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**Purpose and Goals**

The goal of this course is to discuss criticism in its many different forms. The aim is to shape your communication skills, attitudes about criticism, to help you understand the basis for many criticisms, and to help you understand your reaction to criticism.

It will focus on various types of criticism and techniques used for coping. The information will be applicable to any health professional or supervisor who desires to learn and utilize tools to assist with interpersonal/professional skills. It applies to all areas of practice because positive criticism and communication skills are vital in all levels of the healthcare industry.

### Instructional Objectives

Upon completion of this course, the motivated learner will be able to:

1. Enumerate some of the myths associated with the realities of criticism.
2. Select some of the factors directly related to the caregiver’s self-esteem, self-worth, and self-confidence.
3. State three actions demonstrated with passive behavior.
4. Identify techniques to reduce critical behavior in clients.
5. List three methods to cope positively with criticism.
6. List some typical dialogues contained in the “black tapes.”
7. Provide some prerequisites necessary for handling criticism.
8. Provide some prerequisites necessary for handling criticism.
9. Describe how an individual demonstrates assertive abilities.
10. List some types of personal power.
11. Name some of the various types of criticism and techniques used for coping.
12. Name some of the various types of criticism and techniques used for coping.
13. Identify techniques to reduce critical behavior in clients.
14. List some factors that support stress theory.
15. Define communication & variables that influence communication interaction.
16. Select some of the behavioral and physiological manifestations of anxiety.
17. Provide some of the ways the caregiver can effectively handle a critical supervisor.
18. List some factors to consider prior to criticizing others.

*This text has been prepared using a “she” as the nurse/healthcare professional. This was done only for ease of writing, to avoid saying he/she, not to slight any male nurse or nurse supervisor, or to establish gender by occupation.

### Introduction

It has been suggested that the most powerful weapon in the world is not a gun or even a nuclear bomb, but rather, the tongue. With the words we use — or abuse — as we communicate with those around us, we can encourage or discourage, forgive or condemn, lift up or tear down.

Whether your practice is in an acute hospital, a public health agency, a long-term care facility, clinic, or even if you are not currently employed, you will come in contact with people who may criticize you or try to “put you down.”

This course will help you understand why you react the way you do to criticism. Further, it offers guidelines to help you know when and how to respond when criticized. You will also learn why people respond defensively and how to avoid this response.

These principles and techniques are applicable to healthcare professionals at any level, in any work situation. The principles can easily be converted and used outside the work environment.

The course builds on the philosophy that you must understand and like yourself before you will be able to assert your viewpoint and deal with criticism in an effective, productive manner. But first, let’s lay the foundation, of the concept of communication.

### Communication Principles

The word communication is derived from the Latin “communico”, from “communis” or the word “common”. It means to share, to impart, to take part in, to join, to unite or to connect. Communication, therefore, is a special process seen as a dynamic social interaction involving exchange of ideas between two or more people. It is also to express feelings and probably the most significant of all human behaviors. It is said that all behavior is communication and all communication affects behavior.

Communication is a system of operations that includes language, gestures or symbols to convey intended meaning and sharing of experience. Communication is the process of creating meaning between people.

Communication is the foundation of all
interpersonal relationships and our daily lives are filled with one communication experience after another. The purpose is twofold: the giving and receiving of information; and the making of contact between people. If there is no communication there can be no relationship, therefore some will say that communication is not only a behavior, it is the relationship.

Therapeutic communication utilized in the healthcare professions is facilitative in nature, focusing on a specific goal. The message conveys a presenting problem, learning of more effective coping mechanisms and the self-development of ego-strengths. The core of this is meaningful reaction of the nurse.

Clients use communication to share their ideas and feelings, express thoughts and convey their life stories to co-construct new meanings. Through the contact between health professional and client, new meanings (stories) are co-constructed and clients learn more effective ways of communicating with others. Through communication, we reach some understanding of each other, learn to like, and empathize with each other. The process is continuous, that’s why we can say it’s a cyclic process. It is important, though, to remember that the sender and receiver mentioned are people, whose experiences and interactions will affect the way in which they communicate. The contextual factors include community, individual, family, and social influences, such as age, gender, educational background, specific aims, and attitudes.

Communication is a key tool that health care professionals must use to elicit cooperation among individuals in the delivery of health care services. It is an integral part of socialization and imperative in establishing relationships. In the medical community, it can be described as a process for sharing information through utilization of a set of common rules. These rules vary with circumstances: for instance, the transfer of information can be interrupted by situational pressure; differences between the professionals’ perspectives can interfere with shared meanings; and the rules of the process of communication can be changed with inappropriate responses.

**Communication Among Health Professionals can:**

1. increase awareness of a health issue, problem, or solution
2. affect attitudes to create support for individual or collective action
3. demonstrate or illustrate skills
4. increase demand for health services
5. inform or reinforce knowledge, attitudes, or behavior

With the disciplines of medicine and nursing working in close proximity, communication is not just practicing together, but individually interacting to achieve a common good: the health and well-being of patients.

Human communication is a subset of symbolic language. For example, it can be an ongoing dialogue about a patient concern, behavior, attitude, or diagnosis. It reflects how medical professionals seek to maintain health and deal with health-related issues. These transactions that occur among health professionals can be verbal or nonverbal, oral or written, personal or impersonal, and issue oriented or relationship oriented.

Communication is a cyclic, dynamic, ever-changing process where information is continuously transmitted to a receiver and where the reaction of the receiver changes the sender’s next message. This process is continuous, that’s why we can say it’s a cyclic process. It is important, though, to remember that the sender and receiver mentioned are people, whose experiences, feelings, values, beliefs and cultural backgrounds will affect the way in which they communicate. These contextual factors include community, individual, family, and social influences, such as age, gender, educational background, specific aims, and attitudes.

The meaning of communication cannot be transferred; it must be mutually negotiated, because meaning can be influenced by many of the above-mentioned contextual factors.

**Communication Techniques**

Some techniques one can use for communication include:

- effective speaking
- effective listening
- feedback
- alert to nonverbal signals

**Effective Speaking**

In communication between health professionals, the use of precise terminology is most effective in promoting a collegial environment. To ensure communicative clarity, formulate your thoughts before speaking and be cognizant of the verbal and nonverbal feedback from your listeners.

**“I” Statements**

“I” statements indicate to others that you believe and trust your thoughts and feelings and that you are taking responsibility for what you’re saying. Try and avoid “you” messages as they can be confrontational and judgmental. The following is an example of how to use an “I” statement instead of a “you” statement. “I become very irritated when you slam the door so hard when I’m trying to study” instead of “You irritate me, please go away”.

**Giving and Getting Information**

In conversation with another person you can give information about yourself by utilizing the skills of active listening and empathetic responses. It is also important for the other person to be able to have a chance to share personal information. This is the foundation of mutual trust, mutual respect and the chance to get to know each other.

**Constructive Criticism**

It is important that an assertive person is able to give constructive feedback. Some of the guidelines in giving constructive criticism are: utilizing “I” messages instead of “You” messages; be direct; matter-of-fact firm voice; describe the behavior that you are critical about and not the person; try and view the situation from the receiver’s point of view.

**Persistence**

It is positive and helps to be persistent when you want to be heard or you want change in another person’s behavior.

**Precise Words**

Use direct, concise words to communicate what you think so that the other person can understand what you say.

**Effective Listening**

Definitely, one of the most crucial aspects of successful communication is the ability to “really listen”. An effective listener is as actively involved in the
Feedback

Feedback is another important aspect in communication that can reinforce some behavior and extinguish others. This can also describe the effect you have on other people and can point out the importance that communication problems are the result of mutual contribution. Thus, feedback can also be an important source of information about yourself.

Initially, a response to communication (feedback) is internal. The person’s emotions, knowledge, and past experiences initiate a particular response. Some common styles of response by listeners are withdrawing, judging, analyzing, questioning, reassuring, and paraphrasing.

Withdrawing can occur when the topic of discussion creates uncomfortable feelings. It usually is interpreted as lack of concern or callousness. Judging almost immediately extinguishes open communication. Judgmental responses can be damaging to relationships, especially when a person is judged negatively. The judged person has to defend her/his opinion, belief, or behavior, placing the person in a position of rejection or resistance to the judge.

Analyzing is similar to judging. It explains to a person why they reacted as they did. This leads to the person becoming defensive and less willing to reveal their thoughts and feelings. Questioning can either enhance or inhibit communication. Helpful questions are neither judgmental nor threatening, but allow the individual to gain insights that they previously overlooked. These questions usually encourage people to communicate rather than become defensive.

Reassurance indicates acceptance to the person. When appropriate, it includes addressing positive ways of viewing the troubling situation, but also guarding against making a judging response.

Paraphrasing is the listener reiterating the speaker’s message and providing the speaker with the opportunity to correct any misconceptions. It emphasizes the listener’s attentiveness to the speaker’s words.

Alert to Nonverbal Signals

Effective communication requires that one is alert to the many nonverbal cues expressed by listeners. These include posture, gestures, facial expression, tone and inflection of words, personal dress, and personal space. It reflects the individual’s personality and culture. For example, how close to you does a person stand as you talk? In general, moving close to you indicates an interest in you or the discussion. Keeping a distance may indicate uncertainty about you, or a dislike of or disinterest in your topic.

Watch the person’s hands as you interact. Even though the person appears calm, nervousness is often revealed through hand activity. The classic sign of folded arms over the chest may indicate that the individual may be feeling defensive, and it is necessary for you to regress in your approach; or it can indicate that the person is cold. This action demonstrates how easily body language can be misinterpreted.

The most important signs to watch for are incongruent facial expressions. Genuine emotions usually cause a quick smile that encompasses the entire face. If someone is faking an emotion, they often hold the expression too long. During interactions, nonverbal and verbal messages often conflict. Usually, the nonverbal message is the more accurate. It is easy to control our words, but more difficult to control tone of voice, facial expression, posture, and other nonverbal signals.

The following comparison is made between non-assertive, aggressive and assertive behavior in the nonverbal skills.

Myths and Realities

Reactions to Criticism

How do you react when criticized? Are you defensive or do you know how to turn it around and make it work for you?

As humans we are complex organisms. Likewise, our reactions and emotions are complex. There are no pat answers to how we feel or what we think or believe. Nurses, like many other health professionals, are subjected to intense scrutiny every working day. Because of our close patient contact, we are constantly evaluated by our peers, supervisors, physicians, and our patients.

