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Empowering counseling—a case study: nurse–patient encounter in a hospital

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Abstract

This study illustrates practices that a nurse uses in order to empower patients. The emphasis is on speech formulae that encourage patients to discuss their concerns and to solicit information about impending surgery. The study is a part of a larger research project and a single case was selected for presentation in this article because it differed from the rest of the data by manifesting empowering practice. A videotaped nurse–patient health counseling session was conducted in a hospital and transcribed verbatim. The investigator interviewed the nurse and the patient after the conversation, and these interviews were transcribed as well. The encounter that is presented here as a case study is a concrete example of a counseling session during which the patient is free to discuss with the nurse. The empowering practices that the nurse employed were as follows: encouraging the patient to speak out, tactfully sounding out the patient's concerns and knowledge of impending surgery, listening to feedback, and building a positive vision of the future for the patient. We suggest that nurses should pay attention to verbal expression and forms of language. This enables them to gain self-awareness and discover new tools to work with.

Introduction

In recent literature, empowerment has become an important concept of health education (Feste and Anderson, 1995; van Ryn and Heaney, 1997), health promotion (Labonte, 1994; Tones, 1994, 1995; Williams, 1995; McWilliam *et al.*, 1997) and health counseling (Poskiparta *et al.*, 2000). The process of empowerment has been related more to community and organizational levels than to micro levels of practice (van Ryn and Heaney, 1997) where it is constantly crucial (Tones, 1994). In addition, operationalization of the concept of empowerment has been relatively vague. According to Tones (Tones, 1994), empowerment is a major goal of health promotion. This article focuses on health counseling as a means of interpersonal health education practice and uses health promotion as an umbrella term.

Empowerment is as much a process as an outcome of developing the skills and perceptions of clients. It is not only something that happens but a process that is facilitated. In interpersonal health counseling, the primary goal is not to change clients' behavior and seek their compliance with the presented message but rather to raise critical awareness through learning and support, to give clients tools for making changes on their own. The aim is personal empowerment, control and choice, which means that patients become aware of changes in their knowledge and understanding, decision-making skills, enhanced self-esteem/sense of personal control, and development of various social, health and life skills (Labonte, 1994; Tones 1994; Anderson *et al.*, 1995; Feste and Anderson, 1995; van Ryn and Heaney, 1997; Kar *et al.*, 1999).

The basic point of departure for empowerment is taking into consideration the interactive nature of the individual and the environment: people are not completely controlled by their environment nor can they fully control their physical, social

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or economic circumstances (Tones, 1994). Empowering health counseling is based on recognizing clients' competence, resources, explanations of action styles of coping and support networks. Client initiative, clients' realizations and clients' expressions of their opinions and interpretations are the basis on which clients can approach health issues in collaboration with professionals. They are of crucial importance for their decisions on future action (Anderson, 1996). All this supports the notion that empowering health counseling is significant.

Because learning about personal health is complex, the key issue of empowering health counseling is partnership and reciprocal conversation in a confidential relationship. This means that clients not only analyze their situation but also have an opportunity to plan what to do next, and how to go on and to construct their own solutions to health issues. In this type of hospital health counseling, either patients raise the issues (i.e. determine the topics) or the nurses do so in a sensitive and non-threatening manner (Poskiparta *et al.*, 2000). Nurses recognize and respect patients' experiences, knowledge and skills, and make their own professional knowledge and expertise available to them (Williams, 1995; McWilliam, *et al.*, 1997), which are important aspects of nurse–patient relationships that are also reported by patients (Häggman-Laitila and Åstedt-Kurki, 1994; Lindsey and Hartrick, 1996; Wiles 1997). The emphasis is placed on patient-driven [see (Lindsey and Hartrick, 1996)] health counseling, where patients' life situations are respected, patient-initiated actions are supported, and shared knowledge and deep understanding are nurtured.

The nurse's institutional task is not only to facilitate patient participation but also to promote patients' awareness of their routines and preconceptions as they are revealed to both interlocutors. This should lead to the aim of interaction, which is to activate self-reflection and re-evaluation and reorganization of patients' activities. The assumption is that new knowledge is gained in this process as a result of empirical realization and deliberation (Feste and Anderson, 1995), which means that both patients and nurses have linked new knowledge to existing knowledge. Thus, patients learn to interpret and outline even familiar health problems in new ways that conform to their worldview [*cf.* (Mattus, 1994)]. As for nurses, empowerment calls for not only sensitivity but also an ability to accurately perceive patients' messages.

