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IMPROVING COMMUNICATION SKILLS AMONG NURSING STUDENTS: ASSESSING THE COMFORT CURRICULUM AS AN INTERVENTION

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IMPROVING COMMUNICATION SKILLS AMONG NURSING STUDENTS:
ASSESSING THE COMFORT CURRICULUM AS AN INTERVENTION

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree Master of Arts in the
College of Communication and Information
at the University of Kentucky

By Rachel Steckler

Lexington, Kentucky

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Lexington, Kentucky

2012

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ABSTRACT OF THESIS

IMPROVING COMMUNICATION SKILLS AMONG NURSING STUDENTS: ASSESSING THE COMFORT CURRICULUM AS AN INTERVENTION

Effective communication is just one of the many skill sets nursing students must master to be effective in their field. A nurse's role goes far beyond that of medical care. In addition, Today's nurses should be equipped with a working knowledge of medical management, communication skills, ethical/legal issues, end-of-life care, and team collaboration, among others (e.g., Ferrell, Dahlin, Campbell, Paice, Malloy, & Virani, 2007). Wittenberg-Lyles, Goldsmith, Sanchez-Reilly, and Ragan (2010) contend nurses need to have specialized training protocols focused on developing effective communication skills. The current study employed one such protocol, the COMFORT curriculum, as a tool to teach nursing students how to break bad news (BBN) using a social cognitive theory approach. To clarify, when individuals feel confident about their abilities (self-efficacy), they are more likely to reach their goals (Bandura, 1986). Hence, this study posited that nursing students would become more confident about their communication knowledge and skills through the modeling and interactive adaptive learning exercises taught in the COMFORT curriculum. Although no significant increase was reported by students with regard to perceived self-efficacy or attitude about communication skills training, students did demonstrate sufficient to excellent cognitive understanding of the communication skills taught in the lesson.

KEYWORDS: Communication, COMFORT, Curriculum, Intervention, Nursing Students,

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CHAPTER ONE: INTRODUCTION

Health communication is an important field to study for many reasons. One such reason rests with the fact that health care providers lack the skills necessary to communicate effectively with patients and their family members (e.g., Krimshstein et al., 2011; Villagran, Goldsmith, Wittenberg-Lyles, Baldwin, 2010; Wittenberg-Lyles, Goldsmith, Sanchez-Reilly, Ragan, 2008). Some researchers have investigated the experiences and desires of health care providers, patients, and family members to establish guidelines for effective communication training (Eggly et al., 2006). From a pedagogical standpoint, health communication research has helped increase health care provider awareness, contributed to building national health policies, provided theoretically driven work, and created textbooks for undergraduate and graduate students (Query, Wright, Bylund, & Mattson, 2007; Rogers, 1996). However, more tools are still needed to train providers to be effective communicators in a variety of contexts and situations. Specifically, specialized communication skills training programs that are individualized to each specific profession are warranted.

Unfortunately, there is a deficit in the amount of specialized communication training available to nurses specifically, and researchers believe that nurses would benefit from a more focused training module specifically suited for them (Krimshstein et al., 2011; Villagran et al., 2010; Wittenberg-Lyles et al., 2008). The goal of this study is to examine whether or not nursing students believe their communication skills are better after participating in a communication training session that has been created especially for nursing students to deliver bad news and to test their communication knowledge about the concepts taught in the module.

Problem and Rationale

There have been discrepancies about nursing education for many years. Traditionally, nurses learned about their profession through apprenticeships and practice in the health care system (Ferguson & Jinks, 1994). However, in the 1940s there was a push to add theoretical learning to nursing instruction. Initially, students were trained on theory over several weeks before entering the health care setting, but in the 1970s the curriculum moved toward a modular scheme where courses were offered that encompassed both theory and practical learning (Ferguson & Jinks). Unfortunately, the modules were taught by tutors who were well educated in theory, but they did not have the clinical background the nursing students need. Based on this information, it is obvious that nursing curriculums have struggled over the years to consolidate its learning outcomes.

The appropriate curriculum in nursing school continues to be up for debate among academicians, universities, and institutions. Academic and health care panels have come together to create guidelines about nursing school curriculum and many of these guidelines are still under debate today. For example, the National League for Nursing focuses on the importance of caring and humanitarianism in the nursing curriculum; while other groups feel that effective communication skills and end-of-life training are important skills for nurses to learn (Ferrell, Dahlin, Campbell, Paice, Malloy, & Virani, 2007; Sadler, 2003; Wittenberg-Lyles, Goldsmith, Ragan, 2010).

Based on the need for a changing curriculum in nursing schools, additional health care provider training guidelines have been developed to help physicians and nurses deal with communicating stressful information to patients and family members

(Eggly et al., 2006). There are a number of health care issues that patients and providers encounter that may be considered stressful and difficult to discuss. However, research also suggests that most of these guidelines were created specifically for physicians. Therefore, all health care providers undergo the same training for effective communication skills despite their different roles in the industry. For example, nurses often play a different role in handling patients than physicians do. Nurses tend to provide additional information after patients speak with the doctor, and nurses are often expected to understand the needs of the patient and family members and foster communication among all parties (Krimshstein et al., 2011). Although the need for effective communication skills is clear, relatively few instructional programs exist today focused specifically on developing effective communication skills for nursing students.

More specifically, specialized communication skills training programs are needed to help nurses learn to break bad news (BBN) and communicate about end-of-life (EOL) to patients and their loved ones (Eggly et al., 2006). EOL and BBN conversations are undoubtedly difficult and may cause high levels of distress among physicians and nurses (Back et al., 2007; Eggly et al., 2006; Wittenberg-Lyles et al., 2008). Back et al., (2007) suggested “the communication skills required for these settings (patients with life-threatening illness) go beyond basic interviewing taught in medical school; complex biomedical issues must be integrated with patient-centered values. However, educators face significant challenges in addressing this competency” (p. 453). Additionally, Wittenberg-Lyles, Goldsmith, and Ragan (2010) noted that “a patient-centered approach emphasized the collaborative, reciprocal nature of nurse-patient-family interactions as participants mindfully create and adapt to a shared meaning” (p. 2). According to the

researchers, discussing EOL care and BBN are often uncomfortable topics of conversation; however, with proper training in effective communication, medical professionals may become better able to manage these distressing encounters as effective communicators.

Research points to multiple protocols for teaching effective skills for BBN; most of them derived from the SPIKES model (Villagran et al., 2010). While the SPIKES model is a protocol to deliver BBN, it primarily focuses on physicians' stress related to perspectives with delivering bad news, and focuses very little on other health care providers and their communication goals (Baile, Buckman, Lenzi, Glober, Beale, & Kuelka, 2000; Buckman, 2005). On one hand, the fact that a curriculum is available to promote effective communication in BBN is beneficial. On the other hand, a real need remains for additional programs focused on communication training for other types of health care providers, especially nurses.

Wittenberg-Lyles et al. (2010) discovered that "nursing education lacks required communication training in their undergraduate preparation, unlike that for medical students who must receive a minimum of eight contact hours" (p. 2). Using a training model that is specifically geared toward physicians could pose a problem for nursing students because the nurse's role is quite different than that of the physician (Wittenberg-Lyles et al., 2010). For example, the nurses' role may consist of speaking with patients after they have received the initial set of bad news from the physician, and these conversations may be more spiritual and/or religious in nature and may demand more attention to palliative care for the patient and caregiver (Malloy, Virani, Kelly, & Munevar, 2010). Nurses also ought to have a more individualized training program for

communication skills that is tailored specifically to the kinds of demands placed on them as nurses (Wittenberg-Lyles et al., 2010).

The End-of-Life Education Consortium (ELNEC) is currently used as the guideline for training nurses on EOL communication skills and is based in part on the SPIKES model. The curriculum trains nurses on communication processes, barriers, and BBN (Ferrell et al., 2007). Although the ELNEC takes a step in the right direction as far as focusing on training nurses specifically for BBN, the ELNEC may benefit from a new protocol for communication training that is specifically focused on the needs of nurses. Because the ELNEC uses protocols from the SPIKES model, which presents challenges to communication training based on its emphasis to stick to an algorithm that requires adherence to communicating in sequential steps rather than adaptation to the bad news scenario, there is little opportunity to guide nurses in how to react to an unscripted situation. Eggly et al. (2006) suggested that guidelines for delivering bad news should be built on a foundation of theoretical perspectives that goes beyond casual and linear communication skills. The authors reported that often times breaking bad news is nonlinear, and health care providers must rely on unscripted communication skills (Eggy et al., 2006).

