NONVIOLENT COMMUNICATION: APPLICATION TO HEALTH CARE

by

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DEDICATION

To those who courageously overcome patterns of violent programing and created peace, harmony and authenticity in their part of the world.

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Major Department: Transpersonal Psychology

Nonviolent Communication is a process developed by Marshall Rosenberg more than 40 years ago. Very little research has been done exploring the many potential applications of this process. This dissertation explores one application: applying Nonviolent Communication to a health care system. In the course of this study, I wrote two books and two workbooks about the topic. The results provide much needed data in order to begin to make further headway in transforming systems with Nonviolent Communication.

My dissertation explores the tools of Nonviolent Communication. It gives some background on how Nonviolent Communication was developed and what influences motivated Rosenberg to create his process. The paper explores some issues health care systems have that prevent them from fulfilling their own mission, which is to provide compassionate care to patients. *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* by Sears looks at both system problems and communication problems in health care organizations.

This book that is included in this dissertation uses real examples to illustrate the concepts. It also cites the quantifiable results of the experiment to integrate NVC

into the forensic unit at Mendota Mental Health Institute. The results clearly show that by training staff and patients in Nonviolent Communication the institution saves money, reduces use of force in dealing with violent patients, decreases staff turnover, and creates a more peaceful environment where healing can happen.

My book, which was written for this dissertation, is now translated into German and is known throughout the world. It is used as a resource for others who are writing dissertations and for systems that are changing the usual way of operating to a more compassionate paradigm. Regulatory bodies no longer condone violent, punitive measures that health care systems have operated from in the past. The stakes are high to find effective, nonviolent ways of doing business. My book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*, paves the way for health care organizations to create compassionate, effective systems.

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CHAPTER 1

NONVIOLENT COMMUNICATION: APPLICATION TO HEALTH CARE

Introduction

This dissertation is about Nonviolent Communication (NVC) and its application to health care systems. The purpose of this research is to find out what happens when NVC is integrated into a hospital unit. It suggests that when communication patterns change on the unit, outcomes for both patients and staff improves dramatically. By using the tools of Nonviolent Communication on a forensics unit, I observed and recorded the outcome in a book, which I published. The book is: *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* (Sears, 2010).

This paper will describe what Nonviolent Communication is and illustrate how using NVC can create transformation on a health care unit. I will compare NVC with other training programs such as Crisis Prevention Institute (CPI) that is commonly used to train staff who work in psychiatry. I will also compare Nonviolent Communication with Cognitive Behavioral Therapy, which is commonly used in psychiatric hospitals to teach patients how to untangle their thinking patterns.

Ten years ago, it was common in the United States to have psychiatric units that used power over and punitive measures to manage psychiatric patients. The belief was that control measures were the best way to maintain a safe environment. Research did not substantiate that belief, so changes began to be made. In order to meet the standards that the Joint Commission Accrediting Organization demands, behavioral health programs need to provide safe, high-quality care to all patients. Hospitals need Joint Commission

accreditation in order to maintain a good reputation and credibility in the community. This is one factor that has driven psychiatric units to change from violent management of patients to more gentle, compassionate care.

There have been numerous studies done with empathy training, but my research found no research, except the cases I cited, where NVC was used to create a safer, more humane hospital system.

NVC is a process that can make a positive difference when applied in most areas of society. Its effectiveness has been documented with couples and families, in education, in businesses, in resolving conflict, in creating peace, and in healing emotional wounds of individuals (to name a few). However, I could not find any research besides mine where NVC was applied to a health care system. Anyone who has experienced health care, especially in the US, would agree that more empathy is needed in order to deliver compassionate care. The lack of empathy and the tendency to dehumanize patients by focusing only on their diagnosis is obvious to me, a nurse with more than 30 years' experience. Research corroborates this evaluation. A study done by Ward, Cody, and Hojat (2012) showed that as students gained more clinical exposure, they demonstrated a much greater decline in empathy scores over the year than did those with limited clinical experience during that year. Ward et al. speculate that several factors contribute to this decline, including lack of time (which limits opportunities for empathetic patient communication), anxiety, lack of support from colleagues, an intimidating educational environment, and expanded roles for nurses, which require increased technical skill (Ward, Schaal, & Hojat, 2012, p. 28, 34-–40).

Research has also been done with physicians and the effect of empathy on patient

outcomes. Danielle Ofri, MD explains in the following quote:

> It's no wonder that the third year of medical school figures prominently in studies that document decline of empathy and moral reasoning in medical trainees . . . the erosion of empathy, for example, may have long-reaching consequences. Patients of doctors who score lower on tests that measure empathy appear to have worse clinical outcomes. Diabetic patients, for instance, have worse control of their blood sugar and cholesterol. Cancer patients seem to experience more depression. Medication compliance diminishes. Even the common cold can last longer. (Ofri, 2013)

As a nurse and also a trainer for the Center for Nonviolent Communication, I suspected that by integrating NVC into a health care system there would be both healing for the individuals working in the system and healing for the patients. I presented my ideas to several people in positions of authority in health care, but none of them would allow me to implement my ideas into their systems. However, I decided to use the tools as I went about doing my job (as an RN in a locked psychiatric unit) and record the outcome. When the first edition of my book, *Humanizing Health Care with Nonviolent Communication* (Sears, 2006,) was published a nurse manager, Donna Riemer, RN, PMHN-BC, read it and used the ideas to implement the tools into her forensics unit. A forensics unit is a psychiatric unit that houses patients who have a history of violence and severe mental illness. The results of this experiment (integrating NVC into the forensics unit) are included in the second edition of my book, which is titled, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*. (Sears) I wrote these books in partial fulfillment of this PhD The second edition is included in this

dissertation.

Academic Area Being Addressed

There is a movement throughout the world where people are using psychological, consciousness and language theory to grow and heal. What used to be known and practiced only by licensed professionals is now being practiced by the layperson. The process of Nonviolent Communication contains tools that people can use to transform systems and heal pain in individuals. The tools guide people to be aware of their own feelings and needs and those of others. Since feelings and needs are at the core of what makes us human, the tools lead us toward greater compassion and humanity. NVC encompasses the tools of empathy and language so that people can heal themselves and the world around them.

Projects Contribution to Society and its Importance within the Academic Discipline

Nonviolent Communication translates academic theory and discipline into a language that can be disseminated to large groups of people and used to transform dysfunctional systems into compassionate, operational systems that assist people to grow emotionally and thrive. Helping to educate and heal people who may not otherwise have access to expensive psychotherapy helps evolve the planet from its current state of violence, unrest, loneliness, and despair to a planet that is more aware of how to meet people's needs. Current strategies used in an attempt to meet unconscious needs can be changed to more efficient and effective strategies that are more in harmony with values of peace, love, and connection. The NVC tool can be used to create new cultures that focus

on meeting human needs instead of cultures that focus on power, punishment, and consumerism. This will help create a shift in global consciousness.

Background of the Study

Since the mid-nineteenth century the biomedical model has been the standard in Western medicine. Its focus on pathology, biochemistry, and physiology of a disease has allowed some advancements to be made in medicine, yet has totally ignored and suppressed the effect of emotional and psychosocial issues on a patient's level of wellness.

Doctors were not taught communication skills in medical school because the emphasis was on the physical aspect of the disease. Patients were often referred to by their diagnosis instead of their names. Not until about 35 years ago was this biomedical model questioned.

In 1977 a physician named G. L. Engel defined a new theoretical model for medicine: the Biopsychosocial model:

> By integrating the biological, psychological and social needs of patients within a single framework, Engel's work permitted important distinctions to be made between a person's illness and disease, between curing and healing. The model placed the physician and patient in a dynamic interactional and cultural context, giving additional weight to the physician-patient encounter as a social relationship. (Frankel, 1994, p. 2)

The importance of communication between the clinician and the patient has been studied, and results have shown that patients' perception that their doctors heard them was the single variable associated with the resolution of symptoms. Research shows that

the qualities of caring and concern exhibited by doctors make a difference in health care outcomes. It is also known that skills associated with these qualities can be taught and learned. “Evidence is mounting in support of Dr. Engel’s assertion that caring and compassionate communication between doctors and patients is both a central task and at the heart of medical work” (Frankel, 1994, p. 3).

In a paper entitled “What Is Empathy and Can It Be Taught,” Spiro (1992) suggests that medicine, at least in the modern era, has been driven by the image and value of clinical detachment and neutrality. “Empathy, on the other hand, is based on passion and relationship, joy and sorrow, and the experience of being in the world. Spiro suggests that we could improve our own satisfaction and involvement in the delivery of care by learning and practicing empathic understanding in encounters with our patients and with ourselves(Frankel, 1994, p. 9).

In her thesis, “Empathy Training and Stress: Their role in Medical Students’ Responses to Emotional Patients,” Higgins shows that empathic communication skills training increased the level of empathy doctors in the experimental group showed and decreased their perceived level of stress (Higgins, 1974).

> Developing therapeutic relationships is a key ingredient in the health and healing process. Empathy, support and understanding are core skills in achieving such relationships. Research on the medical interview suggests that where caring is communicated, patients have improved adherence to medical recommendations, are more satisfied and are less likely to bring suit in the event of an adverse outcome. The opposite also appears to be true. Where caring is experienced as absent, patients report increased dissatisfaction and litigiousness regardless of

> whether the outcome was adverse or the care was negligent. Where adverse outcomes occur in a context perceived as uncaring physicians may be at increased risk for malpractice. (Frankel, 1994, p. 11)

Empathy is an important skill for the medical practitioner or medical students to develop when interviewing patients. It helps the interviewer establish effective communication, which is important for accurate diagnosis and patient management. Two facets of medical education limit students' development of accurate empathy: the traditional format of interviewing training and the social ethos of medical training and medical practice, which stress clinical detachment. A number of researchers and educators have developed consulting skills training programs, designed to enhance students' empathic skills and ability. One difficulty for researchers has been the conceptual complexity of the term *empathy* and greater difficulty in measuring the dimension (Evans, et al.,1993).

Domination Systems

Communication, or lack of it, is a major factor in the failure of medicine today. Another factor is the way our medical systems are structured. Marshall Rosenberg calls structures such as most health care systems, domination systems. Domination systems are hierarchal systems where few people control many. It requires that people think and speak in certain ways that support the system. Rosenberg uses the term life-alienating communication to describe this kind of language. “Life-alienating communication both stems from and supports hierarchical societies, the functioning of which depends upon large numbers of docile, subservient citizens. When we are in contact with our feelings and needs, we humans no longer make good slaves and underlings” (Rosenberg, 2002, p. 23).

Domination systems require: (The following five points are taken from: (Rosenberg, 1999):

1. Suppression of self: you deny your own feelings and needs
2. Moralistic judgments: judging another person as wrong or bad when they have different values than yours or when they do things differently than you. Insults, judgments, labels, name-calling, criticism, diagnosis, and comparisons are examples of moralistic judgments. Labeling by the dominant members of society is a form of oppression. For example, when a psychiatrist diagnoses a person as mentally ill, he/she now has the power to determine this person's fate. The psychiatrist can give the person powerful medications against the patient's will and lock the person up.
3. *Amtssprache*: an expression used by Nazi officials to describe bureaucratic language which denies choice and self-responsibility by using words such as should, must, have to, and blaming the actions on superiors orders.
4. Use of the word and concept of *deserve*: In domination systems people in positions of power have the right to punish or hurt others because they believe they "deserve" it, but really, it is just their way of using their positions of power and authority for their own benefit.
5. Demands: If someone in authority tells you to do something and you say no, there will be repercussions. When my manager told me I had to float to the Psychiatric ICU, I knew if I said "No" I would be punished in some way (probably fired). In domination systems you are not allowed to say no unless you want some discipline to occur. (Rosenberg, 1999)

Domination Systems contradict the heart of medicine. When you understand that they require employees to deny their own feelings and needs, yet care about the feelings and needs of the patient, you see that such an expectation is impossible. A person cannot give what he/she does not have. If someone is required to suppress his/her feelings and needs then they certainly will not be able to recognize and honor the feelings and needs of the patient.

Moralistic judgments are the norm in health care systems. The system operates on diagnosis. Without diagnosis, medications would not be the intervention of choice for helping people. Staff are judged and labeled by other staff and by management. My book that appears later in this paper talks more about this and about the other characteristics of domination systems.

Communication and Domination systems are two reasons why health care systems are not meeting the needs of patients and employees. I explore both in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* and show how interrelated they are. By changing the way we communicate we affect the domination structure. A domination system cannot survive if people do not support the structure with certain language and behavior.

Another way of looking at domination systems is called Management by Intimidation (MBI). MBI is the practice of managing or governing people based on fear. MBI affects the overall financial health of an institution. Costs increase, productivity diminishes, and revenue decreases. It aversively affects the morale of its employees (Warigon & Bowers, 2006).

Some Signs of MBI at the hospital where I did my research: use of threats, censored communications (employees who express unfavorable opinions about the working conditions are reprimanded by superiors) self–centeredness, unchallenged authority, lack of transparency, double standards (Warigon & Bowers, 2006).

The Consequences of MBI Practices: unmotivated employees, overstressed workforce, non-enterprising employees, high employee turnover, climate of distrust, climate of vindictiveness, ineffective disputes resolution. All of these symptoms occurred at the hospitals where my research was done.

MBI practices are not in harmony with our democratic ideals (Warigon & Bowers, 2006).

Practicing NVC will go a long way in reducing MBI. The NVC tools help managers respect and motivate the people who work for him/her.

> The rapidly changing nature of business given today's economy and global competitiveness requires a fundamental rethinking in how organizations manage people. Organizations will not be successful or profitable if they do not pay sufficient attention to their working people. Those people have faces. They have feelings. They have aspirations. They want to do their best every working day to help make their organizations successful. And most importantly, they demand to be treated unfailingly as human beings. (Warigon, 2012, p. 2)

Specific Problem Being Addressed

Health Care organizations are assumed to be places where people go to receive compassionate care and find healing. Instead many health care organizations perpetuate dysfunction and illness by using unconscious static language patterns, which trigger pain in others and keep people stuck in their illness. These language patterns are used in staff interactions and between staff and patients. When staff communicates with other staff using static language the organization becomes a hostile place to work. Staff cannot treat others compassionately when they are not being treated compassionately themselves.

When patients are spoken to using static language it puts them in a box defined by the known parameters of their disease process. Their symptoms become a diagnosis that can limit their perceptions of the possibilities of healing. For example, when someone is diagnosed as schizophrenic, the common medical belief is that the person will always have this diagnosis and will need to receive treatment for the rest of his/her life. The patient, who feels powerless in the face of his/her symptoms, believes what the medical expert says and limits the possibilities for his/her life. The person may go on disability because he/she believes that a person with schizophrenia cannot work. This person may take the medications that are prescribed and develop side effects, such as neurological disease or diabetes, which further limits his/her life. On the other hand, there are many cases where people have recovered from schizophrenia and have gone on to live a fulfilling life. They have not gotten stuck in their diagnosis. They have escaped from the box of a static diagnosis and figured out how to grow and heal. The truth is that people are growing and changing all the time.

Changing from static language to process language (such as Nonviolent Communication) benefits an organization in many ways. It raises the consciousness of

the organization and creates a learning environment. The book I wrote, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication,* that is included in this dissertation, explores this concept in depth and illustrates some of the benefits that are possible when NVC is used.

Health care providers need NVC training in order to become reacquainted with their natural empathy and compassion. As people are educated away from their natural compassion, NVC provides a tool to help them reconnect with themselves. NVC also provides a tool to teach how to apply that compassion to language so that it becomes visible. Although at times it is possible to sense whether someone is feeling compassionate toward you, it is often not clear until it is put into words.

Some of the learning that occurs when an organization embraces NVC concepts follows:

- Understanding the difference between static language and process language;
- Becoming connected with body sensations and emotions;
- Developing a feeling vocabulary;
- Understanding your own needs and those of others;
- Being connected with your intentions;
- Translating static language into feelings and needs;
- Taking responsibility for your feelings (self-responsibility, no blame);
- Developing insight into your own habitual patterns;
- Using the model of NVC to reprogram the way you respond or react;
- Learning the difference between a demand and a request;

- Making clear requests.

Nonviolent Communication is based on the premises that:

- We are all simply trying to get our needs met;
- We fare better if we know how to get these needs met through cooperation rather than aggression;
- People naturally enjoy contributing to the well being of others when they can do so willingly (Rosenberg, 2002).

The Intent of Nonviolent Communication is to:

- Create more satisfying personal connections;
- Meet our needs in ways that honor and respect our values and the values of others;
- Heal from previous experiences and relationships that have been painful or unsuccessful (Rosenberg, 2002).

With Nonviolent Communication skills you can:

- Resolve feelings of anger, guilt, shame, fear, and frustration;
- Redirect anger or frustration toward coalition building and cooperative outcomes;
- Create solutions based on safety, mutual respect, and consensus,
- Meet basic individual, family, school, community, and societal needs in life-serving ways (Rosenberg, 2002)

Learning NVC is a journey of many miles. Creating learning environments is essential in order to keep the growth process moving forward. Systems need to be in

place that will maintain a structure, which employees can use to guide them in the principles and practice as they go about their work.

Purpose of the Study

The two areas determined to be in need of change in order for health care systems to thrive, and for patients and staff to get their needs met, are communications and structure. Two questions occur that affect this. Can patient and staff satisfaction be improved by changing the way language is used? Can an environment be created where people feel safe and where human feelings and needs are honored?

Information on these areas was obtained through personal observation and through studying a variety of books and papers about these topics. By informally implementing the tools of NVC into the day-to-day tasks of nursing, I was able to observe what happened when the NVC tools were used and what happened when the tools were not used. Donna Riemer, RN, PNHN-BC, followed up on my research by integrating the tools into the Management and Treatment Unit (MTU) at Mendota Mental Health Institute in Madison, Wisconsin. The patients on this unit were the most acutely aggressive patients in the state's mental health system. If NVC could work in such an environment then its effectiveness would be obvious.

