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Overcoming High Communication Anxiety of Trainee-nurses with a Two-dimensional Approach at the Zuarungu Health Training School, Ghana

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Abstract

High communication anxiety (HCA) dispossesses individuals' inter-personal communication skills that are needed in the academia and at other public places. Admittedly, research on HCA abounds but lack holistic remediation in providing a comprehensive cure. In Ghana, knowledge on how teachers can effectively manage HCA and its instruction is limited. Moreover, most teachers have limited knowledge of how instruction may be ineffective due to HCA. Interestingly, nursing is constantly evolving. And to-be-nurses who have high communication anxiety may suffer many effects while in training and in practice if their HCA is not ameliorated. Because, nurses, by the nature of their work, cannot be shy, avoid public communication or inter-personal relations that are needed in providing effective health service. This study was to actualize classroom participation in order to reduce the HCA of 50 to-be-nurses with a two-dimensional approach involving communication instruction and motivational persuasive contexts that co-constructed inter-personal communication relations. The study resulted in reducing trainees' fear of speaking in public and great improvement in their 2014/2015 second semester GPAs.

Keywords: anxiety/apprehension, communication, debating, high, instruction, overcoming.

INTRODUCTION

Every person experiences some communication anxiety or nervousness in public speaking (McCroskey, 2001). It is however, the uniqueness of it, especially with potential health workers, which is the thrust of this study that matter. Communication anxiety or fear of speaking in public grounded in personality characteristics or situational anxiety (Witt, Brown, Roberts, Weisel, Sawyer & Behnke, 2006) has immeasurable consequences on people suffering from it. In the classroom, its effects are both instructional and social as students suffering from especially extreme communication anxiety tend to obtain low grade point scores and talk less or show less interest in public communication activities (Pearson, Nelson, Titsworth & Harter, 2003). Further consequences such as avoiding communication situations (Beatty, 1988), and being less competent, less composed and less attractive (McCroskey & Leppard, 1975) are detrimental to academic progress.

Though research has suggested ways of managing the effects of high communication apprehension, scholars have not specifically and most especially in the Ghanaian health training schools, considered reducing high communication anxiety for improved health service delivery. Interestingly, health and/or nursing training must be interactive in order for trainees to fully appreciate health instruction that will ground in-depth understanding of health issues, positive academic results and eventual handling of health cases.

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This study thus ameliorated student nurses' extreme communication anxiety (also known as high communication apprehension) with a two-dimensional approach at the Zuarungu Health Training School, Ghana. The twofold instructional approach included a 3-credit communication course, (Communication & Study Skills) that offered all 250 trainee-nurses instruction on communication and its related concepts for a semester (which compares with Pearson et al, 2003 Skills Approach) and debating lessons that epitomized MacIntyre, Babin & Clement, 1999 variety of situations and William J. Bryan (cited by Carnegie, 1955) that 'the ability to speak effectively is an acquirement rather than a gift'. Pearson et al, MacIntyre et al and Bryan approaches suggest that increased exposure to public speaking reduces communication anxiety.

The communication course imparted listening, reading, writing and speaking skills and their related mechanics while the debates increased trainee-nurses' public speaking exposure through persuasive dialogues in class and among themselves. The debating approach was grounded mainly on its interactional relevance in building self-confidence and providing space for speech.

The debating sessions constructed pedagogic communication contexts which provided trainees an enabling opportunity to express their reflections both in writing and speaking after appreciating the various motions that were given them. The overriding aim was to get trainee-nurses speak constantly. Again, the use of debates compares the behaviourists contention that language is a behaviour that develops as other skills through regular practice.

MATERIALS AND METHODS

The action research methodology was used for this study. The study added debating sessions to further the objectives of the 3-credit communication course (Communication & Study Skills) regarding overcoming high communication anxiety of selected trainees. Eighty (80) trainees were first purposely sampled from a total of 250 first year trainees by me with the assistance of the academic-tutor and the class-tutor. Subsequently, the Personal Report of Communication Apprehension (PRCA-24), appendix A, was administered on the 80 purposely selected trainees leading to a sample size of fifty (50) who were immersed with the two-dimensional approach. The sample size comprised 30 females and 20 males; all ranging from ages twenty (20) to twenty-six (26). The 50 students were further pre-observed for a week regarding their communication anxiety using basic checks of high communication anxiety as was administered on them.

The additional instructional intervention (the debates) was administered twice a week on Tuesdays and Fridays for four months till the end of the second semester of the 2014/2015 academic year in the first year class. Each session lasted three hours from 7:00 – 10 pm each meeting day. On each of these days, trainees came with informed ideas and poised to argue their opinions on a given motion or topic (which were self-selected through ballot at immediate past sessions).

