

Nurses' communication skills: an evaluation of the impact of solution focused communication training

Nick Bowles BA MA RMN

Senior Lecturer, School of Health Studies, Division of Nursing, University of Bradford, Bradford, UK

Carolyn Mackintosh BSc MSc RGN PGDip

Lecturer, School of Health Studies, Division of Nursing, University of Bradford, Bradford, UK

and Alison Torn BSc RMN

Research Officer, School of Health Studies, Division of Nursing, University of Bradford, Bradford, UK

Submitted for publication ■

Accepted for publication ■

Correspondence:

Nick Bowles,
School of Health Studies,
Division of Nursing,
University of Bradford,
25 Trinity Road,
Bradford BD5 0BB,
UK.
E-mail: n.b.bowles@bradford.ac.uk

BOWLES N., MACKINTOSH C. & TORN A. (2001) *Journal of Advanced Nursing* 36(3), 000–000

Nurses' communication skills: an evaluation of the impact of solution focused communication training

Aims. This paper describes the evaluation of a short training course in solution focused brief therapy (SFBT) skills. This evaluation examined the relevance of SFBT skills to nursing and the extent to which a short training course affected nurses' communication skills.

Background. Nurses' communication skills have been criticized for many years, as has the training in communication skills that nurses receive. The absence of a coherent theoretical or practical framework for communication skills training led us to consider the utility of SFBT as a framework for a short training course for qualified nurses, the majority of them are registered nurses working with adults.

Design and methods. Quantitative and qualitative data were collected: the former using pre- and post-training scales, the latter using a focus group conducted 6 months after the training. Data were analysed using the Wilcoxon signed-rank test and content analysis.

Results and findings. Quantitative data indicated positive changes in nurses' practice following the training on four dimensions, and changes in nurses' willingness to communicate with people who are troubled reached levels of significance. Qualitative data uncovered changes to practice, centred on the rejection of problem-orientated discourses and reduced feelings of inadequacy and emotional stress in the nurses.

Conclusions. There are indications that SFBT techniques may be relevant to nursing and a useful, cost-effective approach to the training of communication skills. Solution focused brief therapy provides a framework and easily understood tool-kit that are harmonious with nursing values.

Keywords: communication skills, solution focused brief therapy, conversation, counselling, education evaluation, nursing

Introduction

Nursing, caring and communicating

The importance of effective communication as a fundamental element of nursing has been repeatedly acknowledged (Wilkinson *et al.* 1998, 1999, Booth *et al.* 1999) and is regarded as integral to the provision of high quality patient focused nursing care (Macleod Clark 1988, Lubbers & Roy 1990, Dunn 1991). Yet nurses' communication skills have long been a source of concern (Smith 1983, Macleod Clark 1988, Wilkinson 1991, Heaven & Maguire 1996, Jarrett & Payne 2000). Early work by Menzies (1961) demonstrated how nurses avoid close contact and emotional engagement with patients in order to reduce their exposure to upsetting and possibly damaging stressors. She also observed how the institutional and professional cultures in which nurses work inhibit and devalue nurse–patient intimacy.

Menzies' views have been widely supported and the phenomena she described do not appear to have changed significantly. Fielding and Llewelyn (1979) argue that organizational and individual factors result in 'lip service [being] paid to the importance of good communication' (p. 284). Others have described some of the mechanisms nurses use actively to avoid or block communication, such as denial of patients' concerns, abruptly changing the subject, or focusing on the least threatening aspect of a conversation (Webster 1981, Booth *et al.* 1996).

Burnard and Morrison (1991) sought to identify the key factors underpinning nurses' perceived failure to communicate. These include the organizational culture, a lack of time, the emotional cost to the nurse, a view of nursing as a practical task orientated profession and emphasis on communication solely as a means of providing information.

Recent research indicates clearly that nurses do need to protect themselves as the institutions in which they work can impair their performance and, in some cases, their health. Cheng *et al.* (2000) have demonstrated that the high task demands, low levels of job control and inadequate support which are a feature of nursing practice lead to declining work performance and health over time. It is unsurprising, then that nurses should seek to protect themselves from harm. Indeed this is precisely what they should do if they are to continue to nurse.

