Facilitation Skills for Nurses

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Abstract

Using the person-centered approach, facilitation in this study was conceptualised as providing opportunities for personal growth in the patient, and operationalised in a skills workshop for 40 nurses from different hospitals in Gauteng. The first objective was to evaluate the workshop and the second to ascertain its effect on the participant's experienced performance. A combined quantitative and qualitative research design was used. The quantitative measurement (Personal Orientation Inventory, Carkhuff scales) indicated that the workshop stimulated self-actualisation in terms of intrapersonal awareness, and the interpersonal skills of respect, realness, concreteness, empathy, as well as in terms of attending and responding behaviour. The qualitative measurement (a semi-structured interview) indicated that the participants were able to empower patients to find their own answers to difficult personal questions. The alternative hypothesis was accepted, namely that this workshop in facilitations skills significantly enhanced the intra- and interpersonal characteristics associated with self-actualisation and the facilitation of growth in patients. The findings highlighted the difference between the two roles of instructor and facilitator, and recommendations to this effect were formulated.

Opsomming

Vanuit die persoonsgesentreerde benadering, is fasilitering in hierdie studie gekonseptualiseer as die beskikbaarstelling van geleenthede vir persoonlike groei in die pasiënt, en geoperasionaliseer in 'n vaardigheidswerkswinkel vir 40 verpleegkundiges van verskillende hospitale in Gauteng. Die eerste doelstelling was om die werkswinkel te evalueer en die tweede om die effek daarvan op die deelnemer se ervaarde prestasie te bepaal. 'n Gekombineerde kwantitatiewe en kwalitatiewe navorsingsontwerp is gebruik. Die kwantitatiewe meting (Persoonlike Oriëntasievrealys, Carkhuffskale) het daarop gedui dat die werkswinkel selfaktualisering gestimuleer het in terme van intrapersoonlike bewustheid, en die interpersoonlike vaardighede van respek, egtheid, konkreetheid, empatie, sowel as aandaggewings- en responderingsgedrag. Die kwalitatiewe meting ('n semi-gestruktureerde onderhoud) het daarop gedui dat die deelnemer daartoe in staat is om pasiënte te bemagtig ten einde hul eie antwoorde op moeilike persoonlike vrae te vind. Die alternatiewe hipotese is aanvaar, naamlik dat hierdie werkswinkel in fasiliteringsvaardighede die intra- en interpersoonlike kenmerke wat met selfaktualisering en die fasilitering van groei in pasiënte geassosieer word, beduidend verhoog. Die bevindinge het die verskil tussen die twee rolle van instrukteur en fasiliteerder beklemtoon, en aanbevelings hieroor is geformuleer.

Introduction

As applied to the helping professions, facilitation originated from group therapy (Raskin, 1986a, 1986b) with hospital patients (Braaten, 1986) as well as from person-centered groups used in the National Training Laboratory (NTL) tradition (Reddy & Henderson, 1987). Today, it is applied in education (Rogers, 1982), as well as in industry and organisations in general (Cilliers, 1996) and refers to the helper's role as a resource or indirect guider (Patrick, 1992:331-340). As a communication skill (Du Toit, Grobler & Schenk, 1998; Plas, 1996) it provides an opportunity for the client (or patient) to experience aspects of the self, thereby stimulating the process of personal growth and taking responsibility for reaching his/her goals (Bentley, 1994; Corey, 1990:65-66; Goldstein, 1993:273-299; Gordon, 1994:208-212; Kinlaw, 1993; Weaver & Farrell, 1997). Although sometimes confused with instruction, facilitation differs from pedagogic and autocratic ways of instructing the patient (O'Connor, Bronner & Delayney, 1996:320), and focuses rather on empowering the person to make use of his/her own potential to develop.

The process whereby individual empowerment is facilitated is best described in humanistic psychology (Quitmann, 1985), the person-centered approach (Corey, 1990; Rogers, 1975a, 1975b; Sklare, Kenner & Mas, 1990; Westley & Waters, 1988) and the human potential movement (Carkhuff, 1969, 1972, 1983; Egan, 1990a, 1990b; Ivey, 1971). This framework offers a strong "tool" for the enhancement of personal growth amongst patients, which is directly influenced by the nurse's level of self-actualisation and helping communication skills, called nursing "for the better". Nursing "for the worse" refers to the opposite, which leads to hindering the patient in his/her personal learning and growth (Carkhuff, 1983). From the findings above, the general hypothesis in this study is formulated, namely, that the nurse whose self-actualisation and helping communication skills are enhanced will act in an empowered way in an interactive nursing situation, and thus empower patients towards personal growth.