Pragmatically, the trainees verbally expressed their views on topics involving health, nursing, science or technology, sexuality, religion, education and politics. A few of the topics or motions included:

Health/Nursing/Science/Technology

- Students in the rural schools have more advantages than those in the urban schools, Traditional foods have no virtues,

- Technology has made the world a better place,
- Modern society has nothing good to offer the youth,
- In a developing country, it is more useful to study science than business,
- The computer has worsen writing,
- The demerits of mobile phones outweigh their benefits in modern life,
- Science has done more harm than good to humanity,
- Science has made a great difference to our lives than religion,
- The rise in science is the cause of decline in faith,

Gender/Sexuality/Education/Religion/Politics

- Women are better nurses than men,
- Women are sexually weaker than men
- Courtships are no longer useful,
- Students in rural health institutions are harmful,
- The problems of unemployment among school leavers stem from a bad system of education in a country,
- Inter-school sports promote division among students,
- Day schools are better than boarding schools,
- Religion has failed our society,
- One's personality is determined by nature not by nurture,
- Tribal associations should not be allowed in public secondary schools,
- Traditional rulers have no place in a modern democratic nation,
- Ghana is better off with agriculture than with oil, etc

The arguments were always verbally presented; trainees spoke without reference to any prepared paper. Trainees were always regulated, at each session, into two groups: the Cons and the Pros, just for identification. Trainees, on a face-to-face sitting arrangement, took turns to express their views or messages to their colleagues and audience with a maximum of two points each on their selected motions or topics. Trainees were adjudged on each session but these were not made known until the final session. During the debate sessions, trainees were advised to speak loud, look into the eyes of their co-debaters as well as audience and to freely move about while speaking. Once a debater ended, I signaled the corresponding respondent to express or present his/her views. At the end of each day's session, two volunteers from the audience summarized the main arguments of each of the two main groups while other members of the audience stated what interested them most and why. I played a supporting role of helping trainees gather points before actual debate sessions and a corrective role on aspects that were noted as wrong or unconvincing reasoning.

Trainees were closely monitored with some scaffolding activities. Trainees' verbal and argumentative skills including conversation and participatory levels were observed. Finally, a self-appraisal (appendix B) was conducted at the end of the programme on all the 50 trainees.

Data was collected using observation and a self-appraisal tool. Trainees GPAs were also analyzed. First, pre and post observations were made during debate sessions and normal classroom sessions. These observations were to measure trainees' high communication anxiety including weaknesses and strengths before and after the intervention. Besides, the entire process was video-recorded. The video-recordings were used to augment the study of trainees' progress in terms of overcoming challenges that amounted to high communication anxiety.

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RESULTS AND DISCUSSION

Pre-intervention Observation

The entire 250 students were qualified for the two-year certificate health-assistant training programme. Most of them however had weak grades (D7 or E8) a fail grade (F9) in English Language at the West African Senior School Certificate Examinations – WASSCE. The sampled 50 trainees had scores above 80 in the PRCA-24 and low scores, ranging from 15 % to 30 %, in the first semester results of 'Communication & Study Skills'. They also appeared shy, participated less and spoke less in class. It was further noted that all 50 trainees had very low Grade Point Average (GPA) of 1.0 to 2.0 in the first semester. Most of the teachers including the one in-charge of academics confirmed that the sampled 50 trainees hardly ask questions in class despite their poor performance. Trainees' speeches had errors including tense, pronunciation and dangling constructions.

Table 1: Pre-intervention observation of 50 trainees' classroom speech attitudes

Attitude	Number of Traniees	Percentage
Shy-Speaker	21	42%
Spokeless but not Shy	13	26%
Shy-Speaker & Spokeless	16	32%
Total	**50**	**100%**

