill and/or emotionally disturbed patients.

The only data available on the effectiveness of the WSC program is the successful completion of the National League of Nursing psychiatric nursing exam and the Utah State Board of Nursing licensing examination. However, both of these tests are over the theoretical aspect of the course and do not measure actual clinical skills. Some of the multiple

choice questions are constructed to represent actual clinical situations and hence communication skills are tested to this degree.

The accessible population corresponded with the more general population in that all registered nurse education programs in the State of Utah as well as the other forty nine states in the United States must meet the same requirements on the registration examination established by the National League of Nurses. In addition, upon graduation and successful completion of the State Board of Nursing Examination these nurses will enter health care systems in which interpersonal relationship skills is a vital part of health care delivery.

The sample consisted of four class sections, Nursing 212, Emotional Needs of People, two with 12 students, one with 11, and one with 10 students. The majority of students were female; of the total nursing majors three were males. The students who participated in the study were intact groups available due to the teaching assignment of the writer as their theoretical and clinical instructor in psychiatric nursing.

Treatment

The treatments included the "established" interpersonal relationship course and the Basic Interpersonal Relations method. The two methods will be described as well as the similar aspects of the two training programs.

Training Program Objectives for Interpersonal Relationship Skills

NOTE: Objectives, learning experiences and methods of evaluation were supplied to each student.

Central objective. Integrates self-understanding and psychiatric concepts to promote effective communication and/or nursing care.

Supporting objectives.

- I. To increase self awareness.
 - A. List ten manifestations of anxiety including physiological and behavioral signs or symptoms.
 - B. Identify at least three manifestations of anxiety in yourself when caring for psychiatric patients.
 - C. In a psychiatric setting identify six fears the nurse may have in caring for patients.
 - D. Given a situation which produces anxiety, identify six alternative methods of decreasing anxiety in the nurse and the patient.
 - E. List at least six differing roles the nurse may assume in a psychiatric setting.

- II. To promote effective communication.
 - A. Can identify at least three examples of therapeutic communication that are both verbal and non-verbal.
 - B. Is able to identify disruptions to communication in own experience and records this in journal or process recordings.
 - C. When specific situations occur is able to successfully use techniques to promote communication and records this in transcript of nurse-patient conversation.

- III. To establish, maintain and terminate an interpersonal relationship with a patient experiencing emotional difficulties.

- A. Is able to identify two examples of behavior of the nurse and the patient that are typical of stages of the nurse-patient relationship.
- B. Without references, identifies six elements necessary for a therapeutic nurse-patient relationship.
- C. Using the problem solving process, develops a nursing care plan for one selected patient emphasizing the establishing, maintaining and termination of the nurse-patient relationship.
- D. In the clinical setting demonstrates therapeutic nursing intervention that is appropriate for selected patient behaviors.
 - 1. hostility
 - 2. manipulation
 - 3. withdrawal
 - 4. hallucination
 - 5. regression
 - 6. "acting out"
 - 7. agitation
 - 8. depression
 - 9. suicidal risk

The Basic Interpersonal Relations Method

The Basic Interpersonal Relations program was designed to teach and facilitate improvement of interpersonal relationship skills in small group situations (Human Development Institute, 1969). It was developed by HDI from the materials contained in two of their previously existing programs: General Relationship Improvement Program

(RP) and the Management Improvement Program. Both RIP and the Management Improvement Program, which was an outgrowth of RIP, were designed to be used by individuals working in pairs. However, HDI found that "the programs were much more interesting, and the materials more effectively covered, when used by small groups rather than pairs of people" (Basic Interpersonal Relations, 1969), hence, the development of the Basic Interpersonal Relations Program.

While several studies have been reported testing the effectiveness of RIP (Baldwin & Lee, 1965; Berlin & Wyckoff, 1964; Brown & Campbell, 1966; Hough, 1965; Hough & Ober, 1966; Perkins, 1968; Willis, 1967), only one study (Fredricks, 1971) has been found reporting tested effectiveness of HDI's group program. Statistical support has been obtained confirming favorable effects for college students, industrial supervisors and in-patients in a V.A. mental hospital who had used RIP. Fredricks (1971) reported no statistically significant difference in interpersonal relations skills among college student volunteers following use of HDI's group form. Fredrick's subjects, however, completed training in a two week period which is three weeks less time than recommended by HDI, and his results may therefore be suspect since his subjects had little time to practice the points made in each session.