Fortunately the ELNEC has recently adopted a new curriculum for the communication component that focuses on a less rigid form of communication education and one that is individualized for nurses referred to as the COMFORT curriculum (Wittenberg-Lyles et al., 2008). Villagran et al., 2010 described the COMFORT curriculum as a learning tool that uses a set of core competences (communication requirements, expectations, and desires of patients and providers) to teach health care

providers how to effectively communicate bad news to patients. Additionally, the authors built the curriculum based on the interaction adaptation theory (IAT) of Burgoon, Stern, and Dillman (1995) and Stephens, Houser, and Cowan (2009). IAT is a useful framework on which to build a curriculum for delivering bad news because it acknowledges the importance of requirements, expectations, and desires of relational communication and allows for more adaptive communication between the patient and provider (Villagran et al., 2010). Thus, nurses are able to speak with patients based on their expectations of their health care situation and talk openly about their feelings and desires in treatment and therapy. Without specialized curriculum such as COMFORT, nurses may not reach their full potential as effective communicators and, thus, patients and family members may suffer unfortunate health outcomes.

Previous research has shown that effective communication skills are beneficial to the patient-provider relationship as well as related to positive health outcomes (Cegala & Broz, 2002; Humphris & Kaney, 2001). Positive health outcomes for patients include such things as: (a) improved compliance, (b) satisfaction with care, and (c) benefits to physical and psychological health. Additionally, providers who have effective communication skills have been found to have less incidents of malpractice, greater levels of satisfaction with patients, and more effective health care delivery (Beckman, Markakis, Suchman, & Frankel, 1994; Roter, Geller, Bernhardt, Larson, & Doksum, 1999). Based on this information, effective communication skills are imperative to the provider, the patient, and the health care institution.

Specialized communication training for nurses is critical because nurses who have effective communication skills may be better at sharing health care information with their

patients. Martin and Koesel (2010) suggested information shared by nurses to their patients can significantly impact the decisions that patients and family members make about their health. According to Krimshstein et al., (2011) “in order for nurses to fully realize their potential for optimal communication as members of the multidisciplinary team, they must be equipped with the necessary skills” (p. 1330).

The need for communication skills training is imperative for nurses because they have reported being fearful of their ability to provide EOL care, and the nurses do not see a direct and clear role that they play in helping patients make decisions about health care (Mahon & McAuly, 2010; Thacker, 2008). This fear of inadequacy is problematic because nurses who do not see themselves as competent communicators may also question their ability to provide adequate care. Wittenberg-Lyles et al. (2010) noted “the lack of attention to palliative care in nursing education only complicates the expectation that nurses will be competent communicators” (p. 2). Furthermore, nurses are expected to be competent communicators in terms of teaching patients and family members about their health care. Without proper training, nurses may be viewed as incompetent or mediocre if their communication skills are not up to par. Thus, it is essential that nurses receive the training necessary to become effective communicators.

Organization

This thesis is organized into five chapters. This first chapter introduces the problem and rationale for the study. More specifically, it highlights the need for individualized communication training curricula for nurses. The second chapter provides a review of related literature grounding the study. Chapter three explains the method

undertaken to conduct the analysis. Chapter four describes the results and chapter five offers conclusions, implications, limitations, and recommendations for future research.

CHAPTER TWO: LITERATURE REVIEW

This study focuses on assessing the utility of a specialized communication skills training program (COMFORT) for nursing students. Social cognitive theory (SCT) provides a framework for explaining its value by highlighting how students may learn effective communication skills using their emotions, habits, and knowledge, as well as institutional rules, social approval, and the physical environment (Bandura, 1986). The study implements the COMFORT curriculum approach to training a class of nursing students to break bad news (BBN) effectively to patients and their families. The curriculum was created to fulfill a need for a more specialized form of training for nursing students in palliative care settings and the communication module specifically focuses on narrative practices including verbal clarity and nonverbal immediacy (Wittenberg-Lyles et al., 2010). The goal of the study is to determine if nursing students believe their communication skills for breaking bad news are more effective after participating in the communication module from the COMFORT curriculum. Additionally, the study investigates the degree to which nursing students who participate in the module understand effective strategies for breaking bad news.

Social Cognitive Theory

Using a social cognitive approach to instruct nurses on how to break bad news (BBN) may be exactly what the standard curriculum for nursing school needs. Bandura's (1986) SCT provides a strong theoretical base that describes how the behavior of individuals as well as groups can be predicted. SCT posits that individuals make decisions based on internal factors such as emotions, habits, and knowledge, as well as, environmental factors such as institutional rules, social approval, and the physical

environment, which are in turn influenced by behavior. du Pre (2000) suggested that when internal and external factors are not aligned, people may change their minds but not their actual behavior. Thus, in order for individuals to communicate effectively, effective communication skills need to be taught focusing on internal and external factors. This point may be especially important for nursing students because they are often instructed from the same curriculum as medical students even though their role with patients is different.

Based on the logic of maintaining a balance between internal and external factors, a social cognitive approach to learning may change students' minds, as well as behavior. According to Rosenstock, Strecher, and Becker (1988) SCT provides a framework suggesting behavior is determined by expectancies and incentives. Therefore, if an individual has expectations about their environment, actions, or competency, their behaviors may change based on the incentives they presume they will receive. For example, when nurses feel respected for being engaged in patient interactions, they may try harder to meet the expectations the patient and their caregivers have of them. To be respected, however, nurses must exhibit appropriate communication skills during their interactions.

Rosenstock et al. (1988) proposed several ways to acquire such skills. The authors suggest individuals may become informed and motivated by reinforcement, and they may gain awareness and observation through modeling and then imitating effective behaviors. Therefore, providing examples of nurses working in palliative care settings, interacting with hospice teams, and communicating with patients and caregivers may provide the modeling behaviors necessary to nursing students learn how to communicate

more effectively. Two specific elements of SCT inform the current study: self-efficacy and social cognitive learning.

Self-efficacy

Individuals must be confident about their ability (self-efficacy) to carry out a behavior effectively (Bandura, 1986). Bandura (1977) defines self-efficacy as “people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives” (p. 71). He hypothesized that efficacy beliefs would determine individuals’ behaviors, feelings, efforts, perseverance, and vulnerabilities.

According to SCT, one’s self-efficacy relates powerfully to individual behaviors and performance (Stajkovic & Luthans, 1998). Additionally, self-efficacy relates positively to outcomes and emotional reactions such as coping behaviors and stress reduction. Individuals with perceived higher levels of self-efficacy tend to have better coping mechanisms for external stress because they believe they have more control over the situation (Bandura 1978). Wood and Bandura (1989) suggested self-efficacy influences one’s motivation, efforts, goal-setting, and persistence. Therefore, self-efficacy may be an important component to displaying effective communication skills in health care settings because individuals believe in their behavioral abilities. Furthermore, if nurses believe they can communicate effectively (self-efficacy), they may be more inclined to engage in a breaking bad news conversation, thus, helping patients cope with the prognosis and health outcomes.

Although many may struggle with feeling confident about communicating with a patient/caregiver, it is possible to increase confidence through instruction and repetition

(Staples & Webster, 2007). By repeating a preferred skill, individuals may learn to communicate more effectively. Individuals also can exercise some control over their confidence through thoughts, beliefs, actions, and motivations (Bandura, 1991).

Self-regulation refers to the capacity to recognize one's ability by observing their own behavior and evaluating its effectiveness and using this information to adapt to new behaviors that may be more conducive to the situation (Clark & Zimmerman, 1990). Zimmerman (1990) noted instructional elements that may lead to development of self-regulation. To get nursing students to believe in the importance of effective communication skills and then to become more effective communicators, professional nursing programs ought to consider implementing a social cognitive approach in the curriculum.

Social Cognitive Learning

First, students will benefit from a social cognitive learning experience when curricula is developed that provides a core set of desired outcomes, and these skills are modeled by instructors or other respected persons. Second, students will benefit from the creation of explicit performance requirements that are linked to a graded system of incentives. As students begin to learn on their own, the need for modeling by the instructor decreases. Thus, the instructor can then focus on teaching students self-reinforcement and self-evaluation skills. Finally, praise should be given to the learner for adapting these new skills (Zimmerman, 1990). Nursing students in this study learn an effective communication skill set based on dyadic, adaptive, verbal and nonverbal messages in BBN. Students are instructed via social cognitive learning using the COMFORT curriculum. The instructional intervention consists of a 60-minute lesson

plan. Students first watch a video. In it, they observe nurses breaking bad news effectively with Hospice teams and caregiver. Then a caregiver provides information on effective communication skills in different health care situations. Finally, students reflect on the skills they learned and take a post survey test analyzing their communication skills, attitudes, and knowledge toward effective communication with patients and caregivers.

This mastery modeling instructional approach has been studied in clinical, familial, and educational context across all age groups. Mastery modeling has been found to be a highly effective instructional tool for acquiring linguistic skills, problem-solving strategies, and judgmental standards (Bandura, 1978; Zimmerman, 1990). Thus, mastery modeling may provide nursing students with the social cognitive rules and confidence necessary to self-regulate and function proficiently in a health care setting where they must provide bad news information to patients and caregivers.