From this point on, the focus is on the content of the interactive process. Tones (Tones, 1994) discusses empowerment theoretically, Labonte (Labonte, 1994) expresses ideas for practice in general, while Feste and Anderson (Feste and Anderson, 1995) provide three empowerment tools for facilitating patients' empowering process: using questions, behavioral language and storytelling. According to them, questions maintain the process of pursuing wisdom, i.e. exploring the meaning of health problems in the context of everyday life. This kind of questioning involves broad questions that relate to one's personal philosophy and lifelong dreams. In addition, it includes practical, day-to-day issues of successfully integrating into one's personal, family, social and professional life. Behavioral language means using words such as 'list', 'describe', 'identify', 'decide', etc., in order to encourage patients to act and make choices instead of being satisfied with receiving information. Stories help to facilitate the process of self-discovery because diseases affect all areas of life and each individual's health status is unique.

Van Ryn and Heaney (Van Ryn and Heaney, 1997) pay attention to interpersonal relations by suggesting concrete strategies and examples for empowering practice. In their article, they demonstrate two principles of interaction: (1) provide clients with unconditional positive regard and acceptance, and (2) facilitate client participation. Both principles include several practical strategies (Table I).

However, the authors pay less attention to empirical findings (Northouse, 1997). The present article describes some linguistic realizations of empowering practice. This article describes a nurse's empowering speech formulae during her efforts to give a patient information about an impending surgical operation and to strengthen her

Table I. *Empowering principles of interpersonal practice (van Ryn and Heaney, 1997)*

Provide clients with unconditional positive regard and acceptance	Facilitate client participation
Make empathic acceptance statements	Ask open-ended questions
Use non-verbal cues that signal acceptance	Meet client statements with acceptance
Avoid criticizing or blaming clients	Develop active listening skills
Avoid engaging in psychological interpretations or psychoanalysis of clients' motives, conflicts or defenses	Reduce social distance between health educator by highlighting similarities
Use active listening processes to identify, to reflect back and to build on clients' strengths	Share all information and resources relevant to the themes that are raised as part of the participatory process
Examine self and setting for barriers to providing unconditional positive regard and acceptance, and generate and implement methods for overcoming such barriers	

feelings of security by providing her with an opportunity to discuss her concerns. This study adopts a holistic approach to interaction and does not focus on isolated sentences or dialogue structure. The relationship of language and context in comprehension, as well as non-verbal communication, are also discussed.

Research design and method

This article describes a single case derived from qualitative data collected from a total of 38 counseling sessions in a Finnish hospital. Nurse–patient encounters were videotaped and transcribed verbatim. Interviews with the nurses and the patients after the sessions were transcribed as well. All participants volunteered to take part in the research, signed a research license and granted permission for the transcribed data to be used in publications. Nineteen nurses participated in this study. Each nurse conducted two videotaped counseling sessions with different patients. There was only one male nurse while the patient group consisted of 24 female and 14 male patients. The research material took shape as nurses volunteered in the hospital and it was found to be adequate for qualitative analysis. The length of the nurses' careers varied from 1 to 25 years. The ages of the nurses were between 24 and 50 years (mean age 36.9 years) while the patients' ages ranged from 18 to 70 years (mean age 47.9 years). The researcher did not attend the counseling sessions, which lasted from 5 to 45 min. The participating patients were experiencing diverse health problems. Various surgical problems, e.g. knee surgery, hernia operation, breast surgery, hip operation, back operation, post status of brain bleeding and post care of bypass surgery, were among the most representative. In addition to the health problems that had led to hospitalization, many patients also suffered from chronic diseases, such as hypertension, asthma, rheumatic illnesses or diabetes. Many patients also found themselves in an insecure situation when a chronic disease had suddenly been manifested or they were undergoing examinations. There were also some mothers in the group who had delivered recently and had no health problems.