With all those individuals looking at us, it is no wonder we become sensitive and defensive. The information you gain will not change others; however, it will enable you to change yourself, if you desire to do so, and learn how to deal effectively with critical individuals.

As children, we were criticized by our parents. These criticisms were often meant as opportunities to instill a sense of intrinsic responsibility and help us grow up to be “good citizens.” Our parents’ criticisms were those of their parents and so on. Therefore, many myths or untrue assumptions were told over and over again. We began to accept these criticisms and make assumptions about our identity and self-worth. See if you recognize a few:

If I am criticized, it means
• I’m bad
• I’m incompetent
• I deserve to be punished
• I’m stupid
If I criticize others, it means:
• I’m insensitive
• I don’t care
• I want to hurt them

We can intellectualize that these things are not true about us. But think back and remember how you felt about yourself when you were criticized. I believe we all harbor a few of these feelings.

The reality is that as healthcare professionals we must not internalize the comments and criticisms of others. Criticism is like an object we might find. We must pick it up, look at it, and decide if we can use it; if not, then we must cast it aside.

Throughout this text we will be evaluating old myths and new realities. Some of our old ideas will be challenged. Be receptive to new ideas, and together we will expand the passages of our minds.

Individual Rights

As individuals, as nurses, and as human beings, we all have basic rights the Constitution provides us. These rights
must be upheld every day if they are to be effective.

As health care professionals we are placed into work situations where our basic rights may be easily abridged. Research supports that we have the following rights:

1. respectful treatment
2. a reasonable work load
3. an equitable wage
4. self-determination of priorities
5. asking for things desired
6. refusal without making excuses or feeling guilty
7. making mistakes and being responsible for them
8. giving and receiving information as a professional
9. acting in the best interest of the patient
10. being Human.

How do you feel about those rights? Chances are, if you’re not comfortable with them or don’t believe them, you’re operating with what Thomas Harris, M.D., author of the classic text “I’m OK—You’re Okay,” refers to as your “not OK” self.

Dr. Harris refers to life positions in which individuals view themselves:
1. I’m not OK—your’re OK
2. I’m OK—your’re not OK
3. I’m OK—your’re OK

**Cultural**

“My Ok’ness Depends on You”

Of course, we all must try to view ourselves in the third position, I’m OK—you’re OK.

To put Dr. Harris’ principles into practice we must look at how we view ourselves. Historically, our culture has told us, “My OK’ness Depends on You.”

There is one theory that believes women generally accept two irrational assumptions:
1. “For me to be OK it is absolutely necessary that I am liked by and approved by everyone.”
2. “For me to feel good about myself I must never make a mistake.”

Now, by just reading those statements we are all saying, “That’s not me — I don’t believe that.” However, by looking at our behavior and thinking about the last situation in which we were criticized, it becomes apparent that part of these irrational assumptions live in many of us.

**Black Tapes About Yourself**

Earlier, we said our parents criticized us as children in order to help us become better adults. We also, then, know that the way we view ourselves and evaluate ourselves evolves, for the most part, from what our parents told us. If our parents were critical, moralizing, or overprotective, we will carry the results of those attitudes with us. Likewise, we carry all the positive criticism of our parents. One theory refers to the criticizing or overprotective dialogues as black tapes. These tapes are automatically replayed when we get in a situation that resembles one in which our parents told us over and over: “no,” “shouldn’t,” “never,” “should,” “now remember to”.... Our black tapes also produce negative labels, which we apply to ourselves. A few of these labels are “bitchy,” “hostile,” “unfeminine,” “castrating,” “selfish,” “bad mother,” “hysterical,” and “nagging.” Do these phrases resemble those that your black tapes play?

Our brain has around 10 billion cells that store and transmit messages. Think how many black tapes can be recalled instantly! The prospects are staggering. These tapes automatically replay when we are confronted with criticism, during a crisis, or when we must make decisions.

The healthcare industry is a breeding ground for black tapes. This negative self-criticism can lead to stress and even depression and the belittling of ourselves. Depression leads to more negative self-criticism can lead to stress and even depression and the belittling of ourselves. Depression leads to more negative self-criticism can lead to stress and even depression and the belittling of ourselves. Depression leads to more negative self-criticism can lead to stress and even depression and the belittling of ourselves.

Women personalize these criticisms even more than men. When following this process, keep in mind that the criticism is not an end point, but a starting point. You’re on a ladder to improvement, and the negative criticism is just the first step. Don’t think that you can just sit back and listen. You need to do your part by asking the right questions. Many people, including some supervisors and physicians, don’t know how to give feedback constructively and aren’t comfortable providing criticism.

An attending physician came to the floor and started yelling about something the night nurse had forgotten to do. He said all the nurses on the floor were in competent and we’d better get it together. I stammered and stuttered, “I’m sorry doctor, I will take care of it right away,” and ran off down the hall to do that very thing. I felt furious with the physician and myself.

This is a good example of how women personalize criticism, by immediately taking on the responsibility without even a
Teamwork Works

Dynamic Duos: Teamwork Works

Batman had Robin. Superman had Lois Lane. Together they fought the battle of anything...and won. Unlike most girls, boys have been reared to handle criticism. Why? One observation is because most boys have played team sports. Being part of a team and accepting responsibility for a position on that team enabled them to learn how to accept criticism. They ask, “What am I doing incorrectly? What must I do to meet the standard?”

Coaches foster this ability to handle criticism by pinpointing weak areas and demanding improvement. The coach’s attitude helps them see their mistakes for what they are, correct them, and move on.

"Batman had Robin. Superman had Lois Lane. Together they Fought the battle of anything and won."

Today many of the most successfully managed companies in America credit their results to teamwork. The same teamwork skills that contribute to organization excellence can create personal excellence. Teamwork is something that most of us understand intuitively. The American Heritage Dictionary defines teamwork as “a cooperative effort by the members of a group or team to achieve a common goal.” Examples of successful teamwork abound, including the best sports teams, accomplishments of charitable organizations, and many business endeavors. But how does teamwork relate to hospitals, nurses, and medicine? How does it impact the care of our patients? And how does teamwork affect the systems of care within a hospital, and our role in it?

Today there are new technologies, new tools, and new opportunities for the collaborative delivery of patient care. Success, however, will depend on the ability to effectively foster and coordinate a spirit of teamwork, collaboration, and coordination between nursing, respiratory care, pharmacy, rehabilitation services, case management, social service, and many other disciplines.

Developing effective systems to overcome the “old” patterns of care will be among the most difficult challenges. There are many other examples, but the underlying theme is that teamwork clearly strengthens our ability to provide higher quality, more efficient care.

Prerequisites For Handling Criticism

Positive Self-Image

The ability to handle criticism is often related to self-image. Self-image can best be described as the way we view ourselves. Self-image is a combination of self-esteem, self-confidence, and self-expression.

“Imagine yourself as a mansion or cathedral,” suggests Erika Karres, an educator and author of Mean Chicks, Cliques, and Dirty Tricks: A Real Girl’s Guide to Getting Through the Day with Smarts and Style. “Construction means building, so in constructive criticism, you’re gathering information to build your masterpiece.” Your product — you — is a work in progress, so you shouldn’t expect to be finished right away. Every piece of feedback you receive takes you one step closer to a final “product” you can be proud of.

Criticism will hurt if your self-esteem is low. When you have strengths that make you a worthwhile person, it’s easier to accept the fact that you can’t please everyone. If your self-esteem, self-confidence, or self-expression is suffering, responding to disapproval (criticism) can be extremely anxiety-provoking.

Learning to believe in yourself is difficult if you lack confidence. Individuals who lack confidence are often seen as “overly sensitive.” This label and the lack of confidence result in healthcare professionals’ wearing their emotions for all to see.

Environment plays a major role in how we value ourselves. If we are valued, the environment will be pleasant and attractive. If we are seen as lacking value, our environment will be barren and stark. What does the nurses’ locker room or unit break room at your hospital look like? I would venture to guess the latter description.

To build self-esteem and self-confidence nurses must not accept the irrational assumption that something is wrong with us. We must assert our individual and collective rights and open the lines of communication, make communication a two-way dialogue instead of a one-way street.

Communication

Many conversations are one-sided: the physician speaks, we listen; the supervisor speaks, we listen; the patient speaks, we listen. This is the One-Way street. Think instead, of this famous quote. “The journey of a thousand miles, begins with the first step.”

Communication as an interaction takes into account the process of mutual influence in communication. This process is cyclic, where information is transmitted to a receiver, but in which the reaction of the receiver continuously alters or changes the sender’s next signal.

Thus, to be effective, when two people interact, they need to put themselves into each other’s shoes and try and perceive the world as the other. This then helps to predict how the other will respond. In this circular process the participants take turns at being the communicator and the receiver.
Self-Affirmation

Nurses must begin to affirm their worth in conversations and in thought-processes themselves. This self-affirmation must say not only what we believe but must restate our position and our self worth. How many of us may agree with others out of the habit of accepting someone’s criticism even if it isn’t valid? By devaluing ourselves, we invite others to devalue us. If we criticize ourselves and say we’re “not OK,” the path for others becomes abundantly clear.

Before going on, take a couple of minutes to complete the following exercise. List all the things you like about yourself. Take a few minutes and really evaluate the positive, you’re worth it!

You may be surprised at your reaction. Most people don’t stop long enough in their busy lives to consider the good things they do but the negative thoughts seem to stick.

The black tapes we talked about earlier begin immediately to play in most people’s minds. If you listed four or more, your self-image is in good shape but could stand some improvement. If you completed less than four, your self-image is in need of a boost.

Professionals in the healthcare industry tend to be so “other-centered” that we often lose sight of who we are, what we need, and how to fulfill those needs. As nurses, our self-image can vacillate day to day, depending on the interaction or circumstance.

Body Language

Our body language also tells us a lot about who we are and how we feel. Our nonverbal messages are exhibited in varying ways:

Eye contact

Eye contact is a source of power. Looking at someone eye-to-eye states that you feel sure about your position and what you are saying. Fleeting glances or wandering looks convey nervousness and uncertainty.

Facial Expression

Your facial expression is the mirror of your feelings. Nurses often say one thing with their words and something entirely different with their expression.

Tone and Volume of Voice

Your tone and volume of voice tell people when you are happy, sad, mad, or hurt. When your tone and volume match your facial expression a clear message is sent.