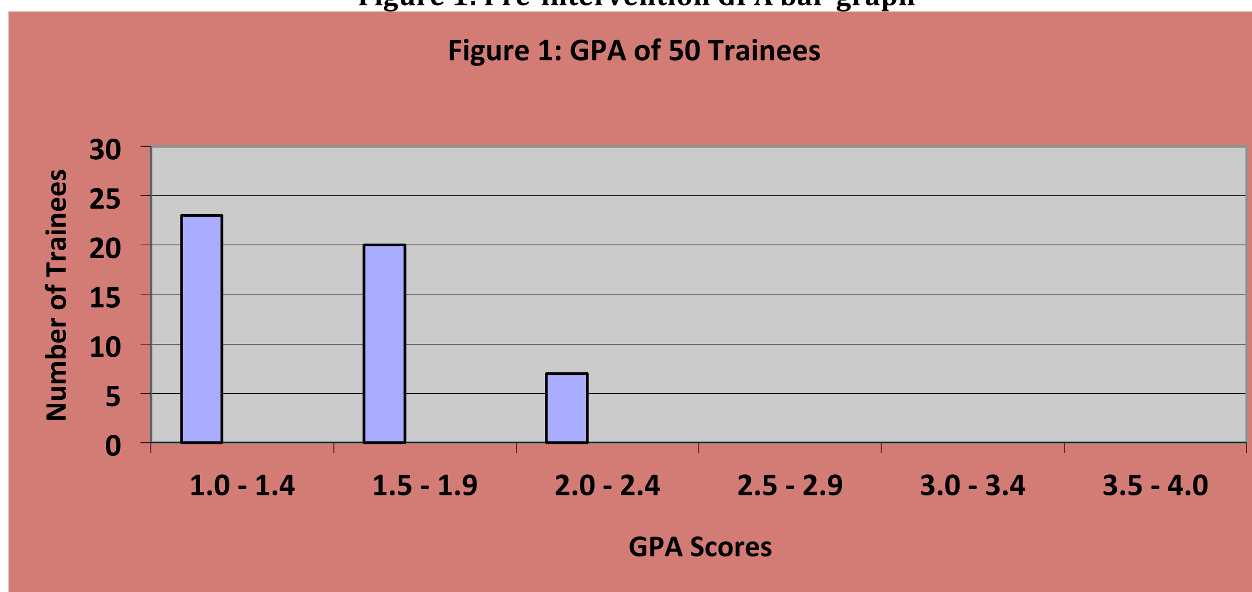
Table 1 indicates that trainees had varying high communication apprehension indicators that may be the bases for their errors in tense, pronunciation and misuse of modifiers. These errors culminate in making trainees less confident in class. A further study of their first semester GPAs is analysed in Table 2 below:

Table 2: Pre-intervention GPAs of 50 trainees

GPA	Number of Traniees	Percentage
1.0 – 1.4	23	46%
1.5 – 1.9	20	40%
2.0 – 2.4	07	14%
2.5 – 2.9	0	0%
3.0 – 3.4	0	0%
3.5 – 4.0	0	0%
Total	**50**	**100%**

From Table 2 above, 23 trainees (representing 46 %) had 1.0 to 1.4 GPA, 20 trainees (representing 40 %) had 1.5 to 1.9 GPA and 7 trainees (representing 14 %) had GPA 2.0 to 2.4. Nobody got GPA ranging from 2.5 to 4.0. The majority (86 %) of the sample size had very low GPA which compares (McCroskey & Andersen, 1976) that students with high communication anxiety score low overall GPA. The bar-graph below simplifies the performance of the 50 sampled trainees as it skews negatively.

Figure 1: Pre-intervention GPA bar-graph



Post-intervention Observation/Self-appraisal

During and after the intervention, the following developments were noted. Most of the sampled trainees were highly motivated to express themselves on the various motions or topics. They thus argued constructively and confidently and willingly participated in the debating activities. They also raised objections and issues of interest during debating sessions and discussed other worrying issues such as topic difficulties. They also participated actively and satisfactorily during normal Communication & Study Skills lessons. Their contributions during Communication & Study Skills lessons were logical, devoid of tense errors and jumbled constructions. These indicators showed that the trainees had remedied considerably their high communication apprehension.

In order to ascertain the reduction, the GPAs of the 50 trainees in the second semester were collected as shown below.

Table 3: Post-intervention GPAs of 50 trainees

GPA	Number of Tranices	Percentage
1.0 – 1.4	01	02%
1.5 – 1.9	02	04%
2.0 – 2.4	18	36%
2.5 – 2.9	19	38%
3.0 – 3.4	10	20%
3.5 – 4.0	0	0%
Total	**50**	**100%**

From Table 3 above, 1 trainee (representing 2 %) obtained 1.0 to 1.4 GPAs against 23 trainees (representing 46 %) in the pre-intervention GPAs (Table 2). Also, 2 trainees (representing 4 %) obtained 1.5 to 1.9 GPAs against 20 trainees (representing 40 %) who had 1.5 to 1.9 GPAs in the pre-intervention GPAs (Table 2). Again, 18 trainees (representing 36 %) had 2.0 to 2.4 GPAs against 7 trainees (representing 14 %) in the first semester GPAs. Further, 19 trainees (representing 38 %) got 2.5 to 2.9 and 10 trainees (representing 20 %) obtained 3.0 to 3.4 GPAs against zero in the pre-intervention GPAs of 2.5 to 4.0. Nobody got GPAs from 3.5 to 4.0.