The health counseling sessions were genuine counseling situations that were related to the patients' treatment. A single video camera was used, which meant that the observation of non-verbal communication was limited to examining the session as a whole, including only eye contact, smiles, laughter, tone of voice, gestures and, to some extent, facial expressions. Consequently, the emphasis of this study was examining verbal communication. Separate interviews with the nurses and the patients where both parties were encouraged to express their evaluations of the health counseling were used for partial support of the interpretations, e.g. when describing the patients' opinions about health counseling. We also checked if there were any nurses or patients who were nervous about the videotaping.

This article concentrates on videotaped data. When we examined all of the data we found many encounters that involved some empowering features from time to time, but there were none that were consistently empowering. In this article, we present a single case from the data. This particular encounter was selected because it differed from the rest of the data (Stake, 1994) by manifesting empowering practice most widely. In order to study the interactive nature of communication, the coding and analysis of the videotaped data was based on principles of Conversation Analysis (Drew and Heritage, 1998). The videotapes were transcribed word by word, including stammering, etc. At the same time, additional data were added to the transcriptions, such as pauses during and between turns, onset and termination of overlapping talk, intonation information, and some non-verbal communication. The following transcription symbols were used to indicate this information:

P	patient
N	nurse
ha+	hands support speech
nod+	nod
vo+	rising voice
vo–	falling voice
[ ]	at the beginning and end of overlapping speech, words enclosed
(( ))	transcriber's comments, e.g. smile, laughter, body movements
(.)	small but detectable pause
underlining	emphasis
...	omission of text
=	no interval between the end of prior and start of next speech unit
°speech°	speech in low volume, words enclosed
'speech'	pitch change, words enclosed

The analysis was carried out on a turn-by-turn basis. The principle behind this analysis was to examine how turns were taken with regard to other participants' speech and what sequential implications each turn had for the next. After reading the transcript and watching the recording several times, we discovered a number of empowering expressions in the nurse's speech and concluded that this case was the one which best manifested empowering action in the data.

The particular case describes at the individual level information about the patient's situation, the nurse's interview after the encounter, an in-depth description of the nurse–patient conversation and the observational data derived from it. Pearson (Pearson, 1991) and Patton (Patton, 1990) indicate that a case study can be used, for example, for examining how different concepts emerge or change in particular contexts. However, an even more important question is what can be learned from a single case. Stake (Stake, 1994) suggests that one should select a case that seems to offer an opportunity to learn and contributes to our understanding of specific phenomena. Here, a detailed single case analysis illustrates how empowerment may be practiced during health counseling and demonstrates how new working tools for empowerment can be developed on the basis of a single encounter (Laitakari, 1998). The present study describes the speech of a nurse when she helped a patient to deal with anxiety and to receive information about surgery in an empowering way.

The nurse anesthetist has come to see a patient who is scheduled to have surgery the next day. The encounter involves, besides interviewing, producing a lot of information about the operation, counseling on the preparations for the surgery and advising how to manage after the surgery. The encounter takes place at a table, with the nurse and the patient facing each other. Both are women; the nurse is 50 and the patient 41 years old. The patient had had problems with her back for 10 years and was suddenly admitted to the hospital because of these problems. The patient has recently been examined and a decision has been made to operate on her the next morning. The interviewing session lasted 14 min.

Opening of the encounter: developing a reciprocal relationship

At the beginning of a conversation the participants evaluate each others aims and concerns, and the communication situation as a whole, and this evaluation directs the entire discussion because the participants base their actions on it (Goffman, 1982). In a hospital, it is typical that nurses initiate a discussion (Leino-Kilpi, 1991) and that is what happened in this case (*Extract 1*). Professional dominance common in medical encounters (Fairclough, 1992) is not so obvious in this conversation. After greeting the patient, the nurse refers to the goal of the discussion and individualizes it by using familiar 'you' (line 1) instead of the formal, plural form of 'you'. This form of address can be viewed as an act of communicating an appropriate degree of informality. It implies intimacy and mutual respect when a relationship is established (van Ryn and Heaney, 1997).