Body Stance

Posture or body stance (positioning) is essential in communication. Standing straight, with your hands to your side, nonverbally tells the other person, “I know what I’m talking about, but I am open to suggestions or comments.” Individuals who stand slouched over with their arms folded and head down are telling the world, “I don’t value my opinion; you shouldn’t either.” These people are made more vulnerable by their nonverbal statement about themselves. Further, people who fold their arms across their chest and then tell you they will listen with an open mind are sending the nonverbal message that they are not responsive to new ideas or opinions.

To send clear messages, your nonverbal and your verbal must be congruent. That is, they must match. If one is out of step with the other, you are less likely to be taken seriously; and your opinions are less likely to be valued.

A positive self-image is invaluable to a healthcare professional. To be helping, caring persons we must put our self-image on the line. We do this every time we confront a physician, a lab technician, or another nurse about our patients. To keep our self-images intact we must put ourselves first. We must spend time with ourselves, reward ourselves for accomplishments, and rediscover who we are and what we are about. Our ability to handle criticism is in direct proportion to our self-image. For example, the better our self-image, the greater our ability to deal effectively with criticism.

Does the way we communicate have the power to HEAL?

Although prior research indicates that features of clinician-patient communication can predict health outcomes weeks and months after the consultation, the mechanisms accounting for these findings are poorly understood. While talk itself can be therapeutic (e.g., lessening the patient’s anxiety, providing comfort), more often clinician-patient communica-

Proximal outcomes, sometimes referred to as “suboutcomes,” are the specific changes in attitudes, beliefs and behaviors, dial, according to a treatment theory, patients are supposed to agree with. These affect intermediate outcomes (e.g., increased adherence, better self-care skills) which, in turn, affect health and well-being. Ways that communication can lead to better health include increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic relationships, increased social support, patient advocacy and empowerment, and better management of emotions.

Ability to Be Assertive

Now that we understand all of the prerequisites for a good self-image and how our images affect us, we have to evaluate how we react to the world, our environment, and those around us. When involved in conflict or confrontation, is your behavior usually passive, assertive, or aggressive?

We have three choices when dealing with criticism: 1) say nothing,

2) attack the person who is criticizing,

3) express our own feelings and opinions directly and honestly with respect to yourself and to others.

Three positions developed in childhood from the classic view:

(1) I’m OK-You’re OK, (2) I’m OK-You’re Not OK and (3) I’m Not OK-You’re OK. In essence, these three life positions reveal three behavioral types: Assertive, Aggressive, and Passive.
Differences Between Passive and Aggressive

The nurse who is generally passive typifies the life position, “You’re OK — but I’m not.” Her conversations sound much like this: “I want to make sure I don’t upset you or do something that might offend you.” “I cannot tell you what I think because I don’t have that right,” or “I can’t say anything, even if I am being hurt.”

The opposite of the passive nurse is one who comes from the position, “I’m OK, but you’re not.” This person conveys the following attitude: “I feel free to say or do what I want, even if it hurts you, since you’re not OK.”

Assertive Responses to Criticism

The assertive person begins with the statement “I’m OK — You’re OK.” This person states, “I express my feelings honestly and openly. However, I won’t allow you to take advantage of me. I want you to feel free to express your feeling. I will not attack you.” By saying these things we can encourage others to be honest and open with us. Assertion discourages games that others play. By being assertive we can express ourselves but not trample others.

Above are 10 statements. In the space provided, identify whether these statements are passive, assertive, or aggressive.

The passive statements reflect a person who does something or listens to something unwillingly but can’t bring themselves to express their true feelings. Many nurses are passive. They feel lifeless and submissive. By continuing to be passive they have no control and merely endure without resistance. They see themselves as unimportant and need to receive outside positive reinforcement when they do express their feelings.

The aggressive statements clearly verbally attack the other person by using “should” and the “You are not OK” message. Aggressive statements usually include “You never,” “You always,” “You should,” “You shouldn’t” or “You can’t.” All of these messages convey, “I’m OK, but you’re not.” Further, they put the other person under attack by name calling or moralizing.

The assertive statements stick to the “I” messages and state directly how the person is feeling, what she wants or doesn’t want. Feelings can be positive or negative. “I am angry with you,” “I disagree strongly with this medication order,” or “I resent your tone of voice” — all convey what you are feeling. Assertive statements do not allow other people to take advantage of you or put you in a “not OK” position.

Many of you may be thinking “I am angry with you” is an aggressive statement. It is crucial that we, as healthcare professionals, be able to distinguish anger from aggression. Anger is an acceptable emotion. We can express anger in a passive, assertive, or aggressive manner. The statement “I am angry with you” only states your emotion at the moment. It is honest and direct. If you said, “I am angry because you’re so immature and petty,” you would have changed your assertive statement to an aggressive one.

Our society typically has not allowed women to express their anger openly but has required them to hide it, to internalize it, and to deny it. By suppressing our anger or negative feelings we tend to avoid situations and people.

Changing our behavior by positive strategies is difficult. New patterns must be practiced in order to become natural.

Erica Jong, novelist, poet and voice of power of women, credits her success to a willingness to change: “Every life decision I have made from changing jobs, to changing men, to changing business advisors, to changing homes — has been taken with trepidation. I have ceased letting fear control me. I have accepted fear as part of my life — specifically the fear of the unknown. I have gone ahead despite the pounding in the heart that says: ‘Turn back, turn back, you’ll die if you venture too far.”

Nurses must follow this example by giving ourselves the right to succeed and the right to have our wants and needs recognized. Treading new ground is scary; being assertive when we want to be passive is scary. However, if we never try, how will we ever learn? How will we ever accomplish? How will we ever grow?

Personal Power

“There is absolute power in our words… They are so easy to utter, often tumbling out without much reason or forethought.”

- James Dobson, PhD.

The Power of Words

Those who hurl criticism or hostility at others may not even mean or believe what they have said. Their comments may reflect momentary jealousy, resentment, depression, fatigue or revenge. Regardless of the intent, harsh words sting like killer bees. Almost all of us have lived through moments when a parent, teacher, friend, colleague, a husband or a wife said something that cut to the quick. That hurt is now sealed forever in the memory bank. That is an amazing property of the spoken word.

By contrast, the individual who did the damage may have no memory of the incident a few days later.
What Is Power?

The word “Power” comes from the French verb pouvoir, “to be able.” Power is the ability to satisfy or fulfill one’s needs and desires. Power is an asset or resource and means energy in general. Women who feel powerless tend to view power negatively:

1. Power is selfish those who possess power are selfish individuals.
2. Power is destructive those who possess power don’t care whom they hurt or what they have to do for power.
3. Power is abandonment — those who possess power have abandoned their morals in lieu of power.

By applying our “to be able” definition of power we can extinguish these negative thoughts about power. We can then understand it is not power itself that is negative, but the way in which it is used.

Types of Power

Phyllis Chester, author of “Women and Madness,” believes the traits that women typically possess (compassion, sensitivity, and docility) are not those that are rewarded by our society. In fact, a woman who permits herself to be overly compassionate, sensitive, and docile is likely to be victimized. A woman who develops only feminine qualities learns to tolerate toxic situations through stoic acceptance and silent martyrdom rather than to take steps to change them.

According to Martin Seligman, author of “Learned Helplessness,” when a woman has no effect on her environment, she often develops a general feeling that her actions do not matter. A general feeling of powerlessness develops, and she doesn’t try to change the environment.

"We tend to forget the day-to-day experiences, but a particular painful comment may be remembered for decades."

Look at the nurses around us; the very nature of healthcare breeds professionals who are compassionate and have great sensitivities toward others. Sensitive, caring individuals are attracted to the healthcare industry. But, the very traits that motivate them to join the healthcare team act as their greatest liability. These traits should not be misplaced; however, they must not serve at the nurses’ expense.

To do the best job for our patients we must not only use the power that is available to us, but also, actively seek additional power. Florence L. Denmark, professor of Psychology at Hunter College and the Graduate School of City University of New York, points out that women actually may have special aptitudes for using power positively. Studies show that male managers most frequently use exploitative power, whereas women leaders are more likely to consider social and emotional factors. A man might simply demand, at the last minute, that a subordinate stay late to work on a project; a woman would be more likely to foresee the need for overtime, alert the subordinate in advance, and explain the importance of the deadline.

Nurses already possess several kinds of power:
1. Intra and interpersonal power
2. Natural ability power
3. Character power
4. Association-influence power
5. Acquired skill power

Interpersonal power

Nurses, through networking skill, and because of their warmth and sincerity, have developed interpersonal power — the ability to get along with others. This power is very strong and is often seen in staff meetings, on committees, and during periods of change.

Natural abilities

Our compassion and sensitivity is the cornerstone of our natural abilities. To be able to empathize is truly a powerful tool. We must be cautious, however, because these natural abilities can be misdirected, not used as power but as symptoms of powerlessness.

Character Skills

Character skills used in our power base are qualities such as loyalty and honesty. By asking the question, “Is this in my patient’s best interest?” we use these powerful character skills.

Association-influence power

Nurses who join together for common good possess the incredible power of association and influence. We have seen a change over the last several years as organizations have influenced policies, bargaining position, rights, and salaries.

Acquired Skills

Our nursing skills are the basis of our acquired skills power. By using our expertise in patient care and the nursing process, our acquired skills become a powerful asset. Those nurses who work in teaching situations can most identify with the power of acquired skills.

Uses of Personal Power

As you see, nurses can possess an immense amount of power. By understanding the kinds of power we possess, we can understand how not to allow others to minimize our authority or power.

As strange as it may seem, the use of names can minimize power and authority. If you refer to the attending physician as Dr. Forrest and he refers to you as Sharon, you have both put him in the position of power and authority. Preferably he should call you Ms. (or Mrs., your choice) Davidson. The title identifies you as a team member, not a subordinate.

"Life is a work in progress: you can't expect to produce a masterpiece all by yourself. Let constructive criticism help you create a better you."

A similar situation exists with sexist language. A class member of mine relates that one of the physicians on her unit chronically referred to nursing staff as “honey,” “sweetie,” “little nurse,” or “the girls.” Staff felt they were being treated as children, if not handmaiden. One way to confront this problem is, “Dr. Forrest, I prefer to be called Mrs. Davidson.” This allows you to take back your legitimate power as a team member on the unit.