Facilitation

Facilitation is conceptualised as the nurse's ability to create an accommodating climate and to provide an opportunity for the release of the patient's actualising tendency (Carkhuff, 1983; Rogers, 1973, 1982). This depends upon the quality of the relationship between the nurse, who is functioning on a

high level of self-actualisation with its accompanying intra- and interpersonal characteristics, and the patient, who as a result, learns how to learn and thus experiences personal growth.

The personality characteristics of the facilitator

These characteristics are knowledge and self-actualisation (Brazier, 1993; Hirschenbaum & Henderson, 1993; Maslow, 1971; Rogers, 1973, 1975a, 1975b, 1982; Segrera & Araiza, 1993:83).

Knowledge

This refers to the insight into and understanding of individual and group behaviour (Rogers, 1975a, 1975b). The facilitator understands the nature of the self, of interactions between the self and others as well as the facilitation process.

Self-actualisation

This term describes a natural, dynamic and creative growth process in which the individual, while fully acknowledging his/her own responsibility, gradually develops a unique sense of integration and wholeness through self-definition and the optimisation of psychological potential, and in whom the expression of the actualising tendency leads to enhancement and enrichment of life, intrapersonally as well as interpersonally (Hirschenbaum & Henderson, 1993; Maslow, 1971; Rogers, 1982).

Intrapersonal characteristics are those related to cognitive, affective and conative behaviour (Hirschenbaum & Henderson, 1993; Rogers, 1973, 1982).

* Cognitive. Realistic, objective and flexible thinking without inappropriate feelings such as guilt, shame, inferiority or superiority influencing the thinking process.
* Affective. Sensitivity towards one's own feelings and emotions (yet neither hypersensitive nor insensitive), which are honestly recognised, taken responsibility for and expressed in a natural and self-respectful way. This process stimulates self-knowledge, insight, a realistic self-concept characterised by self-respect, acceptance, confidence, a sense of one's own worth and a purposeful involvement in meaningful life situations.
* Conative. Acting from an internal locus of control, in an independent, autonomous, self-directed way, experiencing freedom of choice without feeling victimised by external forces.

Interpersonal characteristics refer to the facilitator's showing an optimistic and unconditional acceptance of and respect towards the patient, a preference for qualitative, intimate, deep, rich and rewarding interpersonal relationships, and sensitivity, consideration and love towards others (Hirschenbaum & Henderson, 1993; Maslow, 1971). These factors allow for genuine, spontaneous, non-exploitative and responsible non-verbal and verbal contact with the patient, in terms of the unique demands of each situation. This "sensitive relationship forming" (Cilliers & Wissing, 1993) involves the initiation of facilitative interpersonal processes and the creation of a relational climate that can stimulate constructive interactional processes between the facilitator's self and the patient, irrespective of any difference in for example gender, race or status.

The facilitation process

This process consists of two phases, namely attending, leading to involvement, and responding, leading to exploration. Within each, the facilitator exhibits the skills of respect, realness, concreteness and empathy, referred to as the core facilitative dimensions (Corey, 1990; Meador, 1975; Rogers, 1957, 1982).

* Respect. A profound recognition and appreciation of and regard for the value of the patient as a unique person and for his/her rights as a free individual, irrespective of differences, manifesting itself in warmth, unconditional positive regard and in the quality of the attention given to the patient.
* Realness. The degree of correspondence and congruence between what the facilitator says or does, and what he/she truly feels and means, existing in an honest, sincere and transparent way, without affectations.
* Concreteness. The extent to which the personal or task-related information that is reflected back to the patient is specific and factual, rather than vague or over-generalised, thus contributing towards accurate and clear communication.
* Empathy. The ability to transcend one's own self-consciousness in order to arrive at a conscious and accurate understanding of the patient's deepest feelings and intentions, in terms of the latter's own frame of reference, and to explicitly communicate this understanding to the patient (without prescription, evaluation or assessment).