COMFORT Curriculum

The COMFORT curriculum was created in response to a lack of communication training modules tailored specifically to nurses. It builds on existing empirical research, as well as several years of primary research conducted by its creators (Wittenberg-Lyles et al., 2010). The authors of the COMFORT curriculum collected data by working in medical schools, conducting field research with Hospice teams, and spending time observing interactions between nurses and their patients in palliative care centers (Wittenberg-Lyles et al., 2010). COMFORT is an acronym that stands for seven themes or principles that make up a framework for teaching communication skills to nurses (Villagran et al., 2010). The COMFORT acronym stands for (a) Communication, (b)

Orientation and Opportunity, (c) Mindfulness, (d) Family, (e) Oversight, (f) Reiterative and Radically Adaptive Messages, and (g) Team (Wittenberg-Lyles et al. 2010). The authors strived to create a tool that could be used to train nurses to use higher quality messages and reduce the quantity of information, thus not overwhelming patients (Villagran et al., 2010).

A teaching module was developed for each of seven principles of the COMFORT curriculum. Instructors can teach any of the modules independently as needed for their particular course. However, the authors of the COMFORT curriculum advise using all seven modules in order to achieve the best possible learning outcomes (Wittenberg-Lyles et al., 2010). Additionally, it may be most beneficial to use the modules in the order laid out by the authors. However, for the purpose of this study, nursing students were instructed using only the communication module.

The overarching goal of the entire seven module series that makes up the COMFORT curriculum is to provide communication skill-building instruction to nurses (Wittenberg-Lyles et al., 2010). As mentioned earlier, there is a need to update and add skills to nursing education curricula from a communication standpoint, and as most researchers in communication may agree; becoming an effective communicator is a teachable skill (Back et al., 2007; Berkhof et al., 2011; Cegala, 2006; Krimstein et al., 2011; Query et al., 2007).

Communication Module

The communication module is the first of the seven principles adapted for the COMFORT curriculum. Ferrell, Wittenberg-Lyles, Goldsmith, and Ragan (in press) begin their curriculum with communication training because it is the “cornerstone of

palliative nursing care” (p. 2). Additionally, communication training is especially important for nurses because they often work with patients just after they received bad news from the physician. Thus, nurses must help distraught and depressed patients cope. Frankly, communication training is imperative for nurses because of the role they play in patient care before bad news is received, while patients are learning to deal with the news, and later on when treatment is being addressed (Ferrell et al.).

The communication module intends to meet the need of teaching fundamental ideas of dyadic, adaptive, verbal, and nonverbal communication messages for BBN (Villagran et al., 2010). Nurses are often faced with both task and relational communication responsibilities. Nurses may actually be tasked with breaking the bad news initially and then, after the news has been revealed, nurses are often expected to both comfort and reduce uncertainty for the patient and their family (Ferrell et al, in press). Therefore, nurses must be trained to communicate effectively in terms of both verbal clarity and nonverbal behaviors (Wittenberg-Lyles et al., 2010).

As patients deal with the bad news they receive, they often engage in a story-telling, narrative process. That is, they reveal information about themselves that may include past, present, and future health information (Aloi, 2009). Aloi noted that nurses are often invited into these narratives that often reflect one’s sense of self, their perspectives on the world, and even their perspectives of others. Without proper training, nurses may find it difficult to engage in this story-telling process that is so vital to patient care.

Understanding the importance of narrative communication is a primary goal of the communication module (Wittenberg-Lyles et al., 2010). The narrative

communication process involves three steps: (a) deconstruction, which incorporates active listening on the part of the nurse; (b) externalization, which is when and how nurses solicit more information and respond with affirmation; and (c) re-authoring, which is when the nurse employs a process of re-focusing the bad news to recreate the patient's sense of self (Ferrell et al. in press).

Afterward, nurses may use the information learned through the narrative process to guide the patient's care plan and to provide the necessary person-centered messages are appropriate for difficult situations. The narrative process helps patients and their families by articulating a shared experience of the medical illness story (Wittenberg-Lyles et al., 2010). Verbal clarity and nonverbal immediacy play an intricate role in the effective narrative story-telling communication process.

Verbal clarity and nonverbal immediacy are not necessarily innate skills, and some individuals may not be aware of their inability to be effective communicators. Krimshtein et al. (2011) reported that nurses must be both self-aware and knowledgeable about patient needs in order to respond appropriately. For example verbal clarity means that nurses are able to effectively use compassionate, clear, and unambiguous language. Nonverbal immediacy refers to the ability to maintain eye contact, avoid fidgeting, and demonstrate attentiveness through body language (Wittenberg-Lyles et al., 2010). Specifically, Wittenberg-Lyles et al. suggested using person-centered messages (PCM) as one way to provide emotional support through verbal clarity. Burrelson (1994) explained that person centered messages allow the distressed person to feel emotionally supported about their situation. Communicating support through verbal clarity and person-centered

messages allows nurses to address both task and relational communication, as well (Ferrell et al. in press).

Nonverbal immediacy cues such as maintaining eye contact, nodding, and appropriate proximity and touching, also communicate caring for the patient and his or her caregiver (Ferrell et al., in press). The use of effective verbal clarity and nonverbal immediacy also may increase the patient's cognitive understanding, as well as heighten their perception of the nurse's credibility. Thus, specialized instruction in communication is crucial to be the most effective nurse they can be.

Research Questions

To discover whether the social cognitive learning approach used in the communication module of the COMFORT curriculum is an effective way to teach nurses to break bad news to patients and caregivers, the following questions are posed.

RQ1: To what degree will nursing students who participate in the COMFORT curriculum communication module believe they have improved their communication skills for breaking bad news?

RQ2: To what degree will nursing students who participate in the COMFORT Curriculum training module understand the effective communication strategies for breaking bad news taught in it?

Summary

This chapter explained how and why the COMFORT curriculum is grounded in social cognitive theory. Specifically, self-efficacy and social cognitive learning were discussed as they inform instructional communication theory. Additionally, the COMFORT curriculum was described from conception to implementation along with the

specific details associated with teaching the Communication module. Ultimately, this chapter provides theoretical grounding and support for the present study.

CHAPTER THREE: METHODS

This chapter outlines the methodology used to conduct this study. More specifically, this chapter describes the nursing student participants, instruments, procedure, and data analysis method.

Participants

Participants for the study were students from the college of nursing at an accredited university in the south. Participants for this study were enrolled in an elective course offered at the university titled End-of-Life Care in the Acute Setting. The course is designed to teach nursing students about the role of nurses during challenging patient encounters and end-of-life care. The instructor designed the syllabus to include one class period of instruction for health care communication. Thus, the students are expected to participate in at least one 60-minute session devoted to communication. The instructor agreed to allow the researcher to use this class period to present a lesson on the communication module of the COMFORT curriculum.

Originally, 17 students were enrolled in the course; however, only 12 students were present for the communication training session. It was not mandatory for the students to take part in the study. However, after an introduction and overview of consent, all of the students who were present that day agreed to take part in the research. In total, one male and 11 female students participated in the study. None of the students were familiar with the COMFORT curriculum nor had they had any previous training with the communication module before the study.

Instruments

Instruments used in this study consist of a demographic survey (see Appendix A), a pre- and post-test survey (see Appendix B and Appendix C), and a multiple-choice exam (see Appendix D). The three instruments used for the pre- and post-test survey are the Communication Skills Attitude Scale (CSAS) (Rees et al., 2002), the Perceived Importance of Medical Communication (PIMC) modified for nursing (Languille et al., 2001), and the Caring Efficacy Scale (CES) for nurses (Coates, 1997). Goldsmith and Wittenberg-Lyles (2010) created the multiple-choice exam (the Communication Knowledge Assessment Post-Evaluation) to measure cognitive understanding of the concepts taught in the communication module of the COMFORT curriculum.

The CSAS is a 26-item questionnaire that uses a five-point Likert-type scale to measure positive and negative attitudes about communication skills training. For example, a positive statement includes “Learning communication skills has helped me or will help me to respect my colleagues” and “I think it’s really useful learning communication skills in the nursing program.” An example of a negative statement about communication skills training would include “I haven’t got time to learn communication skills” and “I can’t see the point in learning communication skills.” “Factor analysis was conducted to determine the factors underpinning the scale. The internal consistency of the subscales was determined using alpha coefficients. The test-retest reliability of the individual scale items were determined using weighted kappa coefficients and the test-retest reliability of the subscales were established using intraclass correlation coefficients. After running the tests a 2 factor scale was adapted for the CSAS. Factor I represented positive attitudes towards communication skills learning and factor II represented

negative attitudes. Subscale I had an internal consistency of $\alpha=0.873$ and an intraclass correlation of 0.646 ($P < 0.001$). Subscale II had an internal consistency of $\alpha=0.805$ and an intraclass correlation of 0.771 ($P < 0.001$). The majority of items on the positive ($n=9, 69.2\%$) and the negative attitude subscales ($n=8, 61.5\%$) possessed moderate test-retest reliability” (Rees, Sheard, & Davies, 2002) (p. 141).