The outcomes being affected involved both the staff and the patients on Riemer's unit. The task was to create a program that increased the safety of the MTU. Riemer's goal was to decrease violence on the unit by 1% in a year. To do this she taught the clinical staff, which consisted of the doctors, the psychiatrists, the occupational therapist, the social worker and the nursing supervisor the four steps of NVC. These staff members then used the four steps when talking with patients and the rest of the staff who provided

care. There were groups twice a week on the unit where both staff and patients were taught the tools of NVC. Staff would work out their conflicts with each other with the patients present and the patients would also work out their conflicts during the groups. The mutual sharing created a sense of community. Violence had been normalized on this unit and people had become insensitive to it. Many meetings were used to define violence. At first violence was only defined as physical altercations. Later the definition expanded to include, glaring, failure to redirect, verbal threats, impinging on someone's personal space, and colluding with someone against another person. It was a joint effort between staff and patients to determine exactly what would reduce violence on the unit and they rewrote the unit rules together. Riemer wanted to create a sanctuary for healing. She realized that most of the patients on the unit and some of the staff had histories of physical and sexual abuse and other types of trauma-inducing experiences. Based on this background, these individuals would be more vulnerable to triggers that traditional service delivery approaches could exacerbate. Survivors of trauma have strong needs for respect and collaboration. With the intention of providing trauma-informed care, Riemer had both staff and patients write their own self-care plan. Patients were thus empowered to help create what they needed to stay safe. Patients and staff learned empathy skills and used these skills to connect with each other and to deescalate patients that threatened the safety and sanctuary of the unit.

To measure the results, MTU violence indicators were compared with the previous year. Some of these indicators were a) number of injuries from aggression; b) hours of seclusion/restraints used; and c) number of emergency codes. The number of lost days and days of modified duty due to staff injuries resulting from patient violence were

compared also (Riemer, 2009). At the end of the year, violence had been reduced by more than 50%. (Sears, 2010, p. 3)

Main Objective of the Research

1. Explain the technology of NVC;
2. Explore the background that shaped NVC;
3. Apply NVC concepts to a health care domination system. Observe and measure the results of changing from a static language to a process language;
4. Create a book to distribute the information.

Hypothesis

Research Question: What are the psychological effects on staff and patients when NVC is used in a health care system?

Null Hypothesis: There will be no difference in staff or patient's behavior when Nonviolent Communication is used in an inpatient psychiatric unit.

Alternative Hypothesis: There will be an observed effect on staff and patients when Nonviolent Communication is used in an inpatient psychiatric unit.

Importance of the Study

This is the first research done on the effects of integrating Nonviolent Communication into a psychiatric unit. The effects of integrating NVC positively impacts both staff and patients. It also saves money for the institution by decreasing recruitment and retention costs, and decreasing staffing costs.

There has been some research about the effect of teaching empathy skills to health care professionals (mostly doctors and medical students.) The research shows that health professionals benefit from learning empathy skills. The research does not quantify how

these improved empathy skills impact the patient population these professionals are serving.

This dissertation is the first research project that quantifies the effect of integrating NVC into a health care system. The effect on both staff and patients is recorded. Comparing indicators before and after the integration measure certain aspects of the effect. Other aspects can only be measured in anecdotal form, such as staff reporting they feel happier and safer where they work.

This research is relevant to all health care institutions. It can benefit all personnel working in the institution by creating a safer, happier place to work. It can benefit the patients by creating an empathic environment where they are more likely to get their needs met. It can also benefit management and administration. Management can use the tools to create more functional relationships with the staff. Knowing the tools will decrease the stress and loneliness that managers often feel because they will know how to open up communication and connect with people on an authentic instead of autocratic manner. Administration will benefit because of a cost-saving decrease in litigation and improvement in systems.

After I wrote the first book, *Humanizing Health Care with Nonviolent Communication* (2006), a young man called me to set up a coaching session. He had read my book and asked, “How did you know what it was like where I work?” I asked him if he worked in health care and he said, “No, I’m a janitor in an office building.” This helped me understand that although my book is directed at the health care industry, it is relevant to many businesses. Where domination systems operate you can expect to see the same dysfunctional characteristics among management and staff no matter what the

business is. My book can be used as a guide to all businesses on how to create more humane compassionate systems, which will have a positive effect on all aspects of the business.

Why Nonviolent Communication?

There have been some empathy training programs and other programs to enhance communication skills with nurses and doctors. However, very little research has been conducted to assess the effects of Nonviolent Communication (NVC). NVC is not only an empathy-training program but disseminates a deeper understanding of language in general. It is important to realize that empathy is only one part of understanding and connecting with others. The definition of empathy as taught in NVC may be different than that of other training programs, which may not emphasize mastery of language, as NVC does. The definition of empathy is often misunderstood and is often confused with sympathy. Since empathy has been shown to be the predominate factor for success in therapy and transforming behavior it is important to clearly understand what it is. Dr. Guy Azoulai teaches empathy in Motivational Interviewing to therapists and doctors in France. To help his audience understand the difference between empathy and sympathy he uses prefixes to explain: SYM PATHY means, “Sharing other’s distress” whereas EM PATHY means “understanding without sharing other’s distress” (Azoulai, 2006, p. 11). These prefixes are defined as: SYM-“in union, acting together” (EnglishClub, 2013). EM-“put into or on, bring into the condition of” (EnglishClub, 2013).

With sympathy, a person listens, understands, judges, but is not able to help because he/she is personally involved in the distress and other emotions that someone is experiencing. With empathy, a person is able to listen and understand. He/she does not

judge and is able to help because he/she is not caught up in the feelings that another is expressing but is firmly grounded in his/her own reality (Azoulai, 2006).

When comparing the empathy training programs in a couple of articles with what is taught with NVC I noticed significant differences. For example, in an article by La Monica (1983): To demonstrate knowledge in a practice situation the student is given four choices and asked to pick out the empathic response. The correct response is: "You feel left out because money problems might cause you to miss the senior prom."(p. 21) By applying NVC principles to the sentence, "You feel left out because money problems might cause you to miss the senior prom," we see that the phrase "left out" is not a feeling. It is a thought. The person is thinking he/she will be left out. NVC teaches us to find the feelings under the thoughts. Accurate empathy would sound more like, "When you think you may miss the prom, do you feel sad because you were hoping to be included?" Using the NVC model also means connecting the feelings to the needs that stimulate them. In the above example, sadness may be the feeling, and the need that is stimulating the feeling is inclusion. When you use words such as *left out* to empathize with someone you join them in their powerless world that believes that there is such a thing as being left out. Using the tools of NVC allows us to move away from thoughts and toward connection on a heart level. Feelings and needs are the language of the heart. Understanding the difference between words that express feelings, words that express thoughts, and language that captures human needs is essential in order to accurately understand what someone is experiencing. Connecting the feelings to the needs is also empowering, as it creates self-responsibility. There is no need to blame others for causing your feelings when you understand that your own needs are responsible. You can quit

being a victim, at the mercy of others who make you “feel” things like “left out.” You have choice and are responsible for meeting your needs.

Teaching NVC is much more than just teaching empathy. NVC teaches people to understand and use language in a way that meets human needs. When language is understood in this way it empowers people to understand that the words they use in the present have the potential for creating the dream of the future.

Communication has two parts: *Listening* and *Speaking*, otherwise known as *Empathy* and *Honesty*. Honesty in NVC language is about self-responsibility, not blame or judgment or other prescriptive forms of language. People often think that being honest means blasting people with their judgments or analysis. This is an outward form of communication that is focused on what people are doing wrong. In NVC, honesty becomes an expression of feelings and needs. The shift from outward analysis of wrongness to inward truth maintains the energy at the heart level.

This focus on language gives people the tools they need in order to understand the inner world of others and to build relationships based on mutual respect and self-responsibility. These skills have been absent in health care for the last 100 years because the focus has been on the physical aspects of illness. The emotional and psychosocial issues that patients express along with their illnesses have been ignored or suppressed. Not knowing how to deal with the emotional lives of people is very stressful, especially in health care. Patients are in crisis when they are ill. The crisis has to do with the whole organism, not just with an injured knee or a weak heart. Emotional issues are stirred up when someone is sick. If the health care worker does not have the skills to deal with emotions then they are constantly stressed.

The closest example of a training program other than NVC that has been integrated into a psychiatric unit is CPI training. CPI stands for Crisis Prevention Institute. In 2006 CPI training for high-risk staff was started at the Seattle hospital that Sears used in the research for her book. CPI training continued once a year for all high-risk staff. In 2009 the hospital had a goal to decrease and eliminate use of seclusion and restraints and determined that a change in culture was needed. In the CPI classes staff was educated about the stages of patient escalation and what kind of intervention is needed for each stage. For example, when a patient is anxious an empathic, nonjudgmental approach is recommended. When a patient is acting out and there is eminent danger, the staff needs to physically intervene in order to control his/her behavior until he/she regains control. Ways to minimize the risk of physical intervention is discussed and staff practice using certain holds and protective measures.

The culture change from a violent, power-over paradigm to a more empathic, patient-centered one, along with yearly CPI training resulted in the following:

One unit reported a decrease in assaults by 34% between 2010 and 2012. Another unit in this hospital reported a decrease in assaults by 22% for this same period. A third unit reported an increase in assaults by over 200% between 2010 and 2012. As expected, there is a positive correlation between use of seclusion/restraints and assaults. The factors that caused an increase in assaults by 200% on the third unit are unknown. Since all staff on the units attended CPI training, one would expect the results to be more uniform. Since I work on all three units, I can express my evaluations. The two units that experienced a decrease in assaults were the two most violent units. There was a power-over paradigm present and the staff treated the patients in an authoritarian manner. It

makes sense that when management told staff members that behavior expectations were changing they started to treat patients in a kinder manner. In the past staff would force patients to comply with their demands. For example, if a patient sat on the floor, staff would physically pick him up and drag him to his room. Now when a patient sits on the floor, staff allows him to stay there until he moves on his own. There are fewer rules now and more empathy. Patients have more autonomy and their needs are better met.

On the third unit, where assaults increased, the employees were already kind to their patients. They actually did everything they could do to sooth and care for the patients on this unit. When they were told that behavioral expectations were changing, they tried even harder to be kind. However giving into a patient's demands is often not the best strategy to maintain peace and harmony. In the CPI training, the technology of language was poorly understood by the trainer. The trainer did not understand the difference between a need and a request. She told the staff to meet the patients' needs in order to decrease violence and used an example of this, saying, "When someone asks for an Ativan, figure out a way to get it for him." Ativan is not a need; it is a request. The need underneath the request for Ativan could be relief from suffering or empathy or relaxation. Once you understand the need, you have many more strategies for meeting the need than if you focus only on the request. You could get the patient an Ativan or you could give him some empathy or you could recommend he use the biofeedback device. Ativan is not always effective if there is a strong underlying need that cannot be met by taking Ativan.

Here is a story to illustrate this point: I had a patient who was very anxious. Her body appeared tense, and she followed me around the unit with a pleading look in her

eyes. I gave her some Ativan because I was too busy to stop and accurately assess her needs. The Ativan did not help. She continued to follow me around the unit and plead with me through her eyes. Finally I sat down with her and gave her some empathy. I heard the pain and fear she was experiencing. As she talked her voice dropped from a high-pitched whine to a lower pitch. After about 10 minutes there was a nice connection between us. I felt compassion toward her, where earlier all I felt was irritation. The patient relaxed and said, “You are the only here that understands me.”

Here is another example that illustrates why it is not always a good idea to meet the patient’s requests: A young woman was making many requests of me. She asked for every kind of food we had, then she asked for all the supplies we stocked. When I opened the utility room door to get her some toothpaste, shampoo, deodorant, and soap, the patient saw some yellow socks. The yellow socks are only used for fall-risk patients in order for the staff to readily see them and be prepared to offer assistance. The patient demanded to receive a pair of the yellow socks. I knew it was a demand and knew that when I said “no,” the patient would act out. I told the charge nurse that I was not going to give this patient the yellow socks and to expect some bad behavior. When the patient did not get the yellow socks she yelled and cussed me out and demanded a different nurse. The charge nurse backed me up and refused to give her a different nurse. Eventually the patient calmed down and was seen playing a board game with other patients on the unit. I believe that the patient did not really want all the stuff that she asked for but instead needed limits set in order to get underlying needs met. Even though it was difficult to set the limits and difficult for the patient to receive them, people need limits in order to feel safe. I imagine the need that the patient was expressing was for safety.

When my 3-year-old granddaughter was on vacation, her parents did not set limits for 2 days. They let her stay up as late as she wanted, and they bought her everything she requested. By the end of 2 days my granddaughter was an angry, biting, yelling child. The limits were reestablished and the child became her usual sweet self again. Limits are needed in order for children to feel safe. People in the psychiatric hospital have often had a traumatic childhood where needs were not met. The patient in the above story had learned to bully others in order to get her needs met. People did not dare say "no" to her because they were scared of her. Yet, I could see the hurt child in this patient who needed limits in order to grow. When I said "no" to her, I actually met her need for safety better than if I had said "yes." Giving a patient what they request may not be the best way to meet the underlying needs. This is why it is essential to understand the difference between a request and a need. Using communication technology accurately is essential in managing and connecting with psychiatric patients. Empathy is only one strategy to meet underlying needs.

I took care of a woman who spent most of her time crying and howling. Since staff members were told that they should be empathic with patients, staff gave her empathy for her imagined pain. (She had delusional parasitosis.) They let her stay in bed when she refused to get up, which caused the patient to develop a bed sore. I tried giving this patient empathy and noticed that it did not seem to help. In fact, the patient howled louder. Her howling behavior was disruptive to the unit. I decided not meet her requests but to take care of her in a way that was less likely to cause complications and distress. I got her out of bed in spite of her protests and took her out of her room. The patient started howling. I told her that every time she howled I would add 5 minutes to the time she had

to stay out of bed. The patient quit howling. Earlier the patient said that she could not help howling. “The doctor says it’s unconscious,” she said. I told her that I believed she had the power to stop it if she wanted. Throughout the shift I did what was needed to provide good care to this patient, in spite of her verbal threats. I repositioned her on her sides every 2 hours, encouraged her to drink fluids, which she did not want, and in general took care of the physiological needs of her body (but not her verbal requests). Other staff members remarked that this was the quietest the patient had been in weeks. If I had listened only to the patient’s requests, she would have lain in bed all shift becoming dehydrated and her bed sore would have worsened. The patient was not happy with me. She said, “You are so mean.” Kindness is not empathy. It is more akin to sympathy and pity. Sympathy and pity are not needs. Sometimes the strategy of *kindness* goes against what needs to be done to provide good care to the patient. If kindness is defined as giving patients what they request, than it can be a disservice.

Understanding how communication works is essential in providing the best care. When I noticed that the CPI trainer did not understand communications, I was doubtful that her training would be as effective as it could be. When the skills and understanding of Nonviolent Communication are used, people become more sophisticated in how they care for patients. But until staff learns to listen to their own inner wisdom instead of doing what the authority figure says, there will be confusion and poor outcomes. In spite of being *kind* the assaults on the unit increased by more than 200%. CPI is a useful training program for educating staff in hands-on physical response. The biggest problem with CPI, at least, as it was taught at the hospital I researched, was that employees were told to be empathic but were not taught how to do it. Everyone has a different idea of

how to show empathy. People often confuse empathy with sympathy. They think being empathic is about being nice. The communication aspect of CPI does not appear as effective as NVC training. NVC trains people in empathy skills and empowers people to figure out the best strategy in dealing with each situation. A combination of being able to understand the needs of others, combined with being grounded in your own needs helps create empowered responses. Also the power of community in healing cannot be stressed enough. Riemer's experiment showed that training everyone in NVC on the forensics unit, including the patients could create a safe, healing environment.

Scope of the Study

The process of Nonviolent Communication has been around for more than 4 decades. It has spread in a grass roots sort of way, so most of the research done with it has been informal and not documented. There are many personal testimonials about its effectiveness though. As a student of NVC I experienced internal change and healing so I knew from the inside out that the tools worked. I wanted to take the tools into the system where I worked and test them for my dissertation. I wrote my books on the two things I know the most about, Nonviolent Communication and nursing.

The research I did provides some much needed statistics about the effectiveness of Nonviolent Communication. The subject population of the research study consisted of staff and patients in locked psychiatric units. Staff consisted of doctors, nurses, and mental health specialists. The patients had varying diagnoses (schizophrenia, bipolar disorder, antisocial disorder, borderline disorder, major depression, sociopath, etc.) and all were in locked psychiatric units. Some of them were considered to be the most violent mentally ill offenders in the state. Even though the patients had severe psychiatric

diagnoses, the premise for the research was that they were still human beings and had the ability to grow and heal like all humans. The belief that supported this was from Carl Rogers. He said that all humans move in a positive direction when given the support and caring and safety they need. Carl Rogers writes about this belief in his book, *On Becoming a Person*. He says,

> It has been my experience that persons have a basically positive direction. In my deepest contacts with individuals in therapy, even those whose troubles are most disturbing, whose behavior has been most anti-social, whose feelings seem most abnormal, I find this to be true. When I can sensitively understand the feelings which they are expressing, when I am able to accept them as separate persons in their own right then I find that they tend to move in certain directions. And what are these directions in which they tend to move? The words which I believe are most truly descriptive are words such as positive, constructive, moving toward self-actualization, growing toward maturity, growing toward socialization. (Rogers, 1989, p. 26)

The data obtained in this research was through my own personal observation. Riemer's follow-up study measured decreased violence by integrating the tools into her forensic unit. Violence indicators used to measure the results were compared with the previous year. Some of these indicators were a) number of injuries from aggression; b) hours of seclusion/restraints used; and c) number of emergency codes. Number of lost days and days of modified duty due to staff injuries resulting from patient violence were compared also (Riemer, 2009).

Some of the variables assessed were the witnessed differences in patient/staff response when the tools of NVC were used versus when they were not used.

Limitation of the Study

The most glaring limitations of the study were that not more indicators were used to assess the effectiveness of the program. If I had it to do again I would have given patients and staff a before and after questionnaire in order to evaluate emotional factors related to the study. Factors such as happiness, sense of well being, clarity of thought, trust, and improved sleep could have been measured more objectively. As it was, these states were reported but not measured. It would have been interesting to measure physiological responses also. Taking pretest blood pressure and comparing them with post-test blood pressure could have achieved this. It would also be interesting to document how cortisol levels were affected pre and post. A simple blood test could be done to check that.

The indicators used in Riemer's experiment were those that were measured every year at Mendota Medical Institute. The data was available and tracked on an ongoing basis by the institution. The advantage of this is that it eliminated the possible bias of the researcher. The results were objective.

The psychiatric units studied were in Seattle and Wisconsin. The subjective data revealed that patients in both locations reacted in a similar way when NVC tools were used. The tools have been effective in connecting with people's humanity no matter where they live. If the research had been done in other countries I suspect that the outcomes would corroborate the results of this study.