Attending with respect, leading to involvement

The facilitator attends to the verbal (listening to what is said and how) and non-verbal (looking at body language) behaviour of the patient, with respect for the patient's right to experience whatever he/she is going through, stimulating him/her to become involved in the here-and-now of the experience.

Responding with realness, concreteness and empathy, leading to exploration

The facilitator responds by reflecting the patient's observed content and feeling, for example, "what I hear you say is ...", "you seem to feel ....", "you experience ... and that makes you feel ...". The facilitator (1) models realness, (2) phrases the core experience in a concrete way and (3) reflects with empathy from the frame of reference of the patient (instead of the facilitator's own) in "you"-language, to facilitate the patient's identification with the experience. This stimulates the patient's self expansion and growth, characterised by his/her awareness of his/her own subjective experiencing, inner feelings, incongruities between beliefs and behaviours, the willingness to listen to and trust the self and to rely on his/her awareness. The patient's identification with the response gives the facilitator feedback on the level of accuracy of his/her listening and looking.

Research question, aim and design

The research question is stated as follows: can the above fa-

cilitation characteristics and skills, be stimulated amongst nurses when operationalised in a workshop and what effect will this have on the participant's experienced nursing performance? The aim is, firstly, to evaluate such a workshop in facilitation skills and, secondly, to ascertain its effect on the participant's experienced performance. Quantitative research is undertaken to evaluate the workshop and qualitative research to ascertain the nurse's experience. The workshop is seen as the independent variable and the facilitating skills as the dependent variable.

Method

The workshop in facilitation skills

* Aim of the workshop. This is to provide an opportunity for nurses to gain knowledge about, experience in and the skills of facilitation as defined and described above.
* Module 1 - Knowledge. A short instructional, self-study and self-examination method in the form of a handout is used. The aim is to study literature on facilitation and self-actualisation with its intra- and interpersonal characteristics, as well as the facilitation process described from the person-centered approach (Rogers, 1975a, 1982). The workshop starts with a summary of this content (1 session / 1 hour).
* Module 2 - Intrapersonal awareness. Encounter group experiences with two facilitators are used (Rogers, 1975a). The aim is to provide an opportunity at the beginning of the workshop to experience the facilitation process as well as to enhance intrapersonal awareness. Next, these experiences are scheduled in between other workshop modules, providing opportunities to reflect on personal learning during the workshop (6 sessions / 9 hours).
* Module 3 - Interpersonal skills. The facilitation process is operationalised (Carkhuff, 1978, 1983; Egan 1990a, 1990b) with the aim of practising attending and responding behaviour. Role-play in role of facilitator, in one-to-one and group situations, is used, receiving feedback from the presenters and using self measurement according to the Carkhuff (1969) scales for respect, realness, concreteness and empathy (5 sessions / 7,5 hours).
* Module 4 - Revision and application. An open discussion with two facilitators is used. Revision aims to ascertain the level of learning taking place, and application aims to process the workshop experience and to support the transfer of learning back to the work situation (5 sessions / 6.5 hours)
* Administration of the workshop. A small group format with between eight and twelve participants and two presenters is used. The authors acted as presenters in the roles of instructor (in modules 1 and 3) and facilitator (in modules 2 and 4). To ensure enough time for intensive personal and interpersonal experiences, the workshop lasted 24 hours (excluding tea and lunch times), held over three working days. Table 1 contains the workshop programme.

The population and sample

The population consists of nurses from nine large hospitals in Gauteng Province, each with a three year nursing diploma and at least 5 years nursing experience. The female/male ratio was 86%/14% with ages ranging between 24 and 65 years. A voluntary sample of 80 was drawn, and individuals were paired off according to gender and age into an experimental (N=40) and a control group (N=40). To accommodate work

Table 1 : The workshop programme

TIME	DAY 1	DAY 2	DAY 3
08:00-09:00	Module 1 - Knowledge (an introduction)	Module 4 - Revision	Module 4 - Revision
09:00-10:30	Module 2 - Intrapersonal awareness	Module 2 - Intrapersonal awareness	Module 3 - Interpersonal skills
10:30-10:45	Tea	Tea	Tea
10:45-12:15	Module 2 - Intrapersonal awareness	Module 3 - Interpersonal skills	Module 3 - Interpersonal skills
12:15-12:45	Lunch	Lunch	Lunch
12:45-14:15	Module 3 - Interpersonal skills	Module 3 - Interpersonal skills	Module 3 - Interpersonal skills
14:15-14:30	Tea	Tea	Tea
14:30-16:00	Module 2 - Intrapersonal awareness	Module 2 - Intrapersonal awareness	Module 4 - Application
16:00-17:00	Module 4 - Revision	Module 4 - Revision & application	Module 4 - Revision