There is no benchmark for effective nurse–patient communication. In the absence of a standard, it may be that the style of the communication does not fit with the preconceptions of researchers. Some of those who have criticized nurses' communication skills are likely to have been professionally socialized and educated at a time when humanistic, predom-

inantly Rogerian, perspectives on communication were at their height (Burnard 1987). Fundamental to this perspective is the formation of a nondirective relationship over a lengthy period of time. Few nurses, outside mental health or primary care settings have time to fulfil this function, even if patients were to want it, which is doubted by some (Waterworth & Luker 1990). Furthermore, there is no robust evidence that counselling is effective in secondary medical or acute areas (Roth & Fonagy 1996).

Hence, some of the criticism of nurses' communication may be unreasonably harsh or unrealistic and in some cases little more than the expression of different values rather than justifiable evidence of deficit. This perspective raises new questions on what is appropriate and clinically effective communication, given the high demands nurses routinely face, and requires consideration of how effective communication skills may be taught, both at pre- or postregistration levels.

Clearly, nurse education should address communication skills (Smith 1983, Burnard 1987, Lubbers & Roy 1990, Burnard & Morrison 1991, Gijbels 1993, Wilkinson *et al.* 1999, Suikkala & Leino-Kilpi 2001). However there is some evidence that communication skills training does not significantly change practice in clinical areas (Neeson *et al.* 1984, Dunn 1991, Wilkinson *et al.* 1998, Booth *et al.* 1999). As Dunn (1991, p. 4) states: 'although nurses are aware of the importance of nurse–patient interaction, there is difficulty in applying taught interaction skills in practice'.

Socialization, a lack of role models or clinically credible educators may partially account for this finding. But equally important, perhaps, is the nature of the skills being taught. Nondirective 'Rogerian' counselling techniques have little utility at the bedside, but it is likely that they still form the backbone of many communication skills programmes. Indeed, Suikkala and Leino-Kilpi (2001), in a review of the student nurse–patient relationships, use 'nursing' and 'counselling' interchangeably as does Nagano (2000, p. 25), who states that 'the demands of nursing require the nurse to play counsellor (sic) with the patient' and argues the object of nursing communication is to enter the client's private world. Suikkala and Leino-Kilpi (2001, p. 48) discuss 'empathetic ability', the 'development of counselling skills' and 'active listening' in a person-centred relationship without any critical reflection on the effectiveness or utility of these techniques.

Fielding and Llewelyn (1979) criticized the content of many communications skills training programmes on the grounds that they failed to provide a theoretical framework that was applicable to all areas of nursing. This view has been echoed more recently by others who argue that current

approaches to communication skills training are inadequate and that such training should provide a greater range of skills within a coherent theoretical framework (Crute *et al.* 1989, Gijbels 1993, Heaven & Maguire 1996). In the following section, the relevance of brief focused approaches to communication skills education is considered, with reference to effectiveness and 'trainability'.

Solution focused brief therapy

Solution focused brief therapy (SFBT) is both a system of communication and a set of assumptions about how best to motivate individuals to change, adapt and grow. It was first developed in the United States of America (USA) in the 1980s (de Shazer 1982, 1985) and has since been used effectively in a variety of settings (Webster 1990, Hawkes *et al.* 1993, Iveson 1995, Hillyer 1996, George *et al.* 1999).

The key difference between SFBT and other communication models is its strength-orientated approach. Being solution-focused requires a shift of attention, from a problem-dominated, deficit or pathology perspective to a solution-orientated perspective. For example, the nurse may use the 'miracle question', which invites discussion of what the client wants to happen in the future despite their present circumstances, what the client is doing already to make this happen and what are the signs that tell the client that change is possible. Progress is assessed and reinforced with numerical scales; the nurse uses positive feedback and compliments, and may leave the patient with a 'task' at the end of their conversation. In short, the solution-focused nurse elicits, amplifies and reinforces the strengths, abilities and hopes of the client.

