Nurses' perceptions of communicating with minority parents in a neonatal
nursery: A communication accommodation theory approach.

Liz Jones, Nicola Sheeran, Karina Evans, Hanna Lanyon

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Health communication failures are the leading cause of error and adverse events in health (Leonard, Graham, & Bonacum, 2004; Ong & Coiera, 2011). There has been growing interest in how an intergroup perspective may increase our understanding of the underlying causes of ineffective health communication, with implications for improving health care education and delivery (Watson, Gallois, Hewett & Jones, 2012). In particular, a number of researchers have been using communication accommodation theory (CAT) to study health communication. CAT constructs interpersonal interactions as grounded in the social identity(ies) of the interactants, and predicts that communication is influenced by the “group” memberships that are salient for each participant (Gallois, Ogay & Giles, 2005).

In health care, these identities/groups include those of patients and a range of health professionals, but may include a range of other cross-cutting identities such as ethnicity or age. Research to date has found both more problematic communication and poorer outcomes for patients from minority groups (Kreps, 2006), suggesting the importance in health communication of examining the interplay between multiple social group memberships. The current study uses CAT to examine nurses’ perceptions of communication with adult parents, adolescent parents and culturally and linguistically diverse (CALD) parents in neonatal nurseries. Adolescent and CALD parents are among the most numerous parents with a minority group status in nurseries in Australia. We argue both adolescents and those who are CALD are, to some extent, stigmatized and their interactions with health professionals are often intergroup (Drury, 2010, Watson et al., 2012). Our interest in the current study was nurses’ perceptions of communication with parents from different social groups.

CAT describes a number of communication strategies interactants may use to reduce or increase social distance (Gallois et al., 2005). Approximation refers to changes in verbal or nonverbal behaviour to become more or less like the other interactant, to reduce or accentuate social distance. Interpretability refers to the way speakers adapt their behaviour

to make it more understandable or not to the other interactant. Discourse management is how the management of the interaction is shared and how interactants facilitate their partners' contribution to the interaction through sharing topic selection and turn-taking. Interpersonal control is about the roles interactants are able to enact in an interaction, where interactants may attempt to keep themselves and others in a particular role, or may try to establish a common role. Positive face takes into account a person's need to be liked and have their wishes understood and appreciated, and negative face a person's need for independence. Finally, emotional expression involves interactants responding to the emotional or relational needs of the other person, including reassurance, care and warmth.

CAT then uses the term accommodative stance to refer to how interactants use these strategies to adapt their communicative behaviour to appropriately move towards or respond to the needs of the other person (accommodating) or to be distinct from, or inappropriately move towards the needs of, their speech partner (non-accommodating) (Gallois et al., 2005). Non-accommodation includes both under-accommodation, where a speaker maintains (or accentuate differences in) their behaviour, with insufficient movement toward the behaviour or conversational needs of others, and over-accommodation, where a speaker goes beyond the style necessary with patronising or ingratiating moves, typically to a stereotype of the other person's group. Overall, accommodation is generally evaluated more positively than non-accommodation, and is consistent with "patient centred" care (Jones, Woodhouse & Rowe, 2007).

In the current study we used CAT to examine nurses' perceptions of effective and ineffective interactions with parents. We investigated the question "How do nurses' communication strategies and accommodative stance differ when talking to parents from different social groups?"

Method

Participants

Nurses working full-time or part-time in the Special Care Nursery in two tertiary hospitals in Queensland participated in the study. The hospitals were similar in size and acuity of infants. The data were collected in two phases.

Phase 1. Twelve nurses were recruited from the first tertiary hospital who had worked in the nursery for 6 months to 23 years. These nurses were asked about their interactions with parents in general.

Phase 2. Thirty five nurses were recruited from the second tertiary hospital who had worked in the nursery for 1.5 to 38 years. These nurses were asked about their interactions with CALD and adolescent parents.