Table 2 : Significance of differences between pre and post scores for the intrapersonal characteristics of facilitation as measured by the POI

Item no	Item name	Exper gr X	S	Contr gr X	S	t-value
POI 1	Time competence	17,35	02,59	15,56	02,52	0,0150 *
POI 2	Inner-directedness	89,50	08,46	78,46	09,64	0,0057 *
POI 3	Self-actualising values	21,07	03,92	19,88	02,38	0,0034 *
POI 4	Existentialism	19,56	05,08	16,25	04,27	0,0046 *
POI 5	Feeling reactivity	16,86	02,32	14,64	02,89	0,0018 *
POI 6	Spontaneity	13,68	02,64	10,83	02,04	0,0064 *
POI 7	Self-regard	13,78	03,05	12,05	03,68	0,0012 *
POI 8	Self-acceptance	16,69	05,13	14,97	04,93	0,0008 *
POI 9	Nature of Man	11,86	02,84	11,04	02,34	0,0864
POI 10	Synergy	07,35	01,94	06,18	01,84	0,0187 **
POI 11	Acceptance of aggression	17,48	05,08	15,55	04,08	0,0048 *
POI 12	Intimate contact	20,05	05,82	16,65	02,85	0,0052 *

* $P < 0,01$ ** $P < 0,05$

schedules both groups were divided again into small workshop groups of between eight and twelve.

Quantitative measurement

Knowledge was not measured. Measuring instruments were chosen according to the personality characteristics of the facilitator. For the intrapersonal characteristics the Personal Orientation Inventory (POI) (Shostrom, 1974; Knapp, 1990) and for the interpersonal skills, the Carkhuff scales (1969) were used. Both instruments correspond conceptually with the above definitions and characteristics and are seen as the most appropriate available for measuring these behaviours (Cilliers & Wissing, 1993). Cilliers (1996) reports high reliability and validity for the POI and Carkhuff scales in similar training scenarios. The empirical hypothesis is formulated as: participation in the workshop in facilitation skills. does not enhance any intra- or interpersonal characteristics associated with self-actualisation or the facilitation of growth in patients.

Qualitative measurement

A voluntary 30-minute, semi-structured, tape-recorded interview was conducted by the researchers with each participant, and transcribed. The aim of the interview was to ascertain the long-term effect of the workshop on nursing performance. A single question was asked, namely: "How did the workshop affect your performance as a nurse?". After this the interviewee was encouraged to give more responses by the interviewer's summarising and reflecting on the patient's already given material according to the person-centered approach (Rogers 1975b, 1982). The interview was analysed by means of content analysis (Strauss & Corbin, 1990), and specifically open coding (a process of breaking down, examining, comparing, conceptualising and categorising data). By this means the main and sub-themes and their relationships were determined (Jones, 1996; Kerlinger, 1986). Trustworthiness was ensured by having the results checked by two psychologists, to whom these techniques are well known.

Procedure

A brochure, explaining the aims and administration of the workshop, was sent to all nine identified hospitals, asking for voluntary participants amongst nurses who fitted the above requirements of qualification and experience. Four workshop events were scheduled.

Four weeks prior to each workshop, the handout was given to every participant in the experimental group. Before starting each workshop, the quantitative instruments were administered as a pre-measurement to both the experimental and the control groups. Then the control group went on with their daily activities while the workshop was presented to the experimental group. Immediately after each workshop, the instruments were administered again as a post-measurement, to both groups.

The Carkhuff (1978) scales were administered in two situations. The first was a written communication situation containing typical verbal nursing questions of a challenging nature to which the respondent had to react and then record his/her own spontaneous verbal reaction. The second was an individual role-play recorded on video, with the respondent acting as the nurse in a five minute interaction with a second person in the role of patient, who threatens to leave the hospital in fear of illness and an upcoming operation.