Extract 1.
1 N: Hello, Rose (.) you are going to have surgery
2 tomorrow...but now I would like to ask you
3 <u>you</u> well about the operation tomorrow if
4 there is (.) something that would influence
5 the preparations for your operation (.) and
6 then you ((ha+)) can bring things up ask well
7 er if something is unclear to you ((nod+)) <u>If</u>
8 you want to know anything about what's
9 going to happen to you tomorrow ((vo–))
((at first the nurse looks at papers on the table, while she speaks she turns her eyes to the patient and nods))

This opening was not typical of the other interviews in the data set, because in the data these encounters were usually initiated with the nurses' brief statements about the impending operation. They explained that they interviewed patients in advance in order to get information and that they could provide information to the patients as well. Nurses usually used formal, plural forms of address when speaking. When referring to the preoperative encounter, they used the plural, institutionalized form 'we' [see (Drew and Heritage, 1998)], instead of first person singular 'I', and plural 'you', instead of the singular, when addressing the patient. Other nurses did not individualize their speech. On the contrary, they maintained a distance from the patients. In this particular case, a familiar mode of address reduces social distance, which is very important in health education practice [*cf.* (van Ryn and Heaney, 1997)]. We explain our interpretations in more detail below.

The nurse uses the verb 'ask' (line 2), but her remark further on (line 6–9) 'then you can bring up ask well er if you were unclear about something if you want to know something about what's going to happen to you tomorrow' introduces a context for the discussion. Even though the nurse goes on to ask a question about previous operations, the interview becomes an interactive dialogue, with the patient actively participating. On her own initiative the patient discloses symptoms that she has experienced during the last few months, what happened when she needed to come to the hospital and the doctor's decision to perform surgery.

Thus, the nurse introduces the context of the discussion with her opening words [*cf.* (Peräkylä, 1995)]. She expresses her acceptance by offering collaboration [*cf.* (van Ryn and Heaney, 1997)] when asking questions. The verb form 'would like to' (line 2) gives the discussion an air of voluntariness. The conditional form softens the notion of the necessity of the questions, and the verbal mode implies respect for the patient. At the beginning of the session (lines 1–9), the nurse combines two topics into a single long sentence, which also encourages (lines 6–9) the patient to clarify matters that are unclear to her. The nurse's words leave room for the patient's own thoughts and invites her to look for a personally meaningful way to connect the nurse's questions about the preparations (line 5) for the operation to her lack of information (lines 7–9). Encouraging statements can stimulate the patient to think in a way that is personally meaningful to her and to participate in the conversation (van Ryn and Heaney, 1997; Tomm, 1988). Here, encouragement takes a form that is different from what Feste and Anderson

(Feste and Anderson, 1995) suggested; it is given in a more sophisticated manner. The opening words (*Extract 1*) correspond with the goal that the nurse states later during the interview: 'that the patient would receive the information she needs, what she wants to know and that she would feel safe to come, that at least those worst fears would be like forgotten. That she would feel safe'.

An encounter can threaten a patient's need for autonomy and freedom because it gives the nurse the legitimate power to request information about the patient's private life (van Ryn and Heaney, 1997). Here, the nurse is mitigating her power by avoiding threatening terms and using tentative formulations ('would like to, well er, you you'), the emphasis being on the patient's needs. The opening of the interview by the nurse plays an important role in the development of the atmosphere. The act has been planned in advance but is not thoroughly thought out. In addition to conveying information, the main consideration in setting the goal for the discussion is to help the patient deal with her concerns. These are issues that have also been stressed in earlier studies (Häggman-Laitila and Åstedt-Kurki, 1994; Breemhaar *et al.*, 1996; Leinonen *et al.*, 1996; Lindsey and Hartrick, 1996; Otte, 1996).

Tactful exploration: activation of reflection

Later during the interview, the patient mentions having thought about the impending surgery, which the nurse interprets as an indication of fear for the operation (*Extract 2*). She indirectly gives the patient an opportunity to deal with her fears. The patient's words (lines 1, 3, 5 and 7) are related to the previous topic and her status during the operation and conclude the discussion. The nurse changes the subject (line 9) by praising the doctor's skill. The nurse and the patient look at each other.

Extract 2.

1 P: mmm [think about during the day]=
2 N: [of] course ((nod+))
3 P: =what's going to happen and (.)
4 N: right ((nod+))
5 P: °like [that]° (.)
6 N: [mmm]
7 P: °it's [okay]° ((nod+, vo–))
8 N: [that's] right (.) ((glance at papers: doctor's
9 name)) is is an excellent surgeon so in that
10 respect you can definitely (.) ((vo–)) feel
11 safe ((nod+)) that
12 P: yes of course I am
13 N: mmm
14 P: and and absolutely 110% (.) I trust that (.)
15 the thing is that (.) this is small case for
16 him but this is a horribly big thing for me...

