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PSYCHIATRY

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T Anbu



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Chapter

4 Therapeutic Relationship

COMMUNICATION

- A personal, interactive system; a series of ever-changing, ongoing transactions in the environment.

Therapeutic Communication

A meaningful relationship between the patient and professional helper. The patient-centered approach is influenced and directed by the professional.

Components of the Communication Process (or Model)

- **A sender or encoder**—person sending the message—can be verbal or nonverbal.
- **A receiver or decoder**—gets the message.
- **A message**—unit of information received.
- **Message variables**—verbal and nonverbal communication.
  - Verbal—is written and spoken–structural defects, malfunctioning due to disease, auditory and verbal impairments, sensory deprivation, overload or learning disabilities may affect or decrease accurate communication. Examples: A schizophrenic person, a stutterer, a mentally retarded or autistic person.
  - Voice pitch, voice quality (harsh, weak or strained), voice amplification (soft or loud), words, grammar and understanding are included in assessment.
  - Nonverbal—is gestures, facial expressions and dress and represents 65% of the communication. Examples of nonverbal behavior include: Crying, screaming, laughing, moaning, giggling and sighing, facial expression, body posture, gait, tone of voice and gestures.
  - Space and territory are forms of nonverbal communication as well. Personal space is the space preferred for interactions. Territory refers to implied space such as a patient's room or a specific seating arrangement.
  - Intrusion or violation of these areas can distract or distort communication.
- **Noise**—sound interference can impair accurate transmission.
- **Communication skills**—include being able to observe, listen, clarify and validate by both sender and receiver.
- **Setting**—where communication takes place.
- **Media**—refers to sensory channels that carry the message – hearing, sight, touch, taste and smell. Example: You get the message a patient needs pain

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medication – you hear (hearing) complaints of pain, you see (sight) tears in their eyes, they grasp (touch) your arm in pain.
- **Feedback**—involves the continuous interpretation of response of the sender and receiver as messages are simultaneously encoded and decoded.
- **Environment**—are the internal and external influences affecting the communication process. External examples: room temperature, smells and lighting. Internal examples: Feeling cold, tired or experiencing pain.

Interpersonal Communication

- It is the most direct and pertinent form of communication because through this transaction needs are met.
- The main focus of interaction occurs at the interpersonal and group levels.
- There are three basic interpersonal styles of communicating:
  - Nonassertive or passive—letting others control behavior
  - Aggressive—threatening, blaming and hostile
  - Assertive—openly expressive, spontaneous, yet considerate of others.

Important Elements in Therapeutic Communication

- Empathy—which is a communication skill and behavior.
- Attending—being with the patient both in physical and psychological presence.
- Observing
- Listening.

Congruence between Verbal and Nonverbal Communication

There are two levels to every message—content and feeling — when content and feeling do not 'match' this is termed incongruent. Example: A patient with a sad facial expression and tear filled eyes, tells you he is fine. Or a husband says he is supportive of his wife's therapy but will be too busy to attend family sessions with her.

Barriers to Therapeutic Communication

- Lack of planning by the nurse.
- Poor data collection.
- Inappropriate nursing diagnosis and outcome criteria.
- Lack of regard or respect for the patient.

INTERPERSONAL COMMUNICATION

- Interpersonal communication is a transaction between the sender and the receiver. Both persons participate simultaneously.
- In the transactional model, both participants perceive each other, listen to each other, and simultaneously engage in the process of creating meaning in

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a relationship, focusing on the patients issues and assisting them learn new coping skills.

- Both sender and receiver bring certain preexisting conditions to the exchange that influence the intended message and the way in which message is interpreted.

Context of Therapeutic Communication

Values, attitudes and beliefs

- *Example*: Attitudes of prejudice are expressed through negative stereotyping.

Culture or religion

- Cultural mores, norms, ideas, and customs provide the basis for ways of thinking.

Social status

- High-status persons often convey their high-power position with gestures of hands on hips, power dressing, greater height, and more distance when communicating with individuals considered to be of lower social status.

Gender

- Masculine and feminine gestures influence messages conveyed in communication with others.

Age or developmental level

- *Example:* The influence of developmental level on communication is especially evident during adolescence, with words such as "cool", "awesome," and others.

The environment

- Territoriality, density, and distance are aspects of environment that communicate messages.
  - ***Territoriality***—the innate tendency to own space
  - ***Density***—the number of people within a given environmental space
  - ***Distance***—the means by which various cultures use space to communicate

Proxemics: Use of space

- ***Intimate distance***—the closest distance that individuals allow between themselves and other.
- ***Personal distance***—the distance for interactions that are personal in nature, such as close conversation with friends.
- ***Social distance***—the distance for conversation with strangers or acquaintances.
- ***Public distance***—the distance for speaking in public or yelling to someone some distance away.