Reliability for this study is reported using Cronbach’s alpha coefficient in Table 3.1. The interitem reliability of the CSAS resulted in measures of student’s perceived communication skills and attitudes ($\alpha = .91, M = 105.9, \text{ and } SD = 14$).

Table 3.1. Cronbach’s Alpha of the Communication Skills Attitude Scale.

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.906	.916	26

The perceived importance of communication skills were measured using Languille et al.’s (2001) scale, modified for nurses, consists of 12 Likert-type scale items assess attitudes of medical providers as they relate to communication. The items are measured on a scale ranging from Strongly Disagree to Strongly Agree. Examples include “Good nurse-patient communication improves patients’ health outcomes,” and “Patients are generally unaffected by nurses’ nonverbal responses.” The reliability coefficient for the PIMC was 0.79 (Wright et al., 2006).

Table 3.2 illustrates the interitem reliability for the PIMC scale. The reliability based on how students perceived their communication skills resulted in ($\alpha = .18, M = 49.3, \text{ and } SD = 3.36$).

Table 3.2 Perceived Importance of Communication Skills

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.180	.399	11

Coates' (1997) Caring Efficacy Scale is a 30 item six-point Likert scale that assesses one's belief in themselves to have the ability to express a caring attitude and develop a caring relationship with patients and caregivers. Coates tested reliability on a random sample of 47 new nurses – proving that there was strong reliability and validity. There were two tests (Form A and Form B) of reliability conducted on the long form of the caring efficacy scale – returning alpha values of .85 and .88. The caring efficacy scale was also tested for content validity and was shown to have a high validity (Coates, 1997). This investigation was carried out by Coates where faculty members were asked to rate the 30 items in Form B based on Watson's Theory. This scale was especially important to this study because it measures self-efficacy. As noted earlier, Bandura's (1977) framework for efficacy is based on a triadic model in which three factors influence behavior including; (a) environmental factors, (b) biological factors, and (c) cognitive factors.

The interitem reliability of the CES was also conducted using Cronbach's alpha. The perceived efficacy of caring for the students in this study resulted in ($\alpha = .866$, $M = 130.3$, and $SD = 15.2$). Table 3.3 illustrates the results for the CES.

Table 3.3. Cronbach’s alpha Caring Efficacy Scale

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.866	.871	29

Goldsmith and Wittenberg-Lyles’ (2010) Communication Knowledge Post-Evaluation assessment tool was used to measure knowledge about communication skills specific to the communication module after the training. The tool consists of eight multiple-choice questions and two open ended questions. The open ended questions were not examined for this study. Students who scored 75% or higher were considered to have adequate communication knowledge of the communication concepts taught in the module. Students who scored lower than 75% were considered to have not achieved adequate communication knowledge of the concepts taught in the module.

Procedure

After obtaining IRB approval, the researcher scheduled one, two-hour class period to teach the module and collect data. The students were informed by their instructor that they would have a guest speaker for the class, and they would have the option to participate in a study that required them to take two surveys, a multiple-choice test, and participate in a 60 minute lecture.

First, the students filled out an informed consent to participate in the study, next they completed a pre-test survey that consisted of three surveys testing communication skills and attitudes as well as a demographic survey. After the students completed the pre-test survey and returned them, the researcher taught a 60 minute lesson plan on the

students reported answers to a post-test survey that mirrored the pre-test survey and turned that in. Finally, the nursing students completed an 8-item multiple-choice exam focused on communication knowledge and returned it to the researcher. After all the students finished the multiple-choice exam, the researcher collected the materials, thanked the participants for their time, and exited the classroom.

Data Analysis

The first research question was assessed using a paired samples t-test that compared the means of pre and post-survey test results for the CSAS, PIMC, and CES (Rees et al., 2002; Languille et al., 2001; Coates, 1997). The differences between the pre and post-test surveys were obtained using SPSS and were reported for each instrument used. The second research question was assessed and analyzed by hand scoring the 8-item multiple-choice knowledge exams. The results from all procedures are reported in the results chapter.

CHAPTER FOUR: RESULTS

Twelve surveys were collected and examined to answer the two research questions posed for this study. The students completed a pre and post-test survey packet that consisted of three surveys. The goal of the survey was to assess communication skills and attitudes of the students. Eleven students completed an 8-item multiple-choice exam to examine the second research question about the degree of communication knowledge obtained after the communication module was taught.

Communication Skills Improvement

The first research question asked whether nursing students who participated in the communication module training of the COMFORT curriculum would improve their communication skills and attitudes toward breaking bad news to patients according to pre and post-test survey results. A paired samples t-test was conducted to compare nursing students' communication skills and attitudes before and after communication skills training.

The findings indicated no statistically significant change in self-efficacy regarding communication skills before the intervention according to the CSAS (M=3.9, SD=.53) and after the intervention (M=4.2, SD=.33) conditions; $t=-1.97$, $p=.075$; however the p value does indicate the student's scores were trending toward a significant value. Additionally, there was no statistically significant difference for students' output for the PIMC or CES survey; PIMC pre-test (M=3.41, SD=.25) and PIMC post-test (M=3.31, SD=.20) conditions; $t=1.175$, $p=.265$, and CES pre-test (M=4.5, SD=.51) and post-test (M=4.6, SD=.44) conditions; $t=-.418$, $p=.684$. These results suggest that neither self-efficacy about communication skills nor attitude about the value of communication skills

training improved as a result of instruction using the communication module of the COMFORT curriculum.

Communication Knowledge Post-Evaluation

The findings for the second research question indicated that five of the students scored an 87% on the multiple-choice exam, five scored a 75%, one scored a 62%, and one student did not finish the exam. According to the threshold given for passing the knowledge assessment, 10 of the 12 participants scored a 75% on the exam and passed the knowledge assessment. Based on these findings, students who participated in the training of the communication module did attain communication knowledge for breaking bad news. It should also be noted that 100% of the students answered question seven incorrectly. If this question were to be withdrawn from the results, 90% of the students would have scored an 87% or higher on the exam, suggesting that student's communication knowledge was adequate after completing the communication module.

CHAPTER FIVE: CONCLUSIONS, IMPLICATIONS, LIMITATIONS, AND SUGGESTIONS

This study tested a new protocol for training nurses on effective communication skills associated with BBN. Specifically, the study assessed the utility of the communication module of the COMFORT curriculum for training nursing students. The research used evidence-based pedagogical methods of the SCT in teaching the COMFORT curriculum. The study sought to train nursing student's effective communication skills including narrative communication, verbal clarity, and nonverbal immediacy during a one hour lesson plan. This chapter suggests several conclusions and implications based on the analysis, as well as limitations and suggestions for future research.

Conclusions

Effective communication skills for nurses are important components to today's nursing curriculum. Thus, university instructors are striving to find and use the most effective methods for doing so (e.g., Back et al, 2007; Krimstein, et al., 2011; Villagran et al., 2010). Furthermore, effective communication skills training programs point to the importance of learners taking an active role in the learning process (Fallowfield, Jenkins, Farewell, Saul, Duff, & Eves, 2002).

The goal of the study was to inform and motivate nursing students by using modeling and reinforcement methods outlined in the communication module of the COMFORT curriculum. According to SCT, students learn by observing others modeling behaviors (Bandura, 1986). Although there was no significant improvement with regard to perceived confidence (self-efficacy) to break bad news effectively or with regard to the perceived value of effective communication skills among nurses after completing the

module, students did achieve sufficiently high scores on the communication-knowledge examination. It appears that the module is effective in teaching important communication skills for breaking bad news even if students (a) do not perceive these skills to be important or (b) believe they will be able to communicate effectively themselves in such situations. Perhaps attitudes about the value of effective communication skills cannot be fully realized in a classroom where students merely speculate about being called upon to break bad news. Perhaps attitudes will change when students actually find themselves in a situation where they must do so for real. With regard to self-efficacy, research suggests that repeated practice in addition to modeling heightens perceived self-efficacy (Bandura, 1986; Staples, et al., 2007). The lesson plan enacted for this study focused on modeling, but not repeated behavioral practice followed by reflective evaluation and reinforcement. Perhaps the communication module would improve nursing students' perceived self-efficacy if a portion of it were devoted to students actually practicing verbal clarity and nonverbal immediacy in simulations and then reflecting on their performance afterward.