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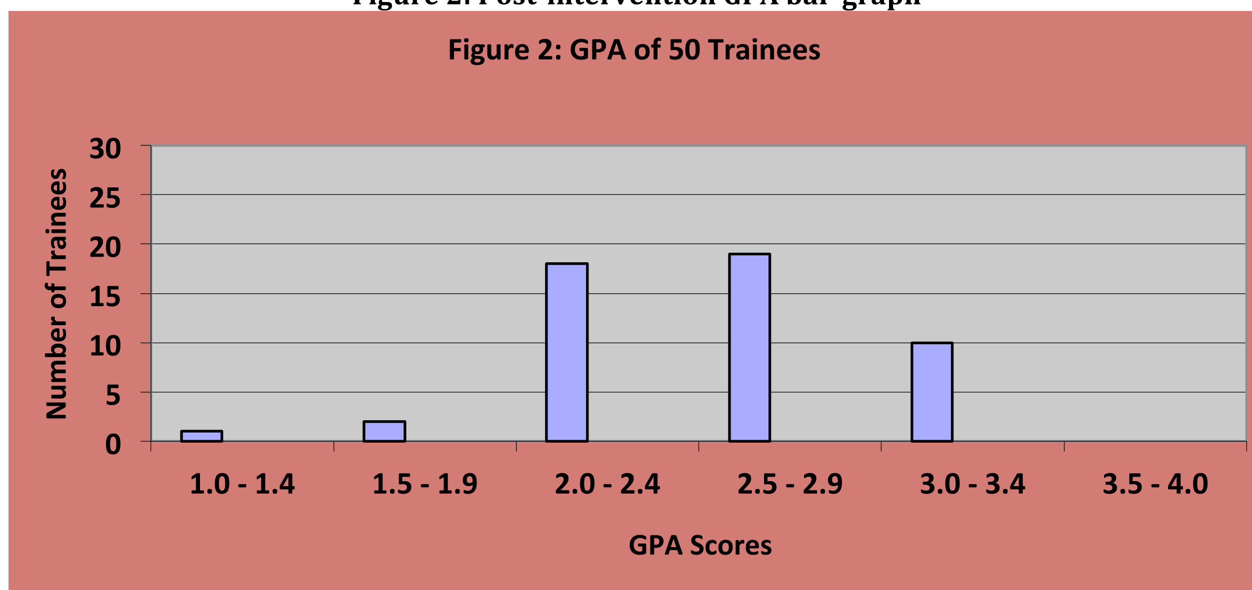
Tentatively, at the 1.0 to 1.4 GPA range, 22 trainees (44 %); while at the 1.5 to 1.9 GPA range, 18 trainees (36 %); and 11 trainees (22 %) at the 2.0 to 2.4 had improved their GPAs respectively. This implies a substantive 29 trainees (58 %) had improved their GPAs.

That is 50 trainees (pre-intervention GPAs) of 1.0 to 2.4 minus 21 trainees (post-intervention GPAs) of 1.0 to 2.4 GPAs. Thus, 50 – 21 = 29.

Notably, the Zuarungu Health Training School standard end of year progression GPA is 2.0 (Minutes, 2011/2012 Academic Board). It implies that a large number of 47 trainees (representing 94 %) of the 50 sampled trainees obtained promotion as against 7 trainees (14 %) that would have been promoted as per the pre-intervention GPAs in Table 2. Below is a bar-graph showing the post-intervention GPA performance of the 50 trainees.

Figure 2: Post-intervention GPA bar-graph



The post-intervention GPA bar-graph (Figure 2) is averagely (majority of trainees scored between 2.0 to 2.9 which gives an average score of 2.45) and positively skewed. The average performance signals some significant improvement in trainees' GPA in the second semester. Nonetheless, 3 trainees (representing 6 %) could not improve their GPAs and per the standards will not be promoted since their overall GPAs for the second semester were below 2.0.

Finally, a self-appraisal (Appendix A) was conducted on the 50 trainees to assess their high communication anxiety status. The self-appraisal had three sections titled I, II and III. The 12-questions self-appraisal sought responses regarding the benefits of the approach and ways of further managing high communication anxiety since no one therapy works for all (Dwyer, 2000).

CONCLUSION

The study found that there are high communication anxiety (HCA) students in the 1st year class of the 2014/2015 academic year of the Health Assistants Clinical Training programme at Zuarungu. It also noted some consequences of HCA students having few friends and being less confident especially in answering questions in class and during examinations which result in low GPA.

Significantly however, adequate communication instruction including motivational contexts like debates can reduce high communication anxiety of students by making them good speakers who will intend perceive themselves as competent and are more likely to engage in inter-personal communication contexts.