The Human Development Institute (HDI) extended programmed teaching methods into the field of interpersonal relationships in 1963 with the development of RIP (Human Development Institute, 1963). HDI altered the classical presentation of programmed material in the preparation of RIP and developed didactic teaching programs which are taken by two

people in interaction with each other (Berlin & Wyckoff, 1963). RIP consists of a series of ten interviews using Rogerian principles programmed on a Skinnerian schedule. Each session takes approximately one and one-half to two hours to complete. In the use of RIP, two people, who may be either strangers or acquaintances, sit side by side and take turns reading the step-by-step instructions aloud and answer questions, discuss items, or go through other special exercises such as role playing according to the printed instructions given in the program. The general aims of RIP are: (a) to deepen one's ability to be more aware of his own feelings and the feelings of others; (b) to enhance one's appreciation of his own potential; (c) to increase flexibility in both the emotional and cognitive aspects of behavior; and (d) to develop the ability to apply these new behavior patterns to the life situation (Berlin & Wyckoff, 1964).

The newer Basic Interpersonal Relations programs used in this study are essentially the same as RIP except that it is structured for use by a group of five or six people and consists of five one and one-half to two hour sessions instead of ten. Basic Interpersonal Relations resulted from HDI's finding that RIP was much more interesting and the materials more effectively covered, when used by small groups rather than pairs of people (Basic Interpersonal Relations, 1969). Accordingly, the RIP material was adapted and rewritten in order to be usable by small groups.

The two groups of student nurses that were taught interpersonal relations by the BIR method (Groups II and III), consisted of eleven and twelve subjects. They met weekly for one to one and one-half hour sessions for five consecutive weeks.

Research concerning the effectiveness of the Basic Interpersonal Relations program and RIP is comparatively scarce. Statistical support has, however, been obtained confirming favorable effects following the use of these programs (Brown & Campbell, 1966; Lere, 1965; Berlin & Wyckoff, 1964; and Hurst, 1966).

The "Established" Method

- I. Five weeks of lecture-discussion.
- II. Audiotapes on Science of Personal Success from Learning Dynamics, Inc.
 - A. Lesson #4 Personality Styles.
 - B. Lesson #5 Personality Styles Cont.
 - C. Lesson #11 Cooling Anger and Wholesale Criticism
 - D. Lesson #12 Dealing with Stubbornness and Indecision.
- III. Filmstrips
 - A. Trainex Corp., "Understanding Relations with Others."
 - B. Concept Media.
 1. "The Patient"
 2. "The Nurse"
 3. "The Interaction"
- IV. Videotape - WSC, "Games People Play."
- V. Handouts on therapeutic and non-therapeutic communication.
- VI. Reading references.
 - A. Nursing, "How to be a Good Communicator and a Better Nurse," December, 1974, p. 57-64.
 - B. Nursing, "Listening," March, 1975, p. 93-95.

- C. American Journal of Nursing. Field, William E., and Ruelke, Wylma, "Hallucinations and How to Deal with Them." April, 1973, p. 638.

Similar Aspects of the Two Training Programs

(Established and Basic Interpersonal Relations Methods)

- I. Assigned readings from two texts. (Mereness & Taylor, Essentials of Psychiatric Nursing, Ninth Edition, St. Louis, 1974, and Burgess and Lazare, Psychiatric Nursing in the Hospital and Community, 1973).
- II. Weekly tests over the textbook material.
- III. Clinical experience of fifteen hours weekly for five weeks on the psychiatric ward of the same general hospital.
- IV. A daily journal kept to record experiences and how their clinical objectives were met while on the psychiatric ward. Handed in to the teacher and critiqued weekly.
- V. Two process recordings covering actual interaction with selected patient during the first and last week of the clinical experience.
- VI. Pre- and post clinical conferences held daily before the clinical experience discussing objectives and following sharing with the group the days experiences.

Instrumentation

The degree of effectiveness in interpersonal relationship skills learned by the students was measured by the Interpersonal Checklist (ICL), the Fundamental Interpersonal Relations Orientation-Behavior (FIRO-B) and process recordings, on a pre-post basis.