Implications

This study suggests a specialized curriculum such as the COMFORT curriculum will enhance nursing students' attitudes, skills, and knowledge about effective communication. Current national guidelines for communication skills training have been criticized for being too focused on training physicians, and research suggests that nurses and physicians play very different roles in communicating with patients and family members (Krimshstein et al., 2011). Therefore, there is a need for individualized communication training guidelines and tools. Based on these criticisms, the COMFORT

curriculum is a tool that was created to fill a void in communication skills training for nurses (Villagran et al., 2010).

The COMFORT curriculum provides instructors of nursing programs a unique opportunity to develop effective communication skills in their students. In addition to the module used for this study are seven additional modules tailored specifically for nurses. Curriculum should be offered to nursing students focused on each of the seven principles if graduates are to enter the profession equipped to confidently and competently handle the difficult communication situations they will inevitably face. The COMFORT curriculum is need not be limited to nursing students. This curriculum could easily be used to teach practicing nurses in the form of professional development workshops.

Finally, communication skills training will likely continue to be an important part of training for nursing students. Academia needs to continue to develop and implement the use of effective communication skills to nursing students to exemplify the need for these critical skills and the importance of their part in the nursing curricula.

Limitations

Like any research project, this study has a number of limitations. According to Wittenberg-Lyles et al. (2010), the COMFORT curriculum, although it is not a rubric or algorithm, should be used as a set of principles to be taught concurrently and reflectively. Thus, it is assumed that nurses will benefit from a pedagogical lesson plan that teaches all seven principles of the COMFORT curriculum intermittently versus teaching the modules independently. However, based on time and scope for the purpose of this study, only the communication module was taught. Therefore, the students in this study were not trained on the six other principles. Based on this information, students receiving training on the

entire curriculum may respond differently to the post-survey tests used resulting in more robust findings.

The research was also limited in the number of respondents available for the study. There were 17 students enrolled in the nursing course that agreed to participate in the study; however, four students were absent from class on the day of data collection, and one student was disqualified because she had previously worked with the creators of the COMFORT curriculum while attending a different university. Therefore, the study was inadequately powered to detect small to moderate effects sizes.

Additionally, the study focused on perceptions based on self-reports the nursing students had about their ability to communicate successfully but did not measure their actual communication skills based on behavior. Based on SCT and its role as a pedagogical tool, the students need to practice their communication skills through instruction, repetition, and self-regulation to truly reach maximum learning potential (Staples et al, 2007). Again, because of time limitations, it was impossible to incorporate role playing or self-observation of communication skills into the lesson plan.

The study also was limited in the results that students reported for the 8-item multiple-choice exam on communication knowledge. The exam was only offered as a post-test instrument; therefore the knowledge of students before the training is unknown. In the future, it may be best to provide the students with a knowledge test before and after the training module. Additionally, there is one question on the multiple-choice exam that all 12 students answered incorrectly. Based on these findings, the question may be reviewed and either rewritten for clarity or completely dismissed from the assessment tool in the future for more accurate findings.

Suggestions

As with any exploratory research study, this analysis suggests a need for additional research. There was insufficient variability and growth with this study. One suggestion for further research is to study the COMFORT Curriculum over time. Students should be trained on the curriculum, allowed time to utilize the skills they have learned, and then re-tested using the post-test survey weeks or months later rather than directly after the training.

Additionally, the COMFORT curriculum is a seven module learning system intended to be taught in its entirety and in succession. Research should be conducted assessing the utility of the entire curriculum used in succession rather than on only one module as a stand-alone instructional intervention.

Similar studies of the curriculum could also focus on students during their first year as nursing students to see whether this type of curriculum is better placed early in a nursing student's education rather than later. Further research also should be conducted in multiple nursing programs to compare the value of the COMFORT curriculum among different populations. Longitudinal studies could also potentially shed light on changing attitudes about the value of communication skills training, as well as perceived self-efficacy regarding communication in stressful situations.

Summary

Existing research points to a need for more focused protocols for teaching nurses effective communication skills (e.g., Back et al., 2007; Ferrell et al., in press; Wittenberg-Lyles et al., 2010). This study examined the utility of one module in the COMFORT curriculum for doing so. Students did demonstrate adequate content knowledge about

effective communication concepts and skills after completing the module, but did not report valuing communication skills as important to their success or confidence (self-efficacy) to communicate effectively when breaking bad news. Thus, this study reinforces previous research in concluding that instruction in communication ought to be foundational in any nursing curriculum.

Overall, heavy viewers perceived medical miracles to occur less often, perceived believing in medical miracles to be less normal, and perceived medical drama storylines to be more credible than light or non-viewers. In sum, being a heavy viewer of medical dramas may actually increase the accuracy of a viewer's perception of medical miracles. The more participants viewed medical dramas, the more realistic their perceptions about medical miracles became. Also, individuals who had personal experience with medical miracles had a stronger belief about the normality of believing in medical miracles and will believed that medical miracles occur more often (than individuals who do not have personal experience with medical miracles). These perceptual increases, however, were consistent across medical drama viewership levels and, therefore, did not alter the overall perception effect between viewership levels. Although H1-H3 were not support, the effects observed while addressing H2 and H3 are still significant contributions to cultivation research. These effects support that there are different perception effects with regard to medical miracles for the different viewership levels of medical dramas.

Limitations & Future Directions

The first limitation of this study is with regard to the sample. The sample is of a specific population (college students) with a narrow age range and educational background. Cultivation effects have been found to be different from population to

population; thus cultivation researchers do not recommend generalizing from a demographically narrow sample (Drew & Reeves, 1980; Lee et al., 2009; Rossler & Brosius, 2001). Therefore, the results from this sample may not be generalizable to other populations. Future research should focus on perception effects from medical drama viewership in other populations, particularly those whose health may be poor and, therefore, whose medical decision making may be more consequential.

Another limitation of the study is that perceptual influences on medical miracle beliefs were not heavily controlled for. Although this study measured personal experiences with medical miracles, there are still a number of other influences that could affect participant perceptions about medical miracles (e.g., literature, Internet use, field of study, non-fictional television exposure, etc.). Future research should measure additional sources of influence to control for other sources of exposure that could influence participant perceptions of medical miracles.

Another limitation of the study was the TMM scale that was used to measure participant trust in modern medicine. The scale was developed on the basis of a model used to measure patient satisfaction and physician perception. Although questions were carefully adapted and pretested with graduate students, the scale did not work as well as hoped. More precise examples of medical miracle situations may be needed. The scale factors may need to be more narrowly defined and wording should be clarified before future use. More work should be done to develop this scale as a reliable and valid measure of trust in modern medicine.

Future research should continue to investigate perception effects that occur from heavy viewing of medical dramas. Research should also perform content analyses of

medical dramas to more precisely know what is and is not portrayed realistically on medical drama programs. Previous content analyses have found discrepancies between television portrayals and real world portrayals on issues such as the CPR process, portrayal of the mentally ill, and cancer experiences (Diefenbach & West, 2007; Diem et al., 1996; Eisenman et al., 2005; Gray, 2009; Harris & Willoughby, 2009; Hether et al., 2008). However, future content analyses should focus on character discussions and portrayals of survival from various conditions. Cultivation research should also continue to measure genre-specific exposure as opposed to general television exposure. Genre-specific cultivation research should focus on perception effects that occur from the most unrealistically portrayed information on medical drama programs.

Appendix A- Demographic Survey Instrument

1. I am MALE FEMALE (circle one)

2. I am (mark one):
___ CAUCASIAN ___ AFRICAN-AMERICAN ___ HISPANIC

___ ASIAN-AMERICAN ___ NATIVE-AMERICAN/PACIFIC ISLANDER

___ OTHER _____

3. I am ____ years old.

4. My religious preference is: _____.

Thank you for your time!

Appendix B- Pre-Test Survey

Before we begin, please be assured you that all of the information you provide in this survey is completely anonymous. When answering the questions, please circle or mark the number that best represents your answer. Although answering every question is preferable, you have the right to skip any question that you do not want to answer. Please read all instructions carefully and answer each question as accurately as possible.

Please read the following statements about communication skills learning. Indicate whether you agree or disagree with all of the statements by circling the most appropriate response.