Don’t get sidetracked! When dealing with nursing issues it is important to understand when you are giving up your own priorities in favor of others. Said another way, nurses in general tend to give up their personal agenda to others.

The last way women minimize their authority and lose their power is by not asserting or acknowledging their own credentials. As head nurse of CCU, Connie had authority and responsibility for the care of patients in the CCU. When asked her opinion she would often mumble something or simply agree. By not asserting her credentials (as the head nurse), she minimized her authority. Connie believed she shouldn’t “flaunt” her position. This
belief is a negative self-label. Not until she realizes this can she change her position to, “As the head nurse here, I believe patients will get better care if we…”

We have spent a lot of time talking about how we perceive and should evaluate ourselves. These are important concepts in learning to evaluate criticism. The next part of this text will relate the negatives and positives of criticism: how to respond when criticized, how to deal with critical people, and how to criticize others.

**Criticism**

**Different Kinds of Criticism**

**Motivations**

The word “criticize” comes from the Greek word Kritikos, “able to discern, to judge.” Criticism in its purest form is a helpful self-evaluation and originally was meant to denote a neutral, objective appraisal of ideas and actions. One who criticized was expected to assess the merits as well as the demerits of an object or situation and to make judgments accordingly. The goals of criticism were to communicate, to influence, or to motivate.

Definitions of criticism: “to communicate information to others in a way that enables them to use it to their advantage and benefit.”

Criticism is vital to build a reciprocal, symbiotic, and respectful community. Critics need to be honest, direct, and civil; receivers need to be flexible, adaptable, and outward centered. When these qualities are present, idea sharing is indeed pleasurable and effective.

**Negative or Destructive Critical Patterns**

Unfortunately, criticism is perceived mostly as negative; consequently, it is seen as destructive. It helps to remember that constructive criticism is actually a form of encouragement. Constructive criticism tells you that you have the potential to do much better, so it’s worth it to keep trying. Before we can turn the criticism of others around, we must identify the negative or destructive patterns. We all use these destructive patterns on occasion. Identify the ones you use most frequently:

**Using shame**

Embarrassment and humiliation. This type of criticism is counterproductive. Example: “You aren’t going to leave your med cart there are you?” This type of criticism almost always provokes rejection of the criticism.

**Accusation/blame**

This assumes that the person who is criticizing knows the intent of the other person: “Look at your notes. You don’t seem to care what you write!” The critic assumes the person wants to do poor work. Often times these critics lecture, use generalizations (never, always), and use presumptive questions. The person being criticized will usually become defensive.

**Insufficient feedback**

This type of criticism doesn’t deal with specifics but uses lots of generalizations, e.g. “This report is not good.” The critic is vague in his or her assessment. The receiver’s response is one of helplessness. “What do I do now?”

**Unstated beliefs**

This critic assumes that the person understands what is being stated. An example of this faulty pattern is sometimes evident when technical material is being explained. The listener doesn’t really understand the material; however, the critic continues, merely assuming he or she is understood.

**Unclear alternatives**

“This transcription procedure will never work.” The transcriber tries a different approach but is still criticized. The critic must be prepared to give alternatives, not just criticisms.

**Emotional responses**

The receiver is often unable to separate the criticism from the critic’s personal feelings of irritation. This situation can cause the receiver to feel anger, fear, or frustration.

**Dwelling on the negative**

Everything that this type of critic says is negative: “The broccoli is overdone,” or “The lettuce is limp, and the meat is too salty.” This type of criticism usually stops the behavior completely!

**Rigid attitudes**

This critic believes he or she is correct; furthermore, he or she knows how you should behave. This person uses a lot of “shoulds” and “shouldn’ts.” This critic’s implied rules invariably make others defensive.

**Environment**

Some critics choose the wrong time and place. Criticizing people in front of others is always negative.

**Threats**

The critic who relies on threats produces results but for the wrong reasons! This critic causes deep resentment and hidden hostility.

“I told you so”

The results of this expression are self-explanatory; no one likes to hear these words. Most individuals are aware of mistakes. However, if they are not, this expression is a counterproductive way to point them out.

**The accusing question**

“What makes you think this is a good idea?” The receiver must not be baited by this hook but should turn it around, “What do you think about this?”

Are you able to spot yourself in one or more of these 12 destructive factors in criticism? Since we have developed destructive factors, we have also developed destructive responses, whether the criticism be positive or negative. The following are examples of Destructive Response Methods:

**Stonewalling**

The responder reiterates one of his or her own points or ideas, “You missed my point; what I was saying was…” We block the criticism by defending our own ideas instead of listening to the criticism.

**Excuses**

“Yes, but…” How many times can you identify yourself saying this? This response defends our ego; we don’t have to accept who we are or what we’ve done. We allow ourselves to say, “They just don’t understand.”

**Getting Even**

The response is retaliatory, a form of “one-ups-man-ship,” “I’m OK, you’re not OK.” This response sets up a destructive interaction between the participants.
Avoidance/Withdrawal
This response accomplishes nothing and leaves the receiver of the criticism running from any truth that might be found in the criticism.

Pretending acceptance
“Yes, you’re right. Sorry about that.” This allows the receiver to take herself off the hook. The receiver really doesn’t want to deal with the criticism in a realistic or productive way. She believes she has accepted the criticism and it is time to move on.

Interfering emotions
By letting her emotions interfere, the receiver loses the chance to benefit from the criticism. By “blowing up” the receiver doesn’t have to deal with the criticism. By “blowing up” the receiver loses the chance to benefit from the criticism running from any truth that might be found in the criticism.

Positive Critical Patterns
All of these destructive styles of reacting to criticism have a reward system:
1. The criticized person doesn’t have to confront or deal with the criticism in a realistic manner.
2. Self-image is protected.
3. Behavior is unchanged.
4. Negative response is reinforced.

Both destructive factors and negative responses to criticism are nonproductive. Optimally, we need to evaluate the way we perceive criticism, the way we respond to criticism, and the way we criticize others. Are your patterns negative and destructive, or are they positive and productive?

Positive Critical Patterns
Most of us would rather hear we’re doing just fine. But the truth is, whether in class, playing sports, or working, everyone is bound to get some constructive criticism eventually. The trick is to know how to use that feedback to become better at what you’re doing.

Responding to criticism in a productive manner takes two things: 1) a willingness to want to clarify the criticism, and 2) practice, practice, and practice.

To help you understand ineffective responses to criticism we have gone over all the negative attitudes and responses. Now let’s look at how we should respond positively to critical people.

One research study noted five ways to respond assertively to criticism:
1. Accept
2. Disagree
3. Set limits
4. “Fog” it away
5. Delay the response

Let us look at each response and the way in which it can be most effectively used.

Accept the Criticism
Accepting the criticism means just that. We don’t apologize or try to defend our behavior. Before accepting any criticism we must ask ourselves one question: “Is the criticism valid?” If so, we must accept it. By accepting it we’re saying, “Yes, you’re correct; but I’m still OK. I’m not a bad person. I made a mistake.” By using an assertive response it reiterates that a mistake was made however, it does not mean you are “Not OK.”

Disagree with the Criticism
Unfortunately, many people equate disagreeing with attacking another person. That’s just not true. Disagreeing is stating that you view things differently. As we discussed earlier, many critics use broad generalizations that can be person-oriented rather than event-oriented. With these kinds of criticisms we must disagree with a “focused disagreement.”

Broad generalization:
“Don’t you ever get the nursing schedule done on time?”

Focused disagreement:
“This month I am late with the schedule. This month really is the exception.”

Differentiation must also be made between person-oriented and behavior-oriented criticism.

Broad person-oriented:
“You are a sloppy person.”

Disagree:
“Well, I certainly am sloppy today, but I’m not a sloppy person.” By narrowing and focusing the criticism we can disagree and still accept the responsibility for our share of the criticism.

Another good technique is to use self-affirmation. Self-affirmation is saying what we did that was good and how it contributed to the success of the project or goal:

Crisisim: “This nursing schedule isn’t well done.”
Response and Affirmation: “I don’t agree. In fact, I spoke to most of the nurses and took their needs into consideration. I believe it’s a very good schedule.”

By using this technique you not only disagree with the criticism, you honestly and openly state your position.

Set Limits
Setting limits is teaching others how we expect to be treated, our “bottom line.” Limit setting defines the parameters of our person. By limit setting we determine who we are and what we expect.

Crisimic: “You’re stupid.”
Response: “I resent being called stupid. I lack experience, not intellect.”

This is a very dramatic example of limit setting, but there are many situations we encounter every day in which limit setting is manipulative criticism.

Crisimic: “You should clean up your desk.”
Response: “You may be right. Sometimes it is a mess.”

Crisimic: “You’re selfish.”
Response: “You may be right. Sometimes I am selfish.”

“Fogging”
You can use the words “may,” “might” or “sometimes” when you wish to “fog.” This response neither accepts nor disagrees with the manipulative criticism; it merely acknowledges the sender’s message and then leaves freedom for moving on.

Fogging can be used most successfully when the criticism doesn’t evoke a strong response. I could fog away being called “sloppy” but would have to disagree with “insensitive.” Therefore, if your emotional response to the criticism is nil, use fogging.

Manipulative criticism is probably the type most often seen. The critics believe they know all the rules by which you should abide. These critics use “should,” “should not,” and “ought to.” They are constantly trying to get you to live by their rules and standards, which often don’t match your rules and your standards. You may choose to use fogging with these critics.

Delay
Delaying is the fifth tactic used in coping positively with criticism. Delaying can be used when you’re really taken by surprise, the recipient of criticism totally unexpected. Simply respond to the
criticism by saying, “I don’t know how to respond to that. Let me consider it and get back to you.” This allows you to step back, dust yourself off, and get your emotions under control. Then you can decide if the criticism is valid or invalid and decide what you want to do about it.

Under no circumstances should you fail to “get back” to the critic. If you do, you lose your credibility, and the next time the critic won’t allow you to step back. In other words, you must follow through, even if the criticism is true and it hurts!

Constructive criticism is an important tool for self-improvement. But does every bit of feedback deserve the same attention? Consider the source. If your critic is someone you value, respect, and trust, then you should give attention to what he or she says. If not, you may need to disregard it. Consider whether your critic has appropriate expertise. “If you’re the football quarterback, you probably won’t go to your English teacher to get input on your last play.”

