**JOURNAL AND SUMMARIES OF SELECTED ARTICLES FOR NURSING COMMUNICATION CLASS: SUMMER 2012**

**Summary of “Why emotional intelligence is an invalid concept” by EDWIN A. LOCKE**

In this article, Locke argues against the concept of emotional intelligence. To him the idea behind this concept is nothing different from ‘intelligence’, since there are no forms or types of intelligence. The meaning of “EI” as explain is his article by it advocates as “the ability to monitor one’s own and other’s feelings and emotions to discriminate among them and to use this information to guide one’s thinking and action” is not valid because emotions are subconscious. He further uses “reason” and “emotion” to support his claim that emotions and reason are dissimilar thought processes. Locke states that one “cannot reason with emotions” but only in the course of reasoning, can a person recognize what emotions they might be feeling. Nonetheless he praises his rivals that, an aspect of “EI” which is “introspection” is an imperative human skill in our daily lives.

**Summary of ‘WHEN THE SHOE MUST GO ON’: SURFACE ACTING AND DEEP ACTING AS DETERMINATS OF EMOTIONAL EXHAUSTION AND PEER –RATED SERVICE DELIVERY by AA Grandey**

This article explains use the act of deep acting versus surface acting. Employees demand the employer acts a certain way or speak in a particular manner to please customers. Grandey writes that surface acting which “Intentionally faking” is associated to job burnout and depression. He use various hypothesis and job related circumstances to prove that both deep acting which seems to have a higher rate than aka authentic is needed just as much surface acting to provide good customer satisfaction. Even though both acting is needed it is important to know they come in to play in delivery if service. In his conclusion he suggest to employees that acting is not equal and more emphasis should be placed on educating “service personal” in deep acting if good service to customers must go on.

Journal 1

 I started my day at 7am with my client a 15 year old boy HR with cerebral palsy asthma seizure disorder and a past surgical history of hip replacement in 2011 and 8 hours of nursing care at home per day. His order for activity is out of bed to wheel chair. Client weighs over 100lbs and very difficult to lift but if he stays in bed all day he has to be turn and reposition q2hrs. In the summer time according to his mother the client is up all night and sleep all day so in this scenario he has to reposition every two hours. After going through the morning routine, it was time for him to be reposition. I tried to use the chuck to reposition him up but his mother wanted me to lift him

Mom: if you have to lift HR you have to get on the bed because it is much easier and you have put him all the way on the other side of the bed close the wall. You have to so with the head of the bed elevated so you don’t hit his head.

Me: is this the normal way of lifting him up, I don’t want to hurt him or myself in the process.

Mom: move move let me do it myself, if you know you cannot work with my son you have to call your agency and let them know

Me: (silent) watched mom turn the boy herself.

Mom: first of all you complained that the bed is too low but the nurse who worked before you is taller than you and she was ok with it.

At this point I wanted to take my bag and leave but I put myself in her shoes and asked myself if I had a nurse whom I felt was incapable of caring for my son how will I react.

Me: Mrs. F I understand your concerns and feelings. I feel you are upset but I was being careful not to hurt your son. I can’t lift him up but the chucks will help to move him easy for me we can try it in the next two hours or have you had any problem using the chuck before

Mom: we will see

We tried the chucks in the next two hours and even though she was a little hesitant, she got it that the chuck was much easier. With empathy, the use of I and some client education I was able to get through my day without the frustration.

**Summary: Preparative waiting’ and coping theory with patients going through gastric diagnosis by *Tove Giske & Eva Gjengedal***

The aim of this article is to give us readers the effects of waiting in a diagnosing period on a client and the measures which patient’s uses to adjust in this critical time. In this study the clients had alterations with their GI systems. The authors Giske and Gjengedal launch their article by referencing Lazarus and Folkman’s (1984) ideology on cognitive appraisal which consist of primary and secondary. According to the authors the two main forms of coping is to handle or adjust the environment causing the stress. Their study comprised of eight women and seven men of ages 35 to 84 all of Norwegian nationality. In their findings they realized that the clients used different forms of coping to deal with their situations. “Four pattern” of balance emerged through what they term as “Preparative waiting”; they are rational awaiting, denial, painful control and acceptance. Dealing with the hospital environment is in itself stressful. Though all clients viewed the uncertainty of their life a threat, others took it as a challenge. Some saw it at harmful whiles others took it as beneficial. Amidst these coping mechanisms nurses play a vital role during the diagnostic phase. Nurses must be very supportive to patients by being very sensitive and understanding to appraisals and coping. It is important to build trust, offer precise information, assess past coping experiences, encourage support systems and value the client’s privacy. In our world the fear of the unknown is deadly, not certain about your health can cause serious psychological problems. It is important as nurse we render all the support we can.