Recruitment and data collection

Prior to data collection ethical approval was obtained from hospital and university Human Research Ethics Committees. In-service sessions for staff were conducted in each nursery, and information sheets left in key areas of each unit. Nurses were then approached to participate in the study. Nurses were interviewed at a time and location convenient (e.g., meeting room at hospital or a quiet area in a café).

For Phase 1 interviews nurses were asked: 'Can you tell me about a time here when you talked to a parent and it felt really good?'. Nurses were then asked: 'Now can you tell me about a time here when you talked to a parent and it didn't feel as good?'. For Phase 2 interviews the same questions were used except that the parent was described as a CALD parent or an adolescent parent. Interview questions about adolescent and CALD parents were counterbalanced. Interview length lasted an average of 30 minutes. All interviews were digitally recorded and transcribed.

Analysis

The interviews were analysed quantitatively using content analysis. A coding scheme was developed for each of the six strategies based on CAT and previous studies by Jones, et al. (2007) and Watson and Gallois (1998). Each description of effective or ineffective communication for each participant was then content coded for whether it mentioned each particular strategy and whether it was accommodative, under-accommodative or over-accommodative. Thus for some participants a description mentioned only one strategy (rarely), for others up to five strategies. Table 1 provides a description of the coding scheme. Thirty percent of the data was coded by a second coder with interrater reliability of .82 using Cohen's kappa for Phase 1 and .91 for Phase 2. The analysis confirmed that descriptions of interactions with parents in Phase 1 were about adult Anglo-Australian parents, with only 2 statements across all interviews mentioning a minority group membership.

Table 1
Communication Strategies Coding Scheme

Strategy Type	Level ^a	Examples
Discourse Management	Over	Letting others direct conversation, passiveness, avoiding talking to mother, waiting for them to initiate conversation
	Accom	Asking questions, asking opinions, chatting, listening, openness to suggestions
	Under	Dominate conversation, do not listen or let them speak, gives unsolicited advice, controls, bombards with questions
Emotional Expression	Over	Too much sympathy, exaggerated need to understand teenager, extra effort to get to know them
	Accom	Reassure mother, show empathy, supportive, recognises and adjusts for teenager's emotional needs
	Under	Nurses not empathetic or understanding, unsupportive
Interpretability	Over	Too simple, patronising, assuming no knowledge, spoken down to like children
	Accom	Clear, direct, honest, explain situation, check understanding, provide sufficient and accurate information, adjust appropriately to cognitive and psychological level
	Under	Not bothering/giving up explaining, using complex medical terms, not adjusting sufficiently to help understanding, withholding information
Interpersonal Control	Over	Be too personal or familiar, treat like best-friend, denigrate others, over self-disclose, over-nurturing toward mother
	Accom	Treat each other as equal individuals, disregard roles, develop shared identity, get to know as individual
	Under	Emphasis on professional status, too formal, treat like teenager, treat everyone the same instead of as individuals, applying generic or impersonal approach
Negative-face	Over	Nurses ask by putting themselves down, denigrating self, puts self-down with humour
	Accom	Does not demand/impose mother, approaches at appropriate time, considerate of mothers' wishes
	Under	Demand or order parents, nurses prioritises her own needs
Positive-face	Over	Try to counteract prejudice, avoid negative information, give special treatment, overly encouraging or optimistic
	Accom	Polite, respectful, encouraging, showing interest in individual, promotes confidence
	Under	Criticise parent, condescending, put them down, rude toward teenager, disrespectful

^a Over = Over-Accommodation, Accom = Accommodation, Under = Under-Accommodation,

Results

Table 2 presents the percentage of nurses mentioning each strategy for effective and ineffective interactions for each group of parents. Chi-square tests of independence were conducted to examine differences between nurses' perceptions of effective and ineffective communication with the CALD, adolescent and adult parents.