Part of the research was based on personal observation. The skill level and bias of the researcher could have affected the results. In this case, the skill level of the researcher's empathy skills and knowledge of the NVC tools was high. She had more than 20 years' experience using NVC and had attended hundreds of hours of training. She routinely taught NVC to couples, groups, and businesses. If the skill level had been lower, one would think that the results might have been different. However this did not hold up when the data was collected. The biases of the researcher were acknowledged through the use of language. When the researcher noticed she was using judgment, blame, or analysis she took responsibility for that and revealed more vulnerably what was going on. This is one reason why the book was rewritten and published twice. Language was used in the writing that is congruent with NVC principles. Someone who was relatively new to NVC implemented the program in Wisconsin. She had only been studying NVC for about a year and had only attended one training given by Rosenberg. In spite of different skill levels, the patients responded in a similar way in the two locations. This showed that the tools of NVC are able to transcend the skill level of the practitioner.

Definitions

Static language: An outwardly directed use of language that focuses on what others are doing right or wrong. It does not reveal what is going on inside the person using this language. Wendell Johnson, the American psychologist and speech pathologist says this about static language:

> Our language is an imperfect instrument created by ancient and ignorant men. It is an animistic language that invites us to talk about stability and constants, about

> similarities and normal and kinds, about magical transformations, quick cures, simple problems and final solutions. Yet the world we try to symbolize with this language is a world of process, change, differences, dimensions, functions, relationships, growths, interactions, developing, learning, coping, complexity. And the mismatch of our ever-changing world and our relatively static language forms is part of our problem. (Rosenberg, 2002, p. 26)

Empathy: Qualitatively it is an active process of desiring to know the full, present and changing awareness of another person, of reaching out to receive his words and awareness that are most important to him at the moment. It is an experiencing of the consciousness behind another's outward communication, but with continuous awareness and this consciousness is originating and proceeding in the other. (Barrett-Lennard, 1962, p. 43)

> "Empathizing is being able to identify the thoughts and emotions of another persona and having an appropriate emotional response to these." (Baron-Cohen, 2013) There are two types of empathy: 1. *Cognitive empathy*, which is the ability to understand the thoughts and feelings of another person and 2. *Affective empathy*, which is the ability to respond with appropriate actions to people's feelings. Baron-Cohen reports that autistic people lack cognitive empathy but have affective empathy. This allows them to deal with others in non-harmful ways. A psychopath on the other hand has cognitive empathy but lacks affective empathy. This gives them the ability to manipulate others and allows them to harm people. (Baron-Cohen 2012)

Rogers said that empathy is a way of being rather than doing. An empathic attitude is necessary for client-centered therapy to avoid distortions (Rogers, 1980).

Rogers defines empathy as:

> To perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition. Thus, it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. (Rogers, 2012)

Marshall Rosenberg defines empathy as: "Empathic connection is an understanding of the heart in which we see the beauty in the other person, the divine energy in the other person, the life that's alive in them" (Rosenberg, Wikipedia.org)

Elements of empathy: Empathy is about understanding the feelings and needs being expressed. It is a compassionate flow of energy extended toward oneself or another.

To be in an empathic space requires you to be fully in the present moment of another (without losing yourself.) “Empathy comes through you but is not of you.” (Rosenberg, 1993) You clear a space inside of you to receive others. If you are unable to receive others without judging or reacting in some way that is an indication that you need empathy yourself. By healing your own reactions, you become more present toward others.

When extending empathy toward another person, the focus is totally on them. You understand their feelings are not yours. If you have thoughts or feelings while giving

empathy, you notice them and let them pass. It is much like meditation. When you notice thoughts during meditation, you do not hold on to them, but let them filter through your consciousness and then you refocus.

When receiving others empathically, you connect with them as they are. Any of the following habitual patterns of responding and reacting can prevent you from being present. These patterns take the focus away from the person speaking and place it on you.

Giving advice: “You should exercise three times a week.”

Fixing it: “Just take vitamin D and you will feel better.”

Story telling: “That reminds me of the time when my dog died…”

One-upping: “You think that hurts? You don’t know what pain is until you break your arm like I did.”

Educating: “A delusion is not real.”

Consoling: “It will turn out better next time.”

Shutting down: “Don’t feel that way.”

Sympathizing: “I feel bad for you.”

Interrogating or questioning: “Where were you when this happened?”

Explaining: “I would have called sooner but I didn’t have my cell phone with me.”

Correcting: “No, it happened this way.”

Judging: “You’re acting bossy.”

Reassurance: “Don’t worry, you’ll get better soon.”

Factors that decrease empathy in a person:

Social factors:

1. Obedience to authority (This is what allowed Nazi's to kill millions of Jews.)
2. Ideology (a person's strongly held beliefs. For example, the Boston Marathon bombing suspect, Dzhokhar Tsarnaev, wrote on the boat, which he was hiding in, "Fuck America" and "Praise Allah." He expressed that his actions were retribution for US actions in Iraq and Afghanistan. He justified killing and injuring people by saying collateral damage is inevitable, just as it was when the US were killing people in other countries.)
3. In-group and out-group relations (this is when one group dehumanizes another group and makes them the enemy. It is easier to harm others if they seem different from oneself).

Childhood treatment:

1. Absence of parental love
2. Childhood mistreatment

Biological Factors:

1. Increased testosterone in the fetal fluid (This can lead to an increase in autistic traits as the children grow up. An autistic person has trouble with Cognitive empathy. They do not have trouble with Affective empathy (Baron-Cohen, 2012).

Chapter Reviews

The following is a chapter-by-chapter discussion of the main principles involved in *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*:

Chapter One: A Crisis in Health Care

Health care workers have a higher rate of depression and suicide than other full-time workers. Lack of communication skills is a significant contributor to this.

Nonviolent Communication has been successfully integrated in two hospitals in the US (Mercy Hospital in Baltimore and Mendota Mental Health Institute). Statistics show that the following occurred when NVC was used: At Mercy Hospital there was improvement in patient satisfaction, reductions in employee turnover, and improved worker performance. At Mendota the results showed that there was a decrease in use of seclusion and restraints, a decrease in time loss due to staff injuries (from several months lost to 0 months lost) and there was more than a $10,000 saving in staffing costs.

Chapter Two: Understanding Nonviolent Communication

This chapter covers some background of NVC and explains how the NVC tool works. It also describes some of the principles of NVC: 1) Each of you is responsible for choosing your reactions to people and events; 2) Each of you is responsible for your own feelings; 3) Your needs are a gift, not a burden to others; 4) The experience of empathy is at the heart of constructive communication. The chapter discusses what is and what is not empathy and gives examples of both. It also talks about the change in consciousness that occurs on a personal and organizational level when NVC is used.

Chapter Three: From Domination to Partnership: The Evolution of Health Care Systems

There is movement occurring in businesses, families, and other organizations away from hierarchical domination systems to collaborative partnership systems. This chapter discusses the language of domination and gives examples. It also compares characteristics of domination systems and partnership systems.

Chapter Four: The Language of Diagnosis, Judgment, Analysis, and Labeling

This chapter discusses the use of judgment, diagnosis, and labeling and the effects that using this language has on individuals, patients, and the organization. It also explains how Nonviolent Communication (NVC) can be used to improve the common negative dynamics of health care organizations.

Chapter Five: From "Power Over" to "Power With": The Case of Psychiatric Medicine

This chapter covers the following topics:

- Controlling psychiatric units with violence (restraints, punishment, labels);
- Using NVC to create more humane and safer systems;
- Discussion about mental illness—is it a physiological condition or a reaction to stressful, dysfunctional environments?
- What are the underlying beliefs about mental illness?
- Discussion of protective versus punitive use of force;
- Repercussions of power-over tactics;
- The need for choice in order to heal;
- Using empathy to de-escalate a patient;
- Shifting from a demand and control conversation to a request and empathy model;

- The difference between demands and requests;
- Acknowledging the effects of childhood abuse.

Chapter Six: Compassion, Empathy, and Honesty: A Road Map for Creating Life-serving Systems of Care

This chapter covers the topic of expressing honesty using NVC and explains why honesty is needed in organizations. It also gives the reader ten starter ideas for integrating NVC into an organization.

Conclusion: Empathy is one of the simplest yet most potent human technologies on the Planet.

Other reported outcomes with the Mendota Mental Health Institute experiment: Since implementing NVC in their unit, the culture of the unit has changed from one of violence to one of peace and harmony. Staff turnover and staff injuries have stopped and nurses are now competing to work on the unit that used to be one of the worst places to work. The chronically mentally ill patients are actually getting better and are being transferred to less restrictive units. The unit has become a sanctuary that promotes recovery.

CHAPTER 2

REVIEW OF THE LITERATURE

I was unable to find any research on integrating Nonviolent Communication into a hospital unit or health care system. I was able to find some research on using NVC in educational systems and in other applications.

NVC was developed about 40 years ago. In 1973, *Mutual Education: Toward Autonomy and Interdependence* (Rosenberg, 1973) was published. Although the model of NVC evolved from 1973, much of the philosophy that Rosenberg embraced was articulated in this book. Some of goals of education that Rosenberg described later became generalized to encompass all systems, not just education systems. Some of these goals were: to make life more wonderful, to get everyone's needs met, to connect with self and others, to motivate through the joy of natural giving, and to learn how to receive freely from others. (Wikipedia, 2013d)

Most mediation and conflict resolution practices developed from the early to mid-1900s. It was not until the 1980s that modern Western conflict resolution approaches arose from interest-based conflict resolution, negotiation, and mediation models (Yarn, 1999).

The interest-based approach to conflict resolution shares many similarities with NVC: An Interest-based approach separates the problem from the people. I-statements

instead of you-statements are used. Each person listens closely to what the other is saying and checks for accuracy. There is no blame. Interests are identified. Interests are defined as needs, desires, concerns, or fears that underscore a position (Fisher, Ury, & Patton, 1991). NVC encompasses most of these principles; the major difference being that emotions are explored more in depth in relation to *needs*. NVC not only teaches I-statements but also builds in language that creates taking responsibility for one's feelings. This allows an individual to express fully without blaming. The NVC process becomes a tool for personal transformation as it is used to resolve conflicts and to connect with others. "The interest-based negotiations offer more specific direction around developing strategies or options for mutual gain, as well as methods for maintaining a negotiated agreement" (Little, 2002, p. 34).

In 2004, Dominic Barter developed the Restorative Circle (RC) process using NVC principles and practices. By using the four steps of NVC as a conflict resolution tool, strategies are reached that work for all parties. The process is very effective in restoring harmony between participants.

At the time that Barter created Restorative Circles, he went into favelas in Brazil where violence was rampant. Homicide rates in Brazil in 2010 were 23.8% (per 100,000 inhabitants) making it one of the most criminalized countries in the world (Wikipedia, 2013a). Some of the favelas were run by gun-carrying teen-agers. Barter began to work with the youth in the favelas and created a system based on Restorative Justice and NVC. "Restorative Justice fosters dialogue between victim and offender and shows the highest rates of victim satisfaction and offender accountability" (Wikipedia, 2013g). "It is based on a theory of justice that considers crime and wrong doing to be an offense against and

individual or community, rather than the state" (Wikipedia, 2013g). Restorative justice promotes responsibility and healing instead of punishment and incarceration. As in interest-based negotiation, the Restorative Circle process brings the offender and victim together (as well as any support people that are desired) and agreements are reached that are derived from listening to each other's feelings and to the meaning beneath the feelings (which could be the need or the intention). These agreements are then implemented. The participants meet again after an agreed upon time to evaluate if the agreements are working. A person trained in the process of RC facilitates the Circle. The strategies that are created evolve out of the process of listening. Research shows that the consequences of using a Restorative Circle process in schools and in community significantly decrease the cases that reach the judge. "In over ninety percent of cases agreements are reached and kept, transforming the experience of all those involved in violent conflict and promoting an unprecedented cultural shift wherever Circles have been adapted as a way to handle conflict" (Barter, n.d.).

Systems and Psychiatry

Toward the end of his life Abraham Maslow wanted to apply his basic theory of motivation to social organizations and structures. He developed a threefold model that included 1) deficiency motivation, 2) humanistic motivation, and 3) transcendental motivation. Maslow explained how these three levels of motivation could be applied to government, business, religion, interpersonal relations, and psychotherapy. Deficiency needs are the most basic human physiological needs, such as the need for food and water. Once these needs are met then other needs can be met, such as the need for safety and security. Deficiency needs "arise from an actual or perceived deficiency in the

environment or self. The individual strives to complete these deficiencies through extracting what he or she needs from the physical, interpersonal, or social environment" (Battista, Chinen, & Scotton, 1996, p. 55). The traditional medical model in which the therapist or doctor is the knowledgeable authority who tells the person what to do and supplies him with what he needs is operating on deficiency motivation. (p. 56) This has been the model for health care systems for the last 100 years. "Organizations operating at the deficiency level use a managerial style of power-authority in which the employee is paid to do the job he/she is told to do" (p. 57).

A question this paper strives to address is what would happen to the structure of an organization when domination style or deficiency language is changed? What will happen to the medical model when a health care organization moves from the deficiency level to the humanistic level or even the transpersonal level of operating? In a humanistic organization the business functions through mutual respect. An employee is empowered to participate as fully as possible in the organization. Authority resides within each individual. In a transcendent organization, all workers are devoted to service. The purpose of the organization is to serve the client as fully as possible. "Authority is assumed to be transcendent and ethically apparent to each individual" (Battista, Chinen, & Scotton, 1996, p. 57).

In the traditional medical model that operates on deficiency motivation, the practitioner's job is to meet the needs of the client by giving him/her what he/she lacks. In Western medicine the strategy for meeting the needs of the patients is to give them medications or surgery. By practicing medicine this way there is an assumption that what the patient needs is drugs or surgery. There is no effort to check and see what the patient

really needs. Looking at the problem from deficiency needs, a question arises: Do medications address the need? Consider a depressed patient that is given Prozac; does a patient who is given Prozac, lack Prozac? (Is the patient deficient in Prozac?) What are the actual deficiencies needs of this person?

In our current system there is no effort to connect the need to the strategy. This is because people are not educated to understand the difference between needs and strategies. The doctor sees that there is a problem with someone. From there he/she jumps to a strategy to fix the problem, without considering the feelings and needs of the patient.

NVC breaks down communication into four steps: Observation, Feelings, Needs and Requests. Requests can be interchanged with strategies. Take the problem of depression. The strategy of Western medicine is to fix the problem by giving medications. Sometimes the medications help and other times they do more harm than good. The only thing considered by the health care practitioner is the problem and the strategy to fix the problem. NVC teaches us to look more closely at what is going on. By listening deeply to the patient we use the NVC process in the following way: 1) *Observation*: The patient says he feels depressed. 2) *Feeling*: He feels hopeless and lonely. 3) *Need*: He needs community, friendship, and connection. 4) *Strategy*: Help him find some community resources where he may be able to meet his needs. Also teach him NVC so he can become aware of what his needs are and better able to meet them in a life-serving way. In Western medicine the observation is that the patient says he feels depressed. The accepted strategy is to give medications. Without listening to the feelings and needs of the person, the medically accepted strategy may not address the needs. The patient also may not know how to communicate his feelings and needs. Without knowing

how to use language to express his inner world, the patient is dependent on an expert to take care of him.

If this patient is given Prozac, he may be less likely to meet his needs. For one thing, Prozac causes sexual side effects in 60% of people. It can also intensify depression and cause people to commit suicide. The strategy of giving medications to treat psychiatric disorders is a strategy that needs to be seen for what it really is. Psychiatric medications repress the emotions so the patient sometimes feels better for a while. Medications do not help a person heal the cause of his disorder or learn new coping tools. Without doing personal growth work to heal his pain or learn new tools a person will find himself in the same situations over and over again (because his consciousness will attract this). If his reliance is sorely on medications then his life will spiral downward. The medications may lose their effectiveness and the person may become impaired by the side effects of the medication. What was a strategy to fix the problem actually added to the problem.

Looking at the strategy to give medications to fix mental health problems, let us see if medications meet physiological needs. The pharmaceutical companies claim that medications are needed because people who are mentally ill have a biochemical imbalance in their brain. According to Peter Breggin, MD, this theory has never been proved. He says that there is currently no technique for measuring the neurotransmitters between cell synapses. In his book, *Your Drug May Be Your Problem*, Peter Breggin (1999) explains the following:

The research in no way bolsters the idea that psychiatric drugs correct imbalances.

> Rather, it shows that psychiatric drugs *create* imbalances. In modern psychiatric treatment, we take the single most complicated known creation in the universe-the human brain-and pour drugs into it in the hope of "improving" its function when in reality we are disrupting its function. (p. 7)

A different point of view by Dr. Daniel Amen gives some persuasive evidence that medications can correct imbalances in the brain. Dr. Amen is able to show where the brain is imbalanced through the use of nuclear brain imaging called SPECT (single photon emission computed tomography). This test measures cerebral blood flow and metabolic activity in the brain. The data gathered from these brain studies correlate with behavior patterns. When certain areas of the brain are underactive or overactive it shows up on the SPECT. Disorders can be better treated with the information received from SPECT. For example, when the temporal lobes in the brain are underactive (shown on the SPECT as dark areas), people are more prone to rapid mood shifts, anger, and memory and learning problems. When the prefrontal cortex is impaired, people have problems with attention span, focus, and organization. "Learning how to activate the prefrontal cortex in a positive way leads to better internal supervision" (Amen, 1998, p. 9).

The ability to correlate behavior with specific brain patterns helps patients receive the proper treatment. For instance Dr. Amen tells the story of his 9-year-old nephew who changed from a happy child to one who appeared depressed, aggressive, and had suicidal and homicidal thoughts. Instead of placing him on medications, which is what many psychiatrists would do, Dr. Amen took a SPECT scan of his brain. The scan showed that the left temporal lobe of the nephew's brain was completely dark. The nephew went on to get an MRI, which reveals that there was a cyst in the left temporal lobe. After surgery to

remove the cyst, the nephew returned to his previous pleasant 9-year-old behavior (Amen, 1998).

A SPECT study of the brain can help diagnose the difference between conditions that demonstrate the same behavior. For instance both a patient who has Alzheimer's and one with depression may appear forgetful. The treatment for a patient with Alzheimer's and one with depression are very different. Without the proper diagnostic tests, treatments prescribed can be a disservice to patients. After doing a SPECT scan of his patients, Dr. Amen uses various modalities to treat their disorders. He is conservative in using medications and uses them to target the part of the brain that shows up on the SPECT scan as imbalanced. For instance; if there is a temporal lobe abnormality, a mood stabilizer such as Depakote is used. If the deep limbic system is affected than an antidepressant is used. The initial SPECT scan is sometimes compared with one that is taken after the drug has taken affect and shows the effectiveness of the treatment.