Solution focused brief therapy is brief, which means that the nurse should use the least amount of time necessary to engage the patient effectively. This may take place over several encounters or may be as little as a single session (Talmon 1990). The techniques may even be used in a nursing assessment interview or everyday conversation.

Solution focused brief therapy is culturally congruent with nursing practice as it focuses on wellness and health, not pathology, and is orientated towards empowering the patient to recognize their own strengths and competence. Its theoretical basis has much intuitive appeal and is easily understood, making it accessible to a wide range of practitioners and practice situations.

In practice SFBT is progressively structured, from goal negotiation to patient strengths and the steps they may take towards their goal. The notion of a therapeutic relationship, which may take many sessions to achieve, is less relevant than collaboration, which can be achieved in a matter of moments.

Consequently SFBT provides nurses with a clear framework for communication that augments existing skills. The solution-focused orientation reduces many of the emotional stresses and constraints that currently inhibit communication. In our training practice we chose to refer to solution-focused conversation, as most nurses do not regard themselves as 'therapists' and do not have the scope within their role or the desire to become therapists. Nonetheless the abbreviation SFBT is used below.

On this basis, we developed a short training course in SFBT for registered nurses and evaluated the outcomes using quantitative and qualitative methods.

The study

Aims

This study sought to examine relevance, 'trainability' and clinical application of SFBT, as follows:

- To explore the extent to which SFBT was considered to be relevant and appropriate to clinical practice by a range of registered nurses.
- To establish whether a short training course in SFBT could enhance registered nurses' communication skills in clinical practice.
- To identify changes in clinical practice accruing from SFBT practice.

Methods

Sample

Sixteen registered nurses and health visitors were recruited from a variety of clinical settings, both in-patient and community based, including medical, surgical, palliative care and family support. The number of students was determined as suitable for small group teaching, no attempt was made to sample purposefully, and the evaluation embraced all those who applied for the training.

All attended a 4-day training programme in SFBT, delivered as a full day over an 8-week period between May and July 2000. This programme was accredited within the BSc (Hons) Nursing Practice and on completion of a summative assessment led to the award of 20 credits at Level 3.

Students participated voluntarily, with no preselection criteria. The West Yorkshire (England) Training and Education Consortium provided funding for the training and evaluation under an educational development grant scheme. All students were female, with a range of staff from clinical nurses to nurse specialists with a leadership function.

Design

The study design employed a pre- and post-training design and comprised qualitative and quantitative elements.

Quantitative data

Baseline measures in six areas were taken prior to the start of the course, using a Likert scale instrument designed specifically for this study. These were repeated 6 months after course completion.

This instrument examined the following areas:

- Competence in talking with people who are troubled.
- Confidence in talking with people who are troubled.
- Willingness to talk with people who are troubled.
- Frequency with which the nurse speaks with people who are troubled.
- The extent to which the nurse's colleagues tolerated their engagement with people who are troubled.
- The amount of scope their role allows them to talk with people who are troubled.

Each dimension was scaled from 0 to 10, where 0 equated to 'not at all [e.g. confident]' and 10 to 'extremely [e.g. confident]'. The intermediate scores did not carry a label. This is in keeping with scaling practices used clinically within SFBT and was considered to be a novel way to model the process of SFBT within the evaluation. Each dimension had a small note which explained what was meant by confidence, capability, etc.

Written information was provided to students about the evaluation. Responses were anonymized, and they were able to refuse to participate without concern that this would affect their progress on the course or assessment of their written work.

The questionnaire was piloted amongst a different group of 19 postregistration students. No changes were made following the pilot as the questions, scaling and glossary definitions were considered to be clear and unambiguous. The authors and the pilot group considered the questionnaire to have high face validity.

