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From SOLER to SURETY for effective non-verbal communication

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ABSTRACT

Background: This paper critiques the model for non-verbal communication referred to as SOLER (which stands for: "Sit squarely"; "Open posture"; "Lean towards the other"; "Eye contact; "Relax"). It has been approximately thirty years since Egan (1975) introduced his acronym SOLER as an aid for teaching and learning about non-verbal communication.
Aim: There is evidence that the SOLER framework has been widely used in nurse education with little published critical appraisal. A new acronym that might be appropriate for non-verbal communication skills training and education is proposed and this is SURETY (which stands for "Sit at an angle"; "Uncross legs and arms"; "Relax"; "Eye contact"; "Touch"; "Your intuition").
The new model: The proposed model advances the SOLER model by including the use of touch and the importance of individual intuition is emphasised. The model encourages student nurse educators to also think about therapeutic space when they teach skills of non-verbal communication.

Introduction

It has been approximately thirty years since Egan (1975) introduced his acronym SOLER as an aid for teaching and learning about non-verbal communication (Briefly, SOLER stands for "Sit squarely"; "Open posture"; "Lean towards the other"; "Eye contact; "Relax"). There is evidence that this framework has been widely used in nurse education with little published critical appraisal. In this paper, the premise of the work is examined and a new acronym that might be appropriate for non-verbal communication skills training and education is proposed (SURETY).

In the UK, at the present time, there is much discussion around the need for compassion and empathy amongst health care staff (DH, 2008, 2009). Furthermore, this discussion extends to how compassion and empathy might be taught and how they might be measured (Danielsen and Cawley, 2007; Davison and Williams, 2009; Williams and Stickley, 2010). The new model that is proposed in this article is designed to help nurse educators to teach empathic skills for non-verbal communication hopefully, in a less mechanistic way than Egan originally proposed. An outline for the model has already been published in a book chapter describing skills for a caring relationship in mental health nursing (Stickley and Stacey, 2009) however the chapter does not give a critique of SOLER that is offered in this article.

By way of background, I have taught counselling skills to both counsellors and nurses for the last 15 years and have frequently used SOLER and I have considered it a useful tool. As I continued to develop my teaching however, I began to think that whilst SOLER has been useful as a teaching tool, students have tended to accept this and practise it mechanistically, at least for classroom use, and perhaps ignore it once in practice. I wanted a model that was more relevant to nursing practice, less rigid and more reliant upon natural human ability and a model that acknowledged personal intuition and the appropriate use of touch. To this end, I have developed a similar model that uses a mnemonic and incorporates both touch, and the use of the nurse's intuition whilst retaining what is positive about SOLER. Furthermore, I have been using the new model over the last 7 years with student nurses and it has been tested and refined.

In this article, SOLER is described and literature is identified that refers to the acronym. Other literature relating to non-verbal communication is also introduced before an overview of SURETY is presented.

An introduction to SOLER

For readers unfamiliar with SOLER, the model is briefly described and how it was first introduced. Gerard Egan is Emeritus Professor of Psychology and Organizational Studies at Loyola University of Chicago. His book *The Skilled Helper* was published in 1975 and in chapter three of this book he detailed what he referred to as "microskills". He presents SOLER as a way the listener can:

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"…*make sure you are physically present to a client*" (page 75). The acronym is explained by Egan as follows:

S ("Squarely")

It is advocated that the listener "sits squarely" to the client. By this Egan meant that the preferred position is opposite the client. He acknowledges that this position may feel threatening to some clients and that an angle between the chairs may be preferred.

O ("Open posture")

Egan recommends an open posture. One that is not crossed either with legs or arms.

L ("Lean towards the other")

Egan suggests this as a way of communicating interest in what the other person is talking about.

E ("Eye contact")

Good eye contact is recommended and is differentiated from staring by having occasional breaks in the contact between the eyes of client and helper. Egan acknowledges the need for cultural sensitivity with eye contact and communication in general.

R ("Relax")

This is largely in terms of not fidgeting or demonstrating nervousness.

Having taught SOLER for a number of years, I realised that I was not sticking to its literal instructions and that is why I began to adapt it, leading to my own variation of the original. I struggled with the notion of sitting "squarely" to the client; leaning towards the client felt false; and furthermore, there was no room in the model of the appropriate use of touch or for the interpretation of the model of the individual's intuition. These variations ultimately led to my own acronym. This realisation that I was becoming critical of the SOLER model led me to enquire of the literature, whether or not the model had been critically evaluated in nurse education.