After learning the positive ways to cope with criticism we must put it together with our body language, and the way we present ourselves. Our assertive responses are something we must put together with our body language, and the way we present ourselves. Our assertive responses will mean nothing if we look at the floor and stammer. So, when responding to the criticism:

1. Stand up straight.
2. Take a deep breath and blow it out slowly.
3. Maintain direct eye contact.
4. Keep your facial expression neutral.
5. Know what you want. Don’t give up your agenda.
6. Use a low-pitched clear, deliberate voice.
7. State your feelings and beliefs.

**Nursing Practice & Criticism**

**Anxiety and Our Patients**

Nurses receive criticism from their patients. However, just as often we hear from the nurses about the “uncooperative, hostile patient in Room 4.” We must understand, however, that the disease process and hospitalization have a decidedly negative effect, physiologically and psychologically, on our patients. Both patient and healthcare provider are stressed. Let’s examine stress and see how it relates to the nursing process and the patient who criticizes.

**Stress, The Disease Process and Hospitalization**

Stress is a term coined in its medical usage by Austrian-born Hans Selye, a professor at the University of Montreal. By 1950, Dr. Selye had pulled together the threads of literally tens of thousands medical research projects. These studies described bodily reactions to just about every conceivable situation: severe injury, disease, poison, excessive stimulation, or unusual work demand. His work became known as the GAS, General Adaptation Syndrome, the birth of “stress theory”.

Selye’s generalization is that anything can be a stress to the body and that we can use diversion to our advantage in reducing stress. He points out that some of our stress reactions are so subdued that we are not aware of them; others show themselves clearly in sweating palms, loss of appetite, heavy breathing, or a racing heart. It is impossible to go through life without stress. Stress is what prepares us to handle things with which we are unfamiliar or things that appear to threaten us. Stress comes from many circumstances: the home, the job, and the environment. Handled well, stress is a friend that strengthens us for the next encounter; handled poorly, or allowed to get out of hand, stress becomes an enemy that can cause disease.

Change and stress can be closely linked for many of us. We must cope with a rapid pace of life and a large number of major life changes. Such change brings adjustment. A noted author on stress states that when we use energy to adapt to new life circumstances, our resistance is diminished, leaving us more vulnerable to illness, emotional upset, short temper, anxiety, and loss of appetite. The greater number of life changes, the greater the chances of later illness.

Two important facts about major life changes must be recognized:

1. **People vary in their ability to handle change.** Because of different stress filters, some people can adjust to major change with little apparent distress, while others experience wear and tear and a break down.
2. **Major life changes do not need not** inevitably produce stress. The adverse effects of change can be minimized. One way is making sure that too many big changes do not occur together.

Experts in health and change have completed research that indicates a significant correlation between mounting life change and the occurrence or onset of sudden cardiac death, myocardial infarctions, accidents, athletic injuries, tuberculosis, leukemia, multiple sclerosis, diabetes, and the entire gamut of minor medical complaints. Stimulation, challenge, and change are important for personal growth. Too much change in too short a time can create mental and physical overload.

“**When we use energy to adapt to new life circumstances, our resistance is diminished, leaving us more vulnerable**”

There is a normal stress response when one becomes tense, such as before an exam, when getting angry, before speaking in front of a class, or during a code: your body prepares itself instantly to stand your ground and fight or to turn away. The emergency response is called the “fight or flight” response. It works to your advantage when used correctly; however, with the pressure and stress of life, we activate this response sometimes when it is not in our best interest. It gets out of control, causing many body symptoms or making others worse than they are.

The hormones produced during acute stress are meant to alarm you and to keep you up for peak accomplishments. They tend to combat sleep and to promote alertness during short periods of exertion. They are not to be utilized all day long. If too many of these hormones are circulating in your blood, they will keep you awake. This phenomenon can often account for our patients’ insomnia, their heightened stress level, and eventually their criticizing behaviors. These reactions, coupled with the nurse’s frustrations, can easily lead to a “no win” situation for both patients and healthcare providers.

Let’s look away from our patient’s stress and examine our own. There are five broad categories which are sources of frustration for healthcare professionals and which lead to stress:

1. The patients and their care
2. Personnel
Every nurse deals with patients and their care on a daily basis. While recognizing the need for support and/or teaching, the nurse may feel inadequate, uncomfortable, or too pressured by other demands to meet the patient’s needs adequately. Repetitive routines and aggravations, receiving physicians’ orders, passing medication, giving direct care, taking vital signs, fighting with physicians, plus charting and answering the telephone all produce stress and subsequently reduce the nurse’s capabilities to give support and/or respond to criticism by the patient.

Unit nursing personnel themselves produce stress. New personnel who require time to learn the unit’s procedures and who feel insecure, brings about a certain amount of strain on nursing personnel. Every once in awhile an “attention-seeking” personality appears, one who “knows all the answers, has done everything related to nursing and does things better than anyone else.” Needless to say, this personality type can and does cause a great deal of friction and stress among coworkers.

Family members turn to nursing personnel to help them meet their needs for reassurance, information, and guidance. A particular family member’s coping mechanisms may be so disturbing to the nurse that she turns away feeling angry, depressed, and stressed. Many times, despite her interest in a family situation, the nurse feels a lack of time. She may feel unable to meet the family’s needs, or deal with the coping mechanisms of some family members.

Healthcare professionals return each day to environments that produce stress. They work not only with complex technical equipment that requires a great deal of time and energy but also with equipment that is old, functions poorly, or doesn’t function at all. Medications must be passed, treatments given, and charting accomplished within a certain time frame, ever present and stressful.

Last, but definitely not least, is the problem of staffing and of handling emergencies in other areas. There isn’t a nurse today who at one time or another hasn’t faced the problem of inadequate help in relation to the workload. Also, Code Blues are a source of stress to all nurses, particularly those in critical care areas. The stress level of any nurse faced with one or both of these situations is bound to increase. In essence all healthcare settings are stressful.

It is inconceivable to think, then, that nurses can always deal constructively with criticism from their patients. However, nurses can reduce stress levels induced by these five categories of frustration by recognizing what it is about these frustrations that produce stress and by working to rectify the causes. Additionally, we can get involved, clarify lines of medical and nursing authority, provide specific workshops to educate personnel, develop and maintain lines of communication, foster staff involvement, orient family members to the unit, and utilize available resources to assist in meeting patient needs.

When illness strikes, numerous personal factors influence the amount of stress seen in a patient. The patients may be thinking, “I’m not the same. I’m getting old and falling apart,” or, “I won’t be able to satisfy my spouse sexually, and I will be less than a whole person.” The nurse must assess the patient’s coping mechanisms, evaluate each behavior, and provide the right intervention based on the nursing diagnosis.

Patients experience two important stages when trying to cope with stress and face a loss: (1) shock and disbelief and (2) development of awareness. In the shock and disbelief stage, the patient demonstrates the behaviors characteristic of denial. This is exhibited by refusal to admit that there is anything wrong. For example, a myocardial infarction patient persists in trying to get out of bed, despite careful instructions to the contrary; takes off the oxygen; and constantly talks about going home the next day so he can return to work. The nurse’s intervention should be one of support. She communicates acceptance of the patient through the tone of her voice, through her facial expressions, and through her touch.

The second stage, the development of awareness, is the stage of grief; the ugliness of reality has made its impact. The patient looks for something or someone to blame—the last drinking binge; the spouse; the job; and, yes, the physician; or you, the healthcare professional. The intervention in this stage is one of a supporting and accepting nature; support of the patient’s self-worth and encouragement of an expression of anger. We should talk to our patients, not about them and introduce them to strangers, either roommates or physicians. Call patients by name, not by disease ("Oh, you know, the MI patient in bed four"). It is a must that the nurse maintains a non-defensive attitude. It is to our discredit as a professional health provider to approach the patient defensively, warning co-workers about the patient who doesn’t appreciate the time and effort given to them by the staff. It is at this stage of loss or stress that patients tend to be the most critical.

By understanding this, we can choose to approach the patient with patience and compassion. Beyond the interpersonal stress responses that are often involved with our patients, the disease process often

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<th>ANXIETY MANIFESTATIONS</th>
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<td>Behavioral</td>
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<td>Restlessness</td>
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<td>Irritability</td>
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<td>Rapid Speech</td>
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<td>Wringing Of Hands</td>
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<td>Repetitious Questioning</td>
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<td>Inability To Retain Information Given</td>
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<td>Somatic Complaints</td>
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<td>Putting Call Light On Frequently</td>
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<td>Disbelief Of Answers Given</td>
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<td>Anorexia</td>
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<td>Insomnia</td>
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<td>Physiological</td>
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<td>Increased Blood Pressure</td>
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<td>Rapid Breath And Pulse</td>
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<td>Muscular Tension</td>
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<td>Pounding Heart</td>
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<td>Dilated Pupils</td>
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<td>Gastric Discomforts / Anorexia</td>
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<td>Dry Mouth</td>
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<td>Dizziness</td>
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<td>Trembling</td>
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<td>Cold, Clammy Hands</td>
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<td>Perspiration</td>
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<td>Fatigue</td>
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<td>Frequency in urination and defecation</td>
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causes a body image disturbance. Body image is directly related to self-image; and, as we know, self-image is directly related to self-esteem and self-worth. Body-image disturbance is the inability of an individual to perceive and/or adapt to his or her body, or part of it, in a changed form. Body image results from both external and internal stimuli, including input from those around us and “messages” from previous experience.

Nursing responsibilities include an awareness of some of the causes of body-image disturbance:
1. a real or anticipated loss of a body part
2. neurological changes (e.g., paralysis)
3. metabolic disorder (e.g., kidney failure)
4. progressively deforming disorders (cerebral palsy)
5. acute dismemberment (mastectomy)

Nursing assessment involves an awareness of possible behavioral manifestations indicative of a body-image disturbance:
1. refusal to continue to function or to believe a change has happened
2. inability to care for self
3. withdrawal, hostility
4. any negative behavior or response to loss

We should provide openings for the patient to express feelings by validating our own observations and feelings: “You seem upset/sad, etc.” Be a good listener if the patient is angry or hostile, remember not to take these responses personally. Focus on patients’ feelings and deal with the presenting behavior. Accept body change in your patient and give positive reinforcement for patients trying to adapt. Don’t support the patients’ expressions of denial.