The nurse's comment about the operating surgeon contains an allusion to fear of surgery. Instead of soothing the patient by telling her not to be afraid or asking if the patient is scared, the nurse indirectly comments on the doctor's professional skill (line 9) and emphasizes the expertise as a guarantee of success (line 10 and 11). Thus, the nurse allows the patient to save face when she leaves her to interpret her words. Her indirectness implies politeness and gives the patient options: if she does not want to deal with her fear, she may choose not to take the hint [see (Brown and Levinson, 1987)]. Here, politeness can also be linked to and interpreted through empowering practice, where the nurse holds the patient in high regard [*cf.* (van Ryn and Heaney, 1997)].

The extract might have been interpreted as an example of the nurse cutting the patient off if one had not seen the videotape. Our interpretation is supported by a number of factors. First of all, the entire conversation until this extract has been tranquil and calm, the nurse has spoken and asked questions at a gentle pace, with pauses, and she has explored the patient's experiences. In this extract, the situation is similar, and she looks at the patient and nods. She speaks quite slowly, and her voice is low, friendly, and convincing (van Ryn and Heaney, 1997). We can also see that the patient completes her speech by pausing (lines 3 and 5) and lowering her voice (lines 5 and 7). Therefore, after the nurse's words (lines 8–11), the patient presents her fear for discussion (lines 15 and 16) and also returns to the matter later during

the interview. The extract shows how the issue has been constructed together by the nurse and the patient. The nurse raises the theme in a sensitive and non-threatening manner, and the patient continues the same topic. It also shows that the relationship is confidential enough for the patient to disclose her concerns and become aware of her own understanding, and thus contributes to empowerment. Salmon (Salmon, 1993) has stressed that the main goal in the discussions between nurses and patients before surgery is not to reduce the patients' fears but to help them to deal with them.

Indirectness is a polite feature of discourse. There is 'strategic indefiniteness' in indirectness that offers patients an opportunity to continue a discussion according to their own wishes (Brown and Levinson, 1987). In general, nurses' empowering acts are mostly manifested in the form of questions (Poskiparta *et al.*, 2000). In some cases, an indirect comment by a nurse, instead of a question, may encourage patients to talk about topics that they fear. Here it generates reflection in the patient. After disclosing her concerns, the patient analyzes the situation and recounts the conversation that she had with the doctor who explained the reason for her back surgery (*Extract 3*).

Extract 3.

...

1 P: this morning ((doctor's name)) said that
2 N: 'this morning' ((surprised))
3 P: this morning
4 N: that's recent for sure
4 P: yes
5 N: well it happened so
6 P: so it happened suddenly because yesterday
7 it became evident that (.) there was in the
8 X-ray ((doctor's name)) said that there was
9 a cause when I asked if there was anything
10 that caused the pain or if I was just imagin-
11 ing it (.) so he said that yes there was a
12 genuine cause...

The amount of information given always depends on the situation and the nurse needs to continually evaluate the patient's needs: what it is that the patient knows, wants to know and how much she does want to know. This is also important because there are several persons that the patient sees before surgery (Breemhaar *et al.*, 1996). Furthermore, nurses and doctors may deal with the same issues in their counseling. In Finland, the doctors, the surgeon and the consultant anaesthetist inform patients about the medical facts, risks, and benefits of operations. The patient also has an interview with a nurse on the surgical ward and, in addition to these encounters, there will occasionally be an encounter with a nurse anesthetist.

The nurse's empowering approach is manifested in how she raises issues or questions from time to time as if with hesitation. A pause precedes questions ['I don't have any (.) questions to ask you any more but do you—you have anything to ask from me like such things about tomorrow that worry you') ((looks at the patient))]. She asks the questions more quietly than normal and looks at the patient. According to Beck and Ragan's (Beck and Ragan, 1992) study, nurses' softening words and their hesitant and tentative manner of speaking indicate discretion and tact and are aimed at not embarrassing patients. In our data, slow and hesitant speech also encourages the patients to comment more than nurses' more usual and brief question does: 'Do you have any questions?'.