The quantitative data was processed collectively for all the experimental and all the control groups. The significance of any differences between pre- and post- measurement (*t*-test) was calculated by means of the SAS Computer package (SAS Institute, 1985). Each workshop participant (in the experimental group) was contacted three months after the workshop, ensuring that he/she had had enough time to use the newly acquired behaviour. Then the interview was conducted and analysed.

Table 3 : Significance of differences between pre and post scores for the interpersonal skills of facilitation as measured by the Carkhuff scales in the written communication and role-play situations

Item no	Item name	Exper gr X	S	Contr gr X	S	t-value
1	Respect	01,72	00,52	00,18	00,31	0,0009 *
2	Realness	01,46	00,47	00,06	00,05	0,0026 *
3	Concreteness	01,57	00,46	00,07	00,19	0,0008 *
4	Empathy	01,38	00,58	00,13	00,39	0,0079 *

* $P < 0,01$

Results

Quantitative measurement

The results of the measured intrapersonal characteristics are presented in table 2.

The POI results indicate that the workshop stimulated the following characteristics significantly: time competence focussing on the here and now, behaviour motivated from a sense of inner-directedness, living according to the values of self-actualisation, flexibility in the application of values, sensitivity towards one's own feelings and needs and the spontaneous expression of them, self-regard and acceptance in spite of weaknesses, the acceptance of opposites (for example good/bad, masculine/feminine social roles) as non-antagonistic, acceptance of one's own anger and aggression in an interpersonal situation, and the capacity to form warm and intimate interpersonal relationships.
The results of the measured interpersonal characteristics are presented in table 3.

The Carkhuff scales indicate that the workshop led to a significant improvement in performance on all four of the core facilitative dimensions (respect, realness, concreteness and empathy). Thus the empirical hypothesis was rejected.

Qualitative measurement

During the interview there was no audible or visible resistance to being part of the measurement. Most participants were excited about the interview as well as about the learning acquired during the workshop. The interview brought the following themes to the fore.

1. The roles of instructor and facilitator differ, each with its own application. On a knowledge level, it became clear to the participants that the instructor focuses on content, the mechanistic level of nursing, and requires knowledge to impart knowledge to the patient. The facilitator, on the other hand, focuses on personal, behavioural processes and interpersonal relationships. A high level of self-actualisation (defined as intra and interpersonal sensitivity, awareness and facilitating skills) is required to provide the learning opportunity which enhances learning and growth in the patient. This was also called "using the self as an instrument" instead of using nursing and medical equipment, techniques and procedures.
2. Self-actualisation is a life-long process. Although this workshop was too short to get to grips with all growth aspects within the self, the participants realised that they could not turn back to "where they were". Participants were increasingly and actively searching for more opportunities to develop the self, their quality of life and their facilitation skills.
3. The facilitator listens to and responds from the point of view of the patient. If a patient asks a question about knowledge or content (for example, "For how long will I have to be in the hospital?"), the instructor answers the question in the instructor role by giving the correct answer. If a patient asks a question about him/herself, his/her own feelings or personal issues, the nurse in the role of the facilitator (because there is no correct answer) reflects the content and feelings back, providing an opportunity for the patient to explore his/her own answer. For example, "What do you do when you don't want this operation / procedure and would rather just die?", is reflected by the facilitator as "You seem to be filled with fear about your immediate future".
4. The different roles elicit different reactions from the trainee. The instructor answering the patient's questions gives information on the cognitive level, which makes the patient dependent on the nurse. The patient often continues in this mode by asking more questions and does not learn to think for him/herself. The facilitator, neutrally reflecting what the patient is experiencing, makes the patient become aware of and think about his/her own issues and what to do about them. Participants reported that their patients did not like this style initially, because it was uncomfortable and implied introspection on their part. The test of the facilitator role is to resist the pressure to give solutions, and rather to trust the facilitation process and to stay in the role. Nurses reported that their patients said afterwards that the experience offered a great learning opportunity about themselves, their feelings and problem solving style. The patients added that this made the hospitalisation worthwhile, because the learning about themselves made a great impact on them and was remembered longer than the medical aspects. This in turn empowered the nurses because they could see that they had made a difference in a patient's life.
5. Facilitation leads to problem solving without becoming part of the problem. Many participants reported that they were becoming aware of not reacting to conflict (within individual patients and between them) from a personal level, but rather from a neutral, empathic stance, thus enhancing the

insight of the patients into themselves. Again, the patients found this new growth enriching skill as powerful for the self and a relief for their own stress levels.