Nonverbal Communication: Body language

Components of nonverbal communication :

- Physical appearance and dress
- Body movement and posture
- Touch
- Facial expressions
- Eye behavior
- Vocal cues or paralanguage.

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Therapeutic Communication and Problem-Solving

Goals are often achieved through use of the *problem-solving model:*

- Identify the client's problem.
- Promote discussion of desired changes.
- Discuss aspects that cannot realistically be changed and ways to cope with them more adaptively.
- Discuss alternative strategies for creating changes the client desires to make.
- Weigh benefits and consequences of each alternative.
- Help client select an alternative.
- Encourage client to implement the change.
- Provide positive feedback for client's attempts to create change.
- Help client evaluate outcomes of the change and make modifications as required.

Listening to the Patient

To listen actively is to be attentive to what client is saying, both verbally and nonverbally.

Several nonverbal behaviors have been designed to facilitate attentive listening.

- S – Sit squarely facing the client.
- O – Observe an open posture.
- L – Lean forward toward the client.
- E – Establish eye contact.
- R – Relax.

Process Recordings

- Written reports of verbal interactions with clients
- A means for the nurse to analyze the content and pattern of interaction
- A learning tool for professional development
- How do I give a patient feedback.

Feedback is useful when it is

- Descriptive rather than evaluative and focused on the behavior rather than on the client
- Specific rather than general
- Directed toward behavior that the client has the capacity to modify imparts information rather than offers advice.

Nontherapeutic Communication Techniques

- **Giving reassurance—**may discourage client from further expression of feelings if client believes the feelings will only be downplayed or ridiculed.
- **Rejecting—**refusing to consider client's ideas or behavior.
- **Approving or disapproving—**implies that the nurse has the right to pass judgment on the "goodness" or "badness" of client's behavior.

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- **Agreeing or disagreeing—**implies that the nurse has the right to pass judgment on whether client's ideas or opinions are "right" or "wrong".
- **Giving advice—**implies that the nurse knows what is best for client and that client is incapable of any self-direction.
- **Probing—**pushing for answers to issues the client does not wish to discuss causes client to feel used and valued only for what is shared with the nurse.
- **Defending—**to defend what client has criticized implies that client has no right to express ideas, opinions, or feelings.
- **Requesting an explanation—**asking "why" implies that client must defend his or her behavior or feelings.
- **Indicating the existence of an external source of power—**encourages client to project blame for his or her thoughts or behaviors on others.
- **Belittling feelings expressed—**causes client to feel insignificant or unimportant.
- **Making stereotyped comments, clichés, and trite expressions—**these are meaningless in a nurse-client relationship.
- **Using denial—**blocks discussion with client and avoids helping client identify and explore areas of difficulty.
- **Interpreting—**results in the therapist's telling client the meaning of his or her experience.
- **Introducing an unrelated topic—**causes the nurse to take over the direction of the discussion.

Therapeutic Communication Techniques

Communication is the most powerful tool a psychiatric nurse should have. It is the basis of therapeutic–nurse patient relationship. Communication is a complex process and needs practice to use it effectively. Therapeutic communication techniques are methods used to encourage patients to interact in a manner that promotes their growth and moves them toward their treatment goals. All the communication must be aimed at preserving the self-respect of both the helper and helpee.

Listening

Listening is an active process of receiving information and examining reaction to the messages received. It is not simply hearing. It is essential to reach any understanding of the patient. It is the first rule of therapeutic-nurse relationship. The patient should be talking more than the nurse during the interaction. Listening is sign of respect and is powerful reinforcer. Active listening involves all the nurse's senses. For example, maintaining eye contact and receptive nonverbal communication which helps to convey the nurse's interest and acceptance.

Broad Opening

Here, the nurse is encouraging the patient to select topics for discussion. Patient should be welcomed to the communication with warmth and respect.

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Patient should feel that nurse is ready to listen. Open-ended questions result in fuller, more revealing answers.
For example:

What are you thinking about?

Can you tell me more about that?

What shall we discuss today?

Domination of the interaction by the nurse or rejecting the responses by the nurse results in poor therapeutic relationship.

Questioning

The nurse skillfully asks open-ended questions during the initial admission. Interviewing skills are necessary to avoid asking too many personal questions in one session. Questions should be to achieve relevance and depth.

How come you stopped taking your medication?

Tell me how you feel now?