Qualitative data

Qualitative data was collected, using a focus group conducted with students 6 months after they completed the course. The focus group invited comment on changes to students practice, in particular how they talked with patients, relatives and colleagues prior to and following the course; the effects they had witnessed in others and themselves and how the structure of their practice had changed. The focus group was audiotaped, transcribed and analysed by a separate researcher. To reduce the potential for bias the two course

leaders did not participate in the analysis of the results. In addition, the analyst was unaware of SFBT themes and consequently was not actively looking for them in the data.

Findings

Of a total of 16 students, 10 completed baseline and 6-month questionnaires and only five participated in the focus group, a low turnout partly attributable to bad weather and staff sickness.

Respondents were predominantly registered adult nurses ($n=6$) although a health visitor, community mental health nurse, social worker and nursery nurse also participated.

Quantitative data

Figure 1 shows the mean baseline scores of the 10 respondents and their mean scores 6 months postcompletion. Four out of six dimensions indicate a positive directional change: frequency, willingness, competency and confidence. Differences were examined with the Wilcoxon signed-ranks test, and significant differences were found for one of these four dimensions, willingness ($P=0.047$). Whilst positive trends for competency and confidence are apparent, they do not reach levels of significance ($P=0.076$ and $P=0.105$, respectively).

The measure for the frequency with which the nurse speaks with people who are troubled showed negative directional change, which reached a level of significance ($P=0.020$). This suggests that nurses spoke to patients and relatives less frequently following the training and appears to contradict the findings above. This anomalous finding may actually reflect a change in the nurses' perceptions of 'troubled'. Alternatively it may be that solution-focused conversation prompted fewer displays of 'troubled' behaviour or simply that after the training the nurses re-evaluated the extent to which they actually engaged with clients. There are no apparent changes in the two dimensions that reflect the practice environment.

Qualitative findings

Five students participated in the focus group, all of them nurses, and findings were analysed using Burnard's (1991) 14 step thematic content analysis method.

The themes emerging from this analysis fall under two broad headings: life before solution focused brief therapy training and life after solution focused brief therapy training, with three sub-themes in each. These are examined below.

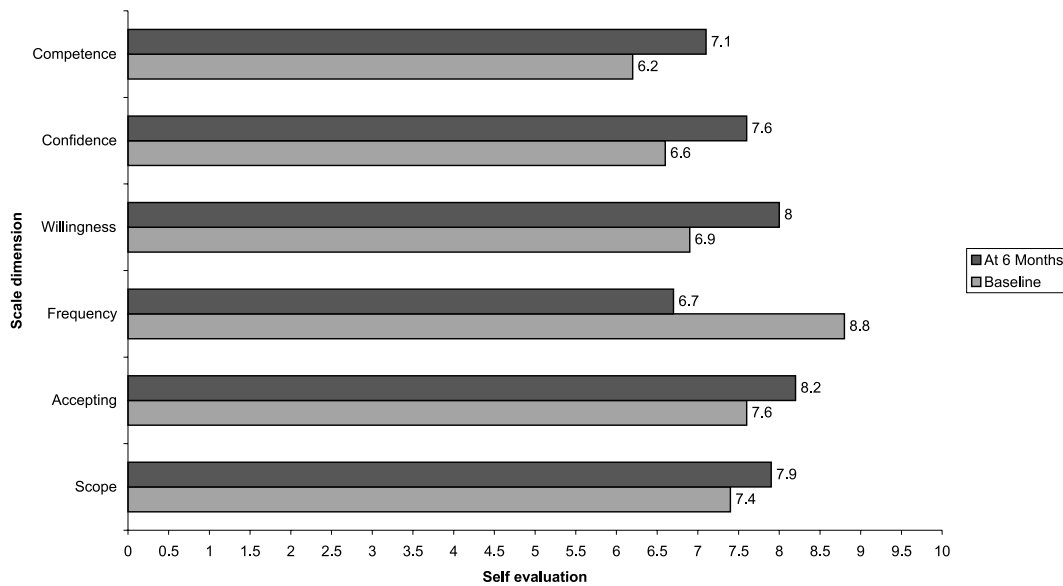


Figure 1 Self evaluations at baseline and 6 months post-training.