**Vulnerabilities of Patients**

**Anxiety**

Often times we will see patients in crisis. Since anxiety is a symptom of crisis, it is important to understand exactly what anxiety is, how it is manifested (in both ourselves and our patients), and how it relates to criticism. Most of all, we must learn how to cope with anxiety.

Anxiety is a universal phenomenon that every individual experiences at some time during our lifetime. It is a normal occurrence, and each individual has a unique way of relieving anxiety. The hospital setting can promote anxiety in patients as well as in hospital staff.

Anxiety may be defined as a reaction that warns the individual of impending danger or threat. It is frequently described as a vague, unpleasant feeling of helplessness, nervousness, an uneasy sense of dread or apprehension. It is a subjective, normal reaction to danger, becoming pathological only when experienced in the extreme stage or when the source is imaginary.

Anxiety is not synonymous with fear. The two feelings are, however, closely associated and often occur at the same time. Anxiety and fear also have common manifestations. In anxiety the danger is unknown, in fear the danger is known. Fear is a response to an objective threat, e.g. being struck by an oncoming car.

Anxiety is the result of a threat to an individual’s self-image. This can be either a physiological or biological threat, such as a cardiac problem or a psychological threat, such as a change in self-image.

In 1967 Dr. Hildegard Peplau, nursing theorist, operationally defined the events that occur in the development of anxiety. She stated that each individual has expectations (wishes, desires) that are held as important. When these expectations are not met, the individual experiences increased feelings of discomfort and apprehension. The person then employs relief behavior to decrease the discomfort and finally justifies the behavior.

The levels of anxiety are on a continuum, ranging from mild to moderate, from severe to panic. A person’s awareness and ability to function are contingent on the level of anxiety.

Although it is difficult to define exactly the nature of anxiety it is usually not difficult to recognize the manifestations of anxiety. Anxiety in its lower to moderate intensity has an alerting and energizing effect, preparing the individual for a “fight or flight” response. (This also occurs in fear.) This response results in physiological manifestations shown in the previous chart. The individual responds to these physiological manifestations by a change in behavior. The response is subjective, so individual behaviors will be unique including: anger, hostility, joking about the situation, resentment, withdrawal or depression, somatizing, denial, or regression.

Constructive behavior, on the other hand, requires using the anxiety to learn. However, this involves enduring the anxiety while looking at the causes. Frequently, the individual will need help to do this. Normal anxiety is handled constructively when the individual recognizes it and confronts it.

As we discussed earlier, anxiety is also present in the healthcare professional. In a very mild form anxiety can be a useful tool to make the individual more alert and attentive. However, increased anxiety can become detrimental and limit one’s actions. We need to be aware of our behavior and perceive when anxiety is hindering the relationship with others. When our anxiety is high, our ability to cope productively with criticism is low.

Healthcare professionals are often confronted with potential anxiety producing situations as we deal with difficult patients, new procedures, and authority figures. What can we do when our anxiety is beyond controlled limits? First, we must learn to face the situation by asking ourselves questions similar to the following:

1. What has the patient said or done that could be upsetting to me?
2. Does this situation remind me of some traumatic past experience?
3. Has something occurred in my personal life that is affecting my attitude?
4. Do I feel adequately prepared to perform my responsibilities?

Once we are aware of anxiety and have determined its cause, we are ready to decide on the behavior necessary to cope with the situation. Discussing incidents with a colleague may lead to more constructive methods of controlling anxiety. If we are not ready to recognize and confront our anxiety, we may seek to relieve it by physically withdrawing from the situation, “becoming busy” with paper work or other clerical duties, or by removing the disturbing factors from the environment. These methods are only avoidance measures and are not constructive.

Patients may develop anxiety from hospital routines, procedures, and environment, which appear strange. This anxiety may be further heightened by an unknown or unacceptable diagnosis. Our responsibility is to recognize anxiety in patients.
Nursing intervention for the anxious patient does not require a skilled psychiatric nurse. It calls for a good listener, someone with ability to communicate, a show of patience, a desire for an honest exchange, someone who is non-judgmental and has a regard for the patient as an individual.

Five steps to help the anxious patient are:

1. Recognize that the patient is anxious by observing psychological manifestations.
2. Encourage the patient to recognize the anxiety and express feelings, listen to the patient’s words and observe nonverbal behavior.
3. Allow the patient to set the pace in working through the anxiety.
4. Attempt to determine the cause of the anxiety and, if external, take steps to change the situation.
5. Assist the patient in finding constructive ways to cope with the threat.

If you are unable to discover a cause for the anxiety, try one of the many anxiety-reducing techniques available, such as:
- allow the patient to talk about his or her feelings
- teach deep relaxation breathing
- take a walk
- allow the patient to cry

Frequently activity can be redirected into a constructive endeavor. This will also allow the patient to participate more in the actual care.

Other avenues to get help are: re-evaluate the situation and obtain more information; discuss the problem in a team conference; or notify the patient’s physician in order to obtain specific help or counseling.

Anxiety exists in a hospital environment. We can be instrumental in being aware of its existence, recognizing the manifestations and instituting intervening measures. By taking a positive active approach to anxiety, you decrease the chances of criticism and increase the chances for positive interactions with the patients. The following information may help you understand the stages and the solutions to help resolve anxiety.

### Feelings of Hospitalized Patients that Produce Anxiety:

#### Feelings of Powerlessness

The patient feels that they can’t influence or understand what is happening.

No control over the situation:

A. Exposure to hospital staff as a governing body
B. Threat of force. “If you don’t eat, we’ll start an IV”
C. Threat of punishment for not abiding by the rules, e.g. staff not answering call lights.
D. Fear of unknown
E. Imposed restrictions and limitations

#### Feelings of isolation the patient feels alone, set apart:

A. Physical separation from family and friends
B. Emotional separation from others because of the staff’s use of medical terms, e.g. “the MI in bed 4”

#### Feelings of loss

The patient is deprived of something/someone who was previously there:

A. Real or anticipated loss
B. Loss of self-image
C. Loss of control

#### Feelings of culture shock

Person is placed in unfamiliar environment and doesn’t know how to deal adequately with the situation:

A. Moving a person into an unknown environment
B. Exposing the patient to a new language (hospital jargon)
C. Exposing the patient to new authority structure
D. Enforcing dependency and submissiveness

#### Anger

Anger and aggression often go hand in hand. How often can you determine if the patient is angry for a good cause or if the emotion is really an anxiety reaction?

Each angry or aggressive outburst should be reviewed with the goal of improving patient care. Identify situations that contributed to the outburst, evaluate and revise interventions.

Anger may take many forms:

- abusive verbal language
- constant negative statements about hospital staff
- refusal to eat/drink/participate in care
- throwing things
- pulling out IV’s

First, tell your patient you will prevent any further expression of anger that is physically harmful. Be aware that a patient’s anger is not usually meant for you personally — so don’t respond defensively!

After the patient’s anger has dissipated, get down to the basics. Underlying anxiety usually causes anger.

**Try to:**

1. Involve the patient in his care
2. Spend time daily conversing, use open-ended questions

When we express anger, we feel we gain power over the object causing our distress, either by destroying it or driving it away. When this occurs, relief is felt. If we still perceive the situation as threatening, we will not feel relief and may have to engage in similar behavior to attempt to relieve the remaining anxiety.

When intervening in an aggressive situation, it is important to recognize the steps leading up to the final angry outburst. Anxiety should be dealt with at a low level, when it was just beginning. The nurse can use any of the techniques we have talked about in order to avoid heightened anxiety or anger for the patient and herself.

#### Manipulation

Manipulation is the process of influencing another in such a way that meets one’s own needs without regard to the needs, wishes, and functions of others.

Manipulation is a method used by all persons who attempt to have the world as they want it. Lifelong patterns of manipulation are difficult to change and are changed only if something else replaces the behavior. The patient will present behavioral manifestations of manipulation:

1. Pretending to be helpless
2. Pitting staff, nurses, and doctors against each other
3. Insincere complementing of staff to their faces, followed by negative comments to others
4. Making undefined, ongoing demands
5. Making excessive, unnecessary demands on staff time
6. Presenting self as lonely and distraught in order to evoke staff’s concern

The patient using manipulation is extremely hard to deal with because you never know if something has triggered this behavior or if the behavior is chronic.

If you try techniques to reduce the anxiety and the behavior continues, you must assume the behavior to be manipulative and try the following:
- Confront the patient with his attempts at manipulation; then ignore when possible
- Give praise, positive feedback, and rewards for non-manipulative behavior
- Allow verbal expression of angry feelings
- Set limits for destructive behavior
- Tell patient to deal directly with you; other wise you will continue to confront the behavior
- Accurately record the instruction and information you give the patient in the nursing notes and nursing care plans.

This approach will discourage the patient from changing, ignoring, or distorting communications.

The fact that the patient uses manipulating behaviors undoubtedly will lead them to use criticism with the manipulations. Beware, don’t get thrown off course. Use your “I” messages. If you disagree, say so; be honest and direct.

Criticism From Physicians, Colleagues & Supervisors

Criticism from Physicians

An article by Gloria Donnelly, RN, MSN, stresses that nurses have further been taught that being self-effacing is the best way to avoid conflicts with doctors. The “ideal” nurse is cool, efficient, and conciliatory; and experience has taught her to be passive and indirect with the doctors.

Ms. Donnelly believes this “ideal nurse” leads to trouble-free relationships. Here is why: the nurse and the physician agree on her role.

If your role as you view it is different from the way the physician views it, you have communication problems. Said another way, we understand who people are only in terms of what we think they ought to be.

If both the nurse and physician see the nurse’s role as that of a “handmaiden or help mate”, less important and powerful than the physician, the doctor will just give the orders and the nurse follow them.

When a doctor loses his temper we as nurses often try to “understand” or ask ourselves how we could ease his load. By these acts nurses place themselves in a subservient position. Or, as we learned earlier in the text, we put ourselves in the “You’re OK, I’m not OK” position.

Our main problem in the “handmaiden syndrome” is the lack of the viewpoint that the nurse and the physician are professional colleagues. Remember, without this critical viewpoint we can’t offer complete care to our patients.

Accepting Criticism

Encourage peers to accept negative criticism with an open mind. Create situations where there is:
- Separation of feelings from actual information
- Acceptance of all feedback, whether true, unclear or even false
- Responding to criticism in a positive way
- Use of feedback to develop confidence

As professional colleagues we must focus on issues, not personalities. We must ask each other for clarification when needed. Openness and negotiation are natural parts of this relationship; therefore, compromise is probable.