The ICL was especially constructed to measure conscious self-description and description of others, one of the levels of behavior studied by the Interpersonal System of Personality (Leary, 1956). This test consists of 128 items (e.g., able to give orders, usually gives in, irritable, kind and reassuring); eight for each of sixteen interpersonal variables called octants. The octants are: (1) managerial-autocratic, (2) competitive-narcissistic, (3) aggressive-sadistic, (4) rebellious-distrustful, (5) self-effacing-masochistic, (6) docile-dependent, (7) cooperative-overconventional, and (8) responsible-over-generous. The ICL raw data are converted to dominance and love scores which are obtained by solving the following equations: $\text{Dominance} = (1-5) + 0.7(8+2-4-6)$, $\text{Love} = 7-30+0.7(8-2-4+6)$. The numbers refer to the octants and the number of items the subject checks for each octant are substituted in the equation. For example, if a subject checks eight octant one items, three octant five items, ten octant eight items, seven octant two items, three octant four items, and one octant six item, the appropriate formula for dominance would be $(8-3+0.7(10+7-3-1))$, the solution of which would yield a raw score of 14.1. Raw scores may be positive or negative and vary through a wide range (-38.4 to +38.4).

Reliability and validity for the ICL indicate that (test-retest reliability correlations) for octant reliability averages .78, suggesting that ICL scores have sufficient stability to be useful in personality research and clinical evaluation.

The test manual suggests that perhaps more important than reliabilities are intervariable correlations which are particularly accessible to the psychometrician. Also, the ICL has been used in a large variety of situations providing validation for its use as a research, as well as a clinical instrument.

The Fundamental Interpersonal Relations Orientation-Behavior (FIRO-B) has two primary purposes as described by Schutz: (1) to construct a measure of how an individual acts in interpersonal situations, and (2) to construct a measure that will lead to the prediction of interaction between people, based upon the measuring instrument alone (Schutz, 1958, p. 58). The second purpose is unique among most instruments.

The test provides scores in three need areas, inclusion (I), control (C), and affection (A) which Schutz says constitutes a sufficient set of dimensions to predict interpersonal behavior. The test also attempts to measure both the extent to which the subject expresses behavior toward others in each area and the extent to which he wants others to express the behavior toward himself. Thus each subject receives six scores: expressed-inclusion (Ie), wanted-inclusion (Iw), expressed control (Ce), wanted-control (Cw), expressed-affection (Ae), and wanted-affection (Aw).

The FIRO-B validity and reliability data indicate that internal consistency (reproducibility index) is high for all subscales (.93 and above). All test-retest correlations are adequate (over .70). The subscales are related to non-test interpersonal behaviors and personality measures. Scale scores have been found to be correlated with several groups including diagnosis of schizophrenia. According to a review by Bruce Bloxom in Buros (1972) the number and strength of these correlations are great enough to validate the use of the FIRO-B as an instrument for research.

The process recording is an instrument now in use by Weber State College Nursing Program during the psychiatric course to measure the

level of interpersonal communication skills. It is a written transcript made by a student as soon as possible after an actual conversation with an individual patient. Included in the record is an account of the verbal content of the interaction, observations of non-verbal communication, student feelings about the interview and a self-critique of communication blocks or therapeutic interventions.

The process recordings were read and scored by two instructors other than the author who are psychiatric nurse instructors on the Weber State College and Utah Technical School campuses. A critical requirement sheet was developed by the writer following the format for clinical evaluation at WSC. Both instructors used this same evaluation tool to score the process recordings (see Appendix A for the evaluation form).

Design

Fall quarter of 1976 the sophomore class of the Weber State College/Utah State University Cooperative Associated Degree Nursing Program was divided into two groups on a random basis. Group I consisted of twelve students, Group II contained eleven students. The course lasted five weeks. Pretesting with the ICL and FIRO-B was administered to students in both groups before any classwork began. After the treatment had been administered all students were administered the post-tests.

During the five week course of Fall quarter 1976, Group I was taught interpersonal relationship skills via the established method by the investigator. Group II was taught the pediatric, community health course by a different instructor. The second five week period, Group II

was taught interpersonal relationship skills via the Basic Interpersonal Relations program taught by the investigator while Group I was taught pediatrics - community health by the other instructor.

During the Fall quarter of 1977, 24 students were randomly divided into two groups of twelve, Group III and IV. Group III was taught the interpersonal relationship course by the Basic Interpersonal Relations Method and Group IV the pediatric community health nursing course. After five weeks Group IV was taught the interpersonal relationship course by the "established method" and Group III was taught the pediatric community health nursing course. Before the end of the first five weeks of the quarter Group IV (Pediatric-community health nursing) was decreased to ten students, one student transferring to another campus and one withdrawing. Reversing the sequence of teaching between the two years was done in order to prevent any possible sequencing effect. Pre- and posttesting occurred as outlined in Table 1.