Dr. Amen also uses other modalities to treat brain dysfunction. Some of these are psychotherapy, Cognitive Behavioral Therapy, EMDR, exercise, and herbs (such as Saint John's Wart). All of these have been shown to be effective in changing behavior and in correcting the brain dysfunction on the SPECT scan.

According to the research, medications can be effective in treating some brain dysfunction. There is concern about the long-term effects of the medications and the potential side effects. Some of the side effects include apathy, abnormal dreams, acute respiratory distress, akathesia, agitation, aggression, agoraphobia, paranoia, assorted blood pressure and heart problems, weight gain, diabetes, breast enlargement in young boys, measurable brain damage, cerebral atrophy, disinhibition, hostility, homicidal and

suicidal ideation, convulsions, diabetes, Parkinson's symptoms, tardive dyskinesia, tremors, convulsions, psychosis, cerebral vascular accident, inability to express emotion, lethargy, increased chronicity of emotional problems, early dementia, and early death (Breggin, 2008).

Considering the potential toxicity of psychiatric medication, it is essential to consider non-medication approaches to treating mental illness. Successful programs in the past and present have used different therapeutic approaches to treat mental illness without using medications or only using medications sparingly. One of these is the Pocket Ranch in Healdsberg, California. Pocket Ranch uses a transpersonal perspective to treatment and sees psychosis as an altered state of consciousness. The focus is on the patient's growth and activities such as art therapy, holotropic breathwork, and guided imagery are used. Other programs with successful outcomes in treating psychotic patients without using medications are Kingsley Hall, Diabysis, and Soteria House. Patients attending these programs came through their psychosis in 6–10 weeks (Battista, Chinen, & Scotton, 1996).

In Nonviolent Communication we learn that there are many strategies that can meet a need. Finding the strategy that best serves the totality of the person will be more effective than finding a short-term solution. Using medications to treat some mental illness may be helpful in the short run, although relying on medications will not teach a person the skills he/she needs to have a successful life. It will not help a person heal the underlying issues that precipitated the problem. The adverse effects that medications place on a person's physiology will prevent the overall needs of the person from being met. For instance, a client of mine, Bill, has been on Zoloft for 5 years. He likes the

Zoloft because it gives him confidence and helps with his social anxiety. However, he feels apathetic on the drug, which prevents him from meeting other needs. Bill says the Zoloft filters out the lows but dulls his experience so he does not feel anything. He says he does not feel like himself since taking the drug.

Feelings are our internal feedback system. When we have positive feelings we know that our needs are being met. Negative feelings tell us that our needs are not being met. By honoring our feelings we can become smarter about meeting our needs. When this internal feedback system is knocked out by medications, the ability to grow and change is decreased. Being human is not about always being happy. It is about experiencing our feelings and growing through challenges. By honoring our feelings and letting them guide us toward growth, we become progressively more enlightened. Without an awareness of our feelings we may not learn from our mistakes, or find the motivation to get the healing we need. People on psychiatric medications report a dulling of their feelings.

Another client of mine, Michael, has been on Celexia for 6 years. As he weans himself off the medication, Michael is noticing that he feels his feelings more intensively. With his feelings more readily available to him, Michael can now do the growth and healing work that he needs in order to move forward with his life. The issues that he has been suppressing for many years and which have been adversely affecting his life are coming to the surface to be healed. It is not easy for him to face these issues or to notice that by hiding from his feelings for so long he has done a disservice to himself and to the people around him. Growth is about facing our fears and acknowledging our humanity.

Learning to embrace our feelings helps develop self-compassion. Having compassion for self allows us to have compassion for others.

On the one hand, medications can be useful in eradicating acute disabling symptoms of depression, psychosis, or anxiety. By providing this relief a patient may be better able to enter into a psychotherapy process. On the other hand, relying only on medications to fix the problem perpetuates a sense of powerlessness. The patient becomes dependent on a drug in order to feel good and to function. Therefore it is extremely important to determine if the emotional pain a person is experiencing can act as a motivator for personal growth or if the emotional pain can retard the person from doing emotional growth work.

> Transpersonal practitioners from Western culture bear the same responsibility as traditional healers to differentiate growth-producing experiences from those that are likely to be debilitating. One important role of pharmacotherapy is to titrate the level of symptoms, whether they be pain, depression, anxiety, or psychotic states, so that they can be integrated by the person in the service of growth. (Battista, Chinen, &Scotton, 1996, p. 332)

Some psychiatrists recommend that medications only be used for a short time to allow a patient to feel safe enough to enter into a therapeutic relationship. Once a person begins to do the work of therapy and understands how to better meet his/her needs for empathy and support the medications can be decreased or discontinued. It is important to use medications in a way that minimizes side effects and maximizes mental stability and agility. The client, Bill, who was experiencing apathy while on Zoloft, quit taking the drug and reported that the apathy went away. He now has some resources in place that

provide him with empathy and help him get the support he needs to do personal growth work. Bill had no idea that he needed empathy or that he could change. He believed that he was a flawed human being and he needed the Zoloft in order to function. Indeed people who have not experienced empathy and emotional healing do not know that it is possible to heal their emotional pain without medications.

There are many strategies that can help someone with a mental illness. Medications are a quick fix but not a lasting one. Duke researchers did a study on the long-term benefit of exercise in treating depression. This research compared three groups of depressed people. The first group took Zoloft to treat their depression. The second group took Zoloft plus they exercised. The third group only exercised. At the end of 10 months the third group (which only exercised and did not take Zoloft) was much less likely to be suffering from depressive symptoms. Seventy percent of the exercise-only group was asymptomatic at the end of 10 months. In the Zoloft only group, less than 50% of the patients were asymptomatic. In the Zoloft plus exercise group, only 45% of the patients were asymptomatic (Whitaker, 2010, p. 346).

Western Lapland in Finland had one of the highest rates of schizophrenia in Europe in the 1970s. “Furthermore, these patients regularly became chronically ill. But today the long-term outcomes of psychotic patients in western Lapland are the best in the Western world, and this region now sees very few new cases of schizophrenia” (Whitaker, 2010, p. 336–337).

The success in this region is attributable to the following:

1. Decreased use of neuroleptics: In a study done by Keropudas Hospital from 1992–1997, 67% of patients were never exposed to antipsychotics, 33% were

occasionally exposed, and 20% had ongoing use at the end of 5 years. Seventy-nine percent of patients were asymptomatic at a 5-year follow-up; 73% of patients were working or in school; 7% were unemployed; and 20% were on disability.

2. Mental health professionals (psychiatrists, psychologists, nurses, and social workers) completed a 900-hour course in family therapy and they all practice open-dialogue therapy both in the hospitals and in the community. The mental health system in this region consists of one hospital and several outpatient clinics. When a family is having trouble with a loved one, they call the hospital or clinic. A team of trained professionals goes to the family's home and connects with the patient and family using open-dialogue therapy. This team believes psychosis arises out of frayed social relationships. The psychotic patient is the one that makes the difficult situation visible. The team works with the family and other people that the patient has contact with (teachers, employers, friends,) repairing relationships both in the family and in the larger community. "It's about restoring social connections" (Whitaker, 2010, pp. 343).

> Since 1992-93 not a single first-episode psychotic patient has ended up chronically hospitalized. Spending on psychiatric services in the region dropped 33 percent from the 1980s to the 1990s, and today the districts per-capita spending on mental-health services is the lowest among all health districts in Finland. (Whitaker, 2010, p.343)

Finland needed to find a new way to treat mentally ill people because their system, which was much like the system in the US, was bankrupting the country. When I notice how much money is spent on treating mentally ill people in the US. I am amazed that this country has not found a better way to treat this problem. The amount of money

the US spends is not creating a more sane population. In fact, things are spiraling out of control. Many of the mass murderers that are prominent in the news lately were on psychiatric medications at the time they committed their horrendous crimes.

I imagine the US. can better spend the money that is currently spent on mental illness and get better outcomes like the ones reported in Finland. In my book, *Humanizing Health Care*, I suggest ways to change the consciousness of our institutions by changing the language and the structures used (Sears, 2010). Once people have the language to express themselves, solutions can be found that will be more life-serving to patients and institutions will evolve. I would like to see all mental health workers trained in Nonviolent Communication. Nonviolent Communication is much like Finland's open-dialogue therapy. Decreasing the use of psychiatric medications would not only save money but would create a better quality of life for patients.

Many things need to change in our culture in order to decrease the use of medications, and to provide deeper levels of healing for people. Currently people are socialized to look outside of themselves for answers. They seek out authority figures to tell them what to do. This is a symptom of the domination systems currently in place. In order to decrease the use of medications people will need to be supported to find their own inner authority. They will need to learn to embrace their feelings and use them to heal and grow instead of numbing them with medication. This would be a major paradigm shift in a culture that values thoughts over feelings.

The need for a change in structure of Health Care Systems is pressing if health care systems are to survive. They will not survive if actions are not taken to meet the needs of the customer. Peter F. Drucker suggests that all businesses ask the question:

Who is our customer and what is of value to him/her? (Drucker, 1973) The main customer in health care is the patient. What the patient values is to feel better and to be treated with respect and dignity. The patient has physical, emotional, and psychosocial needs. When these needs are not met the patient (customer) is dissatisfied. Dissatisfied customers cost the institution time and money. Health Care systems must be open to change if they are to survive. There also needs to be a shift in the power and financial reward given to pharmaceutical companies. Medications should only be used to help people when they are needed, not as a routine treatment for every complaint.

When the structure of the health care institution changes from a deficiency-motivated system to a humanistic or transcendent level, the treatment of patients will change also. Instead of using medications as a fix-all strategy, assessment of patients' needs with appropriate interventions will create less costly interventions for the patient and for the culture. Understanding how to use language to assess the patient's needs is vital to providing competent care.

"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete." (Fuller, B., 1975)

Communications training is not wide spread in medicine. "Recent research shows that more attention needs to be given to the development of communication skills in Medical students and physicians." (Bernstein, 1985, p. 68) Even though communication is vital in health care there was an assumption in the past that some people had instincts to be good communicators and others did not. Research has shown that communication skills can be taught. Empathy can be learned.

Recent research is available on the use of empathy in medicine. In the book, *From Detached Concern to Empathy: Humanizing Medical Practice* (2011), Jodi Halpern makes a strong case for doctors using empathy with patients instead of detached concern. She recommends training doctors and nurses in empathy skills. In all the research I read though, none but my research on integrating NVC into a forensic unit actually trained not only the doctors and nurses in empathy skills but also the patients. Healing became a joint effort of everyone involved. It was no longer the responsibility of the medical staff to heal the patient but included the patient in his own healing. Using the tools of NVC a healing community was formed which allowed chronically mentally ill patients to get better. Sears recommends in *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* that small healing centers be established where people can do the work of healing with decreased use of medications.

Nonviolent Communication Research

The following research was found that uses various applications of Nonviolent Communication. The discussion of these applications and their success points to success when applying NVC to a health care system.

A research program was developed for a group of 19 parolees recruited from a treatment center in order to determine what the impact Nonviolent Communication would have on coping and communication skills for this group. The research is important because 60% to 70% of individuals released from prison return within 3 years of release. The reason for this lies in the psychosocial adaptations and coping strategies that occur in a harsh prison environment. Behaviors such as social isolation, aggression, and distrust of others create conflict and cause social isolation when exhibited in free-world life. The

speculated outcome of this research program was to decrease recidivism and increase successful reintegration of parolees in society. Nineteen men completed an 8-week program that consisted of eight 1-hour sessions where Nonviolent Communication was taught. The research structure was a "single group, pre-/post test design with post intervention focus groups and individual interviews" (Marlow, 2012, p. 10). Some of the outcomes of the 8-week program follow: 1) Participants articulated how their capacity to listen to others increased. 2) The ability to sustain a meaningful conversation increased. 3) There was an increase in the participants' empathic awareness of others, which allowed participants to offer support and build community. 4) Conflict was decreased. 5) Understanding, connection and trust between themselves and their families and communities increased (Marlow, 2012).

> Results suggest that NVC training may (a) be a useful addition to substance abuse treatment programs for parolees, (b) be effective in addressing problematic coping and communication styles resulting from incarceration and criminal behavior, and (c) assist paroled individuals in building and sustaining positive social support networks.(Marlow, E. et al., 2012, abstract)

In a thesis by Marion Little, titled *Total Honesty/Total Heart*: *Fostering Empathy Development and Conflict Resolution Skills: A Violence Prevention Strategy* (Little, 2002), a small group of "at risk" adolescent girls (ages 16–19) were given a 9-hour training program in Nonviolent Communication. The girls were from an alternative public school in Canada and were pregnant, parenting, and/or on probation. The skills taught involved conflict resolution, emotional awareness/management, and empathy development. Previous research indicated that these skills reduce adolescent aggression

and violence and support respectful, considerate relationships (Little, 2002). Little's thesis showed that there was an increase in comprehension of conflict resolution and empathy and self-empathy skills and suggested, "that self-empathy may be integral to supporting the development of conflict resolution skills specifically, and healthy relationships generally, for young women who have experienced abuse, trauma, and domestic violence" (p. iii). Little's:

> Project combines a simple quasi- experimental pre-training and post-training written test (providing descriptive statistics) with qualitative data gathered through training sessions and interviews. A case illustration is included to further enhance the findings. This approach allowed a rich multi-dimensional analysis to be generated for such a small pilot project (N=14). (p. iii)

The project consisted of 7 girls who went through the training and 7 girls who did not attend the training but took the pre- and post-test.

As in the study done with male parolees, this NVC training program created a socio-linguistic transition from a retributive to a restorative social paradigm. Through understanding different ways of speaking and listening participates were able to shift patterns of thinking and language that lead to violence. In both populations, violent aggressive behavior was experienced and unhealthy patterns of responding and reacting to that violence was adapted. This unhealthy adaptation prevented both groups to successfully integrate into free society (Little, 2002).

In her sociology thesis for Virginia Polytechnic Institute and State, Andrea Lynn Nash trained staff at Tekoa Institute (a boy's facility for juvenile delinquency) in Nonviolent Communication skills. The outcomes of this training were: There was an

increase in use of nonviolent resolution skills to resolve conflicts by trained staff (when compared to staff who were not trained). There was also a decrease in use of violent resolution by the trained staff (Nash, 2007).

Nash made an interesting comment on the cycles of violence that occur in treatment facilities (which is the same cycle of violence that occurs in abusive relationships). In the first stage, staff that are threatened verbally or physically bottle-up their feelings in order to appear strong. This causes internal stress. To cope, the staff person often becomes apathetic. As frustration increases because the staff's expectations toward the residents are not met, verbal or physical violence occur. This is stage two of the cycle of violence. As the pattern continues, the staff person finds her/his emotional energy declining making it unlikely that she/he will be able to use conflict resolution skills to deal with conflict. If no intervention occurs than the cycle will repeat itself. (Nash, 2007) This seems to be a universal pattern that occurs in violent situations, be it abusive relationships, facilities for juvenile delinquents or, as I have discovered, in psychiatric hospitals.

In her thesis, "A Step Toward Violence Prevention: Non-violent Communication as Part of a College Curriculum" (2002), Susan Blake based her project on two key assumptions:

> The first is that beliefs in hierarch and aggression are embedded in one's identity and worldview. The second is that a destructive way of seeing the world is created and reinforced by aggressive communication but it need not be permanent. Individuals have the capacity to create a peaceful identity and worldview by learning and practicing compassionate communication. (Blake, 2002, p. 17)

Blake commented on the escalation of violence and oppression in the United States and believed that by teaching Nonviolent Communication in schools, this tendency toward violence could be changed. Blake designed a college class where NVC was taught for a semester and measured the change in students' level of empathy and verbal aggression. The outcome was that students taking her class were receptive to positive change in the direction of increased empathy and decreased verbal aggression. "The majority of students expressed a desire that their communication and that of others be consistent with the behavior outlined in Rosenberg's model of NVC" (Blake, 2002, p. 94).

Blake's thesis is relevant to my study because it reinforces the notion that communication is linked to fostering identity formation and critical consciousness (Blake, 2002). By developing these in individuals, behavior changes in a positive direction. In the psychiatric unit discussed in my research, patients who learned communication skills quit acting out, got better, and were transferred to a less restrictive unit.

In 1994 Donna Steckal did a dissertation, which measured the results of attending a Nonviolent Communication (aka Compassionate Communications) workshop, on empathy and self-compassion. Twenty-one adult university students attended a 7-hour workshop presented by Marshall Rosenberg. Before and after the training empathy and self-empathy were measured in both the experimental group and the control group. The control group consisted of 20 students who did not attend the workshop but who took the pre- and post-test. The study showed that the "training had a positive and significant effect on participants' levels of empathy and self-compassion" (Steckal, 1999, p. ii).

This research project made it clear that empathy can be taught. It is important to know this so that programs can be created, the purpose of which is to increase empathy in a group of people. Ever since President Barack Obama said the following there has been an explosion of research and interest in empathy:

> There's a lot of talk in this country about the federal deficit. But I think we should talk more about our empathy deficit—the ability to put ourselves in someone else's shoes; to see the world through those who are different from us—the child who's hungry, the laid-off steelworker, the immigrant woman cleaning your dorm room. (Obama, B. 2006)

Background on the Creation of Nonviolent Communication

While studying the factors that affect one's ability to stay compassionate, Marshall Rosenberg was struck by the importance of language and how words are used. The language he developed, Nonviolent Communication (also known as Compassionate Communication) helps people give and receive from the heart in a compassionate way. Rosenberg was able to identify ways of expressing that disconnect people from compassion, and ways of expressing language that create a compassionate flow between people. Rosenberg developed the language of compassion by combining elements he learned from Carl Rogers and also by studying people who were good communicators such as Virginia Satyr. He broke down what these communicators were doing and created the steps of Nonviolent Communication. As a student of Rogers he may have gotten an idea about how to go about changing the world.

Rogers declared:

> By developing a society in which parents and teacher and all of those in positions of leadership, whether governmental or otherwise, were skilled in providing the conditions which make for personal growth, we would have a society in which variability and individual self-actualization would be present. We would have individuals developing uniquely, with a sense of personal freedom, freely seeking solutions to the problems of society. In this kind of a culture, every citizen would be a responsible planner. We would have initiated a process of continuing and self-directed change, not a community of static goals established by one person or established by an elite. The likelihood of society being a living, changing flow of intelligent encounter with the problems faced in the world would be greatly enhanced.
>
> To me the most important task of the behavioral sciences is to discover and to endeavor to establish the conditions which release variability, release creative behavior and self-directedness, thus making the individual less predictable and less likely to be controlled. (Rogers, 1989,p. 122)

One internal shift that is made when one works with the NVC model is a shift away from relying on external authority and toward becoming your own internal authority. Using the tools that are part of the NVC process creates the conditions for this to happen. So using the model of NVC allows a person to support others in finding empowerment. This sets up the conditions for building a culture of "responsible planners."

