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Accommodating nursing: a communication perspective

Abstract

Effective communication is, of course, vital to successful nurse-patient relationships and care. An array of empirical investigations in this arena has invoked communication accommodation theory (CAT), either interpretively or by driving the design of studies. However, most of these rely on earlier iterations of the theory and there have been many theoretical intergroup (and other) advances in recent years that could benefit developments in future research on nursing practices. This article not only addresses the potentialities available, but is really the first where general CAT Principles explicitly attend to nurses' communications with medical and non-medical persons. Herein, we introduce recent formulations of the theory, then provide a flavor of prior CAT-related nursing studies. A novel selection of foundational CAT Principles are introduced explicitly crafted for nursing and, finally, allude to ways (with an attending conceptual model as a template) in which the theory could be mined for training programs.

Keywords: communication accommodation theory, nursing, health care

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Introduction

Nurses work with an array of different health care providers and groups, including hospital administrators, physicians, and patients as well as their relatives and friends. Needless to say, effective communication is vital for a range of successful personal and clinical outcomes.[1] However, such communication can involve relational and or intergroup processes that can be distinguished as qualitatively different.[2] Put another way, nurses may communicate with others - and be addressed by them - as individual persons with their own idiosyncratic personalities and attributes *or* as members of distinctive social groups with their own values, expertise, and characteristics. Although there is a fair body of research and theory on nursing and communication,[3] there are many studies that have invoked - with a variety of methodologies - communication accommodation theory (CAT) in its generic form.[4-5] These were studies driven, or findings interpreted, by the theory involving nursing inter-professional encounters and interactions relating to different kinds of nurse-patient discourses whilst variably focusing on interpersonal or intergroup facets of the theory.

In this article, we first introduce, briefly, recent formulations of the theory, and then provide a flavor of prior CAT nursing studies which, in the main, were conducted or guided by means of much older versions of the theory. Thereafter, we provide a selection of CAT Principles that are explicitly crafted in terms of nursing communications, pointing to ways (with an attending conceptual model) in which theory could be devised for nursing training.

Communication accommodation theory

CAT has a history now of over 50 years[6-7]and has been studied across numerous disciplines, languages and cultures, social groups, applied and institutional contexts, and even a range of non-human species.[8] Indeed, it continues to flourish and expand beyond these recent works to, for example: gossip and rumor;[9] online sports fans' communiques;[10] students' use of emojis on Fijian social media;[11] American female leaders' public speeches;[12] newspaper and twitter reports on political discourses in Nigeria;[13] and human-machine communication.[14] To provide a flavor of the essence of CAT, foundational assertions of the theory are that, under certain social circumstances, people will accommodate or converge to what they *believe* to be the communicative practices (e.g., tempo, volume, accent, and appearance) of those whom they respect, admire, and like, or have a higher relative status and power. In contrast, people will likely *not* accommodate (or even diverge from) the assumed communicative features of a person or members of an outgroup they disdain or with whom do not identify. That said, many caveats exist in that individuals can, also, diverge with positive intent and, also, converge with malevolent motives. Convergence and divergence - labeled also, "approximation strategies"[15]- are not the only accommodation strategies CAT contends facilitate productive conversations; others include emotional expression, interpretability, interpersonal control, and discourse management.[15-16] Taking into account the affective and relational needs of others is the focus of emotional expression strategies. Interpretability strategies involve avoiding jargon and accommodating others' expressed or perceived abilities in order to facilitate mutual understanding among speakers. Interpersonal control strategies are concerned with how people modify their communication depending on relative status and role relationships with others The use of discourse management strategies, such as active listening, open-ended questioning, and topic redirection relate to modifying communication to accommodate another interlocutor's expressed or perceived conversational demands.[17]

In 2023, the theory was extended and revised to what amounted then to eleven CAT Principles which since have been expanded.[18] For the sake of parsimony, two of the major CAT Principles[19] suggest that: When communicators seek to reduce the social distance between themselves and others, they will accommodate their speech and/or other communicative behaviors towards where they *believe* others to be. Whereas: When communicators seek to increase the social distance between themselves and others, they will not accommodate their speech and/or other communicative behaviors (e.g., by under- or over- accommodating) from where they *believe* others (or their social groups) to be.