We have all been faced with physicians who are highly condescending. We feel humiliated and put down by their attitude. We must learn to deal with their criticizing attitude and condescending manner.

We have to go back and get our self-image, self-esteem, and self-worth on board and then approach the situation of the criticizing physician. Remember, we’re there to protect and help our patients, even if at times we must challenge the physician. If we don’t, we are failing our patients and ourselves.

Imagine an intern trying to insert a CVP line for the third time. The patient is crying and obviously distressed. Ask yourself the question, do I feel safe enough in my professional position to step in and challenge the physician by telling him to stop trying to put in the line, give the patient some sedation, and get someone more experienced to finish?

If we bypass this situation, our own standards of care are in question. An article on criticism suggests, “The worst attributes of a caring person are both the lack of self-appraisal and the lack of criticism of self and others in the administration of care. These create inferior status.” While dealing with a colleague relationship the nurse should feel free to criticize the physician in a productive way, criticizing the behavior not the person. Deal with issues, not personalities.

With confidence, not hostility explain, I am this patient’s primary nurse. He depends on me for his care. He and I have established a therapeutic relationship. He is comfortable, receiving good care and wishes to remain here.

You have told the physician you are the primary nurse; that you know what you are talking about; and, further, you know what is best for your patient. You have addressed the issues, not the personality. Had you lost your temper, you would have opened up the situation for another angry retort from the physician and given up your agenda of doing what was best for the patient.

You may not change this doctor’s personality, but by this small interaction you did two things:
1. Helped your patient
2. Got rid of the “handmaiden” image

Professional relationships must be worked out on a one-to-one basis. The following guidelines have been suggested:

Establish Your Position

The way you represent nursing to the physician is the way it will be perceived. If you jump when he gives an order or makes a request, he will continue to see nurses as subordinate.

When you are giving patient care and the physician walks in and asks you to get the chart, establish your position by saying, “I can’t stop what I’m doing right now, but the chart is in the rack at the desk. Help yourself.”

This gives the doctor several messages:
1. Patient care comes first.
2. You are independent of his control and able to refuse requests.
3. You give him permission to go into your territory and get the chart.
Anxiety is an energy that is related to cultural or social needs. Since it is energy it must be studied indirectly through its effects on behaviors. By observation we can note both the presence and intensity of the anxiety. Below are the degrees of anxieties:

<table>
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<tr>
<th>Anxiety Type</th>
<th>Description</th>
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<tr>
<td><strong>Mild Anxiety:</strong></td>
<td>The person is alert and the use of senses is increased. Motor behavior is stimulated and the person is more interested in what is going on.</td>
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<tr>
<td><strong>Moderate Anxiety:</strong></td>
<td>The perceptual field is reduced; Other effects may be present, such as muscular tension. The person sees and hears less; Motor behavior more active. At both mild and moderate levels, the person is still in control, and capable of learning.</td>
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<tr>
<td><strong>Severe Anxiety:</strong></td>
<td>The perceptual field is reduced to a very small proportion; whole events are not noticed; Sometimes the focus may be scattered; Heightened but ineffective awareness, r/t focus on small portion of surroundings. Connections between details may be distorted; Motor behavior less organized, i.e. restless behavior that lacks purpose.</td>
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<td><strong>Panic:</strong></td>
<td>Person perceives only the smallest detail and loses control; then senses the terror &amp; may magnify a detail (such as an insignificant object in the room) beyond proportion in order to sense some control. Connections of meaning between details distorted; Intensely uncomfortable experience (some say it's as if they were disintegrating).</td>
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issue.

With hidden agendas as motivators, a peer can criticize anything from your shoes to your professional performance. Here is an experience where a jealous peer criticized professional performance: “One of my patients in CCU, who was doing well, suddenly went sour. I instituted emergency procedures, called the physician, and in a few minutes the patient was responding. Shortly after the emergency was over, another staff nurse began to tear apart the situation, telling me what she would have done had she been there. I was furious.”

Putting that aside, this nurse has several positive alternatives. She must ask:
1. Was the criticism valid?
2. If so, what parts am I willing to accept/reject?
3. How can I focus this criticism?
4. How am I to use the valid parts?

This confrontation could have quickly got out of hand, resulting in hostility. The critical factors in the successful handling of the situation are:
• appearing confident
• being positive
• keeping interactions brief, task centered, and non-threatening

Another level of colleague relationships includes managers, e.g. head nurses and nursing supervisors.

A nursing supervisor shares this peer problem: “In our management meeting, another manager put me down in order to advance her point. This was done in front of three other managers. She had a good idea, but I objected to the way she presented it. I talked with her later and told her I was hurt and disappointed. I told her this and then implemented her idea.”

The nursing supervisor was right in her decision to address this problem by talking to the managers after the meeting. She may also have been correct in saying she was hurt and disappointed. However, by letting the conversation end there, she deprived her colleague of knowing what she expected of her. She could have also used this opportunity to set limits on the behavior. The interaction could have gone like this:

“When you criticized me in the staff meeting this morning I felt hurt and disappointed. I agreed with your idea but felt put down in the process. Next time, rather than putting me down, I want you to talk to me about suggestions or problems so we can suggest them as a team.”

In this conversation the nurse accepted her hurt and disappointment yet didn’t let it overwhelm her. But, more importantly, she let the other manager know how she felt, and she set limits.

Peer criticism comes in many forms. Many criticisms are not always situational. They are ones called “base,” or criticisms about our very person. Such criticisms like “You’re sloppy,” “You’re selfish,” and “You’re inconsiderate” all attack us where we live — at our self-image. We must decide whether these criticisms are true or false.

Ask yourself the following questions:
1. Do I hear the same criticism from more than one person? If your office mate is the only one who calls you sloppy, you might conclude that you have different standards. But, if your supervisor complains about the nursing station and co-workers can’t find the charts, you should take another look at your behavior.
2. Does the critic know a great deal about the subject matter? If your critic is the head of supply, she may not know enough about nursing to judge appropriately your behavior.
3. Are the critic’s standards reasonable? If a peer makes remarks about your wound dressing procedure, ask yourself if your technique could be improved. Asking yourself this kind of a question requires total honesty. You might consider asking others their opinion.
4. Is this criticism really about you? A patient who is worried about a prognosis or who is in pain often blurts out statements that would normally be suppressed. Look at the roots of the criticism; it may not be directed at you at all. This goes back to the discussion of the angry, anxious, and aggressive patients.
5. How important is it to respond to the criticism?

First, ask yourself what is the worst possible thing that will happen if you don’t respond? In some circumstances, it is best to ignore or at least not respond to the criticism. However, I wouldn’t suggest this if the critic is your boss or someone who has direct influence over your job.

If you answer affirmatively to one or more of these questions, the criticism may be valid. At this point, you should step back and take a look at your behavior. Are you wrong? Should you change your behavior?

Constructive criticism, in its best sense, is a way to solicit and provide others with measures of success; with ways to improve on past or future performances; and with affirmation, support, and encouragement. Quality constructive criticism unconditionally recognizes importance in another’s work. It also builds a positive good will bond when improvement, assistance and support are offered; and it adds to the receivers’ credibility by demonstrating willingness to adapt, to be flexible, and to be concerned with overall expectations and needs.

One researcher suggests “Over all you’ll find it easier to make changes if you switch your thoughts from the pain of being wrong to the benefit of improving.” Instead of dwelling on how sloppy your office is, get to work on cleaning it up.

**Criticisms From Supervisors**

**A Daily ‘Grind’**

Supervisors come in all shapes and sizes, and each has a different style and philosophy of supervision. Most common supervision theories identify three styles of leadership:

1. Authoritarian - very structured, highly controlling.
2. Democratic - information gathering, allows input in decision-making process.
3. Laissez-faire - vacillating on decision; taking the path of least resistance.

No matter what style of leadership we work with, criticism is a part of work life with supervisors. Being criticized can be a frightening situation. After all, this is the person who writes your performance evaluations, schedules your days off, and may be responsible for your raises in salary. Therefore, you will want to be concerned about your supervisor’s opinion and knowledge of your work.
When a supervisor criticizes you it is to your benefit to pay special attention to what is being said. As related in the above colleague examples, you must ask yourself, “Is this criticism valid or invalid? What is the best response to this criticism?” If, after asking yourself whether or not the criticism is valid, the answer is “No,” you must take some positive steps to resolve the problem.

One other situation we find ourselves involved in is criticism during our evaluation process. As nurses, we are usually formally evaluated once a year. For most of us this is an anxiety-producing situation, no matter how we feel we have performed.

Many supervisors believe all employees can improve, and each evaluation must include a criticism of the employee. Use this opportunity to have the supervisor outline in measurable terms, what you need to do to improve in the criticized area. If the criticism is that you’re not organized in your daily work, ask the supervisor to help you develop a plan, including measurable goals, to become more organized.

If You Are the Supervisor

Let’s put the shoe on the other foot for a few minutes. As the supervisor you are responsible for making sure things are running smoothly and efficiently and that employees are performing up to standards. Part of these responsibilities includes the criticism of others. You have a choice. You can be a critical boss or a criticizing boss.

The critical boss is just that—no positive, all negative. This boss does not attempt to cultivate employees; rather, focus is placed on any and all of the negative aspects of behavior. She believes that in order to keep employees on their toes, she must be on their backs.

On the other hand, the criticizing boss attempts to create positive change in the employee. Criticism is based on the “to enable” principle. Employees are rewarded for their positive behaviors and counseled in regards to the areas that are in need of growth. This supervisor nurtures the individual and enhances growth potential.

Make your choice to strive for positive change in each employee. To do this your goals must be:

- To break down resistance and misinterpretations of criticism
- To obtain the employee’s active participation
- To convey the message that the employee’s work is important
- To produce positive change

As the supervisor you must remain non-threatening to keep employees from becoming defensive in the face of criticism. When you believe it is necessary to criticize an employee, it is essential that your remarks be fair and justified.

If the employee is falling below minimum standards, you must counsel her; let her know exactly what areas are below standard and how to bring her performance up to an acceptable level. You must make it clear to the employee that you will be meeting occasionally to review progress and to make adjustments as necessary.

You should keep accurate records and document absences, late assignments, and excuses. This documentation is invaluable in helping the employee understand exactly what you expect. When you reevaluate and the employee has made progress, don’t forget to praise and positive reinforcement!