**Summary: Nurses' communication skills: an evaluation of the impact of solution-focused communication training by *Nick Bowles, Carolyn Mackintosh, Alison Torn***

 Effective communication is the core of nursing yet still remains a common worry. Nurses usually employ denial of client’s concern and change of subject to block communication. They do this due work load, getting things done, time limit and fear of getting emotionally caught up. Good client-nurse communication has no standard yet over the years harsh criticisms and need for nurses to relay information effectively has not ceased therefore the need for education on communication. The introduction of “Solution-focused brief therapy (SFBT), both a system of communication and a set of assumptions about how best to motivate individuals to change, adapt and grow” has proved a more enhanced way of communicating. This approach is centered on nurse client collaboration than the therapeutic approach using “miracle questions”. The study of this article shows that after 6 months training of 16 registered nurses on SFBT, they saw an improvement in “competence, confidence, willingness, frequency, acceptance and scope”. Individual testimonies by the nurses indicate the SFBT is good approach to effective communication. In my view this program should be added to the school curriculum or taught in health care facilities to benefit nurses.

Journal 2

I knocked on the door and a lovely woman opened it, she smiled and I introduced myself as the nurse for Mr. A.J on a routine visit. She welcomed me and informed me she is Mrs. S.J. She led me to the room where Mr. A.J was laying. I greeted him with a smile and asked how he was doing but he looked at me from top to bottom and turned his head to the wall. Mrs. S.J told me not to worry because he has been like that lately when we were on a little tour of the house. I thanked her and assured her of my best.

Mr. AJ was a 62 year old man with a history of diabetes, hypertension and had recently been admitted at the hospital for CVA. He has been smoking for 40 years, 3 packs per day. He is now hemiplegic and needs 10 hours of nursing care at home. He has a GT tube and is NPO. He has little difficulty with speaking but can get his words across with time. With the initial response I got from him I thought to myself “this will be a tough one”. After the tour I went back to his room for assessment, administration of medication and feeding. All through these while I could see the frustration on his face as he refused to make eye contact with me. I tried to lighten the mood by asking if he liked the song playing in the background but got no reply. I sat with him from 8am to 12pm in silence and I died in there. The room felt as if there was no life in it, the windows had heavy curtains. I felt imprisoned.

Me: Mr. A.J we should let some sunshine in here, what do you think?

Mr. A.J: nodded

I felt good; at long last I have a response. When I sat down again I touched his hand and commented on a picture he had next to his bed

Me: nice family you have

Mr. A.J: slowly, he said my kids but I don’t see them lately wish they will visit more often. All I see is nurses, my wife and these four walls. I have no life.

Me: I understand how missing your love ones can be very hurting and sad. We can work something out so they can come to visit.

Mr. A.J: they always have excuses, only my daughter came once to visit when I was in the hospital.

Me: Mr. A.J, please give me few minutes I will be right back

I went to talk Mrs. S.J about the importance of support system like family and friends when one is going through emotional crises. I told her Mr. A.J frustrations are because he misses his children. I asked her to hold a family dinner, invite her kids and other members of the family. That might lighten his mood and make him happier. Mrs. S J promised to call her children and host a dinner. I broke the news to Mr. A.J when I went back to his room, he smiled and thanked me. I felt satisfied. The rest of the day went smooth as he talked about past and fun times in his life. I left the house feeling very accomplished.

**Summary: Adherence in Patients On Dialysis: Strategies for Success**

The article discusses on adherence to treatment regimen and in this scenario, with respect to patients on dialysis. The author opens his work with the view that adherence remains a big problem in the healthcare field. He uses clients on dialysis because of the different aspects of their treatment such as fluid retention, medications, hospital visits for hemodialysis and others. Managing all of these issues can be very complex for a patient to handle. Understanding compliance, adherence and persistence clearly makes a distinction between these three. The author vividly explains that these words even though sometimes used interchangeably by health care providers are not related. Competence is the degree to which patients follow medication treatment. On the contrary adherence is greater than just following instructions; its aim is based on negotiations between client and HCP. Persistence on the hand is to determine whether a client continuously uses therapy or medication. I like his idea that, it is possible for a client to persistently take his or her medication but not adhere to taking it as directed.