Life before solution focused brief therapy training

1 Sub-theme: Problem oriented discourse

The first theme concerned the prevalence of problem-dominated talk in nurse–patient exchanges and the emotional strain this placed on nurses. The group agreed that prior to the training they had not considered that there might be an alternative to problem-dominated talk, other than to avoid interpersonal engagement. In this respect respondents' descriptions echo some of the literature discussed above. For example one nurse said:

I dreaded clinic, because it was so depressing...it was very much doom and gloom and problems (Nurse A).

2 Sub-theme: Inadequacy and blame

Another respondent described how she felt that she had to be a 'good nurse', by empathizing with and absorbing the negativity her patients brought to the clinic. This left her with feelings of loss of control over her interactions with patients and of personal inadequacy. Others supported this perspective, and one described how she took every opportunity to refer her patients on rather than work with them herself. Another described feeling an inappropriate degree of responsibility for solving her patients' problems. She commented that several of them were likely repeatedly to fail in their attempts to come to terms with their illness, after which she expected them to express their disappointment with the care she had provided or even overtly blame her. Thus, dialogue with these patients remained problem-dominated and a challenge to her nursing skills:

I really didn't feel that I was offering anything in terms of solutions (Nurse B).

3 Sub-theme: Nurse as befriender

In some instances, the nurses described feeling adequate, skilled and confident in talking with patients, but even at these times they described a sense of not knowing where to take their interactions and a feeling that they somehow should be in the 'driving seat':

I felt fairly confident in talking to people but what I realized – when I was doing the course and afterwards, was that I had no direction. There was lots of waffling going on, I let people waffle, a hell of a lot...I was a good listener, yes, but I could listen for England. (Laughter) This could go on for weeks with no solution in sight (Nurse C).

Students described a characteristic role of the nurse as a befriender or 'comforter' who enabled and encouraged patients to offload their problems, with the responsibility for solving those problems shifted to the nurses.

In each of these sub-themes, the notion that the nurse is or should be an expert who can resolve patients' problems for them is apparent.

Life after solution focused brief therapy training

1 Sub-theme: New tools which work

It was clear that these students understood SFBT and were using it as part of their approach. solution focused brief therapy techniques were described as a toolbox to be 'dipped into' and used when they felt appropriate. One nurse

described how her practice was wholly orientated to SFBT, with good results. With this exception, the remaining nurses did not structure an entire patient encounter around SFBT, but used it flexibly:

Now, I'm not saying that in each of those sessions with individuals, that I'm going through the whole run of solution focus. I might use one or two questions off it and then go on to something else (Nurse A).

Respondents described how this toolbox had increased feelings of confidence in their interactions. They felt more capable and more able to structure these interactions with patients, without having to take the lead or play the expert problem solver. However, there was an encouraging denial of a 'cook book' approach in which SFBT techniques might be used in an insensitive, formulaic manner. On the contrary, each described adapting SFBT to suit their personal style of communication and the range of patients they worked with. For instance, one had set up a drop-in clinic at a school, where the children readily engaged with SFBT and explored alternative solutions to their presenting predicaments. Another illustrated the importance of adapting the emphasis and language of SFBT to make it appropriate to the context. Here, she describes how she initially tried to use the miracle question (a key SFBT element which invites the patient to presuppose that the problems have gone away and then consider how life would be). In this case she was trying to use the miracle question with patients who are terminally ill:

I tried that miracle question in the very early stages, and I died, I died regularly for a long time, while I was trying this and I was thinking, 'I've got this wrong. I must have got this bloody question wrong. Why is it when I ask this miracle question, people say 'that you'll tell me that I'm going to be all right and I'm going to live?' And I could never capture that, I could never pick it up because it was such a gob-smacking...I couldn't find myself for a long time able to pick that up and say anything. I couldn't think of anything.