It is important to underscore that accommodative, as well as nonaccommodative, moves can be: both simultaneously present in the pursuit of multiple and contrasting goals; consciously- or nonconsciously-enacted; and can change over the course of time as

between encounters with the same persons. Training programs to enhance so-called "accommodative competence"[20] are increasingly being designed and evaluated, as in the case of pharmacists improving their communication dealings with, and advice to, their customers.[21] However, before transforming and elaborating the above Principles explicitly into the nursing landscape, we turn next to a selective overview of past CAT-inspired studies on nursing.

Nursing with CAT: prior studies

Effective nurse-patient communication is an essential aspect of health care and has been emphasized in so-called "patient-oriented" approaches[22-23] that align well with the accommodation approach espoused herein. For example, it has been found beneficial for nurses to converge to the everyday language of patients than to maintain their use of medically-technical words and phrases.[24] CAT has been also been involved in studying nursing students' use of discourse management strategies when responding to the changing needs of the patient and family that, when accommodative, can convey comfort, connection and compassion, openness, and confidence in communicating.[25] Nurses are also responsible for providing care to patients regardless of their culture, religion, and ethnic background or language skills. Indeed, language barriers present significant obstacles to the development of effective communication between nurses and patients and accommodating these barriers is essential for delivering culturally-competent and patient-centered care.[26] During medical interactions with elderly patients or in nursing home settings, some nurses have been found to speak louder than usual or use patronizing speech in the form of so-called "secondary baby talk", stereotypically assuming that the patients need such simplications because of their age.[27-31] This type of over-accommodation occurs when nurses modify their communication style without thinking and without establishing whether such accommodations are needed by the patient whilst also providing them with more help than is needed by them. Many an elderly patient might choose to remain silent in the face of such perceived non accommodations that can also convey a sense of declining capability, loss of control, and helplessness.[32] Unfortunately, these feelings can, in turn, into a negative feedback loop within which the elder's self-esteem and opportunities for satisfying communication decline.[33]

CAT has also be used in guiding nursing for special groups such as cancer, hospice, infant, and maternal patients[34-36] as well as those being discharged from hospital.[37] Other (also, more intergroup) studies have examined the communication of nurses with other medical entities. For example, it has been found that care professionals consisting of obstetricians, nurses, and midwives do not always have similar perceptions or understandings of accommodation.[38] Similarly, longstanding maladaptive nurse-physician relationships have been found to persist in inpatient settings leading to problematic outcomes.[39]

CAT Principles for the nursing context

Returning now to the above CAT Principles, while transforming and elaborating them onto the nursing platform, we propose - while also appealing to recent research on meta-stereotyping[40] and so-called "intergroup felt understanding"[41,42] - that:

a) When nurses (consciously or nonconciously) seek to *reduce* the social distance between themselves and other medical & non-medical staff, patients, and their families and visitors, they will accommodate their speech and/or other behaviors (e.g., non-verbal and discourse management strategies) towards where they believe these others to be communicatively. This, thereby, establishes common ground for shared understandings.

b) "This is especially so if their meta-stereotypes of these other medical and non-medical entities are known – o r presumed to be - accommodative and they also believe the other(s) to understand their perspectives and would take them into account. The outcomes should include: facilitating the clinical organization's communicative and collaborative climate which includes enhancing nurses' self-esteem, efficacy, rapport with others, and job satisfaction."|

c) Whereas: When nurses (consciously or nonconscously) do *not* seek to reduce the social distance between themselves and other medical staff, patients, and their families and visitors, they will not accommodate their speech and/or other behaviors to where they *believe* these others to be communicatively. This, thereby, does not establish or evoke common ground for shared understandings.

d) This is especially so if their meta-stereotypes of these other entities are known - or presumed to be- nonaccommodative and they also believe the other(s) not to understand their perspectives or would wish to take them into account.

e) The outcomes should include not facilitating the organization's communicative and collaborative climate but, rather, diminishing rapport and others' cooperation, job satisfaction, and increasing stress (and even lead to burnout). We would argue that invoking these CAT Principles as a template for potential modules of training and future research on nursing communication will yield valuable and promising outcomes.