Table 1
Testing Sequence

Group	Pre test	1st 5 weeks	Post test	2nd 5 weeks	Post test
Year I					
Group I	X	Interpersonal Rel. Skills "established"	X	Peds-Comm.	
Group II	X	Peds-Comm.		Interpersonal Rel. Skills (BIR)	X
Year II					
Group III	X	Interpersonal Rel. Skills (BIR)	X	Peds-Comm.	
Group IV	X	Peds-Comm.		Interpersonal Rel. Skills "established"	X

Chronology of Program

Fall of 1976

1. Sept. 1 - Ordered FIRO-B and ICL exams for use during both years.
2. Sept. 13 - Met with head of the nursing department at Weber State College, and obtained permission to do research with nursing students.
3. Sept. 14 - Contacted psychiatric nursing instructor at W.S.C. and the instructor of psychiatric nursing of the Weber State College program at Trade Tech. in Salt Lake City.
4. Sept. 29 - Administered the FIRO-B and the ICL to both Group I and Group II.
5. Sept. 30 - First day on psychiatric ward Group I did process recording I.
6. Oct. 4 - Group I begins to be taught interpersonal relations skills by "established" method.
7. Oct. 29 - Last day on psychiatric ward Group I did process recording II.
8. Nov. 2 - Post test on FIRO-B and ICL by Group I.
9. Nov. 4 - First day on psychiatric ward Group II did process recording I.
10. Nov. 8 - Group II began to be taught interpersonal relations skills by the BIR method.
11. Dec. 10 - Last day on psychiatric ward Group II did process recording II.
12. Dec. 13 - Post test on FIRO-B and ICL for Group II.
13. Dec. 15 - Sent all process recordings to W.S.C. psychiatric nursing instructors on other campuses to be scored by January 29, 1977.

14. Scored and recorded all pre and post tests on FIRO-B and ICL.
Recorded process recording scores.

Fall of 1977

1. Sept. 27 - Administered FIRO-B and ICL to both Group III and Group IV of new sophomore class.
2. Sept. 29 - First day on psychiatric ward Group III did process recording I.
3. Oct. 1 - Group III began to be taught interpersonal relations skills by BIR method.
4. Oct. 28 - Last day on psychiatric ward Group III did recording II.
5. Oct. 31 - Post test on FIRO-B and ICL by Group III.
6. Nov. 3 - First day on psychiatric ward Group IV did process recording I.
7. Nov. 7 - Group IV begins to be taught interpersonal relations skills by the "established" method.
8. Dec. 9 - Last day on psychiatric ward Group IV did process recording II.
9. Dec. 12 - Post test on FIRO-B and ICL for Group IV.
10. Dec. 14 - Sent all process recordings to W.S.C. psychiatric nursing instructors on other campuses to be scored and recorded scores when returned.
11. Scored all pre and post tests on FIRO-B and ICL and recorded.
12. Tabulated all scores and program to take to computer for analysis of covariance of all of scales used on the FIRO-B and ICL and for the scores on the process recordings.

Statistical Analysis

Statistical treatment consisted of 3 analyses of covariance of each scale of the measuring instruments with the pre-test as the covariate in each instance.

CHAPTER IV

RESULTS

The results are presented below based on three comparisons (1) comparing group scores on the process recording, (2) comparing group scores on the Interpersonal Checklist, and (3) comparing group scores on factors of the Fundamental Interpersonal Relations Orientation Behavior.

The scoring of the process recordings by the two raters was suspect with regard to (1) low interrater reliability and (2) within rater scores which were so consistent with self in many cases as to indicate a rater bias or halo effect. Due to these problems this data was not included in the statistical analysis.

Differences on the Dominance and

Love Scales of the ICL

Differences between groups on the two derived factors of "dominance" and "love" from the ICL were compared. The results were as follows after analysis of covariance with the pre-test as the covariate: factor 1 (dominance) significant at the .05 level; factor 2 (love) no significant difference.

The original analysis of covariance on the dominance scale of the ICL seemed appropriate. On further examination it was ascertained that this statistical analysis of this data violated the assumption of

homogeneity of regression on this scale. Therefore a two way analysis of variance with repeated measures was done and it was found none of the factors were significant. Summarization of these results are provided in Tables 2 and 3.