The nurse's tentative manner of asking questions makes it easier for the patient to start dealing with her concerns. She repeatedly pauses briefly and, in addition to the closed questions in the medical history questionnaire, she asks open-ended questions that explore the patient's experiences: 'What kind of memories do you have of previous operations?' 'Is there anything else you remember (.) is there something?'. Open-ended questions encourage the patient to speak and participate, e.g. in the naming and solving of a problem [*cf*. (Feste and Anderson, 1995; van Ryn and Heaney, 1997)]. In this particular case, indirectness and hesitation are polite speech formulae that help the patient to save face (Fairclough, 1992). They can also serve as empowering strategies that provide unconditional positive regard and acceptance for patients.

Despite these quite extensive empowering acts, the nurse subsequently evaluated her information skills only. She indicated how difficult it was for her to decide what kind of information to give to the patient:

> I wondered if I should have maintained a more professional role, I mean more facts, if the patient got all that she wanted. Because this is not really medical science, you know, that's up to the doctor. It has to happen on the patient's terms, what she wants to know. I tried to check the patient's needs several times.

The content of the session satisfied the patient as well:

> I got enough information about the operation, things that occupied my mind, so I didn't, she even told me before I asked. There's nothing to find out any more. As I said to her, I'm terribly afraid but I'll go ahead with confidence.

Active listening: power sharing

The nurse's way of posing questions builds up interaction. With her questions she steers the discussion thematically. This is how she controls the conversation. On the other hand, it is the patient who determines the content of the discussion. Her answers are reflective and bring up new issues. When the patient speaks, the nurse supports her with various feedback (e.g. Extracts 2 and 3) 'mmm, right, of course, yes, exactly' and sometimes by paraphrasing. She nods a lot, bends toward the patient and looks at her. The feedback also occasionally includes completing the patient's sentences. According to van Ryn and Heaney (van Ryn and Heaney, 1997), such non-verbal cues signal acceptance and, according to Caris-Verhallen *et al.* (Caris-Verhallen *et al.*, 1999), they are patient-centered. With her feedback the nurse shows that she is there to listen to the patient, that she does not want to interrupt. Her feedback encourages the patient to speak in a similar way as in the doctor–patient conversation of an alternative medical interview described by Fairclough (Fairclough, 1992). The patient interprets the feedback as encouragement, goes on to discuss the matter, and indicates her intention to continue by using the expressions 'What I have been wondering...', 'I did that when...' and 'on the other hand, it's...'. This is how the nurse supports the patient's right to speak, which is not necessarily typical of a medical conversation (Fairclough, 1992). The nurse's multi-facetted listening feedback is empowering, and this can be seen here and there in the data [see also (Poskiparta *et al.*, 2000)]. In this encounter, the feedback is exceptional because it disregards the participant's status. Generally, this type of feedback is directed to the dominant person (Hakulinen, 1989). In a medically oriented environment, the hospital staff are viewed as superior to patients in knowledge (van Ryn and Heaney, 1997; Tones, 1994). In this particular case, the nurse's listening feedback manifests power sharing.

Vision of the future: emphasizing the positive

When the patient discusses the reason for her admission to the hospital, the nurse builds up a positive, healthier vision of the future through other patients' experiences (*Extract 4*). She makes her professional knowledge and expertise available to the patient (Williams, 1995; McWilliam *et al.*, 1997). This lends a touch of reality and possibly builds on the patient's strengths (van Ryn and Heaney, 1997) in this situation. The nurse attempts to dispel the patient's concerns about the risks of the operation. Her tone is convincing, and her non-verbal messages also inspire confidence: she looks at the patient, reinforces her message by nodding her head and gestures with her hands. Encouraged by the nurse, the patient can have a vision of her postoperative future.

Extract 4.