Discussion

The workshop enhanced the level of self-actualisation in terms of the participant's intrapersonal awareness and interpersonal skills of respect, realness, concreteness, empathy, as well as their attending and responding behaviour. This corresponds with research findings by Rogers (1982), Meador (1975), Cilliers (1996) and Rothman, Sieberhagen and Cilliers (1998). The enhanced awareness of the self, one's own interpersonal relationships and those of others, could be interpreted as an increase in personal maturity, personality integration and self-actualisation.

Intrapersonally the facilitation workshop led to enhanced awareness in terms of cognitive, affective and conative behaviour.

* Cognitive. Because the nurse understands the role of facilitator better, he/she is more inclined to listen objectively and to focus on the task of responding to a patient, without his/her own emotional involvement clouding the response.
* Affective. The nurse's emotional maturity and ego-strength are enhanced, as well as his/her autonomy and independence. This enhancement facilitates greater sensitivity and awareness of the nurse's own needs and feelings, a stronger self image based upon self knowledge, insight, respect, confidence and acceptance in spite of weaknesses, the acceptance of one's own feelings (especially aggression) and the spontaneous and natural expression of them, a moving away from rule boundness, self defeat, moralising, rigidity, inhibition and selfmade restrictions. These changes may in future lead to more acceptance of responsibility for the nurse's own behaviour, heightened sensitivity in the handling of their own and others' affective behaviour in a facilitating situation and the modelling of flexibility.
* Conative. The nurse's internal locus of control is enhanced, including self motivation, inner-directedness with his/her own integrated values, needs and feelings, instead of taking responsibility for the needs of others, flexibility according to the demands of the situation instead of rigid, compulsive and dogmatic behaviour. These changes may in future lead to stronger self motivation in decision making and the modelling of such motivation in a facilitation situation.

Interpersonally, the skill of the nurse in respecting and accepting the patient as a valued human being, was enhanced (which implies the awareness of the nurse's own frame of reference, ideas, stereotypes, prejudices and the skill to temporarily put this aside). Also enhanced was the nurse's skill to move into the patient's frame of reference in an honest and genuine way, to have more awareness, sensitivity, understanding and acceptance of the patient's ideas, needs and feelings, and to communicate this understanding and acceptance in a concrete way by means of reflection. His/her own empowerment facilitates empowerment and the stimulation of growth within the patient. The tendency at the beginning of the workshop (in the pre-measurement) to play games, manipulate and prescribe his/her own solution, diminished significantly. This will possibly lead in future to more respectful, real and emphatic interactions in the nursing situation.

Conclusion, limitations and recommendations

This research highlights the difference between the roles of instructor and facilitator. The workshop helped the participant to distinguish between the roles on a cognitive level as well as in the practical nursing situation. The study suggests that facilitation skills, with their focus on self-actualisation, can be significantly enhanced amongst nurses. After the application of the learned self-awareness and skills in the practical nursing situation, the participant feels empowered to facilitate opportunities for learning and growth amongst patients, which again empowers that patient to learn about him/herself and to grow towards his/her own self-actualisation. Thus, the empirical hypothesis is rejected in favour of the alternative hypothesis, namely that this workshop in facilitation skills significantly enhanced the intra- and interpersonal characteristics associated with self-actualisation and the facilitation of growth in patients.

It is important to note that the choice of the research design could have influenced the results. The sample is small in terms of the size of the national nursing fraternity and the absence of a post-post measurement for the quantitative, as well as the qualitative, instruments makes it unsure whether the results will be sustained over a long period. It is recommended that the research design be extended to include more varied samples; also that a post-post measurement including real hospital ward situations, be performed.

Hospital management, training staff and nurses in general should be enlightened about the difference between instructing and facilitation, each with its application and different effect on the patient. Facilitator development as part of nursing education and on-the-job development will stimulate the self-actualisation of nurses as well as their helping communication skills, in order to cope with the dynamic intra- and interpersonal activities within the nursing situation. On a broader level, all hospitals can make effective use of facilitation and its values and principles to empower their workforce.

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