There are various factors that impair good adherence but in order that a client adheres to a treatment regimen, there must be collaboration between client, health care system and providers. We can’t neglect the consequence of non-adherence when they appear, especially for clients on dialysis but the complexity of treatment and lifelong style changes can be testing. HCP must allow patients to be active in their treatment and form good trusting relationships with client. I have heard the word “non-compliant” many times even in nursing school but this article brings to my understanding the many things I can offer to make client adhere to treatment and not just document that they are non-compliant; a mistake most us HCP are guilty of.

**Summary: Challenges of Changing Lifestyle to Reduce Risk for Cardiovascular Disease**

 The awareness on reducing risk of CVD is advertised and preached on almost every media because of its high mortality rate. It is the responsibility of nurses and other health care professionals to educate and council individuals at risk to develop life style changes that reduce their risk. From the authors view point behavioral changes involves awareness, desire and knowledge but changes do not come so easy especially in the clinical setting. Knowledge and skills must be earned from both client and nurse to be effective. Barriers to behavioral changes ranges from age, socioeconomic status, cultural beliefs, literacy level to mention a few but there are weapons to help to battle these barriers.

 Health care providers must promote change, reach out to the community, form partnerships and support groups to aid reduce these risk factors. Self efficacy cannot be left out when one is discussing behavioral changes; it measures a person’s stage of confidence in having the skills to accomplish a behavioral change. It can also be influenced by trustworthy authority. Change is a continuous ongoing business and it is up nurses to rise up to the challenge and motivate our client in developing lifestyle

changes.

Journal 3

I tried my best at this one but I failed. I failed myself, my client and nursing. This is how it started I got to my client house at 8am. She was a 5 year old female with neurological disorder and seizures. She had a trach and GT tube feeding and need 8 hours of nursing care at home. When I got to the house a black man in his 40’s open the door for me but his countenance was not welcoming. I introduced myself he showed me the client’s room and did not say a word to me. About half an hour later I overheard him talking on the phone saying “I thought I told you not to bring any those here again…..” I later found out he was talking to my agency. When he came back to the room he said “you can leave I don’t need you here”. I asked him if I did something wrong but he repeated himself “leave”. I should have thanked him and leave but I made a mistake I asked him “if you did not want me here why did you even let me in”. All hell broke loose he started cursing “you f…g immigrant, African monkey ……” at this point I my phone started ringing and it was my agency. I left the house and picked up my phone.

Me: why did you send me to this house if you know that was the situation?

Supervisor: Sorry

Me: well sorry for yourself, you waisted my day do you know the names he called me you know what I will call you later (I hanged up the phone)

As I walked to the subway I felt like I failed. How could I have responded better? I could have controlled my emotions but I allowed it to get to me. I lost on this one.

**Summary: The Myths of Coping With Loss by Wortman C, Silver R**

The article focuses on how people cope with loss that could involve alteration to life. The loss could be a physical disability or loss of a loved one. It is expected that an individual going through a loss will experience an intense distress. This distress could be an indication of a health problem. It is assumed that a successful adjustment to a loss requires that the individual “works through” the loss rather than deny it.

Depression is considered to be therapeutic because it shows that the person is beginning to confront the truth of the condition. Research has proven that people who fail to display early distress will demonstrate “subsequent difficulty”. Outsiders are always quick to pass judgments on someone going through a loss but it is imperative to understand the stages of grieving in order to help the individual. Health care will be able to help people dealing with loss better if we can identify the responses to loss.

**Summary: Psychological Well-Being after Spinal Cord Injury; Perception Of Loss And Meaning Making.**

The study conducted in this article was to examine medical injury severity and how it affects psychological well-being. The outcome proves that these two are not mutually exclusive. There is the assumption that medical injury negatively affects well-being but the meaning and purpose in life is related to an increased sense of well-being. The perception of people living with SCI is what makes them thrive, and the amount of physical function they have is also what makes life more meaningful to them.

Journal 4

The reading assign for class this week reminds me of a situation which happened when I was still in nursing school. This happened on a clinical rotation in a pediatric emergency room. There were two students assign to the ER that day myself and study mate. We arrived at the ER at 8:30am introduced ourselves to the charge nurse who then assign us nurses whom we will shadow for the day. I realized my nurse, Mrs. B.J was not herself even though she was working appropriately one could smell the aroma of sadness all around her. She did not talk a lot she showed me around the unit; I asked if needed my assistance but she asked me to watch while she works. A few yards I saw my friend in high spirits smiling, practicing and assisting her nurse. I said to myself, ‘this is going to be a long day”.