Differences Between Groups on the FIRO-B Factors

Differences between groups on the three expressed factors (Ie), (Ce), (Ae) and the three wanted factors (Iw), (Cw), and (Aw) were compared. The results show no significant differences exists on any of the factors. These results are summarized on Tables 4 through 9.

A simple analysis of variance was run on the hypothesis comparing the difference in pre-post scores after five weeks psychiatric training. It was determined there was no significant change for either Group I, II, III, or IV.

In this chapter the writer has presented the results of the study. The discussion of the results will be presented in Chapter 5.

Table 2
 Analysis of Variance for Repeated Measures
 of the Dominance Scale of the ICL

Source of Variation	Degrees of Freedom	Mean Square	F
Between Subject	47		
Treatment	3	36.72	.60
Error 1	44	60.99	
Within Subject	48		
Pre-Post	1	2.5	.19
Interaction	3	6.57	.50
Error	44	13.11	

Table 3
 Analysis of Covariance of the
 Love Scale of the ICL

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	4172.645	1.411	0.254
Error	40	2956.364		

Group	N	Adjusted Means
1	12	40.91*
2	11	64.55*
3	12	20.36*
4	10	54.46*

*The individual scores ranged from 19.6 to -23.0

Table 4
 Analysis of Covariance of the Expressed-Inclusion
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	3.789	1.213	0.317
Error	40	3.124		

Group	N	Adjusted Means
1	12	5.77
2	11	4.44
3	12	4.75
4	10	5.08

Table 5
 Analysis of Covariance of the Wanted-Inclusion
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	1.834	0.205	0.893
Error	40	8.957		

Group	N	Adjusted Means
1	12	4.08
2	11	4.65
3	12	3.71
4	10	4.35

Table 6
 Analysis of Covariance of the Expressed-Control
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	2.886	0.936	0.432
Error	40	3.083		

Group	N	Adjusted Means
1	12	4.01
2	11	2.97
3	12	3.65
4	10	3.01

Table 7
 Analysis of Covariance of the Wanted-Control
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	1.678	1.017	0.395
Error	40	1.650		

Group	N	Adjusted Means
1	12	5.20
2	11	5.42
3	12	4.55
4	10	4.84

Table 8
 Analysis of Covariance of the Expressed-Affection
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	5.504	1.380	0.263
Error	40	3.987		

Group	N	Adjusted Means
1	12	4.79
2	11	4.52
3	12	6.01
4	10	4.57

Table 9
 Analysis of Covariance of the Wanted-Affection
 Factor of the FIRO-B

Source of Variation	Degrees of Freedom	Mean Square	F	Significance of F
Group	3	7.661	1.620	0.200
Error	40	4.724		

Group	N	Adjusted Means
1	12	6.61
2	11	4.69
3	12	5.79
4	10	5.54

CHAPTER V

DISCUSSION

The major purpose of this study was to compare groups of student nurses taught by the "established" and the B.I.R. method on factors of interpersonal relationship skills.

This section is devoted to discussing and drawing conclusions and implications about the data reported in the previous chapter.

The results will be discussed in relationship to the hypotheses. The grading of the process recording using the formulated evaluation tool allowed for too much subjectivity and so only findings on the Fundamental Interpersonal Orientation-Behavior (FIRO-B) or ICL scores will be mentioned. The process recording results were eliminated as invalid due to poor inter-rater reliability.

Hypotheses and Results

The hypothesis that there is no difference in the amount of change in pre-post scores between Group I (established) and Group II (BIR) on the FIRO-B on the Interpersonal Checklist was accepted.

The hypothesis that there is no difference in the amount of change in the pre-post scores between Group III (BIR) and Group IV (established) on the FIRO-B or the Interpersonal Checklist was retained.

The hypothesis that there is no difference in the amount of change in pre-post scores on the FIRO-B or the Interpersonal Checklist comparing Groups I and III and between II and IV was also retained.

Method

Analysis of co-variance was done on all group scores for hypothesis I, II, and IV except for the dominance variable of the I.C.L. Because of the lack of homogeneity in the group scores, analysis of variance with repeated measures was more appropriate for this scale.

Simple analysis of variance was done on hypothesis III, there is no significant difference between the pretest and the posttest scores on the FIRO-B or the Interpersonal Checklist after five weeks psychiatric training for either Groups I, II, III or IV and was retained.