If the employee continues to fall below minimum standards, don’t be afraid to begin disciplinary action. Keep calm; think of your patient’s safety and comfort. Nurses tend to want to reach out to employees. We try to be therapeutic with everyone. Sometimes we have to say, “I can’t spend any more time trying to save a person who can’t be saved”. Hard but true.

When You Must Criticize Others

“If You Don’t Have Anything Nice To Say ... Say It Anyway ... But Make It Constructive”, says Psychologist Hendrie Weisinger.

Hendrie Weisinger, a psychologist who dubs himself a “critiqueologist,” has written the book—several critically acclaimed ones, actually—on how to productively criticize in the workplace. He points out that the way criticism is usually given doesn’t get the results we want: improvement in behavior, either that of our employees or, of our own. From explaining timing in critiquing performance to the importance of doing so in a calm manner, Weisinger outlines the rules in his latest analysis, The Power of Positive Criticism. What’s the biggest mistake in the way criticism is usually offered? You have to go back to Aristotle, who coined the word, “to understand what criticism is supposed to be: making a judgment for the sake of improvement.” This isn’t just semantics; it aligns our attitude with the result we want, which is change. The individual being criticized should be encouraged to look at ways to get results. We’ve started using feedback as a euphemism for positive criticism, but that’s because we don’t recognize that criticism isn’t a negative word.

The exact wording of what you say flows from your attitude. Those who consistently get positive responses to their criticism are very careful about what they say. They don’t use the words “never” or “always,” because as soon as you do that, the person being criticized gets defensive and starts thinking of the exceptions. It’s better to say “sometimes.” And don’t emphasize what someone “did”—that freezes the action in the past, which is something they can’t do anything about. Tell them what they’re doing that can be done differently in the future.

What can you do after the initial criticism to make sure you get the results you’ve asked for?

You want to set the right level of expectations. If your expectations are realistic, there’s a good chance the people will get to where you want them to go. The key here is to follow up, to let them know you’re offering support, that this isn’t going to go away until there’s productive action. You’ll be there to help them along the way. And then reward them as they make the changes you want.

When you criticize others you must distinguish between criticism of the job and criticism of the person. Criticism of performance is appropriate. Criticism of the person is inappropriate.

Criticism of job:

“This report is sloppy.”

Criticism of person:

“You are sloppy.”

Be prepared to show the person what areas of the report must be improved and how to improve them.

Be sure your criticism is based on objective facts rather than on subjective perceptions. Never forget the person you are criticizing has “invested” in the product. She has spent a lot of time and energy at the job.
As nurses we often assume we shouldn’t say anything critical to our peers. We feel we’re intruding on their territory. That is simply not true. It is our responsibility as a team member to protect our patients and to make sure they are well cared for. Make your criticism an offer to cooperate (to help the patient).

Don’t set up competitiveness. This is a no win situation.

Your criticism is best taken if you:
• Show your peer you’re working toward a common goal
• Show how her actions affect you both
• Suggest trying another method, be specific
• Solicit her agreement

Remember: You have to work with this person, so discretion is important.

Create Your Own ‘Brand’ Of Leadership

Positive leadership is not just within the grasp of the passionate or charismatic. But can be a way of life for anyone who is willing to not just exist, but to live in the possibilities that every day brings. Commit yourself on a deep personal level, and be open to change and partnership with those around you. Building strength to create your own “brand” happens through many encounters. The initial attraction must be followed by meeting expectations. This creates a loyalty that is part of an emotional connection to that brand. This is the same process people go through when they first meet a leader, and decide if this is a person they want to buy into. People will examine your style, competence, and your standards and what you value as important.

If you fail on these fronts, your ability to lead will be strongly compromised. People expect more of leaders now, because they know and recognize good leaders. Predictably, people are now more cynical of leaders because of the well-publicized extremeness of a few leaders who advance their own causes and agendas at the expense of their people and their financial future.

In a sense this is a good thing, in that it creates a higher standard of leadership that all must strive to achieve. When the bar is raised, our standards of performance and patient care are also raised.

Putting It All Together

Constructive VS. Deconstructive

Which of these are examples of constructive feedback? Which are not? How would you advise someone to respond to each of them?
- “To be a better golfer, you’ll need to learn how to concentrate and ignore all distractions.”
- “You should never try to play the piano. You have no talent.”
- “I’d like to see you use more concrete images in your poetry. Avoid using cliches.”
- “In the future, make sure all your charting notes are formatted correctly. Check the employee manual for instructions.”
- “You never give me the answer I want. I don’t have time to explain it to you.”

Responding To Feedback

What would be the best way to respond in each of these situations?
A. You just received your grade on an essay you wrote for your class. You were hoping for an A, but you got a C+. The teacher’s notes say that your essay lacked focus and needed more examples. What do you do?
B. You’ve been working as a Head Nurse for the last six years, and the Director of Nursing just announced that your co-worker Tara is being promoted to Nursing Supervisor. When you ask why you didn’t get the promotion, you’re told that Tara was a better “fit.” How do you respond?
C. You have an important part in the local theatrical play. After opening night, the lead player says to you, “You looked really clumsy up there. Next time, try not to look like such an idiot.” What do you do?

Review And Discuss

• What is constructive criticism? (feedback that encourages a person to grow and improve)
• What is a good way to respond to constructive criticism? (Listen, look for positive advice, clarify by asking, and apply to future performance.)
• How do you usually respond to constructive criticism, and how would you like to respond?
• How can a person keep criticism in perspective?
  Constructive feedback, mentoring, and performance assessment are key to helping employees reach their potential.

To create a path to better feedback, include:
• Steps to cultivate trust at work, including defining clear boundaries, being sincere with apologies and empowering others to make decisions.
• A feedback plan explaining how to give informal responses as events occur, tips on delivering and receiving feedback constructively, and a script for managers seeking feedback about themselves.
• Techniques for conflict resolution, such as having colleagues list their wants and identify what they would be willing to do to settle the dispute. The results can be improved communication, collaboration and reconciliation.

Peer Mediation

One research group advocates using peer mediators to solve conflicts when possible.

• Focus on the real problem as opposed to the often-expressed disagreement.
  For example, is the issue the new work schedule? Or is it really the supervisor favoring some employees over others?
• Depersonalize the disagreement so that mindless tit-for-tat arguments do not push the conflict up to the next management level.
  Create solutions for problems by encouraging the parties to offer constructive suggestions.
• Build relationships of trust between the supervisors and managers so that colleagues and managers alike believe that they can voice legitimate concerns and be heard even
Summary

Throughout the course we’ve talked about numerous facets and prerequisites for learning to deal effectively with criticism. This last section will be a mini review of the important concepts.

When thinking about this information we must remember to evaluate critically our self-image, self-esteem, and self-worth. These items are the building blocks of who we are and how we deal with critical situations in life. If our concept of who we are is positive and strong, then our ability to face criticism and to cope in a positive, productive manner is likewise positive and strong.

Assertion goes hand-in-hand with our “strong self.” The distinction must be made between assertive and aggressive behaviors. Assertion is essential in our responses to criticism. Assertive responses enable us to keep on the right track, focus on our agendas, make our needs known, and send clear messages to others. Part of handling criticism is taking back our personal power. This power determines how we will be treated. Healthcare professionals have tremendous power that isn’t utilized. Look at the power you have available to you. Decide whether it’s interpersonal, networking, or positional. Then use it in a thoughtful manner toward a productive goal. Make that goal to learn to deal with critics from a position of strength.

Go back a minute to rethink your negative patterns and responses to criticism. Ask yourself again:

“Do I make excuses rather than face the facts?”

“Do I blame/shame or embarrass the other person to take the spotlight off me?”

“Do I just ignore the whole subject?”

If “yes” is your answer, reread the section on negative responses. Get your pencil out and write a plan, showing how to break old bad habits.

With the text concepts in mind:

• Don’t give up your agenda
• State your feelings

Get Ready to Successfully Take Steps to Positive Criticism! Screw

Suggested Readings

Bodin SJ A critical look at critical thinking Nurs Manage. Aug 2012, 43(8) p42-6

Orthop Nurs, May-Jun 2012, 31(3) p190-2

Orthop Nurs (United States), May-Jun 2012, 31(3) p190-2

Carlson EA, Improving patient safety through improved communication and teamwork.


Kalisch BJ, Lee KH The impact of teamwork on missed nursing care. Nurs Outlook, Sep-Oct 2010, 58(5) p233-41


Rosenblatt CL, Davis MS “Effective communication techniques for nurse managers.” Nurs Manage 2009; Jun 40(6): p52-4

Vogelsmeier A, Scott-Cawiezell J, Achieving quality improvement in the nursing home: influence of nursing leadership on communication and teamwork., J Nurs Care Qual, Jul-Sep 2011, 26(3) p236-42


More Suggested Readings Upon Request

Answers: 10 Statement Chart p.10

1. Passive 6. Aggressive
2. Assertive 7. Passive
3. Aggressive 8. Aggressive
5. Assertive 10. Assertive

POSITIVE AFFIRMATIONS

THE whole secret of a successful life is to find out what it is one’s destiny to do, and then to do it.

~Henry Ford

THE journey of a thousand miles starts with a single step.

~Chinese Proverb

OUR true priorities are revealed to others, not by what we say, but by what we do and by the passion with which we do it.

~Roy Lessin

EVERY job is a self-portrait of the person who did it.

Autograph your work with excellence.

~Unknown

GENTLE answer turns away wrath, but a harsh word stirs up anger.

~Proverbs 15:1

WE make a living by what we get, we make a life by what we give.

~Winston S. Churchill

THERE is one who speaks rashly like the thrusts of a sword; But the tongue of the wise brings healing.

Truthful lips will be established forever, but a lying tongue is only for a moment.

~Proverbs 12:18-19 NAS

NO ONE is useless in this world who lightens the burdens of it for another.

~Charles Dickens

THE price of success is hard work, dedication to the job at hand, and the determination that, whether you win or lose, you have applied the best of yourself to the task at hand.

~Vince Lombardi

LIFE is not so short but that there is always time for courtesy.

~Ralph Waldo Emerson

SAY only what is good and helpful … and what will give … a blessing.

~Ephesians 4:29 TLB

BEFTER one word in time, than two afterwards … remember the power of your words …