> Rosenberg refers to working and studying with Carl Rogers, particularly during a research project, which investigated the components of a helping relationship, as

central to the development of Nonviolent Communication (Rosenberg, 2005). The roots of his Nonviolent Communication model began to emerge while Rosenberg was facilitating racial integration in schools and organizations across the Southern United States during the 1960s (Rosenberg, 2005). Certainly, Nonviolent Communication rises directly out of Carl Roger's tradition of Humanistic Psychology, which emphasizes empathy as the fundamental key to human psychological development and fulfilling human relationships. Rogers' 1964 lecture at the California Institute of Technology (Rogers, 1980) is frequently referenced by Rosenberg as a central inspiration. In that lecture, Rogers emphasized: experiential learning; frankness about one's emotional state; the satisfaction of really hearing others in a way that resonates for them; how enriching and encouraging it is to experience creative, active, sensitive, accurate, empathic listening; the deep value of congruence between one's own inner experience, one's conscious awareness, and one's communication; and subsequently, how enlivening it is to unconditionally receive another's love or appreciation and extend the same (Rogers, 1980, pp. 5-26). Further, the Rogerian tradition uniquely trusts each individual's capacity to generate solutions, rather than relying on a therapist's expert advice. Diverging from a clinical focus, the development of Nonviolent Communication is marked at its earliest stages by community-level applications of the concepts outlined above in conflict resolution, interpersonal skills training, and violence prevention efforts. (Little, 2002, pp. 21–22)

Marshall Rosenberg believed that if a person could imagine something then he could create it. To illustrate this concept he used an example of a friend of his in Iowa who owned a plant nursery. This man experimented with peonies and told Rosenberg if he could envision a peony then through years of cross-pollination he could grow it. Rosenberg imagined a different world; one where human needs were valued and people were empowered to access the wisdom and compassion within. Rosenberg understood the power that one person, who is in alignment with inner-compassion and wisdom, had to change the world. Rosenberg spent the next 40 years of his life flying around the world resolving conflicts, creating peace and connection, and sharing the tools of NVC with people. He influenced a multitude of people and left healing and empowerment in his wake.

> Publications from the beginning of Rosenberg's career shed light on the historical and theoretical development of the Nonviolent Communication model. These include a paper titled "Application of Behavioral Science Principles at a Community Level" presented to the American Psychological Association (1970), and an article titled "Community Psychology as Applied by a Clinician", published in the *Journal for Social Changes: Ideas and Applications* (1971). These two publications neatly summarize Rosenberg's early influences as well as his move away from clinical psychological practice and towards community-focused work. This shift was strongly influenced by Erich Fromm's (1955) insistence that individual mental health is dependent on the social structure of a community, George Albee's (1967) assertion that it is not logistically possible for therapists alone to meet the psychological needs of all community members, and

> George Miller's (1969) insistence on giving psychology away to the community, thereby making knowledge about human behavior as widely and readily available as possible (Rosenberg, 1970, 1971).
>
> The idea of giving away expertise was embraced by a number of practitioners in a variety of different fields during the early 1970s. Rosenberg (1970, 1971) cites several as influential in the development of his own "giveaway" work: Rogers (1967) principles of interpersonal relationships fostering psychological growth; Dreikurs and Stoltz' (1964) and Deutsch's (1969) principles of constructive conflict resolution; the principles of experiential learning and student-led classroom instruction as articulated by Cantor (1953), Postman and Weingartner (1969), and Bower and Hollister (1967); as well as Rosenberg's own (1968) principles of collaborative diagnostic assessment and responsive teaching. (Little, 2002, 22–23)

Rosenberg often said that what he taught was nothing new. Everything had been known for many years. What he did differently was his method of distribution. Rosenberg was in effect giving psychology away. By traveling around the world and not charging for his work he was giving psychology away. It took him a while, when he first decided to stop charging for his services, to make a living. He even drove a cab for a while. Sometimes he traveled to poor countries and he had to earn his way to get there. He told a story about needing to fly to a country in crisis and he had no money. He negotiated with the airline to give him a ticket and he gave the airline NVC training in return. He took the tool he developed and taught it to whatever group found him. He worked with unions, gangs, businesses, and education systems among others.

Rosenberg was also strongly influenced by the compassion of his grandmother and his uncle. During the depression Rosenberg's grandmother took in a homeless man who had a large cross made out of tree branches tied about his neck. This man said his name was named Jesus. Jesus stayed with Rosenberg's grandmother for 7 years. His grandmother also took in a tailor and his family when they lost their home. This was done in spite of having a small house and nine of her own children. Later, when his grandmother was dying, Rosenberg's uncle took physical care of her in a loving way. Rosenberg saw the compassion on his face when he turned her in bed or cleaned her up.

In his youth Rosenberg spent time growing up in Detroit, Michigan. There were race wars in Rosenberg's neighborhood and Rosenberg was beaten up after school for being a Jew. Rosenberg believed that people were naturally compassionate and became curious about two questions: "What happens to disconnect us from our compassionate nature, leading us to behave violently and exploitatively? And conversely, what allows some people to stay connected to their compassionate nature even under the most trying circumstances?" (Rosenberg., 2002, p. 1).

While studying the factors that affect one's ability to stay compassionate, Rosenberg was struck by the importance of language and how words are used. The language he developed, Nonviolent Communication (also known as Compassionate Communication) helps people give and receive from the heart in a compassionate way.

Carl Rogers was one of Rosenberg's teachers when he was getting his PhD at the University of Wisconsin, and was of primary influence to him. Rogers included Rosenberg as a therapist in his mammoth study on therapy with schizophrenics sponsored by the National Institute of Mental Health (Rogers, Gendlin, Kiesler, & Truax- 1967) In

later years Rogers spontaneously wrote to Rosenberg congratulating him on his work in NVC and gave him his wholehearted endorsement. Rosenberg kept the letter and greatly values it. Rosenberg learned the practice of empathy from Rogers, although he certainly experienced it from others in his life, notably his grandmother and his uncle. Rosenberg credits Rogers with providing an atmosphere in the cutthroat climate of graduate school that helped him remain sane through the ordeal. Rosenberg was a colleague with Charles Truax, a fellow student at Wisconsin, who did much research on the three conditions that Roger's hypothesized as necessary and sufficient for therapeutic change to occur—congruence, unconditional positive regard, and empathy. He also knew Gene Gendlin (Focusing) the director of the NIMH study and an expander of Roger's work who's primary method of doing therapy is empathic listening or of accompanying someone who is focusing. So he was around the entire Roger's cadre of students and included himself as one, though taking a slightly different tack. He was noted in the NIMH study as one who did more confrontation than other therapists. Even then he was exploring the side of "active" congruence that Rogers and students spoke about and highly valued but did not formally enact. Rosenberg's development of the model of Nonviolent Communication was also slow in coming (Rohlfs,. 2011).

A Manual for Responsible Thinking and Communicating, By Marshall Rosenberg does not list steps of a model, it lists abilities:

> Ways of thinking that increase autonomy: 1. Ability to 'own' messages. 2. Ability to make observations without making inferences. 3. Ability to recognize and verbally report feelings. 4. Ability to identify the reasons for feelings in terms of 'because wants'. 5. Ability to express wants in action terms. 6. Ability to 'ground'

> thoughts and anecdotes in present feelings and wants. (Rosenberg, 1972, p. 4)
>
> Ways of thinking and communicating that increase awareness of interdependence . . . The following skills show increasing awareness of others and interdependent functioning:
>
> 1. Ability to receive wants as wants and not as demands, obligations, or duties.
>
> 2. Ability to receive feelings and wants as feelings and wants and not as personal praise or criticism.
>
> 3. Ability to receive feelings and wants without evaluating the accuracy, morality, or competence of the speaker.
>
> 4. Ability to ask oneself whether the speaker's message was received to the speaker's satisfaction and paraphrase if doubt exists.
>
> 5. Ability to translate any messages into the possible feelings and wants of the speaker. (Rosenberg, 1972, p. 18)

According to Allan Rohlf, who was a student of Rosenberg in the early 1970s, "the third step of the model was: 'what am I doing that contributes to my feeling as I do,' or 'what is going on inside me that contributes to my feeling as I do,' 'What am I thinking or wanting that contributes to my feeling' (Rohlf, personal communication, June 2013). The third step eventually became the Need.

By 1990 the model of Nonviolent Communication was developed and had four steps: Observation, Feelings, Needs, and Request.

Manfred Max-Neef, a Chilian economist and environmentalist who created the human development model of needs, likely influenced Rosenberg in developing the third

step of his model, needs. Max-Neef believed that there are fundamental human needs stemming from the condition of being human. These needs are constant throughout history and throughout cultures. What changes are the strategies to meet the needs. (Wikipedia, 2013c).

Rosenberg's model explains needs in the same way as Max-Neef. Both refer to needs as interrelated, interactive, and non-hierarchal (unlike Maslow's theory of the hierarchy of needs). Max-Neef believes that by focusing on human needs peaceful societies can be developed. Rosenberg believed that people become disconnected from their human needs through the education and socialization process. By learning NVC people can become reconnected to their needs. If people can connect with their own needs they are likely to have greater empathy and compassion for others (as all people have the same needs). An important element of this third step of Rosenberg's model is that it connects feelings to their internal cause (needs). Instead of blaming others for causing their feelings people can take responsibility and begin to develop self-awareness. I imagine an important reason that Rosenberg used *needs* as the third step of his model was to keep the interaction between people focused in the heart and not in the head. Considering that the way people think can also be attributed to causing their feelings, thoughts could have been the third step of the model. Rosenberg understood that human connections were not forged in the head. He said in almost all of his workshops, "Stay away from the head. It's scary up there." (Rosenberg, M. 1993)

Both Max-Neef and Rosenberg separate needs from strategies. In the NVC model, strategies that satisfy the need are referred to as requests. The NVC model is designed to be an interactive model of communication. A person can figure out how to meet his/her

needs or those of others by making requests of him/herself or of others. There are many strategies or requests that can meet a single need. By separating the two (which Rosenberg did in his model) people become aware of what their needs are and can begin to image the many possibilities there are for meeting the needs. Without an awareness of needs people can become stuck reacting in a habitual fashion when feelings arise (using the same strategies over and over again according to the programed response.)

Cultures program people to perceive others in biased ways. (For instance, the perception of what is attractive and unattractive: In one society obese women are considered beautiful while in another thin women are considered beautiful.) These cultural influences become filters that people use to judge and label everything they see. The label, *enemy,* is placed on people who believe differently from you. Conflicts cannot be resolved as long as these filters are in place. In his book, *Thresholds of the Mind*, Bill Harris identifies filters as being, "largely unconscious and running on automatic for most people" (Harris, 2002, p 97). Filters "delete, distort, and generalize input from the environment" (p. 97). Some of these filters are language, memories, decisions, beliefs, values, attitudes, ways of sorting information, and strategies. If these filters are not made conscious, a person will operate with a faulty idea of reality. They will make decisions and react to their own illusion of reality. They will be powerless to change patterns of dysfunctional behavior.

Nonviolent Communication begins to de-program people and connect them with their common needs. By creating an empathic presence, people can explore the roots of their filters. This makes it possible to release the filters and see the humanity in others even if they are not like you. Conflicts can be resolved once each party can understand

the needs of the other. The model of NVC can be used as people become aware of their filters and want to change the way they react. Without a tool to use it is very difficult to change ingrained habitual patterns of responding and reacting. The model of NVC gives people at least one other choice in how they respond to a situation (they can choose their habitual response or use NVC to guide them in a different response.) NVC opens up possibilities for communication. It allows people to have choice in how to respond to any situation. Knowledge is not sufficient to motivate behavior change. People need empathy, support and practice on their journey toward change.

Rosenberg acknowledges that his inspiration for Nonviolent Communication was a spiritual shift in his awareness, which he wanted to incorporate into a useable model. Rosenberg spoke about being in touch with "the beloved divine energy" (Rosenberg, M. 1993) and gave examples of the synchronicity he experienced when he was in touch with this energy. During the last 20 years, Rosenberg put more emphasis on the spirituality of NVC and its ability to change consciousness.

> Rosenberg identifies Mahatma Gandhi as a central influence throughout his adult life and as an inspiration for the articulation and re-articulation of the Nonviolent Communication process over the years. From the beginning, Rosenberg's goal has been to develop a practical process for interaction, with oneself and others, rooted in Gandhi's theory and philosophy of "ahimsa" (Rosenberg, 2005). Ahimsa is translated as the overflowing love that arises when all ill-will, anger, and hate have subsided from the heart (Fischer, 1962). Steven Smith (2006a; personal communication, March 19–27, 2006), lawyer-mediator and Nonviolent Communication practitioner, notes that while deeply inspiring, Gandhi's approach

> to developing nonviolence involves extensive lifestyle changes and complex processes of self-assessment, which are unattainable for most Westerners. According to Smith, Rosenberg's distillation of Gandhian philosophy has provided a practical, adaptable, accessible process for developing "ahimsa" in thought and in communications:
>
> Rosenberg has isolated the critical point where a choice is made, in a moment, regarding how we proceed to relate to others. *Nonviolent Communication* provides a syntax that focuses language on the beauty of needs, which subsequently focuses both thought and attention. (Smith, personal communication, March 19–27, 2006)
>
> Smith asserts that through syntactic structure, Rosenberg's model facilitates increased possibilities for needs-based choices when faced with painful or unwanted stimuli, rather than the restriction of standard "knee-jerk" reactions. "The model is simple enough that anyone can learn it and apply it. It makes readily available the grace that Gandhi was accessing and engaging. This two-step dance [honesty & empathy] accesses what Gandhi called loving- kindness" (Smith, personal communication, March 19–27, 2006). (Little, 2002, p. 26)

Rosenberg was torn about the name of his process, *Nonviolent Communication*. During a personal conversation with Rosenberg, in 1992, he said, "It says what it's not, instead of what it is." He had thoughts about changing the name but because Nonviolent Communication was known worldwide he left it as is.

As stated previously, Marshall Rosenberg was a student of Carl Rogers when he was studying for his dissertation. He was influenced by Rogers and used much of what

Rogers taught in developing the model for Nonviolent Communication. For example, Rogers named three conditions of client-centered or person-centered therapy that are necessary for growth and personal development. The three conditions are unconditional positive regard, empathy, and congruence.

Rogers explains what he means by unconditional positive regard in the following quote: "So I find that when I can accept another person, which means specifically accepting the feelings and attitudes and beliefs that he has as a real and vital part of him, than I am assisting him to become a person" (Rogers, 1989, p. 21).

Rosenberg's model of Nonviolent Communication consists of two parts, Empathy and Honesty. The Empathy part of the model guides people to focus on the feelings and needs being expressed. The model also sets up language boundaries so that there is no confusion about which feelings and needs are whose. Rosenberg's model also helps the user separate words that express thoughts and words that express feelings and it separates evaluative words from feeling words. All of this helps create the sense of unconditional positive regard that the person receiving empathy experiences.

About congruence, Rogers states:

> In my relationships with persons I have found that it does not help, in the long run, to act as though I were something that I am not. It does not help to act calm and pleasant when actually I am angry and critical. It does not help to act as though I know the answers when I do not. (Rogers, 1989, p. 16)

Rosenberg was known for his use of honesty in therapeutic relationships. He created the *Honesty* tool of NVC to help guide people in being congruent without projecting judgments onto others. It is not easy to be congruent in this way. It requires

owning your triggers, your judgments, your analysis, and being vulnerable in expressing the feelings and needs under them.

Rosenberg's focus on language gives people the tools they need in order to understand the inner world of others and to build relationships based on mutual respect and self-responsibility.

Martin Buber was another person who influenced Rosenberg. Rosenberg taught his students how to be present to others. He said that equality is an essential element of presence. A therapist, who sees himself as the one with all the answers, will not be able to meet his client in the way that Buber speaks of. Buber describes the characteristics of a true dialogue: In a true dialogue there is a moment of surprise. Buber compares it to a chess game. "The whole charm of chess is that I do not know and cannot know what my partner will do. I am surprised by what he does and on this surprise the whole play is based" (Kirschenbaum. 1989, p. 57).

Roger talks about meeting a person in equality in the following:

> Because it seems to me again that in the most real moments of therapy I don't believe that this intention to help is any more than a substratum on my part either. Surely I wouldn't be doing this work if that weren't part of my intention. And when I first see the client that's what I hope I will be able to do, is to be able to help him. And yet in the interchange of the moment, I don't think my mind is filled with the thought of "now I want to help you." It is much more "I want to understand you. What are you behind that paranoid screen, or behind all these schizophrenic confusions, or behind all these masks that you wear in your real life? Who are you?" It seems to me that I've learned through my experience that

> when we can meet. Then help does occur, but that's a by-product. (Kirschenbaum, 1989, p. 55)

Rosenberg taught his students "you can't help anyone. The most you can do is to be present." (Rosenberg, M. 1992) Once again his alignment with Roger's viewpoint is obvious.

When I first attended Rosenberg's workshop in 1990, there was little structure to it. About 20 people sat in a circle and individuals asked the group to meet needs for empathy or understanding. This unstructured way of holding a workshop, empowered people to take responsibility for getting their own needs met. Instead of relying on the teacher to tell them what they needed to know, people found the answers inside themselves. Creating an empathic presence so that people could do this work was the role of Rosenberg and others in the group. Rosenberg was the main one, though, who gave empathy and supported people in their process. Others in the group would practice expressing their honesty and asking for what they wanted.

Rosenberg told us during a workshop in 1990 about how he showed up for his first class with Carl Rogers. The chairs were arranged in a circle and the students did not know who the teacher was. There was an older man in rumpled clothes in the circle that turned out to be Carl Rogers. Rogers talked to them about learning and encouraged his students to become empowered to pour milk in their own cups instead of relying on the teacher to pour milk in their cups for them. This is also how Rosenberg structured his workshops until later in his career. In the mid-1990s, his workshops got so big that Rosenberg needed to change what he did. At that time he would sit in front of an audience full of people, telling stories and creating exercises that people could do in

groups or with the person sitting next to them. Sometimes Rosenberg would bring a person or a couple up in front of the group and do empathic work with them or conflict resolution.

These are only some influences that Rosenberg indicated he was affected by. He currently resides in Albuquerque, New Mexico and is working on his autobiography.