1= strongly disagree 2=disagree 3=neutral 4=agree 5=strongly agree

1. In order to be a good nurse I must have good communication skills.	1	2	3	4	5
2. I can't see the point in learning communication skills.	1	2	3	4	5
3. Nobody is going to fail their nursing program for having poor communication skills.	1	2	3	4	5
4. Developing my communication skills is just as important as developing my knowledge of nursing.	1	2	3	4	5
5. Learning communication skills will help me respect patients.	1	2	3	4	5
6. I haven't got time to learn communication skills.	1	2	3	4	5
7. Learning communication skills is interesting.	1	2	3	4	5
8. I can't be bothered to turn up to sessions on communication skills.	1	2	3	4	5
9. Learning communication skills has helped me or will help me facilitate team-working skills.	1	2	3	4	5
10. Learning communication skills has improved my ability to communicate with patients.	1	2	3	4	5
11. Communication skills teaching states the obvious and then complicates it.	1	2	3	4	5
12. Learning communication skills is fun.	1	2	3	4	5
13. Learning communication skills is too easy.	1	2	3	4	5
14. Learning communication skills has helped me or will help me to respect my colleagues.	1	2	3	4	5
15. I find it difficult to trust information about communication skills given to me by non-clinical lecturers.	1	2	3	4	5
16. Learning communication skills has helped or will help me recognize patients' rights regarding confidentiality and informed consent.	1	2	3	4	5
17. Communication skills teaching would have a better image if it sounded more like a science subject.	1	2	3	4	5
18. When applying for nursing, I thought it was a really good idea to learn communication skills.	1	2	3	4	5

19. I don't need good communication skills to be a nurse.	1	2	3	4	5
20. I find it hard to admit to having some problems with my communication skills.	1	2	3	4	5
<hr/>					
21. I think it's really useful learning communication skills in the nursing program.	1	2	3	4	5
22. My ability to pass exams will get me through my nursing program rather than my ability to communicate.	1	2	3	4	5
23. Learning communication skills is applicable to learning nursing.	1	2	3	4	5
24. I find it difficult to take communication skills learning seriously.	1	2	3	4	5
25. Learning communication skills is important because my ability to communicate is a lifelong skill.	1	2	3	4	5
26. Communication skills learning should be left to psychology students, not nursing students.	1	2	3	4	5

Next, we would like to know your thoughts on the role of communication – please use the following scale:

1= strongly disagree 2=disagree 3=neutral 4=agree 5=strongly agree

1. It is important to clarify the treatment plan with patients.	1	2	3	4	5
2. Checking for patient understanding is generally unnecessary.	1	2	3	4	5
3. Even though cohesiveness is a desirable state for health care teams, there is little an individual member can do to promote it.	1	2	3	4	5
4. Good communication is a core clinical skill.	1	2	3	4	5
5. Nurses and other health professionals must work to collaborate more effectively.	1	2	3	4	5

6. Acknowledging the patient's experience is not necessary in nurse-patient relationships.	1	2	3	4	5
7. Dealing with the emotional problems of patients is the responsibility of psychiatrists, psychologists and social workers, not nurses.	1	2	3	4	5
8. Giving information about lifestyle is important in nursing practice.	1	2	3	4	5
9. Addressing patients' emotions and psychological issues is absolutely essential in nursing today.	1	2	3	4	5
10. Good nurse-patient communication improves patients' health outcomes.	1	2	3	4	5

11. Patients are generally unaffected by nurses' nonverbal responses.	1	2	3	4	5
12. Nurses need to be aware of their body language and use of personal space when talking with patients.	1	2	3	4	5

When you are completing the following items think about working with patients/clients in clinical settings. Circle the number that best expresses your opinion.

	strongly disagree			strongly agree			
1. I do not feel confident in my ability to express a sense of caring to my clients/patients.		1	2	3	4	5	6
2. If I am not relating well to a client/patient, I try to analyze what I can do to reach him/her.		1	2	3	4	5	6
3. I feel comfortable in touching my clients/patients in the course of care giving.		1	2	3	4	5	6
4. I convey a sense of personal strength to my clients/patients.		1	2	3	4	5	6
5. Clients/patients can tell me most anything and I won't be shocked.		1	2	3	4	5	6
6. I have an ability to introduce a sense of normalcy in stressful conditions.		1	2	3	4	5	6
7. It is easy for me to consider the multi-facets of a client's/patient's care, at the same time as I am listening to them.		1	2	3	4	5	6
8. I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/patient as a person.		1	2	3	4	5	6
9. I can walk into a room with a presence of serenity and energy that makes clients/patients feel better.		1	2	3	4	5	6
10. I am able to tune into a particular client/patient and forget my personal concerns.		1	2	3	4	5	6
11. I can usually create some way to relate to most any client/patient.		1	2	3	4	5	6
12. I can usually create some way to relate to most any client/patient.		1	2	3	4	5	6
13. I feel if I talk to clients/patients on an individual, personal basis, things might get out of control.		1	2	3	4	5	6
14. I use what I learn in conversations with clients/patients to provide more individualized care.		1	2	3	4	5	6
15. I don't feel strong enough to listen to the fears and concerns of my clients/patients.		1	2	3	4	5	6
16. Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/patients.		1	2	3	4	5	6
17. I seem to have trouble relating to clients/patients.		1	2	3	4	5	6
18. I can usually establish a close relationship with my clients/patients.		1	2	3	4	5	6
19. I can usually get patients/clients to like me.		1	2	3	4	5	6
20. I often find it hard to get my point of view across to patients/clients when I need to.		1	2	3	4	5	6
21. When trying to resolve a conflict with a client/patient, I usually make it worse.		1	2	3	4	5	6
22. If I think a client/patient is uneasy or may need some help, I approach that person.		1	2	3	4	5	6
23. If I find it hard to relate to a client/patient, I'll stop trying to work with that person.		1	2	3	4	5	6

24. I often find it hard to relate to clients/patients from a different culture than mine.		1	2	3	4	5	6
25. I have helped many clients/patients through my ability to develop close, meaningful relationships.		1	2	3	4	5	6
26. I often find it difficult to express empathy with clients/patients.		1	2	3	4	5	6
27. I often become overwhelmed by the nature of the problems clients/patients are experiencing.		1	2	3	4	5	6
28. When a client/patient is having difficulty communicating with me, I am able to adjust to his/her level.		1	2	3	4	5	6
29. Even when I really try, I can't get through to difficult clients/patients.		1	2	3	4	5	6
30. I don't use creative or unusual ways to express caring to my clients/patients.		1	2	3	4	5	6

Appendix C- Post-Test Instrument

Before we begin, please be assured you that all of the information you provide in this survey is completely anonymous. When answering the questions, please circle or mark the number that best represents your answer. Although answering every question is preferable, you have the right to skip any question that you do not want to answer. Please read all instructions carefully and answer each question as accurately as possible.

Please read the following statements about communication skills learning. Indicate whether you agree or disagree with all of the statements by circling the most appropriate response.

1= strongly disagree 2=disagree 3=neutral 4=agree 5=strongly agree

27. In order to be a good nurse I must have good communication skills.	1	2	3	4	5
28. I can't see the point in learning communication skills.	1	2	3	4	5
29. Nobody is going to fail their nursing program for having poor communication skills.	1	2	3	4	5
30. Developing my communication skills is just as important as developing my knowledge of nursing.	1	2	3	4	5
31. Learning communication skills will help me respect patients.	1	2	3	4	5
32. I haven't got time to learn communication skills.	1	2	3	4	5
33. Learning communication skills is interesting.	1	2	3	4	5
34. I can't be bothered to turn up to sessions on communication skills.	1	2	3	4	5
35. Learning communication skills has helped me or will help me facilitate team-working skills.	1	2	3	4	5
36. Learning communication skills has improved my ability to communicate with patients.	1	2	3	4	5
37. Communication skills teaching states the obvious and then complicates it.	1	2	3	4	5
38. Learning communication skills is fun.	1	2	3	4	5
39. Learning communication skills is too easy.	1	2	3	4	5
40. Learning communication skills has helped me or will help me to respect my colleagues.	1	2	3	4	5
41. I find it difficult to trust information about communication skills given to me by non-clinical lecturers.	1	2	3	4	5
42. Learning communication skills has helped or will help me recognize patients' rights regarding confidentiality and informed consent.	1	2	3	4	5
43. Communication skills teaching would have a better image if it sounded more like a science subject.	1	2	3	4	5
44. When applying for nursing, I thought it was a really good idea to learn communication skills.	1	2	3	4	5
45. I don't need good communication skills to be a nurse.	1	2	3	4	5

46. I find it hard to admit to having some problems with my communication skills.	1	2	3	4	5
47. I think it's really useful learning communication skills in the nursing program.	1	2	3	4	5
48. My ability to pass exams will get me through my nursing program rather than my ability to communicate.	1	2	3	4	5
49. Learning communication skills is applicable to learning nursing.	1	2	3	4	5
50. I find it difficult to take communication skills learning seriously.	1	2	3	4	5
51. Learning communication skills is important because my ability to communicate is a lifelong skill.	1	2	3	4	5
52. Communication skills learning should be left to psychology students, not nursing students.	1	2	3	4	5

Next, we would like to know your thoughts on the role of communication – please use the following scale:

1= strongly disagree 2=disagree 3=neutral 4=agree 5=strongly agree

13. It is important to clarify the treatment plan with patients.	1	2	3	4	5
14. Checking for patient understanding is generally unnecessary.	1	2	3	4	5
15. Even though cohesiveness is a desirable state for health care teams, there is little an individual member can do to promote it.	1	2	3	4	5
16. Good communication is a core clinical skill.	1	2	3	4	5
17. Nurses and other health professionals must work to collaborate more effectively.	1	2	3	4	5
18. Acknowledging the patient's experience is not necessary in nurse-patient relationships.	1	2	3	4	5
19. Dealing with the emotional problems of patients is the responsibility of psychiatrists, psychologists and social workers, not nurses.	1	2	3	4	5
20. Giving information about lifestyle is important in nursing practice.	1	2	3	4	5
21. Addressing patients' emotions and psychological issues is absolutely essential in nursing today.	1	2	3	4	5
22. Good nurse-patient communication improves patients' health outcomes.	1	2	3	4	5
23. Patients are generally unaffected by nurses' nonverbal responses.	1	2	3	4	5
24. Nurses need to be aware of their body language and use of personal space when talking with patients.	1	2	3	4	5

When you are completing the following items think about working with patients/clients in clinical settings. Circle the number that best expresses your opinion.