Prospects for CAT training for nursing

Research suggests that receiving formalized instruction in nurse-patient communication can improve the medical interactions between nurses and patients.[43-45] We contend that nursing students should learn to elegantly negotiate the appropriate application of convergent and divergent communication behaviors in patient encounters.[46] Relatedly, applications of CAT to structure communication training strategies to improve healthcare providers' ability to converse and connect with a vulnerable older population and address their social and emotional well-being has already been proposed.[47] Furthermore, it has been suggested that CAT provides nurses with a novel approach to use in *speaking-up* that enhances their ability to listen, understand, and engage in point-of-care negotiations to ensure the physical and psychological safety of patients and staff.[48]

A model for such an interventionist approach already exists in a CAT approach for training health workers for managing and de-escalating patient aggression.[49] Gratifyingly, the scholars devising this program found "a positive, significant association between self-efficacy in managing patient aggression and accommodation, $r = .48$, $p < .001$, indicating that the more efficacious health workers felt, which increased as a result of the training, the more likely they were to report accommodating the patient" (p. 73). Hence, Pines and colleagues not only evaluated the value of their training for health professionals, but also found when re-tested three months later, the positive benefits in self-efficacy were still apparent; one participant even remarked that they expected what they gained from the training would last their "whole life long" (p. 75). We would argue that adapting and appropriately modifying these authors' published training procedures (e.g., lecture and small groups of sequential role-playings) for different kinds of nursing specialties should lead to accommodative competences beneficial to all parties involved, including dealing with, accommodating to, the everyday needs of non-agitated patients as well

as with those nursed who are disoriented, aggressive, or otherwise communicative problematic. Figure 1 provides a conceptually heuristic model of the processes involved.

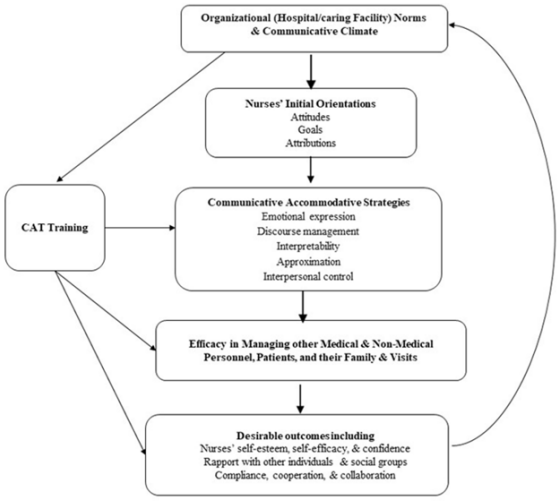

Figure 1 Communication-oriented model of communication accommodation theory training for nursing.

Conclusion

Nurses are, needless to say, required to communicate effectively with patients as they are more often than not the primary healthcare providers.[50] While CAT has been used in prior nursing studies, we argue that more recent renditions of the model could enable more productive studies including those for devising training and, also, for assisting nurse managers. In this article, we have suggested ways in which a general CAT framework could be molded to encapsulate better the communication practices of nurses with medical and nonmedical groups and individuals. Obviously, we could not attend to all aspects of communication in nursing, such as for example maximizing optimal messages between those nurses going off and those coming on ward shifts.[51-52] While this is the first theoretical contribution by CAT explicitly devoted to nursing and communication, it is an interesting question as to whether any revisions - as well as fuller versions (e.g., in terms of engaging all 11 or even more Principles) - should be fruitfully employed for different and specific *nursing specialties,* and or whether we need refined versions for different cultures where nursing practices and institutions vary.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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