Other Useful Models

ORID method: "The ORID (Objective, Reflective, Interpretive, Decisional) method is a form of a structured conversation led by a facilitator. It was developed by The Institute for Cultural Affairs and is used to make intelligent decisions by analyzing facts, feelings, and implications."(Grayson, 2010) Educators, community organizations, businesses, and governments use the process. It is used in personal problem solving, counseling, and community work. Journalists have also used it to structure in-depth, investigatory interviews.

The first step of ORID is O for Objective questions. It is about gathering the facts. The first step of NVC is Observation-making a clear observation without evaluation.

The second step of ORID is R—Reflective questions. This step questions how people feel about the topic. This is about people's subjective perceptions and "allows participants to express their gut feelings even if there are no objective facts to support them"(Grayson, 2010).The second step in NVC is Feelings. NVC educates people about the difference between using words that express feelings and words that express thoughts. It helps people express their feelings in a self-responsible manner.

The third step of ORID is I-Interpretive questions. These questions have to do with the meaning the issue has for you or the organization. During this stage the impacts

of the topic on the individual and organization are explored. The third step of NVC is Needs. A need can be described as universal life energy, the motivator for feelings. A need can also express what meaning something has. The word *meaning* itself is a need.

The forth step in ORID is D-Decisional questions. This is the phase where action steps are decided. It flows out of the prior three steps. This decisional stage focuses on the future—what would be the best course of action? What would be achievable, positive outcomes? What is realistic given the limitation of our resources? (Grayson, 2010) The forth step of NVC is Request. The Request is about asking for action or connection.

The interesting thing about ORID is that is follows the same process as NVC and has been used for more than 30 years successfully. This points to the success of using NVC to transform systems.

In researching the success of ORID and NVC, I could not find a single example where the processes did not work when they were applied to a variety of applications.

Cognitive Behavioral Therapy (CBT): "CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients unlearn their unwanted reactions and to learn a new way of reacting" (NACBT Online Headquarters, 2010). CBT is like NVC in that it teaches people how to understand and change their thinking and behavior. CBT does this through cognitive exercises. NVC does it by giving empathy and teaching skills as the person processes his/her emotional issues. Both practices can lead to long-term results because as people becomes aware of their internal experience and choose to act differently, research has shown that they are making changes in the brain.

According to Dr. Daniel Amen:

> The brain is the seat of feelings and behavior. Your brain creates your world-a radical statement about ordinary thinking . . . How our brains work determines the very quality of our lives: how happy we will be, how well we'll get along with others, how successful we will be in our profession (Amen, 1998, p. 35).

Amen goes on to say, "The actual physical patterns of our brain have a dramatic impact on how we think, feel, and behave from moment to moment" (p. 36). The brain used to be thought of as static, unable to change. Research done in the last 50 years has shown that the brain can change. New neuro-connections can grow and people can recover from depression, schizophrenia, and even dementia.

> Postmortem examinations have shown that education increases the number of branches among neurons. An increased number of branches drive the neurons farther apart, leading to an increase in the volume and thickness of the brain. The idea that the brain is like a muscle that grows with exercise is not just a metaphor. (Doidge, 2007, p. 43)

There are many things that can help the brain grow and change. Learning new life tools is one of them. By learning new tools the brain is forced to think in new ways. Becoming aware of our thinking and choosing different thoughts followed by different actions can change someone's life.

> CBT is based on the Cognitive Model of Emotional Response. Cognitive Behavioral Therapy is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations and event. The benefit of

> this fact is that we can change the way we think to feel/act better even if the situation does not change. (NACBT Online Headquarters, 2010)
>
> Cognitive behavior therapy is often best-suited for clients who are comfortable with introspection. In order for CBT to be effective, the individual must be ready and willing to spend time and effort analyzing his or her thoughts and feelings. Such self-analysis can be difficult, but it is a great way to learn more about how internal states impact outward behavior. (About.com, 2013)

Nonviolent Communication differs from CBT, in that feelings and behaviors are caused by our needs, not our thoughts. When our needs are being met we have positive feelings; when our needs are not met we have negative feelings. The way we behave is an indication of our attempts to meet our needs. Everything we do or say is an attempt to meet our needs. This is an important difference from CBT because it better allows the emotional aspect of being human to factor in on how we grow and change instead of relying only on the mind to untangle itself. In fact, one of the main points in NVC is that empathy comes before education. When you try and educate prior to empathizing, it is difficult, if not impossible, for someone who is distraught to understand what you are trying to teach.

Cognitive Behavioral Therapy evolved from the behaviorist tradition of Ivan Pavlov, John B. Watson, B. F. Skinner, and Joseph Walpe combined with cognitive philosophy of some of the following pioneers: Alfred Adler, known as the founder of individual psychology; Albert Ellis in the 1950s, who created Rational Emotional Behavioral Therapy; Aaron Beck in the 1960s, who formed the basis of the most widely

researched and practiced form of CBT. Albert Bandura helped bridge the gap between the cognitive and behavioral (Binggeli, 2010).

CBT was also derived from Stoic Philosophies. “The Stoics taught that destructive emotions resulted from errors in judgment, and that a sage, or person of ‘moral and intellectual perfection,’ would not suffer such emotions” (Wikipedia, 2013h).

CBT helps patients look at their thought patterns, identify their core beliefs, recognize their cognitive distortions, and, through a variety of processes, unravel their thinking. CBT works with Cognitive Restructuring, Behavioral Activation, Exposure Therapy, and Skills Training (Binggeli, 2010).

Nonviolent Communication categorizes cognitive distortions as “jackal thinking.” People are taught the difference between jackal thinking (also known as life-alienated thinking) and giraffe consciousness. A jackal puppet and a giraffe puppet are used to teach these skills. The jackal puppet is representative of unconscious, habitual, programed thinking. The giraffe puppet represents the language and consciousness of NVC. Through language, cognitive distortions are clarified. For instance, in NVC, using the words *should* and *shouldn’t* are considered jackal. In CBT the words should and shouldn’t are considered cognitive distortions. In NVC labeling, mind reading, making generalizations, thinking in terms of always and never are all examples of life-alienated thinking and all will block communication. In CBT labeling, mind reading, making generalizations, thinking in terms of always and never are cognitive distortions. In both NVC and CBT people learn to use thought records to bring awareness to their thinking and to recreate the event in a way that is more accurate and rational (using CBT language) or more giraffe (using shorthand for NVC.) CBT does this through three steps:

1) Describe the event that triggered a negative feeling, 2) Describe your self-talk during the event (notice if it was negative, angry, blaming, or pessimistic . . .), 3) Rethink the situation with a more accurate, rational approach.

With NVC people keep a *Jackal* journal. It works like this: 1) Whenever a person has a negative, angry, blaming, or pessimistic thought, he/she writes down the triggering event and the jackal thinking. 2) The person goes inside and identifies what feelings and needs the event stimulated. 3) The person figures out a strategy that could either help him/her resolve the triggering event or prepare for future events that could be triggering. The strategy could be to call a friend for empathy or it could be to talk with the person who stimulated your negative emotions and try and resolve the problem (among other things). Getting empathy for what got triggered uncovers core beliefs and/or core wounds. By getting empathy for those things, people notice a shift. They are more likely to react differently in the future if they first get empathy for their reaction in the present. The process of getting empathy heals emotional wounds. When wounds are healed the brain becomes clearer and the person is more able to think and learn new things. It is hard to think when you are in emotional turmoil. Only using thought records to try and change habitual patterns will fail unless the person also receives emotional support. So much of our trauma is stored in our emotions. The way to healing is through the emotions not the brain.

The following are therapies that have evolved from CBT (Third Generation CBT):

Acceptance and Commitment Therapy (ACT)

Mindfulness Based Cognitive Therapy (MBCT)

Dialectical Behavior Therapy (DBT)

Behavioral Activation (BA)

Functional Analytic Psychotherapy (FAP)

Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

Integrative Couple Therapy (ICT)

(Suffolk Cognitive-Behavioral, 2006)

All of these therapies have commonalities and contradictions with NVC. For instance, one of the distraction techniques in DBT is *comparisons.* When you feel distressed, one of the techniques DBT recommends is to compare yourself with people less fortunate or to how you were when you were feeling worse. NVC recommends staying away from *comparisons* because if you can compare yourself with those less fortunate you can also compare yourself with those who are more fortunate (or successful or attractive) which can intensify your depression. When distressed, in DBT you push your emotions aside and cause yourself to feel differently by using humor or other distractions techniques. In NVC when you have an emotion you can choose several strategies to deal with it. You can give yourself empathy for it, or you can call a friend for empathy, or you can journal about it or you can just feel it. By not avoiding emotions they tend to transform. Empathy will open up the emotions so that all of the feelings can be heard and worked through. Emotions do not go away when they are avoided, because they are a biochemical reality in the body. By hearing the emotions, connections can be discovered that help a person make sense of what happened to him/her. Patterns that helped a child survive his/her childhood but are no longer useful can be unlocked with empathy and the person can then create more adaptive strategies for dealing with life.

An example of a commonality between DBT and NVC is that both teach to *observe without judging or evaluating*. The first step in NVC is the *observation.* The *observation* is what happened that triggered a reaction in you. An observation is something a video camera can pick up. A video camera can pick up what someone said or did. It cannot pick up any evaluations.

DBT gives specific strategies in guiding a person to care for his/her physical needs by recommending eating a healthy diet, exercising, sleeping enough but not too much, and avoiding non-prescribed medications. In contrast, by teaching people about human needs and giving them empathy, students of NVC are able to access their own inner wisdom and reach their own conclusions about how to best care for their physical needs. They do not need to rely on an experts to tell them how to manage their own self-care because they become connected with their own inner authority.

DBT teaches emotional regulation through a cognitive process. With NVC, emotional regulation is a byproduct of the growth that occurs when a person receives empathy and learns how to get his/her needs met. The advantage of NVC over DBT is that when a person is in emotional distress they can still respond to empathy, whereas they may not be able to use cognitive tools. NVC guides people in becoming more conscious and aware of their inner world by teaching universal spiritual principles and offering compassion.

CHAPTER 3

RESEARCH METHODS

Each of the studies done with Nonviolent Communication, which were discussed in Chapter 2, were about teaching a group of people Nonviolent Communication skills. The studies compared the group that received the Nonviolent Communication training with a group that did not receive the training by giving both groups a pre- and post-test and comparing the difference.

My research study used Heuristic Inquiry to apply the practice of Nonviolent Communication to a group of inpatient psychiatry patients in order to discern universal principles that could elicit either cooperation or elicit resistance. The setting was ideal for this experiment because the psychiatric unit used classic domination language patterns to control the patients. Some of these patterns were blame, threats, criticism, reprimands, power-over tactics, labels, judgments, diagnosis, analysis, and use of punishment. It was a hierarchal organization where status equaled title and credentials. Overall it was a frightening place to work; a place where hiding your humanity was required in order to survive. Physical and verbal assaults on staff from patients happened regularly. Staff to staff violence in terms of criticisms, put-downs, using titles to assert power over others, using written evaluations to assign wrongness, treating new employees with lack of respect and appreciation, making bored faces when a new employee spoke or gave report, and other subtle behaviors made the unit the most unpleasant place I had ever worked.

All of these characteristics made the unit an ideal place to compare nonviolent principles with the violent environment of the unit.

Having studied Nonviolent Communication for many years before I started working in this psychiatry unit, I understood the power that language had to create cooperation and connection between people. I wanted to see what would happen if I used the tools of NVC to emotionally take care of myself in this toxic environment and what would happen with the patients when I used NVC to connect with them. I believed that when universal principles having to do with treating people with respect and consideration were applied through the use of nonviolent language connection and healing would happen.

I found that when domination-type language patterns were used with patients, their violent behavior escalated. When NVC was used, the patient became calmer and more cooperative.

Using NVC to emotionally care for myself was difficult. My direct supervisor wanted to fire me because I did not fit in. I refused to use the power-over tactics that other staff used to control the patients. When I sat down to talk with a patient I was often interrupted by my boss because talking therapeutically with patients was not done on this unit. The only therapeutic intervention used on the unit was behavioral modification. It was ineffective in controlling people's violent behavior or in creating a healing environment.

I wrote about my observations and experience in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*. My subjective experience was then collaborated with a more formal study done by a student of mine,

Donna Riemer. The results of her study showed that integrating NVC into a forensics unit decreased the violence by more than 50% within a year.

By writing about my personal experience and insight, others were inspired to use NVC on their health care units. Using a phenomenological approach for my project paved the way for other studies to be done. I considered doing a more formal study where I would use a control group and an experimental group as other dissertation students had done in the research cited above. My idea was to teach NVC to an experimental group on a health care unit where staff satisfaction was poor. Then I would compare the participants' resulting experience of job satisfaction with the control groups' experience. Unfortunately, the opportunity to do this fell through. I believe it would have been an interesting study and would have contributed much needed research to the field of NVC. However, by writing about my own observations and experiences on a psychiatric unit in an easy-to-read book, I was able to reach a broader population (beyond an academic population) and inspire others. My book also provided much needed support and understanding to other health care workers suffering in domination systems.

Research Design

My study is carried out through personal observation. The researcher, who is a Registered Nurse and also a trainer with the Center for Nonviolent Communication, obtained data for the research by working on locked psychiatric units in the state-run hospital in Seattle. The patients were there on an involuntary hold, which meant their right to leave and decide their care was taken away from them. They had various diagnoses, such as schizophrenia, bipolar disorder, major depression, borderline personality disorder, drug and alcohol withdrawal, or grave disability. They were deemed

to be a danger to self, to others, or gravely disabled. The employees on the units were unwitting examples of the use of unconscious, habitual communication patterns. Observations were made about how patients reacted when staff spoke to them using these habitual communication patterns and how they reacted when the observer used Nonviolent Communication with them.

In order to do this research the researcher needed understanding of the following:

1. RN skills and experience
2. Understanding of how to communicate using Nonviolent Communication
3. Understanding of domination-type language
4. Understanding of Domination Systems
5. Understanding of Partnership Systems
6. Self-awareness or self-observation

Because this was an observer-driven research project there was concern about Observer Bias. Some definitions of observer bias are:

1. "Observer bias is error introduced into measurement when the observers overemphasize behavior they expect to find and fail to notice behavior they do not expect" (Wikipedia, 2013e).

2. "Observer bias can also be introduced because researchers see a behavior and interpret it according to what it means to them, whereas it may mean something else to the person showing the behavior" (Wikipedia, 2013?).

3. "Researcher's cognitive bias can cause them to unconsciously influence the participants of an experiment" (Wikipedia, 2013f).

The likelihood that observer bias would occur was partially controlled by using the language of Nonviolent Communication. For example, observations were made that were separated from evaluations. This made it more likely that objective observations were made, instead of observations that had been distorted by the researcher's cognitive filters.

The researchers' emotions were separated from the emotions of others so it was clear whose emotions were whose. The needs driving the emotions were identified and assigned to the person they to whom they belonged (instead of one person taking responsibility for causing another's feelings).

The researcher used NVC to connect with the patients and observed and recorded the response. Her bias for the language and her trust in the process could very well have influenced how the patients reacted. If you believe that "the world is your mirror" (a popular belief in self-help culture) then what you experience in the outer world says something about your inner world. Based on this it would be impossible not to influence the experiment in a way that said something about the observer's bias. The whole experiment of using NVC on the psychiatric ward and writing a book about it was subjective, based on the observer's biases. Experiencing the domination system that existed on the psychiatric unit was a reflection of the domination system contained inside the researcher. Awareness of this inner domination system and the choice to use NVC instead of habitual domination language began to loosen the ingrained patterns of domination inside the researcher. As her own patterns of domination loosened and changed, her outer reality also began to change. Even though I cannot attribute a direct correlation of the researcher's inner growth to a change on the psychiatric unit, I do

notice that today the unit that the researcher did her experiment on is, in fact, a kinder, gentler unit. Most people in the world today have been socialized by domination systems and have integrated that in a habitual unconscious way. For example people automatically think in terms of right and wrong, good and bad. They judge and label, criticize and blame. Domination systems inside people are also outside. By becoming aware of these unconscious systems and choosing to speak and act in unfamiliar ways (such as using the NVC model), people can begin to grow and change. As their inner reality changes, the outer world also changes in ways that reflect that. According to new-age thought, when enough people do the inner work needed to change their ways of thinking and behaving, then there will be a positive shift on the planet.

That is why the follow-up work that Donna Riemer did is so exciting. Her experiment on the forensics unit that she managed quantified the subjective research that Sears did in her experiment. Whereas Sears' research was qualitative; Riemer's was quantitative. By implementing the tools that Sears advocated, and making objective measurements of the results, Riemer validated the findings of Sears' research and took the research to a more objective level. In spite of observer bias, the process, principles, and theory of Nonviolent Communication were clear enough that they could be duplicated in an experiment and similar results obtained. When you consider that the experiment (of integrating NVC into psychiatric unit) was done by two different researchers (with different levels of training), in different parts of the country, in different hospitals, with different patients, and yet the responses of the patients were the same, one can speculate that the universal principles of nonviolence and the practice of Nonviolent Communication are relevant and effective in spite of observers bias.

Riemer carried out her research by teaching Nonviolent Communication to everyone on the forensics unit, which she managed. She collected data on violence indicators and compared the level of violence after she had been using NVC on the unit for about a year to the same violence indicators from the previous year. The violence indicators were:

1. Seclusion and Restraints incidents
2. Seclusion and Restraint hours
3. Time loss due to staff injuries
4. 1:1 staffing costs

The outcome was that violence on the unit decreased by more than 50% after NVC tools were integrated.

Research Hypothesis/Questions

Research Question: What are the psychological effects on staff and patients when NVC is integrated into a health care system?

Null Hypothesis: There will be no difference in staff or patient's behavior when Nonviolent Communication is used in an inpatient psychiatric unit.

Alternative Hypothesis: There will be an observed effect on staff and patients when Nonviolent Communication is used in an inpatient psychiatric unit.

Subjects

The subjects used in this research study consisted of the staff and patients in a locked psychiatry unit in a hospital in Seattle, Washington. The patients had various diagnoses including schizophrenia, bipolar disorder, depression, mania, alcohol and drug abuse and withdrawal, borderline personality disorder, antisocial personality disorder,

mood disorder, anxiety disorder, dementia, personality disorder, psychosis, eating disorder, obsessive-compulsive personality, oppositional defiant disorder, traumatic brain injury, and many other diagnoses. The patients were 18 years old or older. There were no children or adolescents on the unit. The patients were all in an acute phase of their illness and were involuntarily committed to the hospital. They all met the criteria for involuntary commitment: danger to self, danger to others, or gravely disabled.