	Strongly disagree						strongly agree
31. I do not feel confident in my ability to express a sense of caring to my clients/patients.		1	2	3	4	5	6
32. If I am not relating well to a client/patient, I try to analyze what I can do to reach him/her.		1	2	3	4	5	6
33. I feel comfortable in touching my clients/patients in the course of care giving.		1	2	3	4	5	6
34. I convey a sense of personal strength to my clients/patients.		1	2	3	4	5	6
35. Clients/patients can tell me most anything and I won't be shocked.		1	2	3	4	5	6
36. I have an ability to introduce a sense of normalcy in stressful conditions.		1	2	3	4	5	6
37. It is easy for me to consider the multi-facets of a client's/patient's care, at the same time as I am listening to them.		1	2	3	4	5	6
38. I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/patient as a person.		1	2	3	4	5	6
39. I can walk into a room with a presence of serenity and energy that makes clients/patients feel better.		1	2	3	4	5	6
40. I am able to tune into a particular client/patient and forget my personal concerns.		1	2	3	4	5	6
41. I can usually create some way to relate to most any client/patient.		1	2	3	4	5	6
42. I can usually create some way to relate to most any client/patient.		1	2	3	4	5	6
43. I feel if I talk to clients/patients on an individual, personal basis, things might get out of control.		1	2	3	4	5	6
44. I use what I learn in conversations with clients/patients to provide more individualized care.		1	2	3	4	5	6
45. I don't feel strong enough to listen to the fears and concerns of my clients/patients.		1	2	3	4	5	6
46. Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/patients.		1	2	3	4	5	6
47. I seem to have trouble relating to clients/patients.		1	2	3	4	5	6
48. I can usually establish a close relationship with my clients/patients.		1	2	3	4	5	6
49. I can usually get patients/clients to like me.		1	2	3	4	5	6
50. I often find it hard to get my point of view across to patients/clients when I need to.		1	2	3	4	5	6

51. When trying to resolve a conflict with a client/patient, I usually make it worse.		1	2	3	4	5	6
52. If I think a client/patient is uneasy or may need some help, I approach that person.		1	2	3	4	5	6
53. If I find it hard to relate to a client/patient, I'll stop trying to work with that person.		1	2	3	4	5	6
54. I often find it hard to relate to clients/patients from a different culture than mine.		1	2	3	4	5	6
55. I have helped many clients/patients through my ability to develop close, meaningful relationships.		1	2	3	4	5	6
56. I often find it difficult to express empathy with clients/patients.		1	2	3	4	5	6
57. I often become overwhelmed by the nature of the problems clients/patients are experiencing.		1	2	3	4	5	6
58. When a client/patient is having difficulty communicating with me, I am able to adjust to his/her level.		1	2	3	4	5	6
59. Even when I really try, I can't get through to difficult clients/patients.		1	2	3	4	5	6
60. I don't use creative or unusual ways to express caring to my clients/patients.		1	2	3	4	5	6

Appendix D- Comm-Knowledge Assessment

(master copy with answers)

1-What are the two communication goals in any interaction:

- A-Task and relational
- B-Relational and objective
- C-Objective and empathy
- D-Teaching and task

Answer: A

Rationale: Every interaction has two levels of meaning: the task level and the relational level. Task communication includes the content of the message and relational goals refer to the relationship between the two people as conveyed by the message.

2-Task communication involves which of the following:

- A-Comforting the patient and family
- B-Making the information provided by the clinician more clear for the patient/family
- C-Reporting the patient's unique situation to the care team
- D-B and C

Answer: D

Rationale: Task communication involves the content of the message and includes the "tasks" of communication, such as instructing, diagnosing, encouraging, supporting.

3-Task and relational communication must:

- A-Be different from one another
- B-Be the same as one another
- C-Occur at different times
- D-Complement one another

Answer: D

Rationale: Every interaction consists of two communication goals, task and relational communication. While the content level of a message is conveyed by the words themselves (task), the relational level generally is manifested by nonverbal communication.

4-In narrative practice, the clinician:

- A-Identifies story structure and characters in the patient/family narrative
- B-Adopts multiple perspectives
- C-The nurse selects non-fiction for patient/family to read
- D-A and B

Answer: D

Rationale: To engage in narrative clinical practice, the clinician engages in active listening by focusing on gaps, ambiguities, and conflicting plots within the patient/family's story.

5-In narrative clinical practice, the clinician:

- A-must accomplish pre-established goals of an interaction
- B-tolerates uncertainty as they listen to a patient/family story
- C-avoids information about a patient's/family's life
- D-follows a script

Answer: B

Rationale: To engage in narrative clinical practice, the clinician acknowledges patient/family by listening to their story and being open to other's judgments, beliefs, values, and actions. This allows the clinician to notice the vulnerability of patients/family members and to recognize their profound differences.

6-One of the three principals of bearing witness is to recognize the patient's individuality. In order to do this, the clinician must _____.

- A-Educate the patient/family
- B-Confirm and explain medical news
- C-Help the patient/family re-define care goals
- D-Engage in deconstruction (active listening)

Answer: D

Rationale: Bearing witness involves "being with and relating to others" while at the same time honoring their voice, their lived experience. A special form of active listening called deconstruction, will help focus on gaps, ambiguities and conflicting plots within the story. This allows the nurse to notice the vulnerability of patients/family members and to recognize their profound difference.

7-The four dimensions in the Quality of Life Model do not include:

- A-spiritual
- B-mental
- C-social
- D-psychological

Answer: C

Rationale: The quality of life model consists of the spiritual, psychological, social, and physical well-being of the patient/family. Sorting the story's content according to physical, social, spiritual, and/or psychological care will naturally help the clinician to identify specific assessments, resources, and additional involvement from interdisciplinary team members.

8- Person-centered messages accomplishes all of the following except

- A-Recognizing and acknowledging patient/family feelings
- B-Elaborating on the explanation of the patient/family feelings
- C-Helps patient/family gain a new perspective on feelings
- D-Instructs patients/families about their feelings

Answer: D

Rationale: Person-centered messages are one way to convey supportive communication. Communicating support allows the clinician to accomplish task and relational goals. Person-centered messages allow the clinician to recognize and acknowledge other's feelings, elaborate on the explanation of the feelings, and help an individual gain a new perspective on feelings. When using person-centered messages, the clinician is able to present a holistic picture for the patient/family, clarify silence, and remind families of all that is being done to the patient.

9-What is the most useful communication skill from this module that you might incorporate immediately into your clinical practice?

10-What communication skill would you like to know more about?