Restating

Nurse is repeating of the main thought the patient has expressed. It also indicates that the nurse is listening, validating, reinforcing or calling attention to what has been said. Usually a part of patient's statement is repeated. When restating patient should not feel the nurse is reassuring, judgmental or defending.

E.g. "Your mother left you when you were 5-year-old?

Clarification

Here, the nurse makes specific questions to help clear up a specific point patient makes by attempting to put in to words vague ideas or unclear ideas of the patient. Patient's verbalizations may not be clear when overwhelmed with emotions. Nothing should be allowed to pass to the patient that nurse does not hear or understand.

"I am not sure what you mean. Could do tell me about it again?"

Failure to probe and assumed understanding result in poor communication.

Reflection

By reflection nurse is directing back the patient's ideas, feeling, questions or content. Reflection lets the patient know that the nurse has heard what was said and understand the content. Reflection of the feelings let the patient know that the nurse is aware of what the patient is feeling. It signifies understanding, empathy, interest and respect for the patient. Other techniques may not represent empathetic understanding.

" You are looking sad and tense. Is it related to what you have explained?"

Reflecting techniques can be used incorrectly, when stereotyping patient's response, inappropriate timing of reflections and inappropriate cultural experience and educational level of the patient.

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Focusing

Focusing helps the patient expand a topic of importance and also helps in analyzing in detail. It helps the patient talk about life experiences or problem areas and accepts the responsibility for improving them. If the goal is to change thoughts, feelings or beliefs, the patient must first identify and down them. It allows the patient discuss central issues and keeps the communication goal-directed.

" I think you should talk more about your relationship with your husband?"

Sharing Perceptions

It involves asking the patient to verify the nurse's understanding of what the patient is thinking or feeling. For example, nurse is interviewing an alcoholic patient:

Patient: My wife and children are so good. They love me. But I do not know what happened to me. I can not care them. I can not stop drinking.

Nurse: You seem to be very disappointed with your drinking. Am I right about that?

If used inappropriately sharing perceptions can make the patient feel challenging, reassuring, testing.

Theme Idenification

Themes are underlying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship, like anxiety, depression.

"It sounds like that is very important to you. You have mentioned it a very few times."

Silence

Here, the nurse use lack of verbal communication for a therapeutic reason. It allows the patient to think and gain insights. Silence on the part of nurse has varying effects, depending on how the patient perceives it. To a vocal patient silence on the part of nurse may be welcome, but with a depressed or withdrawn patient, the nurse's silence may convey support, understanding, and acceptance.

Humor

Humor is basic part of our personality and has a place in therapeutic nurse-patient relationship. It is the discharge of energy through the comic enjoyment of imperfect. It may be helpful with a patient experiencing mild to moderate anxiety. Humor should be consistent with social and cultural values.

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Informing

Informing or giving information is nurse shares simple facts with the patient. This skill is use in patient education like when to take medication, necessary precautions and side effects.

"I think you need to know more about your medication works"

Informing should not fall in to giving advice.

Suggesting

Suggesting is the presentation of alternate ideas. As a therapeutic technique, it is useful intervention in the working phase of the relationship. Suggesting or giving advice can be non-therapeutic. Patient may take nurse's advice and still have an unsuccessful outcome, the patient returns to blame nurse.

Confrontation

Confrontation involves anger and aggression. The therapeutic dimension is assertiveness rather than aggression. Confrontation is an attempt by the nurse to make the patient aware of incongruence in his or her feelings, attitudes, beliefs, and behaviors. It may also help in discovery of ambivalent feelings in the patient. The nurse must be ready to work with the patient through the crisis after confronting the patient. Without this commitment the confrontation lack therapeutic potential and may damage nurse-patient relationship.

Role Playing

Role playing involves acting out a particular situation. It increases patient's insight into human relations can deepen the ability to see the situation from another person's point of view. Role playing can be used for attitude change and to promote self-awareness.

One of the specific ways in which role playing can be used to resolve conflicts and increase self-awareness is through a dialogue that requires the patient to take the part of each person or each side of the problem. If the conflict is internal, the dialogue occurs in the present tense between the conflicting selves until one part of the conflict outweighs the other. If second person is involved , the patient is told to begin the dialogue by expressing wants and resentments about the other person. Then, the patient changes chairs assume the role other person, and responds to what was said. This way patient can express feelings and opinions and gives reality base for the probable response from the other party involved in the conflict.

JOHARI WINDOW

The Johari Window is a communication model that can be used to improve understanding between individuals within a team or in a group setting. Based on disclosure, self-disclosure and feedback, the Johari Window can also be used to improve a group's relationship with other groups.