SOLER in the nursing literature

Whilst there is much published work attending to communication skills amongst nurses, there is little in the literature that specifically refers to SOLER. Where the acronym has been referred to, it is usually almost in passing. It has been used uncritically for testing communication skills in various parts of the world (Arthur, 1999 in Hong Kong; Lauder et al., 2008 in Scotland), and also uncritically to emphasise the necessary non-verbal communication in education and nursing (Studer, 1994 in the USA) and in England (Jack and Smith, 2007; Smith, 2004; Roberts, 1998). Duxbury (2000) drew from Egan's helping model to outline vital skills and rules of therapeutic communication. Active listening' is conceptualised as a disciplined process rather than mere hearing and proposed SOLER as the means of portraying this to the client. Crouch (2005) explored communication skills necessary for holistic health assessment and included SOLER. She identified and discussed optimal communication skills and their barriers to effective gathering of data during holistic health assessment and the use of SOLER in attending skills was advocated as a way of ensuring patients feel uninhibited to express themselves.

MacInnes et al. (2001) examined the importance of therapeutic relationships and critically analysed interpersonal skills. Different therapeutic approaches and their uses are outlined. Counselling is defined and its relevance discussed in the context of mental health practice. Empathy is presented as one of seven qualities of counselling and identifies SOLER as a non-verbal strategy of showing the client that full attention is being paid to him/her.

Burnard (2002) proposed that the art of listening in therapeutic relationships is the most important human action for the nurse. He also referred to '*noticing*' as an aspect of listening that sensitises nurses to the needs of their clients. The importance of non-verbal listening behaviours were discussed and SOLER was suggested as the acronym for vital activities during the listening process. For Nicola and Sale (2001) greater emphasis needs to be put upon the two-way nature of nurse–patient interactions. Nurses need to be aware that their approach to patients will influence the way the patients respond to them. Listening and non-verbal communication therefore form an important part of the nurse–patient interaction. Far from passive, they are skills that require effort and discipline. Dexter and Wash (1997) also introduced counselling skills and suggested some important concepts drawn from client centred-therapy. They focused upon non-verbal communication as one of these concepts and suggest that certain mental health problems can cause clients to become easily upset or lead them to misinterpret non-verbal behaviour. Nurses therefore ought to be aware of their own body signals and to use these appropriately within a helping context, in order to create a rapport with the client. They referred to SOLER as a guideline rather than a prescription for non-verbal attending. Kacperek (1997) presented the author's personal reflection on how her nursing practice was enhanced as a result of losing her voice. Surprisingly, being unable to speak appeared to improve the nurse/patient relationship. Patients responded positively to a quiet approach and silent communication. Indeed, the skilled use of non-verbal communication through silence, facial expression, touch and closer physical proximity appeared to facilitate active listening, and helped to develop empathy, intuition and presence between the nurse and patient. Quietly "being with" patients and communicating non-verbally was an effective form of communication. It is suggested that effective communication is dependent on the nurse's ability to listen and utilise non-verbal communication skills. Stickley and Freshwater (2009:28) argue for the preservation of therapeutic space and suggest that practice is: "…shifting from providing a therapeutic space to one that is more technical, driven by outcomes, policy and external formulaic objectives that attempt to measure efficacy…". Ultimately, what needs to be created by non-verbal communication, is a therapeutic space where the client experiences psychological safety and an opportunity to openly communicate with the helper. Nurses can often take up too much space in their practice and not enough consideration is given to the space between people (interpersonal space). Rather, the focus appears to be more upon how this space can be filled with interventions and treatments, assessments and care plans. Non-verbal communication is about becoming aware of how we behave in the interpersonal space and deliberately creating an environment where the space becomes therapeutic and not oppressive.

Non-verbal communication in various settings

The need for effective non-verbal communication has been recognised in disciplines other than nursing; for example in teaching (Mortiboys, 2005), management (Singh, 2007), counselling (e.g. Brems, 2000) and in Dental Assistance (Phinney, 2003). The topic is most found though in the helping professions, especially nursing. In relation to stoma care, Metcalf (1998) discussed how nurses can effectively utilise listening skills during interactions with patients and allow intuition to develop in practice. Listening is considered a core skill for all health care professionals with studies demonstrating that