She goes on to describe how she adapted the miracle question for the particular needs of the patients she worked with:

And it was only after a long period of thinking about it that I either decided that I'll abandon that question 'cos I felt so lousy at it or I did it, but I did it in a different way'. I actually used the miracle question, not about the miracle being that you could have life and forever, which all of us would perhaps maybe like, but rather that the miracle was how can we make this better? How can this be okay, this next period? What will make this feel more comfortable, more pleasant (Nurse D).

Each of the nurses expressed increased confidence and willingness to interact with patients. They also described a sense of being able to remain positive, although paradoxically

what they were doing was almost unchanged apart from the emphasis they placed on solution-orientated talk:

I feel a lot more confident. I feel as if I know where I'm going now with something. I mean, the listening's still there, that's, but that's different now, it's like I'm really listen', I feel as I'm listening more intently, if you like, before it was like, 'Yeah ...'(Nurse C).

2 Sub-theme: No more 'burnt-out experts' – changes to interaction styles

Respondents reported feeling that they could choose not to play the role of the expert who could cure all. Instead they described being more able to empower patients by negotiating appropriate goals, eliciting and amplifying patients' achievements, strengths and sources of resilience. This led to nurses experiencing greater sense of self-control and reduced anxiety in their interactions. Both nurse and patient were empowered, whilst the responsibility for identifying solutions rested with the patient:

And I think it's empowered me, it's released me from this awful feeling that as the nurse I have to put a plaster on and sort of send them away, so that's been useful to me (Nurse A).

This shift of responsibility was apparent in each nurse, in different practice settings:

I'm still home visiting and I can walk away now and think, 'Well, you know, they'll survive.' But what I am confident is that people will survive. I don't, you know, have to carry it with me and build it up during the day (Nurse C).

This change led to a reduction in referrals to other workers, as nurses reported feeling able to contain some consultations and being more confident in their decision to refer when it was judged necessary.

Evidently, the dynamics of nurse-patient interaction had shifted from being negative and problem orientated to being positive and solution focused. One opening strategy that was consistently used was to begin the interaction in a positive manner, using problem free talk to model that the nurse was interested in the person and not just their condition. The optimism that characterizes SFBT had also led the nurses to feel more comfortable in using humour. As one noted:

to laugh is a great therapy (Nurse A).

One nurse added that she remained aware of how inappropriate humour might be, and a discussion ensued in which nurses acknowledged that a careful balance had to be negotiated between laughing with the patient and trivializing their experiences:

I suppose one good thing is the optimism of solution focus...before it felt very much doom and gloom and problems, problems and now I

have permission to laugh with patients now in clinics...A lot of my patients have chronic problems that I cannot do anything about and to have the permission to sort of, okay not trivialize it by, but to bring some humour into it, to balance it out with a positive, you know, 'What's your good day like?' It makes, yes, it's lightened my load (Nurse A).

Sub-theme: SFBT in other settings and relationships

Interestingly, SFBT techniques were not restricted to nurse-patient interaction but were used in other areas of nurses' professional and personal lives. Letters to patients and colleagues were written in a 'solution-focused' style-amplifying strengths and achievements, even if in some cases they also dealt explicitly with problem descriptions. Social interactions with colleagues also benefited from the optimism, or rather the change of emphasis, fundamental to a solution-focused approach. As one nurse put it, this was a case of 'good it's not raining' instead of 'isn't it dull'. Solution focused brief therapy was also employed to sort out a long-standing problem that revolved around an individual within a particular team. By showing her colleagues how to respond to the individual in a solution-focused manner and not to regard that individual as a problem, one nurse enabled a shift in team dynamics. In this instance, solution-focused conversation was used to good effect in team building.

Discussion

This small exploratory study suggests that SFBT training was regarded as relevant and useful by participants, whose comments indicate that it impacted positively on communication with their patients and colleagues in a range of clinical settings.

Quantitative data showed some positive differences following training; this reached a level of statistical significance on the measure of willingness to talk with people who were troubled. Levels of confidence and competence had also increased although these did not reach levels of statistical significance. Two aspects remained unchanged: the attitude of colleagues and the scope within their role to engage patients. This is to be expected, as the training did not address organizational and social barriers to practice change. However, it is noteworthy that the above changes were possible without change to the environment in which participants worked.