The staff members on the unit were employees of the hospital. They had various levels of communication mastery. Most of them used domination-type communication when dealing with patients and with each other. Their part in the experiment was for the researcher to observe and contrast the results of their domination-style communications with results when Nonviolent Communication was used. Both staff and patients were unaware that they were participating in an experiment.

The unit that the majority of the research was done on was a 14-bed Psychiatric Intensive Care Unit. It consisted of 14 private rooms on either side of a long hall. The rooms had a small window, which was made of reinforced glass, in the door through which staff could observe the patients. There was a bed in each room that was bolted to the floor, so a patient could not tear it apart or use it as a weapon. In general the unit resembled a jail. This environment played a role in some of the behavior problems that a patient would exhibit, as it did not meet needs for safety, beauty, and comfort. When patients, who are already distressed, are placed in a smelly, stark unit and treated with threats, judgments, labels, and diagnoses, they can become more distressed and then tend to act out.

There was no set number of patients or staff members who participated in the experiment. The staff people and patients who were present on the day that the researcher worked were the subjects.

The data was obtained over an 18-month period. Since the research project was to produce a book about the experience of working on a locked psychiatric unit and to observe the effect of using NVC instead of domination type language there was no set experimental or control group. Instead a phenomenological approach was used.

Data Collection Procedures

Nonviolent Communication principles, philosophy and language were used in this experiment. The process of NVC has been described previously in this paper and examples of its use are written in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*. The tools of NVC that I used the most in my research were empathy and self-empathy.

The formal empathy model of NVC follows:

OBSERVATION: When you see (hear or remember)_____(Put a clear observation without evaluation in the blank)

FEELING: Are you feelings_____(put a feeling word in the blank)

NEED: Because you need _____(put a need word in the blank)

REQUEST: And right now would you like _____ (Put a want in the blank)

Usually when giving empathy I focus mainly on feelings and needs and only use the observation and request occasionally. I use a quote from my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*, as an

example of how I empathized with a distressed patient: The patient said, “This place is like a jail. I feel like I’m being punished” (Sears, 2010, p. 66). My response to this in an attempt to empathize was: “Are you feeling angry and need to be understood for what is going on with you?” I focused on the feeling: anger, and the need: understanding.

When I empathized with someone on the psychiatric unit I observed and recorded their reaction. I also observed and recorded how the patients responded when other staff members spoke to them using domination-type language. Domination-type language includes all of the following: advice, judgment, labeling, analyzing, diagnosing, reassuring, sympathizing, questioning, correcting, consoling, educating, fixing it. When a person shares something and you change the focus from that person’s experience and tell a story of your own or do anything else that removes the focus from what that person is sharing, you are blocking communication. Empathy is about hearing what someone is expressing on a heart level. When someone is heard with empathy it gives wings to their expression and helps them integrate their own experience more fully. It is not about coming up with strategies to fix them or advising them how to handle their situation. It is about trusting them to find their own answers that work for them. When people find the answer inside themselves they feel empowered to handle their own lives. Using empathy to connect with patients helps them integrate things they may be violently projecting onto others. It helps them make friends with parts of themselves they may have disowned and by doing so it decreases the violence.

The use of self-empathy is one of the most important tools for a health care professional to understand and use. Because we have all been socialized to use

domination type language, it requires insight and inner work to begin to change our language patterns to a partnership model.

The Self-Empathy Model

1. Observe your thinking. Notice your judgments, analysis, or whatever else is going on in your head.
2. Identify your feelings. Recognize that your feelings point to your needs. If you have positive feelings you know that your needs are being met. If you have negative feelings you understand that your needs are not being met.
3. Name the needs that drive your feelings.
4. Identify how you want to respond to the situation that precipitated the self-empathy event.

One would think, as a matter of course, that empathy would be part of what a health care professional does. It is strange that health care professionals are not trained to give empathy. They are trained to fix people, to advise, to console, and to sympathize. That training is inadequate in helping the professional cope with the rigorous demands of his/her daily interactions with distressed people. It is also tragic that patients do not get the empathy they need, which would help them heal. Because of this, my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*, is needed to remind people of what compassion is and how to express empathy.

My research project was about using the tools of NVC to connect with others. Anyone who has studied NVC and has done the inner-work needed to be able to use the tools successfully should be able to duplicate my experiment. Donna Riemer proved that

the experiment could be duplicated successfully in her application on the Mendota forensics unit.

Data Analysis and Results

In this chapter some of the reasons why NVC is so powerful are related to brain research. By using NVC in the gap between stimulus and response, a person can change habitual patterns and change the structure and function of the brain. This is why learning NVC creates long-term change. By using NVC on the psychiatric unit the following results were recorded: 1) patients were more likely to cooperate when NVC was used versus. when threats or analysis were used. 2) Patients would become calmer and quieter when NVC was used. When domination language was used, the patient's behavior would escalate. 3) Patients would seek me out on the unit when they needed something instead of going to their assigned nurse. Donna Riemer's research confirmed the results that my research alluded to.

In analyzing the data the following theme emerged: NVC is a very powerful tool that can be used both on a personal and a systems level to transform a health care unit. Communication points to belief systems. Belief systems can change by bringing awareness to them and educating people in alternative ways of perceiving. Educating people about communication achieves long-term results because it helps people understand how to change their thinking. When you change your thinking, you change your brain. There is new research out now in the field of brain science that acknowledges that the brain is plastic and can change. "The discovery that our thoughts can change the structure and function of our brains-even into old age-is the most important breakthrough in neuroscience in four centuries" (The New York Times, Doidge , back cover).

One reason that NVC is powerful is because it can guide a person to change his/her brain. In the research done by Riemer, chronically ill patients started getting better after NVC was introduced into the forensics unit. This indicates that change was happening in the way that the patients perceived reality. Instead of reacting in habitually violent ways to stimulus, the patients learned new coping skills and behaviors. Belief systems such as "he's disrespecting me and deserves to be punished," were adjusted through an awareness of language. In the sentence "he's disrespecting me and deserves to be punished," the person learned that he was 1) Analyzing wrongness, 2) Using *deserve* thinking, and 3) Advocating violence (punishment). Instead, this person learned communication skills so he could check out what the person's intentions were. In order to do that the cognitive pattern of stimulus-response needed to be changed in the brain. As Viktor Frankl explains: "Between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom" (goodreads, 2013).

Nonviolent Communication can be placed in the gap between stimulus and response. Using the above sentence as an example: "he's disrespecting me and deserves to be punished," people can use the four steps of NVC to respond in a new way. Let us says the stimulus that triggered that sentence was a patient who said, "You're sitting in my chair." Instead of punching the patient who said that, the person who was triggered is taught to 1) Observe without evaluation: Instead of thinking "he's disrespecting me . . . " the observation is: *the person said, "You're sitting in my chair."* 2) The second step is to notice what feeling is triggered. In this example the feeling is *anger*. 3) The third step is to name what need is not met inside of you. (By doing this step you begin to own your

feelings, and violence toward others dissipates.) The unmet need is this case is *respect*. 4) The forth step is to determine how you want to react to the situation. The person who was triggered can decide to have a dialogue with the patient using NVC so that both people can understand the other's feelings and needs. By placing NVC in the gap between stimulus and response you can use the model to reprogram habitual responses. It is not easy to do so, but, as Frankl says, it will stimulate growth and help you free yourself from programed reactions. By changing the way you react, you will change your life.

My research indicates that Nonviolent Communication is a tool that does more than change systems; it also changes the brain. By using NVC you can become smarter about how you respond and react. You can use the tool to make connections with others and to change habits that do not serve you. NVC is effective in reducing violence as seen in Riemer's research. Its effectiveness in soothing distraught people is illustrated in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*.

The subjects of my experiment were patients on a locked psychiatric unit. They were between the ages of 18 and 90. They had various diagnoses including schizophrenia, bipolar disorder, dementia, brain injury, borderline personality disorder, obsessive-compulsive disorder, post-traumatic stress disorder, depression, anxiety, antisocial personality disorder, eating disorder, et cetera. They were a danger to themselves, a danger to others, or gravely disabled and were committed under an involuntary treatment order onto a locked psychiatric unit. Many of them were physically and verbally violent and would act out with the slightest provocation. By acting out, I mean they would yell, hurt themselves, or try and hurt each other and/or staff members.

The staff consisted of males and females between the ages of 21 and 65. Some of them were nurses, and some were mental health specialists.

My research question was: What are the psychological effects on staff and patients when NVC is used in a health care system? The research I did to determine this was explained in my book. By using NVC in my day-to-day interactions with staff and patients I was able to see the effects that the tool had on patients, staff and on me. Instead of perpetuating domination-type language, I made a conscious effort to use NVC at all times. It was easy to see the contrast of how a patient reacted when a staff person would threaten or analyze wrongness to when I would speak with a patient using empathy and other NVC tools. When I used NVC with patients, they would calm down and seek me out when they needed something. They would become more cooperative and act out less. For instance, one patient who had been lying on the floor cussing out the staff every day remained in her wheelchair during the shift I worked with her and communicated her needs using words. My ability to empathize with the patients' humanity under their difficult behaviors, allowed a connection to be made. When the patients received this kind of understanding and compassion, it disarmed them and they became calmer and more pleasant to be around. Many examples of the results of using NVC with the patients can be found in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* (Sears, 2010).

My Null Hypothesis was: There will be no difference in staff or patient's behavior when Nonviolent Communication is used in an inpatient psychiatric unit. This was found to be incorrect. There was a difference in both staff and patient behavior when NVC was used. The differences were explained in story format in my book, *Humanizing Health*

Care: Creating Cultures of Compassion with Nonviolent Communication. Some of the differences were: 1) Patients were more likely to cooperate when NVC was used versus when threats or analysis were used. 2) Patients would become calmer and quieter when NVC was used. When domination language was used, the patient's behavior would escalate. 3) Patients would seek me out on the unit when they needed something instead of going to their assigned nurse.

Some staff persons' behavior changed but not in a positive way. There was a perception that when I used NVC with the patients, I was being nice or soft. Staff on the unit prided themselves on being tough. The Charge nurse went out of her way to block my efforts to connect with patients. She thought that I was not tough enough to work there and wanted to fire me. Other staff members were affected in other ways. One nurse was impressed when she saw a patient respond rapidly to my request after the patient had refused to cooperate with her. Another nurse was concerned about my well-being when she saw how the charge nurse treated me. A new nurse appreciated me when I gave her empathy for the mistreatment she was experiencing. Using NVC on the unit shook things up. I became a target for judgments, as I was not conforming to the status quo. Cultural change was slow to come to that unit. Anyone who did not conform to the violent culture either quit or was fired.

The Alternative Hypothesis (There will be an observed effect on staff and patients when Nonviolent Communication is used in an inpatient psychiatric unit) was found to be true. The effect on the patients was positive. The effect on the staff was both positive and negative. However, when looking at Riemer's research, the effect on both patients and staff when NVC was integrated into her unit was positive. The reason for this was that

Riemer was the manager of her unit. She had status and power in a domination system that values titles. I was just a staff nurse on the unit I worked on. I had neither status nor power. In fact I was near the bottom of the totem-poll as a new employee. I had not earned the right to be different, to think independently, and to get better outcomes than those in power.

The effect on me, the researcher, was an unexpected bonus, as I did this research. I believed in the tools of NVC and had undergone an internal transformation in the past from using them. Therefore, as I used the tools of NVC on the psychiatric unit I was acting in congruence with my beliefs. I knew I acted differently than others, and I chose to honor my beliefs rather than being part of the gang. Part of me was sad because I wanted to belong. It was actually quite painful at one point, as it stirred up pain about not belonging in the past. One of my core beliefs is that I do not belong. That belief was created because I moved almost every year when I was growing up. About the time I made friends and was accepted in a place, we would move again. Because of this, I longed to belong. In spite of that, I was true to myself and used the tools to give myself empathy for the pain of it all. I learned that I would rather be true to myself than part of the crowd. The experience helped me stay centered and be strong in myself. It allowed me to be clear about the connections I wanted to make based on qualities I valued instead of a desperate need to belong that was created from my emotional wounds.

My research was explained in a book format, using creative nonfiction. I wove the principles of NVC in with the story I told. The truths I learned and the outcomes experienced flowed from each situation. My experiences and beliefs about the power that NVC has to transform systems and create healing were confirmed by Donna Riemer's

research when she integrated NVC into her forensics unit. The fact that violence on her unit decreased by more than 50% in a year is a testament to the truth of what I experienced.

Summary, Discussion, and Recommendations

Summary

Problem: The problem that this research project specifically addressed was how domination communication is used to control and suppress mentally ill patients and illustrated though examples how ineffective that is. About 57.7 million people in the US suffer from a diagnosable mental disorder (Kim Foundation, 2013). The way these people are treated by mental health professionals makes a large impact on the society in terms of costs, safety, and quality of life. Our current system is failing to care for people with mental disorders in a way that will improve their quality of life, decrease costs of care, and protect people from violence caused by a mentally disturbed person Although a person with a mental illness is no more violent than people in the general population, they take powerful medications that can cause them to act out in violent ways. People who were on psychiatric medication committed many of the mass murders that have occurred in the last 10 years in the US. Although medications can be helpful in some ways, they cannot be counted on to provide deep healing and transformation. Our institutions *stabilize* disturbed individuals with medications and then return them to the streets. Once patients are not in the hospital anymore, they often quit taking their medications and return to previous behavior, because they have not learned how to cope nor have they learned how to get the deep emotional healing they need. If they stay on their medications they often develop side effects and their physical health deteriorates. The same patients

will often cycle in and out of the hospital several times in 1 year. This system of caring for patients who have a mental disorder costs the society a lot of money. By placing patients on medications instead of doing deep emotional work with them and teaching them new skills we create chronically impaired people who cannot work or contribute to society and who use a lot of resources to survive. If the person with a mental illness is spoken to using domination style language while in the hospital, their patterns of thought are perpetuated and the coping methods they have learned are reinforced.

Method

For my dissertation project, I chose to write a book. I picked the topic of psychiatry because I was working in an inpatient psychiatry unit as a RN at the time and noticed that the way employees and patients were treated was contrary to my understanding of compassion. I had been studying Nonviolent Communication for the last 20 years and had integrated the skills and developed an understanding of what people needed in order to heal and thrive. What I saw on the psychiatric unit was not congruent with my understanding. As I read different authors' viewpoints on psychiatry, I became clearer on why the current system does not work and what would work better.

I wrote my book by recording what happened every shift that I worked on the psychiatric unit. I observed how patients responded to the treatment they received. I observed how the staff interacted with the patients and with each other. I also observed what went on inside of me in reaction to all that happened. As I recorded the events that took place, I wove in philosophy and literature that was relevant and which helped make sense of everything. I used the stories I told in the book to illustrate concepts about

humans that were universally true and used the structure of the book to explain and demonstrate how Nonviolent Communication works.

Results

Nonviolent Communication is such a simple tool that can make a big difference in raising the consciousness and harmony of a work environment. The research done for my book gives credibility to this claim. People all over the world are now citing my book in their own research on Nonviolent Communication and it is opening doors for other trainers to help businesses integrate the tools. The book, *Humanizing Health Care with Nonviolent Communication* was self-published in 2006. It was rewritten, edited, and published by Puddle Dancer Press in 2010 under the title of *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication*. It was translated into German in 2011. The book became known in many countries and in 2011 I spent 6 weeks facilitating trainings in New Zealand and Australia.

The results of my experiment showed that by using Nonviolent Communication to connect with psychiatric patients, instead of domination-type language, cooperation and awareness would grow. Patients' behavior would calm and they would become more receptive to learning new skills. The safety that the language created allowed the patients' hidden humanity to show. It was not safe for a patient to show his/her vulnerability when he/she was being judged, diagnosed, and analyzed. But when I took the risk to show my own vulnerability by guessing a patient's feelings and needs it showed the patient that I was trying to understand him/her as a person. It also demonstrated unconditional acceptance as I empathized with them when they were acting out instead or threatening them or lecturing them. As I demonstrated compassion for their humanity, they could

develop more compassion for their own humanity. The tools and communications that were sanctioned in the hospital were all about thoughts. Patients were not encouraged to express their feelings and find their needs. This is why Nonviolent Communication was such a radical departure from what was being done. Nonviolent Communication focuses on feelings and needs instead of thoughts. The tools used in the hospital were behavioral therapy (positive and negative reinforcement) and Cognitive Behavioral Therapy (used with higher functioning patients). Patients were taught how to fill out thought records, so they could notice their thinking patterns. They were also educated about cognitive distortions. All of this is useful information, however, patients who were in the acute psychiatry needed empathy and connection. Because they were in such distress it was difficult for them to focus on educational material. When I led a group at the hospital patients got a taste of empathy and they found commonality with other patients. This was healing for them as it began to meet their emotional needs. When people get empathy they begin to heal. Especially when someone gets empathy in a group it creates connection with others and people naturally want to support each other.

In Riemer's follow up experiment where she integrated NVC into her forensics unit, violence decreased by 50% in a year and chronically violent mentally ill patients started getting better. Her unit that historically had trouble retaining and recruiting staff people now has a waiting list of employees who want to work there.

Discussion: Significant Findings

Findings about Empathy

The most prominent significant finding was that using Nonviolent Communication, especially the empathy model, is healing and inspires cooperation even when used on the most psychologically impaired patient. Rogers believed that people grow in a positive direction; that even the most impaired person has the ability to grow and change. Rogers was curious about who the person was underneath the labels and psychological diagnosis. He believed that if he could show unconditional acceptance for the feelings, beliefs, and attitudes that are real and vital for a person then that person could grow toward self-actualization maturity and socialization. When Rogers was confused about how to proceed in a therapeutic encounter, he found that by listening more deeply the process would unfold. Using Rosenberg's empathy model to listen deeply to patients, I was able to observe the healing effect it had. It made my job easier because patients would cooperate with me instead of reacting against me.

Earlier in this paper I mentioned that resolution of a patient's symptoms was in a large part the result of the perception that the doctor had heard him/her. Being heard is a powerful need. In my research, when I listened to a patient and heard what they were trying to communicate through their dysfunctional actions, their behavior started to improve. For instance, in my book I talked about the patient who lay on the floor every day cussing out the staff. On the day that I took care of her she remained in her wheelchair because I gave her empathy instead of judgments, analysis, or threats, which she had been receiving from other staff.