1 N: these <u>these</u> ((ha+)) back operations are
2 like such that patients in them are usually
3 really grateful ((nod+)) after the operation
4 because if the operation like succeeds and
5 something is found (.) then the pain will be

6 left in the operating room (.) ((ha+)) and
7 in that in that this is like like different from
8 other operations (.) and then because the
9 wound pain is in the back somehow it's
10 different than in here if the wound was here
11 in the stomach (ha+)) and it's not that that
12 bad when it is if [you]=
13 P: [yeah]
14 N: =after those stomach operations you often
15 often hear that these patients who have had
16 their back operated are such fortunate
17 ((nod+)) cases in the sense [that]=
18 P: [yeah] ((nod+))
19 N: = because the pain will be left in the
20 operating room and and that's it then
21 ((nod+/ha+))

The nurse encourages the patient to examine her life at some hypothetical future point of time when the operation will have succeeded. Hypothetical questions encourage patients to discuss issues that they fear [*cf.* (Peräkylä, 1995; Tomm, 1987)], while a hypothetical positive situation encourages patients indirectly. In this case, discussing the past would not calm the patient but rather lead her thoughts to the incident that caused her hospitalization. The vision of the future that the nurse provides to the patient with may help relieve her. A positive example is an empowering message and displays the nurse's understanding of the patient's anxiety. This vision can tap new resources in the patient for facing the future that is suddenly uncertain [*cf.* (van Ryn and Heaney, 1997)]. Some manifestations of this can be seen in the patient's words: '...I'm very happy that if it's going to be over (.) yes I'm ready though I feel nervous' or '...I'm going ahead with confidence...'. A skilful use of future focus by the nurse helps the patient to find new solutions to her problems [*cf.* (Tomm, 1987)]. As Atwood (Atwood, 1995) suggests, confining the clients' thoughts to their problems is not sufficient in therapy work (focus on the past). In addition, we need to assist clients to expand their outlook by re-visioning their lives (future focus).

Conclusions

The encounter that is presented here as a case study demonstrates empowering nursing practice in hospital. It is a concrete example of a discussion during which the official and formal nature that characterizes the role of an institutional nurse is not emphasized. It actually emphasizes partnership and reciprocal conversation [*cf.* (van Ryn and Heaney, 1997; Poskiparta *et al.*, 2000)], with the nurse's social interaction skills at the heart of the encounter [*cf.* (Wiles, 1997)]. The patient is free to discuss her thoughts, concerns, experiences and even fears with the nurse, and the nurse adopts an empowerment strategy in order to facilitate the patient's participation. This encounter included the following empowering practices: (1) opening the session in an encouraging and constructive manner, which improves the atmosphere, (2) tactful exploration when examining the patient's need for information and concerns for surgery, (3) active, power sharing listening, and (4) building up a positive vision of the future.

The descriptions of empowerment strategies reported by van Ryn and Heaney (van Ryn and Heaney, 1997) support our findings. However, we agree with Northouse's (Northouse, 1997) criticism that the reported strategies are not completely separated. In our study, empowerment was manifested through intimacy and mutual respect. The nurse's encouragement of the patient's participation and her attempt to share power signaled acceptance, and perhaps gave the patient new insights for controlling her feelings about the impending surgery. Furthermore, the perceptions of active listening feedback and questioning are consistent with our previous studies (Poskiparta *et al.*, 1998, 2000; Kettunen *et al.*, 2000), where we found them to be a means of activating patients' self-evaluation and self-determination. In this study, we did not find evidence for empowering stories or questions that relate to patients' personal philosophy, as mentioned by Feste and Anderson (Feste and Anderson, 1995). In addition, the nurse's encouragement was more sophisticated

than what Feste and Anderson suggest with their empowering tools.

Our research data consisted of only one videotaped session per patient. Thus we have no evidence about how patients' decision-making skills develop or their self-esteem improves. During the interviews we did not ask the patients' opinion on the effects of counseling and that is why the patients evaluated conversations at a quite general level. In this particular case, the patient said that an encounter was '*illuminating*' for her. She mentioned that she received enough information and again spoke about her fears but used the same words as the nurse did when she emphasized a positive vision of future (see *Extract 4*, lines 5, 6, 19 and 20): 'if it's a fact that the pain will be left in the operating room, if it really is possible...that there's going to be an operation and they'll do it tomorrow, then that's how it's going to be'. This could, perhaps, signify some kind of relief or new resources to face an uncertain future. During the interview it also became evident that the patient's fears had not been diminished, but she talked about them and stressed a strong reliance on the professionals and on the operation as a whole: 'I believe what I'm told'. This is in line with the perspective of Salmon (Salmon, 1993), who emphasized that patients' anxiety about surgery should not be seen as a problem but rather as a normal phenomenon, a sign of patients' emotional balance, of an ability to feel fear. Thus, the nurse's task is not to diminish the patient's fears but to facilitate the patient's disclosure and offer help for dealing with fear.