A number of differences were found in the strategies nurses reported using with adult, adolescent and CALD parents in effective interactions. For adult and adolescent parents there was a high frequency for discourse management and interpretability, and to a lesser extent interpersonal control. In contrast, for CALD parents the most frequently mentioned strategy was interpretability, followed by positive face. In general fewer strategies were mentioned with CALD parents and there was significantly less use of discourse management, emotional expression and interpersonal control with CALD parents. Further differences were that emotional expression was mentioned more frequently for adult mothers than adolescent parents and negative face for adolescent parents than CALD and adult parents. There was also significantly more use of an under- and over-accommodative stance with adolescent parents.

Overall, there was less consistency in the strategies mentioned for ineffective interactions. For all groups of parents interpretability was a frequently mentioned strategy. For adult and adolescent parents discourse management was also mentioned frequently and more frequently than for CALD parents. In addition, (under-accommodative) negative face was again mentioned more frequently for adolescent parents. Overall, nurses reported an under-accommodative stance most frequently for ineffective interactions, although a number of nurses also mentioned using an over-accommodative or accommodative stance.

Table 2

Percentage nurses mentioning each communication strategy for effective and ineffective communication with CALD parents, adolescent parents and adult parents

Strategy	Version	Effective			Ineffective		
		CALD	Adolescent	Adult	CALD	Adolescent	Adult
Interpretability	Over	2.9	10.0	-	2.9	-	-
	Accom	51.4	63.3	72.7	20.0	10.0	36.4
	Under	2.9	3.3	-	31.4	23.3 ^e	45.5
Discourse Management	Over	-	16.7 ^a	-	- ^b	20.0	27.3
	Accom	22.9 ^b	90.0	90.9	- ^b	16.7	27.3
	Under	-	26.7 ^a	-	11.4 ^b	30	36.4
Interpersonal Control	Over	-	16.7 ^a	-	2.9	-	9.1
	Accom	11.4 ^b	43.3 ^e	63.6	-	10.0	9.1
	Under	8.6	13.3	9.1	20.0	23.3	36.4
Emotional Expression	Over	2.9	23.3 ^a	-	-	3.3	-
	Accom	31.4 ^b	50.0 ^e	90.9	11.4	-	-
	Under	-	-	-	2.9	10.0	9.1
Positive Face	Over	2.9	6.7	-	5.7	-	-
	Accom	42.9	46.7	54.5	2.9	16.7	9.1
	Under	2.9	3.3	-	-	6.7	-
Negative Face	Over	2.9	6.7	-	2.9	-	-
	Accom	5.7	40.0 ^a	-	-	10.0	-
	Under	2.9	6.7	-	-	23.3 ^a	-

^aAdolescent from adult and CALD; ^bCALD from adolescent and adult; ^cCALD from adolescent from adult; ^dCALD from adult; ^eadolescent from adult at $p < .05$

Implications

Our findings show nurses use different communication strategies when interacting with parents from different social groups. For both CALD and adolescent mothers there was less use of interpersonal control than for adult mothers, suggesting nurses were viewed interactions with these parents as less interpersonal. Instead, for CALD parents there was more focus on the interpretability strategy than other strategies, with a focus on comprehension. However, it is also noteworthy how little use nurses reported use of discourse management, interpersonal control and emotional expression, despite these

strategies being consistent with the collaborative models of care that are policy in the nurseries (Griffin, 2006).

Nurses also emphasised different strategies when interacting with adolescent parents compared to adult parents and, to some extent, CALD parents. The two key differences were the greater focus on negative face and the greater use of an under- or over-accommodative stance, particularly for discourse management. The focus on negative face suggests nurses were concerned about adolescent mothers' need for independence or freedom from imposition. At the same time the use of an under- and over-accommodative is consistent with adolescents' reports of negative communication with health professionals in neonatal nurseries (Sheeran, Jones & Rowe, 2013) and in healthcare more generally (Drury, 2010). Overall, the findings show the value of communication accommodation theory in explicating how health communication is shaped by the social group memberships of patients and families, which in turn may guide new approaches to improving health communication.

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