The focus group that followed the training enabled examination of these issues. Although few in number, participants described changes to their practice following training. These changes centred on the rejection of problem-

orientated discourses and concomitant feelings of inadequacy, emotional stress and patient dependency. After training students described how they had begun to incorporate SFBT principles into their current practice. The use of SFBT techniques also helped shift the boundary of their interactions with both patients and colleagues, and resulted in practitioners feeling less responsible for resolving patients' problems. The frequent reference to optimism and a 'can do' sense amongst the nurses is worthy of emphasis, as these are descriptions of the emotional impetus needed to continue nursing effectively and to remain engaged with patients.

Methodological criticisms

- Whilst high in face validity, the reliability of the instrument developed for the quantitative aspects of this evaluation was not established prior to use.
- The number of students provides insufficient basis for extrapolation of results.
- Six students failed to contribute to the second trawl for quantitative data and 11 were unavailable for the focus group. Clearly, there is potential for sample bias and the possibility that ever-decreasing numbers of enthusiasts contributed to this report should not be discounted.

Conclusion

Nurse's communication skills have been criticized for years, as have the theoretically weak approaches to communication skills training in nurse education. SFBT appears to provide a coherent framework and techniques for therapeutic conversation.

Solution focused brief therapy skills can be learned in short (and inexpensive) training courses. Participants in the training evaluated here regarded SFBT as a useful framework for enhancing communication skills in a range of settings. A significant change to their willingness to interact with patients has been shown, changes that occurred without change to the environment in which the nurses worked. Respondents indicated that SFBT techniques might enable engagement with patients, with reduced emotional cost to themselves.

There are indications that SFBT may be a useful approach to the training of communication skills, as it provides a structure and easily understood tool-kit that is harmonious with nursing values of empowerment, increased patient responsibility and participation in care. Therefore further examination of the efficacy of solution focused communication in nursing is clearly indicated.

Acknowledgements

We wish to acknowledge the financial support given to the training and its evaluation by West Yorkshire Education and Training Consortia.