Appendix E- Lesson Plan

COMFORT Curriculum Communication Module Lesson Plan

Date:	TBD
Time:	60 minutes
Purpose/Rationale	To introduce nursing students to specific communication tasks in the EOL context focusing specifically on task and relational communication.
Objectives	<ul style="list-style-type: none"> ● Understand the unique role of nurses during EOL care ● Using both task and relational communication ● Utilizing narrative communication when talking with patients and care givers (importance of verbal clarity and nonverbal immediacy).
Lesson Plan	<p>Intro to topic (5 minutes) Identify the problem and rationale for communicating with patients and care givers during EOL communication. Provide background to COMFORT curriculum and describe objectives for the class period.</p> <p>Lecture (15 minutes) Task and Relational communication</p> <ul style="list-style-type: none"> • Describe task and relational communication and techniques • Provide examples and ask students open ended questions about what they view as task and relational communication • Allow time for students discuss how they would use task and relational communication techniques <p>Lecture (10 minutes) Narrative clinical practice</p> <ul style="list-style-type: none"> • Discuss the importance of narratives, patient centered messages, and the nurse’s role and the patients’ role. <ul style="list-style-type: none"> –deconstruction- recognize individuality –externalization- understand life prior to illness –re-authoring- go beyond medical facts <p>Video and Q&A (7 min.)</p>

	<ul style="list-style-type: none"> • Show video of caregiver discussing patient with a hospice team. • Use a polling question to see how students respond to what they saw in the video. <p>Video and Q&A (7 min.)</p> <ul style="list-style-type: none"> • Show video of another caregiver making a medical decision about their mother’s EOL care. Focus on how the hospice team responds using patient centered messaging. <p>Case Study and Q&A (8 minutes)</p> <ul style="list-style-type: none"> • Describe a scenario of a patient from diagnosis to EOL care • Have students discuss the case study in groups of 2-3 • Students respond about how they could approach this situation using the tools from the Communication module • How would they respond, what is the best technique, what would they do now that they may have not thought about prior to the Communication module training. <p>Debrief (2 minutes)</p> <p>Task/Relational Communication Narrative Clinical Practice Person-centered messages Q&A</p>
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REFERENCES

- Aloi, J. A. (2009). The nurse and the use of narrative: An approach to caring. *Journal of Psychiatric Mental Health Nursing*, 16(8), 711-715. doi: 10.1111/j.1365-2850.2009.01447.x
- Back, A. L., Arnold, R. M., Baile, W. F., Fryer-Edwards, K. A., Alexander, S. C., Barley, G. E.,...Tulsky, J. A. (2007). Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Archives of Internal Medicine*, 167, 453-460.
- Baile, W.F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kukulka, A. P. (2000). SPIKES- A six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, 5, 302-311.
- Bandura, A. (1977). Reflections on self-efficacy. *Advances in Behavioral Research and Therapy*, 1, 237-269.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive approach*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational Behavior and Human Decision Processes*, 50, 248-287.
- Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopedia of human behavior: Vol. 4*, (pp. 71-81). New York: Academic Press. (Reprinted in *Encyclopedia of mental health*, by H. Friedman, Ed., 1998, San Diego: Academic Press).
- Beckman, H.B., markakis, K.M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-

- patient relationship and malpractice. Lesson from plaintiff depositions. *Archives of Internal Medicine*, 154, 1365-1370.
- Berkhof, M., Jolanda van Rijssen, H., Schellart, A.J. M., Anema, J. R., & van der Beek, A. J. (2011). Effective training strategies for teaching communication skills to physicians: An overview of systematic reviews. *Patient Education and Counseling*, 84, 152-162. doi: 10.1016/j.pec.2010.06.010
- Buckman, R. (2005). Breaking bad news: the S-P-I-K-E-S strategy. *Community Oncology*, 138-142.
- Burleson, B. R. (1994). Comforting messages: Significance, approaches, and effects. In B. Burleson, T. Albrecht & I. Sarason (Eds.), *Communication of social support: Messages, interactions, relationships, and community*. Thousand Oaks: Sage.
- Cegala, D. J. & Lenzmeier B. S. (2002). Physician communication skills training: A review of the theoretical backgrounds, objectives and skills. *Medical Education*, 36, 1004-1016.
- Cegala, D. J. (2006). Emerging trends and future directions in patient communication skills training. *Health Communication*, 20, 123-129.
- Clark, N., & Zimmerman, B. J. (1990). A social cognitive view of self-regulated learning about health. *Health Education Resources*, 5, 371-379.
- Coates, C. J. (1997). The caring efficacy scale: Nurses' self-reports of caring in practice settings. *Advanced Practice Nursing Quarterly*, 3(1), 53-59.
- du Pre, A. (2000). *Communicating about health: Current issues and perspectives*. Mountain View, CA: Mayfield Publishing Company.
- Eggly, S., Penner, L., Albrecht, T. L., Cline, R. J., Foster, T., Naughton,

- M...Ruckdeschel, J. C. (2006). Discussing bad news in the outpatient oncology clinic: Rethinking current communication guidelines. *Journal of Clinical Oncology, 24*, 716-719.
- Fallowfield, L., Jenkins, V., Farewell, V., Saul, J., Duffy, A. & Eves, R. (2002). Efficacy of a cancer research UK communication skills training model for oncologists: A randomized controlled trial. *The Lancet, 359*, 650-656.
- Ferguson, K. E. & Jinks, A. M. (1994). Integrating what is taught with what is practiced in the nursing curriculum: A multi-dimensional model. *Journal of Advanced Nursing, 20*, 687-695.
- Ferrell, B. R., Dahlin, C., Campbell, M. L., Paice, J. A., Malloy, P., & Virani, R. (2007). End-of-life nursing education consortium (ELNEC) training program improving palliative care in critical care. *Critical Care Nursing, 30*, 206-212.
- Ferrell, B., Wittenberg-Lyles, E., Goldsmith, J., & Ragan, S. (in press). *Communication and Palliative Nursing*. New York: Oxford.
- Goldsmith, J. & Wittenberg-Lyles, E. (2010). Comm-Knowledge assessment post-evaluation. [8- item multiple-choice exam and 2 open ended questions]. Unpublished instrument.
- Humphris, G. M. & Kaney, S. (2001). Assessing the development of communication skills in undergraduate medical students. *Medical Education, 35*, 225-231.
- Krimshtein, N. S., Luhrs, C. A., Puntillo, K. A., Cortez, T. B., Livote, E. E., Penrod, J. D., & Nelson, J. E. (2011). Training nurses for interdisciplinary communication with families in the intensive care unit: An intervention. *Journal of Palliative Medicine, 14*, 1325-1331. doi:10.1089/jpm.2011.0225

- Languille, D. B., Kaufman, D. M., Laidlaw, T. A., Sargeant, J., & Macleod, H. (2001). Faculty attitudes toward medical communication and their perceptions of students' communication skills training at Dalhousie University. *Medical Education, 35*, 548-554.
- Malloy, P., Virani, R., Kelly, K., & Munevar, C. (2010). Beyond bad news: Communication skills of nurses in palliative care. *Journal of Hospice and Palliative Nursing, 12*, 166-174. doi: 10.1097/NJH.0b013e3181d99fee
- Martin, B. Koesel, N. (2010). Nurses' role in clarifying goals in the intensive care unit. *Critical Care Nurse, 30*, 64-73.
- Query, J. L., Wright, K. B., Bylund, C. L., & Mattson, M. (2007). Health communication instruction: Toward identifying common learning goals, course content, and pedagogical strategies to guide curricular development. *Health Communication, 21*, 133-141.
- Rees, C., Sheard, C., & Davies, S. (2002). The development of a scale to measure medical students' attitudes towards communication skills learning: The communication skills attitude scale (CSAS). *Medical Education, 36*, 141-147.
- Rogers, E. M. (1996). The field of health communication today: An up-to-date report. *Journal of Health Communication, 1*, 15-23.
- Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education Quarterly, 15*(2), 175-183.
- Roter, D.L., Geller, G., Bernhard, B.A., Larson, S.M., & Doksum, T. (1999). Effects of obstetrician gender on communication and patient satisfaction. *Obstetrics and Gynecol, 93*, 635-641.

- Sadler, J. (2003). A pilot study to measure the caring efficacy of baccalaureate nursing students. *Nursing Education Perspectives*, 24, 295-299.
- Stajkovic, A. D., & Luthans, F. (1998). Self-efficacy and work-related performance. A meta-analysis. *Psychological Bulletin*, 124, 240-261.
- Staples, D. S., & Webster, J. (2007). Exploring traditional and virtual team members' "best practices": A social cognitive theory perspective. *Small Group Research*, 38, 60-97. doi: 10.1177/1046496406296961
- Villagran, M., Goldsmith, J., Wittenberg-Lyles, E., & Baldwin, P. (2010). Creating COMFORT: A communication-based model for breaking bad news. *Communication Education*, 59, 220-234. doi: 10.1080/03634521003624031
- Watson, J. (2002). Caring Efficacy Scale. In Chasek, R. (Eds.), *Assessing and measuring caring in nursing health science (167373)*. New York, NY: Springer Publishing Company.
- Wittenberg-Lyles, E. Goldsmith, J. & Ragan, S. L. (2010). The COMFORT initiative: Palliative nursing and the centrality of communication. *Journal of Hospice and Palliative Nursing*, 12, 131.
- Wittenberg-Lyles, E., Goldsmith, J., Sanchez-Reilly, S., & Ragan, S. L. (2008). Communicating a terminal prognosis in a palliative care setting: Deficiencies in current communication training protocols. *Social Science and Medicine*, 66, 2356-2365. doi: 10.1016/j.socscimed.2008.001.042
- Wood R., & Bandura, A. (1989). Social cognitive theory of organizational management. *Academy of Management Review*, 14, 361-384.
- Zimmerman, B.J. (1990). Self-regulating academic learning and achievement: The

emergence of a social cognitive perspective. *Education Psychology Review*, 2,
173-201. doi:1040-726X/90/0600-0173\$06.00/0

VITA

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