RECOMMENDATIONS

Since every person possesses some amount of communication apprehension, communication instructors need to scan every class for the identification of students with high communication anxiety for early remediation. It is my hope that further research on communication anxiety and propaganda will produce findings to advance the understanding of persuasive communication. Probably worthy researching, is establishing the relationship between communication anxiety and nonverbal communication behaviour.

Generally, Ghanaian health and nursing instruction should adequately employ ways or motivations toward reducing HCA in order to get par with international health/nursing standards in the area of inter-personal communication.

APPENDIX A: PERSONAL REPORT OF COMMUNICATION APPREHENSION (PRCA-24)

The PRCA-24 is an instrument widely used to measure communication apprehension. It is composed of twenty-four statements concerning feelings about communicating with others. Please indicate the degree to which each statement applies to you by marking whether you: Strongly Disagree = 1; Disagree = 2; Neutral = 3; Agree = 4; Strongly Agree = 5

1. I dislike participating in group discussions.
2. Generally, I am comfortable while participating in group discussions.
3. I am tense and nervous while participating in group discussions.
4. I like to get involved in group discussions.
5. Engaging in a group discussion with new people makes me tense and nervous.
6. I am calm and relaxed while participating in group discussions.
7. Generally, I am nervous when I have to participate in a meeting.
8. Usually, I am comfortable when I have to participate in a meeting.
9. I am very calm and relaxed when I am called upon to express an opinion at a meeting.
10. I am afraid to express myself at meetings.
11. Communicating at meetings usually makes me uncomfortable.
12. I am very relaxed when answering questions at a meeting.
13. While participating in a conversation with a new acquaintance, I feel very nervous.
14. I have no fear of speaking up in conversations.
15. Ordinarily I am very tense and nervous in conversations.
16. Ordinarily I am very calm and relaxed in conversations.
17. While conversing with a new acquaintance, I feel very relaxed.
18. I'm afraid to speak up in conversations.
19. I have no fear of giving a speech.
20. Certain parts of my body feel very tense and rigid while giving a speech.
21. I feel relaxed while giving a speech.
22. My thoughts become confused and jumbled when I am giving a speech.
23. I face the prospect of giving a speech with confidence.
24. While giving a speech, I get so nervous I forget facts I really know.

SCORING

Group discussion: 18 - (scores for items 2, 4, & 6) + (scores for items 1,3, & 5)

Meetings: 18 - (scores for items 8, 9, & 12) + (scores for items 7, 10, & 11)
Interpersonal: 18 - (scores for items 14, 16, & 17) + (scores for items 13, 15, & 18)
Public Speaking: 18 - (scores for items 19, 21, & 23) + (scores for items 20, 22, &24)
Group Discussion Score: ______
Interpersonal Score: ______
Meetings Score: ______
Public Speaking Score: ______
To obtain your total score for the PRCA, simply add your sub-scores together. ______
Scores can range from 24-120. Scores below 51 represent people who have very low CA. Scores between 51-80 represent people with average CA. Scores above 80 represent people who have high levels of trait CA.

APPENDIX B: HIGH COMMUNICATION ANXIETY POST-INTERVENTION SELF-APPRAISAL SHEET

SECTION I : *Appraise yourself by choosing or ticking the choice or choices that correspond to your current high communication anxiety*

No.	Item	Disagree	Strongly disagree	Agree	Strongly agree
1	I have been exposed to many communication contexts				
2	The two-dimensional approach was complementing, interesting and I enjoyed				
3	I feel that the approach can reduce high communication anxiety of students				
4	I still feel tensed when speaking in public or to friends/classmates				
5	With the skills acquired I am prepared to communicate in public without fear				
6	I am not confident to ask questions in class				
7	My GPA has improved				

SECTION II: *Rate (1 to 4) the following activities in order of further reducing your high communication anxiety*

Activity	Rating
I will continue to rehearse my notes, thoughts, speeches and ask questions in class and other public places	
I will always look at my audience, friend(s) or teacher(s) and speak loudly or conversational enough to their understanding	
I will communicate reluctantly with friends while in class and various publics	
I will talk less in public because I continue to feel shy	

SECTION III: *Which two ways of the following will you recommend for reducing high communication anxiety*

(a)	(b)	(c)	(d)	(e)
Regular practice of rehearsing notes, thoughts and speeches	Sitting in a comfortable chair in public	Interviewing others on academic topics and those of personal interest	Knowing topics, audience and discussing relevant aspects of the topics before actual contexts	Ever ready to take any instruction aimed at managing high communication anxiety

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