References

- Booth K., Maguire P.M., Butterworth T. & Hillier V.F. (1996) Perceived professional support and the use of blocking behaviours by hospice nurses. *Journal of Advanced Nursing* **24**, 522–527.
- Booth K., Maguire P. & Hillier V.F. (1999) Measurement of communication skills in cancer care: myth or reality? *Journal of Advanced Nursing* **30**, 1073–1079.
- Burnard P. (1987) Meaningful dialogue. *Nursing Times* **83**, 43–45.
- Burnard P. (1991) A method of analysing interview transcripts in qualitative research. *Nurse Education Today* **11**, 24–29.
- Burnard P. & Morrison P. (1991) Nurses interpersonal skills: a study of nurse's perceptions. *Nurse Education Today* **11**, 24–29.
- Cheng Y., Kawachi I., Coakley E.H., Schwartz J. & Colditz G. (2000) Association between psychosocial work characteristics and health functioning in American women: prospective study. *British Medical Journal* **320**, 1432–1436.
- Crute V.C., Hargie O.D.W. & Ellis R.A.F. (1989) An evaluation of a communication skills course for health visitor students. *Journal of Advanced Nursing* **14**, 546–552.
- Dunn B. (1991) Communication interaction skills. *Senior Nurse* **11**, 4, 4–8, 42.
- Fielding R.G. & Llewelyn S.P. (1979) Communication training in nursing may damage your health and your enthusiasm; some warnings. *Journal of Advanced Nursing* **12**, 281–290.
- George E., Iveson C. & Ratner H. (1999) *Problem to Solution*, 2nd edn. BT Press, London.
- Gijbels H. (1993) Interpersonal skills training in nurse education: some theoretical and curricular considerations. *Nurse Education Today* **13**, 458–465.
- Hawkes D., Wilgosh R. & Marsh I. (1993) Explaining solution focused therapy. *Nursing Standard* **7**, 31–34.
- Heaven C.M. & Maguire P. (1996) Training hospice nurses to elicit patient concerns. *Journal of Advanced Nursing* **23**, 280–286.
- Hillyer D. (1996) Solution orientated questions: an analysis of a key intervention in solution focused therapy. *Journal of the American Psychiatric Nurses Association* **2**, 3–10.
- Iveson C. (1995) Solution-focused brief therapy: a tool for health visitors. *Health Visitor* **68**, 236–238.
- Jarrett N.J. & Payne S.A. (2000) Creating and maintaining optimism in cancer care. *International Journal of Nursing Studies* **31**, 81–90.
- Lubbers C.A. & Roy S.J. (1990) Communication skills for continuing education in nursing. *Journal of Continuing Education for Nursing* **21**, 109–112.
- MacLeod Clark J. (1988) Communication the continuing challenge. *Nursing Times* **84**, 24–27.
- Maguire P., Tait A. & Brooke M. (1980) A conspiracy of pretence. *Nursing Mirror* 17–19 January.
- Menzies I.M. (1961) *Functioning of Social Systems as a Defence Against Anxiety*. Tavistock Pamphlet No 3 3–29. Tavistock, London.
- Nagano H. (2000) Empathic understanding: constructing an evaluation scale from the microcounseling approach. *Nursing and Health Sciences* **2**, 17–27.
- Neeson B., Faulkner A., Bridge W. & MacLeod Clark J. (1984) Teaching communication skills to nurses: evaluating the development of communication skills, part 2. *Nurse Education Today* **4**, 54–57.
- Peterson M. (1988) The norms and values held by three groups of nurses concerning psychosocial nursing practice. *International Journal of Nursing Studies* **23**, 85–103.
- Roth A. & Fonagy P. (1996) *What Works for Whom? A Critical Review of Psychotherapy Research*. Guildford Press, New York.
- de Shazer S. (1982) *Patterns of Brief Family Therapy*. Guilford, New York.
- de Shazer S. (1985) *Keys to Solution in Brief Therapy*. WW Norton, New York.
- Smith P. (1983) Teaching and learning to communicate. *Nursing Times* September, 51–53.
- Suikkala A. & Leino-Kilpi H. (2001) Nursing student-patient relationships: a review of the literature from 1984 to 1998. *Journal of Advanced Nursing* **33**, 42–50.
- Talmon M. (1990) *Single Session Therapy*. Jossey Bass, San Francisco, CA.
- Waterworth S. & Luker K.A. (1990) Reluctant collaborators: do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing* **15**, 971–976.
- Webster M.E. (1981) Communicating with dying patients. *Nursing Times* June, 999–1002.
- Webster D.C. (1990) Solution focused approaches in psychiatric and mental health nursing. *Perspectives in Psychiatric Care* **26**, 17–21.
- Wilkinson S. (1991) Factors which influence how nurses communicate with cancer patients. *Journal of Advanced Nursing* **16**, 677–688.
- Wilkinson S., Roberts A. & Aldridge J. (1998) Nurse-patient communication in palliative care: an evaluation of a communication skills programme. *Palliative Medicine* **12**, 13–22.
- Wilkinson S., Bailey K., Aldridge J. & Roberts A. (1999) A longitudinal evaluation of a communication skills programme. *Palliative Medicine* **13**, 341–348.

Author Query Form

Journal: Journal of Advanced Nursing

Article: 1979

Dear Author,

During the preparation of your manuscript for publication, the questions listed below have arisen. Please attend to these matters and return this form with your proof.

Many thanks for your assistance.

Query Refs.	Query	Remarks
1	Au: Please approve the suggested short title	
2	Heaven & Macguire 1996 has been changed to Heaven & Maguire 1996 so that this citation matches the list	
3	Nagano 2001 has been changed to Nagano 2000 so that this citation matches the list	
4	Au: Please verify page range in Dunn (1991)	
5	Maguire et al. 1980 has not been found in the text. Also please update this reference	
6	Peterson 1988 has not been found in the text	