When Riemer integrated NVC onto her forensics unit, chronically mentally ill patients started getting better and were transferred onto less restrictive units. Not only does empathy heal emotional wounds and positively affect dysfunctional coping mechanisms but research shows that the brain actually forms new neuro-connections when it learns how to do things differently. If a person gets empathy for the way /he/she currently does things then that person will be more receptive to learning how to do it differently versus if the person tries to do it differently without first receiving empathy. Empathy sooths the nervous system so a person can think more clearly and learn new skills after receiving empathy. The saying, "when your ear is full of fear you can't hear," is true. When a person is in distress they cannot take in new information. By soothing the distress with empathy, the person will more likely be able to find his/her own solutions to problems. Part of the Rogerian tradition is to trust each individual's capacity to generate solutions, rather than relying on the external expert to give the solutions. With empathy support, a person can get in touch with their inner wisdom and begin to look within for answers instead of relying on an external authority to tell them what to do.

Findings about Psychiatric Systems

According to Frankel, "Caring and Compassionate Communication between doctors and patients is the central task and heart of medical work"(Frankel, 1992, p. 3). This belief is contrary to how doctors are trained in the biomedical model of medicine, which has been dominate for the last 100 years. In the biomedical model, diagnoses are made and the patient is treated with medications or surgery. In our current psychological institutions practice is more in accord with the biomedical model. The doctor diagnoses a mental illness based on symptoms and prescribes medications. Very little time is spent

listening to the patient or giving empathy. Based on the research done for this paper, this approach is doomed to fail. Indeed, by medicating patients instead of listening to them and teaching them tools, a patient is very likely to become impaired, develop chronic health problems, and end up on disability. Western Lapland in Finland used to treat mentally ill people like the US does today. They had the highest rate of schizophrenia in Europe in the 1970s. Just like in the US, psychiatric patients in Lapland were placed on medications and developed chronic health problems. The country was going bankrupt supporting this system. Lapland changed their system in two important ways. They decreased the use of neuroleptics, and they trained teams of mental health professionals in open dialogue therapy. Open dialogue therapy is much like NVC. The mental health professionals would go to patients' homes and work with the patient and families to restore social connections. The belief system that was at the foundation of this strategy was that psychosis arises out of frayed social relationships. The psychotic person is the one who make the difficult situation visible. Now their mental health spending is the lowest in all health districts in Finland.

The belief system that is at the foundation of the way the US treats mentally ill people is that people with a mental illness have a chemical imbalance in their brains and need medications to correct it. This theory has never been proved. Dr. Peter Breggin says that research has not shown that psychiatric medications correct imbalances, rather it has shown that psychiatric medications create imbalances (Breggin, 1999). Other researchers, such as Dr. Daniel Amen, show through Spect scans that medications, when used correctly, positively affect parts of the brain that are not working well. Other research shows that medications can be helpful when used in conservative ways (such as to help a

psychotic patient begin therapy so he/she can begin to become less reliant on medications.) To expect medications to fix people without giving them resources to get empathy and learn new tools is usually not successful in the long run.

As I observed what happened working in the psychiatric hospital, I noticed that the same patients were admitted frequently and they displayed the same symptoms and behavior as the first time they were admitted. The patient's medications were adjusted until their symptoms and behavior improved and they were discharged again. All of the patients were on disability and used public funding for food and housing and to buy medications.

Findings about Domination Systems

My use of Nonviolent Communication on the psychiatric unit got me into trouble with management. Because I was not conforming to the culture on the psychiatric unit, I almost got fired. The culture on the unit was all about conformity, power-over, punishment and reward, repression of feelings, control by authority, perpetuation of unconscious beliefs, and use of domination language. Domination language as defined in this paper contained some of the following characteristics: Use of should/shouldn't, use of *deserve*, use of blame, punishment, and criticism, evaluating others in terms of right and wrong, labeling, diagnosing, insulting, and judging. The unit operated, as in all domination systems, on fear. The patients were scared of the staff that had the power to punish them by putting them in restraints and giving them medications against their wills. The employees were scared of management and could not speak out against the system for fear of punishment and retaliation. New employees were scared they would be judged as *incompetent* and get a negative evaluation. Employees were also scared of the patients

who had a history of violence and dysfunctional coping mechanisms. The domination language used on the unit perpetuated the violence and reinforced dysfunctional coping mechanisms. Because people can tell the difference between a demand and a request, when a patient was told to go to his/her room, the patient rebelled and acted out. When a staff person told a patient to do something, it was always a demand. The difference between a demand and a request is that a demand implies punishment. When people hear a demand, it triggers their autonomy issues and they rebel. If they submit to the demand it results in loss of self-esteem. Eventually the patients who returned to the unit repeatedly became dependent on the system. They developed a learned helplessness. The system expected people (both patients and staff) to blindly obey authority, which ensured that they lost touch with their own sense of self-responsibility and expected others to fix their problems. This is one of the dynamics that occur when people become *institutionalized.* People who are *institutionalized* find it extremely difficult to survive outside of the institution, which is one factor that caused them to return to the hospital time after time.

To make sense of what was happening in the hospital, I wrote the following in my book, *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication:*

> Relationships of dominance cannot be sustained unless everyone in the system is socialized to suppress or ignore their true feelings and needs. Both dominators and those who submit to domination are socialized to repress feelings of anger, and to be ashamed of their human needs for empathy, honesty, and care. (Sears, 2010, p. 25)

The relationships on the psychiatric unit were guarded. When people do not have the freedom to express their true feelings and to ask for their human needs to be met, the environment becomes emotionally dangerous. People put on a mask to hide who they really are. Maintaining this mask is exhausting and contributes to burnout.

As I was puzzling over why I was treated with such lack of respect on the unit, I wrote the following:

> Exerting power over others requires human beings to "be tough." This "toughness" allows the dominator to play the power over role, but requires the suppression of the dominator's own needs for human connection based not on status or role, but on recognition of their deepest inner qualities. The dominator's "toughness" is shored up through minimizing and ridiculing the "soft" human needs for connection, recognition, empathy and care. "To maintain rankings of domination, caring and empathy have to be suppressed and devalued." (Sears, 2010, p. 25)

Since I was not interested in elevating my ranking and I outwardly showed empathy and compassion for patients and staff, I was judged by the charge nurse as being *soft.* Once the charge nurse made that determination, everything I did was judged on that assumption. For instance, once I did not participate in a *Show of Force* because I was in the middle of transferring a patient from the wheelchair to the bed. I did look out the door of the room to see what was happening and I determined that there was plenty of staff present in the *Show of Force* to handle the situation without me. The charge nurse determined that I was too scared to participate and she would not listen to my explanation.

"The wisdom of caring, empathy, and human connection is particularly suspect within domination systems, as are the people who have historically held this wisdom" (Sears, 2010, p. 25).

The fact that I almost got fired for being caring and compassionate was an unexpected outcome in my research. It was motivational, as it inspired me to write my book in order to make sense of what was happening.

Trends

Domination systems have the same characteristics and exhibit the same problems regardless of which industry they represent. I chose the health care industry in my research to illustrate the concept of domination systems and the effects of that system on employees and consumers. It is interesting to notice how deeply the system affects the behavior of the employees and the issues that arise. It is predictable what problems you will see in any domination system. It is unproductive to continue to try and run an organization using a domination structure and expect that these problems will not arise. Organizations tend to try and fix certain problems but it does not work because the problems are not the problem. The problems arise from the structure of the organization. Until the structure is changed the same kind of problems will occur because the domination structure does not help people get their needs met. In fact the structure prevents human needs from even being acknowledged. One manager said to me, "I wish people would leave their personal problems at home before they come to work." This is a common fantasy among managers, but it is not reality. People do not split themselves off from their feelings and needs when they come to work. Sometimes they come to work and they are in need of empathy for something that happened at home. Instead of

expecting people to not have that need, a manager's time would be better spent learning empathy skills. A manager who knows how to meet the needs of her employees is a leader who can inspire people to excel.

Sometimes employees are punished for showing their human feelings at work. They are considered *emotional* and lose respect and esteem from their colleagues. In this culture there is an acceptable range of emotional responses restricted to a very narrow set of what is traditionally endorsed. And in my situation, I was almost fired for expressing empathy and compassion in the domination system where I worked.

When I see people and organizations repeat the same mistakes over and over, I call it being on the hamster wheel. Getting off the hamster wheel requires a change in the fundamental ways of doing things. For couples, who have the same argument over and over for years, it requires that they learn a new way to communicate with each other. This involves becoming aware of their expectations, their beliefs, their programing, and their wounds and finding the healing and the education they need to do it differently. With businesses, doing things differently so that the same problems are not perpetuated, require that the structures be examined, the beliefs changed and the communications humanized. Albert Einstein says the following: "Insanity: doing the same thing over and over again and expecting different results" (BrainyQuote, 2013).

Einstein also said, "No problem can be solved from the same level of consciousness that created it." (BrainyQuote, 2013).

Using Nonviolent Communication to transform an organization elevates the level of consciousness so that effective solutions to the problems can be found. By changing the structure of the language into one which includes feelings and needs and empowers

the employees to express their opinions, the domination structure will transform into one which is more life serving.

As more businesses choose to use NVC as part of restructuring their domination-type paradigm, more people will begin to enjoy their jobs. New business structures will support employees in healing and growth. Creativity will be encouraged and supported. This will all contribute to the evolutionary shift that is happening on the planet now. Happier employees will have a trickle-down effect on families, on communities, and on society. As people become empowered to express their honesty and to hear others with empathy many cultural problems will resolve. People will have the tools they need to get their needs met in nonviolent ways. The world will become more peaceful as people learn tools for conflict resolution and begin to get their own needs met.

Recommendations

Our health care systems are awash in dysfunction, inefficiencies, and financial concerns. With systems of domination in place, patients and employees do not get their needs met, which makes it difficult, if not impossible, to carry out the life-serving mission of the institution. This research project suggests a way to improve many of the problems facing health care. By giving all staff the tools to communicate effectively and the empowerment to think for themselves, changes can be made that will positively impact the health and well-being of both patients and employees.

Future Research on Structural Changes

1. Large hospitals have been the strategy to care for patients. Is this the best structure for providing care? What systems could be more effective in containing pathogens and providing care?

2. Would community outreach programs, such as the ones in Lapland (mentioned earlier in this paper), be set up so that patients do not even need to go to the hospital. Would that be effective in our culture? Can community programs also be developed to educate people how to care for their health, thereby reducing the number of people who need hospital care?
3. Would improving and expanding addiction treatment programs make a difference in the effectiveness of helping people heal, thereby decreasing chronic health problems and need for hospitalization?

Other ideas for improving structures would be to:

1. Increase the use of services, such as hospice to care for people in their own home, which would reduce the need for expensive hospital care.
2. Implement Nonviolent Communication into an entire hospital and compare the results with pre-research data, such as financial impact, employee turnover, and patient satisfaction.

Future Research on Communication

1. Health care systems respond to cultural norms when structuring their policies and procedures. For instance, people in the culture expect that hospitals keep patients alive. So hospitals place patients who have no hope for recovery on ventilators and keep them alive for as long as possible. This makes money for the hospital and enables family members to hold on to hope until the last minute of someone's life. It prevents families from working through their grief together and places the dying patient in a painful situation where all shreds of dignity are lost. A research project could be done where the

experimental group is taught how to communicate about death and dying and the control group is not. Cultural values of what it means to care for someone need to be clarified. Quality of life verses survival need to be discussed. Would individuals in the experimental group choose more diverse options of caring for their loved ones at end of lives after being educated about death and dying?

2. A shift in the consciousness of the culture needs to be encouraged. Instead of relying on the external expert (the doctor) to fix people, individuals need to learn to listen to their inner wisdom. Communication classes can be set up in early education that will begin to shift people's paradigm from domination-type thinking and communicating to a partnership model. Empathy can be encouraged so that people can begin to be heard for their pain at an early age. Children can learn conflict resolution skills, which will begin to shift the violence on the planet as they grow up.
3. A variety of topics could be researched on using communication to transform the culture. In this paper, research was cited on the effect of bringing NVC into a health care unit, a treatment center, an alternative public school, a juvenile delinquency facility, and as part of a college curriculum. Further research can be done on implementing NVC into an elementary and secondary school, into a business, into a nonprofit organization, and into a family. The implication of my research and the research of others is that by changing our communication, we change our consciousness. When we change our consciousness we change the systems that make up our culture. As the

systems change we build a culture that is able to better meet human needs. Developing humane systems that support and educate the population can treat many of the problems that plague the country.

Pioneers like Rogers, Rosenberg, and Maslow brought communication skills to the general public. Communication tools are available now to help people have essential conversations. These tools are needed in every aspect of the culture from the family, to the schools, to institutions and businesses and hospitals.

Project Conclusions

Lessons learned from this project are many. Besides the personal lessons on how to write and publish a book, there are global lessons. The biggest lesson this project points to is the lesson of humanity. People are all human and humans have the same needs. When humans are treated in domination ways they react in similar manners, creating problems for an organization. Systems of violence perpetuate violence. When the feelings and needs of humans are considered and respected, people respond in a more caring, harmonious fashion and organizations benefit. In order to untangle some of the dysfunctions organizations face, it is important to change the belief systems and disarm the language that caused the problems. "No problem can be solved from the same level of consciousness that created it" (BrainyQuote, 2013).

The statement about humanity (that all people share the same needs) is a starting place for all research undertaken on how to change dysfunctional systems. If you consider a person’s feelings and needs and give him or her tools that create healing and harmony the organization will grow in a more functional direction. People want to contribute their unique gifts to their work place. They want to be seen, acknowledged,

and supported. When their needs are met then creativity flourishes. Creativity fuels growth and stimulates abundance for the organization. Nonviolent Communication is a tool that can be used in any organization to induce a culture change and stimulate the positive outcomes discussed above.

Puddle Dancer Press published the second edition of *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* in 2010. It was translated into German and published in Germany in 2012 by Junfermann Verlag, Paderborn.

The book was written in a way that was congruent with NVC principles. An attempt was made to understand behavior instead of to judge it and to find the feelings and needs underneath. NVC tools were also used to obtain the endorsements from famous people. The main tool used for this was *empathizing with the "NO"* or *finding the YES behind the NO.* Most endorsements took several email exchanges before the endorsement came through. The book has sold thousands of copies in the US and around the world. I have been contacted by people who read my book in the US, Spain, Germany, England, France, Korea, Canada, Australia, and New Zealand. In 2011, I spent six and a half weeks in New Zealand and Australia doing trainings as follow up to my book.

NVC Tools that helped me write my books and dissertation:

1. *A giraffe never gives in or gives up.* A *giraffe* is a symbol for NVC consciousness because giraffes have one of the largest hearts of any land animals. They are tall so they can see into the distance. (This relates to being wise in the present as what you say or do now impact what happens down the road.) Giraffes have a tough tongue that can take a thorn and remove the soft

interior of it without problem (like a person who speaks NVC can accept the tough exterior of someone and with compassion extract the softness, the wounds that lies below). By understanding this principle, *a giraffe never gives in or gives up*, I persisted in my endeavor to finish my PhD. I self-published the first book called *Humanizing Health Care with Nonviolent Communication.* As this book circulated, a nurse from Wisconsin, Donna Riemer RN-BC, found it and contacted me. She was the manager of a forensics unit at Mendota Mental Health Institute and was very excited about what I had written. She was inspired to try the principles out in her unit. She and I started having weekly phone sessions as she developed a NVC program for her unit. About this time I felt increasingly uncomfortable with my book for a number of reasons so I began to rewrite it. This allowed me to incorporate the Riemer's experiment at Mendota Mental Health Institute into the new version. Puddle Dancer Press published the new version of the book called *Humanizing Health Care: Creating Cultures of Compassion with Nonviolent Communication* in 2010. Then I found out that the book was not enough for the dissertation. Due to several miscommunications with my advisors at IUPS, I was mistaken about what was really required. So after a couple of mis-starts, I obtained the outline of what was required and wrote and rewrote the dissertation.

2. *Ask for what you want*. In 2012 I learned that I was no longer in the PhD program at IUPS. I knew it was taking me a long time to finish my PhD but I wanted to finish what I started. So I asked to be reinstated. Even when my

request was initially denied, I kept asking. I am grateful for Irv Katz PhD. for reinstating me and allowing me to finish this work.

3. *Empathizing with the NO. (*Or *turning the NO into a Yes.)* This was the most fun principle to experiment with. As I sent out requests for book endorsements to famous people I got back 100% "NOs." Using the principles of NVC I was able to empathize with why the famous people were saying "No." After I empathized I told them how they could benefit from reading my book. I also gave them the choice after reading the book of writing an endorsement, if they felt inspired. It was magical seeing the NOs become Yes's.
4. *Quit taking it personally.* This principle allowed me to take responsibility for my own issues and to have compassion for others. I understood that the abuse that was projected onto me when I started the job at the psychiatric hospital was really an expression of pain that was being expressed in dysfunctional ways. Knowing this helped me stay out of reaction and to do what I needed to do to get the support and healing I needed.
5. *Anything worth doing is worth doing poorly.* Remembering this principle helped me relax, as I did not have an expectation that what I was writing had to be perfect.
6. *Don't just do something, stand there.* Instead of reacting to the toxic expressions from the other staff, I stood there and observed. I observed what got stimulated in me and noticed the patterns that shut down communication and stimulated pain. It became obvious that communication creates consciousness. The consciousness of the staff in that environment was violent,

punitive, and shaming-the opposite of what a patient who is suffering from emotional turmoil needs.

7. *"When we understand the needs that motivate our own and other's behavior, we have no enemies.*" (Puddle Dancer Press, 2009). I worked hard to stay connected to my own needs as I was writing the book and to imagine the needs others were expressing when they behaved in various ways. This helped prevent me from forming enemy images of others and allowed me to have compassion for them.
8. *We need empathy to give empathy.* I gave myself empathy both by writing the book and by listening to my inner self. I also called others for empathy when I needed it.
9. *Become your own inner authority.* This principle helped me feel more at ease around those in power. I was connected to myself and not likely to give up my own power just because someone in authority demanded something of me. Because of this I was able to express my concerns to the managers when other staff could not.

Self-Empathy

My inner voices were howling throughout the writing of this dissertation: "I'm not smart enough," or "I'm too old," and "I can't do this," were so overwhelming that at times I could not even stand to look at the document I was working on. Sometimes I was able to empathize with these voices and hear the fear and discouragement that they were expressing. Finding the need that would help me move forward was more difficult. I needed self-confidence and trust, but I could not find any. I found a little reassurance by

remembering things I had accomplished in the past. I found that getting support from people was the most helpful. The support that helped most was receiving a quote in an email, or getting information on how to actually do what was being asked of me. Getting empathy from others was nice to receive also.

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