At about 9:15 she told me to join her for a coffee break, I obliged. We walked to the cafeteria bought coffee and sat down in silence. Immediately we sat down, a lady approached the table and asked the nurse how she was doing without even looking up she replied she was fine but the lady did not buy that. She reached out and touched her shoulder.

Lady: are you sure because your mood says a different thing

Mrs. B.J: with tears in her eyes, Mrs. burst out like a baby

Lady: it is ok let it all out, cry as much as you want. Am here you will be fine. You cannot be strong all the time. It is ok to show your emotions but I will always be here.

At this point I was lost and Mrs. B.J was not in her right frame of mind to speak to me. I excused myself and went back to the ER. I found my mate and informed her of what had happened. She told me she overheard the nurse saying my nurse lost her only twin sister in car accident. Even though I did not know the details as to how and when it happened it gave me a vivid explanation to what had happened some minutes ago in the cafeteria.

People express loss differently, in this case I realized Mrs. B.J was trying to deny how she felt but at a point she had to give in to her emotions. Grieving can be a challenging moment but how one deals with it and the support they receive is what makes them survive through the challenge.

**Summary: Views on clinical professionals on discussing sexual issues with patients by Haboubi and Lincoln**

Discussing sexuality with clients is a tough topic for most health care professionals. The uneasiness of even initiating the issue makes it less talked about subject. The authors of this article use three groups of health care professionals to experiment on the difficulties about discussing sexual issues with patients and disabled people. The results showed that; gender, age, and the type of HCP had a great impact in discussion. Younger respondents in the study had more training than older one’s on sexual issues but the older ones felt less embarrassed in discussing this topic. Doctors were found to initiate the subject than nurses and therapist. Male nurses showed more comfortable than their female co-workers to talk about sexual issues. HCP on medical units were more willing to discussing this subject that those on the rehabilitation unit.

The article reveals that even though the issue on sexuality remains part of the holistic care, a barrier like; lack of training of staff should be corrected so that HCP will be equipped properly in order to render their best on this subject. The issues of STD’s, non- compliance to medication due to negative effects on sexuality, teenage pregnancy will decrease if HCP talk often with client’s and educate them on sexuality.

**Summary: Anger: The Mismanaged Emotion by Sandra Thomas**

 Anger is a very strong emotion that escalates and cause damaged if care is not taken. Whereas some can control their anger, it is difficult for some deescalate ones the emotion sets in. The less time and heavy work overload on nurses can stir up a variety of brawls between clients vs. nurses, physicians vs. nurses and nurse vs. nurse on the unit. The author of this article talks about causes, manifestations, how men and women deal with anger differently and strategies on how to control ones anger.

 The research revealed that compared to their male counterparts women’s anger stem from within often referred as hurt and associated with crying while men’s anger rises from a threat to their control or their views on right or wrong. In the clinical setting a client’s anger or repeated attention is from an inner feeling of fear and abandonment. Dealing with abuse from all angles in the clinical setting is frustrating but there are ways one can avoid these conflicts as suggested by Thomas; discussing the issue at hand or venting in an appropriate manner can be helpful in dealing with anger. Even though anger is expected, education on anger management can make the working less hostile and anger “semi- free”.

Journal V

I had the opportunity to educate my co-worker some techniques I studied in class. My co-worker, Mrs. M.S is a RN in her fifties and has been practicing for almost 10 years. She works on some night shift whiles I work during the day. Our client; Miss, T.Y is a 49 year old female with a diagnosis of MS for 27years. She is currently on a ventilator at home and needs 24hrs of nursing care at home. Miss T.Y is vocal but one has to be very patient when communicating with her. You have to attentive, watch her mouth to get what she is saying.

One morning as I entered the house for work, I saw the look of frustrations on the night nurse face. After I greeted both she and the client she pulled me to the side and said

Mrs. M.S: you know she (client) likes you a lot because she told me last night

Me: wow great am happy to know

Mrs. M.S I don’t know how you do it but I get frustrated with her she is demanding. Can you imagine she woke up at 3am and wanted me to call her father? This ridiculous and I can’t be her run around maid.

Me: what did you say to her?

Mrs. M.S I told her “you making me frustrated” that’s why she looks a little upset this morning

Me: instead of telling her she is frustrating you, tell her how you feel. It will be better if you say to her “I feel frustrated when you become too demanding”. Also I want you to put yourself in her place and think about how you will want others to treat or respond to you.

She thanked me and promised she will try. Even though I have not seen her since then, I hope my little teaching will help her to overcome this frustration.