Conclusions

The amount of change between all group tested was insignificant. (1) This implicated that neither the established nor the B.I.R. method was more effective in the teaching interpersonal relationship skills to student nurses. (2) The insignificant difference between the pretest and the posttest scores after five weeks training for either groups I, II, III, or IV indicated that none of the groups made an improvement in their skills. (3) And lastly because of the failure to show a significant difference in the amount of change in pre-post scores comparing Groups I and III to Groups II and IV. This showed there was no difference between groups according to the year or sequence of training.

Limitations of the Study

1. The interpersonal relationship training was too short. It consisted of only five weeks in duration.

2. It is difficult to generalize the findings to the student nursing population as a whole, because of the small number of subjects, and the sample obtained from one nursing program alone.
3. The training may have been too broad to have been measured by instruments designed for measuring specific behaviors.

Recommendations

It appears from the results of this study that teaching inter-personal relationship skills to student nurses should include the following:

1. Length of training as it relates to interpersonal relationship skills should be increased to facilitate change. The present five week period should be doubled and perhaps interpersonal relationships taught as a course separate from theory of psychiatric nursing.
2. More specific interpersonal relationship skills be taught such as empathic listening, person centeredness or viewing one's self as a helping person.
3. Appropriate specific measures be utilized to test the outcome of the specific skills taught.
4. Refinement of the process recording in order to make the process more objective.

Implications for Nursing

While the population might not have been representative of registered nurse programs throughout the country, they were similar to students in most associate degree programs. It seems reasonable, therefore, that the study suggests student nurses change very little

in their interpersonal relationship skills during a short term integrated psychiatric experience.

These results, while in need of further replication, suggest implications for further training programs and research.

It is recommended that nursing programs develop a deliberate, sequentially planned, systematic approach to teaching interpersonal skills. That standardized instruments be carefully selected to assess the relative value of the course.

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APPENDIX A

Process Recording Evaluation of
Interpersonal Relations Skills

WSC/USU COOPERATIVE NURSING PROGRAM

Group _____ Process Recording Evaluation of Interpersonal Relations Skills

Student's Name _____ Date _____ Process Recording No. _____

Instructor's Signature _____

Desired Objectives	Student Behavioral Objectives				
		Outstanding	Consistent	Inconsistent	Unacceptable
		4	3	2	1
I. Integrates Self Understanding to promote effective communication.	1. Personal feelings stated in interpretation or summary.				
	2. Explanation of nurse's feelings and behaviors stated in interpretation or summary.				
	3. Has empathy for patients but does not identify with them.				
	4. Maintains a professional, confidential relationship with patients.				
	5. Describes own non-verbal behavior.				
	6. Interprets own non-verbal behavior.				
	7. Identifies blocks in communication made by self.				
	8. Suggests an alternate approach to the previous blocks.				
	9. Identifies and deals constructively with own feelings.				
II. Demonstrates Communication Skills	1. Describes the physical setting that facilitates or hampers Nurse-Patient interaction. (time, place, etc.)				
	2. Identify how the interaction began.				
	3. Describes patient's non-verbal behavior.				
	4. Interprets patient's non-verbal behavior.				
	5. Identifies and deals constructively with patient's behavior				
	6. Identifies blocks to communications made by patient.				
	7. Lists defense mechanisms used by patient.				
	8. Develops good rapport with patient.				
	9. Demonstrates non-judgmental attitude towards patient.				
	10. Displays an attitude of hope and interest in her patient.				
	11. Is courteous and respectful.				
	12. Is tactful, discreet, honest and maintains confidentiality.				

		4	3	2	1
111. Demonstrates a Therapeutic Nurse-Patient Relationship	1. Begins to understand dynamics of patient's behavior and lists in interpretation or summary.				
	2. Identifies behaviors which demonstrate basic psychopathological symptomatology.				
	3. Identification of the stage in the Nurse Patient relationship.				
	4. Assesses patient's basic needs.				
	5. Sets appropriate controls with patient.				
	6. Demonstrates understanding of restraints.				
	7. Does not reinforce maladaptive behavior patterns.				
	8. Promises made to patients are reasonable and carried out.				
	9. Encourages patients to participate in group activities or occupational therapy by participating with or accompanying them.				
	10. Facilitates patient awareness of realistic goals.				
	11. Assesses how nurse-patient interaction went.				
	12. Plans for future therapeutic interventions.				

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