With caution, we can speculate on the factors behind this kind of empowering practice, which became evident during the subsequent interviews. There was no evidence that nurses' or patients' age, education or work experience influenced the format of the counseling. What makes this case different from traditional rigid counseling sessions is that the nurse had a goal that she had planned in advance and pursued flexibly. This indicates that she had reflected on the significance of this situation from the patient's perspective. In most cases, nurses approached counseling without any goal or the hospital provided a detailed agenda based on professional knowledge of diseases, their care and prevention. Then, different kinds of institutionalized health counseling packages seemed to restrict nurses' communication, and health counseling often followed the standard institutional order of phases mentioned by Drew and Heritage (Drew and Heritage 1998).

This study highlights empowering opportunities that arise in actual situations and that nurses can consciously use in their work. The results of this study can be applied to other health counseling practices and we would argue that every nurse should consider how (s)he initiates discussion. The analysis of the encounter shows that a tentative discussion style gives the patient a chance to deal with her concerns and to absorb the information that she needs. Thus, the patient has an opportunity to participate more actively in the discussion from the beginning than she could in the case of filling out a questionnaire in a strict predetermined order.

Clearly there are limitations to the generalizability of these findings. For example, both interlocutors were women, and this could in part explain the nature of the conversation since the highest levels of empathic and positive behavior occur between females [see (Coates, 1986; Roter and Hall, 1993), p. 63]. There is also some concern whether the nurse may have been subject to a performance bias because she was aware of being videotaped and possibly behaved differently. However, we think that this was limited because only two nurses discussed this type of bias in the interviews afterwards and other nurses did not even notice the camera or did so only briefly at the beginning of counseling [see also (Caris-Verhallen et al., 1998)]. Techniques to enhance the credibility of the findings included data and methodological triangulation of research data (Patton, 1990; Stake, 1994; Begley, 1996), and acquiring data that included both verbal and non-verbal communication from the videotaped health counseling sessions and the subsequent interviews. In addition, team analysis sessions (investigator triangulation) ensured the accuracy of data interpretation (Polit and Hunger 1995). Different expertise helped us to get more complete picture from this case and

empowerment philosophy when we discussed interpretations together.

However, in the last analysis, the effect of an empowering encounter could be checked after the operation by checking the patient's perspective, e.g. her satisfaction, recovery rate, etc. Evidence from nursing and medical staff might also be offered as additional evidence. Further research from larger numbers of patients is needed and more evidence from different settings will be required for a more extensive description of empowering practice. We will continue our research, and, for example, present qualitative analysis of interaction by describing how power features and patients' taciturnity are manifested in nurse–patient counseling. In addition, we will investigate how student nurses make progress in empowering counseling.

We suggest that nurses should pay attention to verbal expression and forms of language, in addition to non-verbal messages, because then they can empower patients by opening new and important perspectives for them. Nurses' every question, remark or piece of advice leads to individualized understanding and interpretation by the patient. It is important to remember that each communication situation is a unique, dynamic and transforming process. Nurses should observe what figures of speech they use and thus gain self-awareness and discover new tools to work with. We suggest a training program where the development of health care professionals' empowering skills can occur in practical, dynamic communication situations, be videotaped and transcribed for later theoretical, conscious and instructive evaluation. Analyzing the transcripts of video or tape-recorded counseling sessions opens up the possibility of an exact evaluation of empowering skills.

In health counseling, it is important that patients are able to maintain and strengthen a positive image of themselves as communicators. Positive experiences build up patients' self-esteem and increase their confidence in their ability to influence their care. The mere opportunity to discuss one's opinions and interpretations or different health concerns with a nurse may have the effect of unlocking patients' mental resources. This article demonstrates particularly how unconditional acceptance and facilitation of participation can be used in interpersonal counseling [see (van Ryn and Heaney, 1997)]. The empowering practices that are presented in this article should not be regarded as rigid and formalistic, rather they should be adapted to one's personal style.

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