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Developed by Joseph Luft and Harry Ingham (the word "Johari" comes from Joseph Luft and Harry Ingham), there are two key ideas behind the tool:

- That individuals can build trust with others by disclosing information about themselves.
- That they can learn about themselves and come to terms with personal issues with the help of feedback from others.

By explaining the idea of the Johari Window to your team, you can help team members understand the value of self-disclosure, and gently encourage people to give and accept feedback. Done sensitively, this can help people build more-trusting relationships with one another, solve issues and work more effectively as a team.

Explaining the Johari Window

The Johari Window model consists of a foursquare grid (think of taking a piece of paper and dividing it into four parts by drawing one line down the middle of the paper from top to bottom, and another line through the middle of the paper from side-to-side). This is shown in Figure 4.1 below:

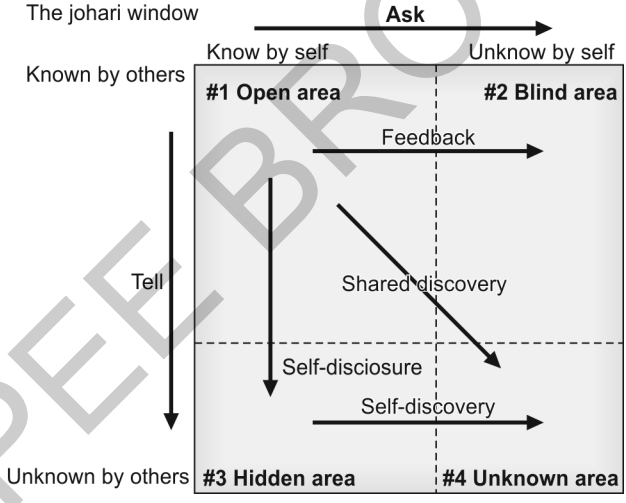

Figure 4.1: Explaing the Johari window

Using the Johari model, each person is represented by their own four-quadrant, or four-pane, window. Each of these contains and represents personal information—feelings, motivation, etc.— about the person, and shows whether the information is known or not known by themselves or other people.

The four quadrants are:

Quadrant 1: Open Area

What is known by the person about him/herself and is also known by others.

Quadrant 2: Blind Area, or Blind Spot

What is unknown by the person about him/herself but which others know. This can be simple information, or can involve deep issues (for example, feelings

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of inadequacy, incompetence, unworthiness, rejection) which are difficult for individuals to face directly, and yet can be seen by others.

Quadrant 3: Hidden or Avoided Area
What the person knows about him/herself that others do not.

Quadrant 4: Unknown Area
What is unknown by the person about him/herself and is also unknown by others. The process of enlarging the open quadrant vertically is called self-disclosure, a give and take process between the person and the people he/she interacts with.

THERAPEUTIC IMPASSES

For variety of reasons therapeutic communication can be hindered. Therapeutic impasses are blocks in the progress of nurse-patient relationship. They arise for variety of reasons, but the all crates stall in the process of nurse-patient relationship. Impasse provokes variety of emotions in both the patient and nurse ranging from anxiety and apprehension to frustration, love, or intense anger. The commonest four impasses are discussed here: resistance, transference, counter transference and boundary violations.

Resistance

Resistance is the patient's reluctance or avoidance of verbalizing or experiencing troubling aspects of oneself. The term was first coined by Freud. Resistance is often caused by patient's unwillingness to change when the need for change is recognized. Patient usually displays resistance during the working phase of nurse-patient relationship, because greater part of problem-solving occurs during this phase. Resistance may be due to:

- Nurse who has moved too quickly or too deeply into the patient's feelings.
- Intentional or unintentional communication of lack of respect.
- Nurse who is an inappropriate role model for therapeutic behavior.
- Secondary gain—favorable environmental, interpersonal, and situational changes occur and material advantages as a result of the illness (secondary gain can become a powerful force in perpetuating an illness because it makes environment more comfortable).

Transference

Transference is an unconscious response in which the patient experiences feelings and attitudes toward the nurse that were originally associated with other significant figures in his or her life.

- They may be triggered by superficial similarity, such as facial features or speech, or by personality style or trait.
- These reactions are the patient's attempt to reduce anxiety.

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- The nurse may be viewed as an authority figure from the past such as parent figure, or lost loved object, such as former spouse.
- Transference reactions are harmful to the therapeutic relationship only if they are ignored and unexplained.
- Two types of transference are particularly problematic in nurse-patient relationship: hostile transference and dependent reaction transference.

Hostile Transference

Patient may express hostility by uncooperativeness, negativism and hostile silence. If the hostility and anger are internalized, this resistance is expressed as depression and discouragement. Patient may terminate the relationship on the grounds that there is no chance of getting well. If hostility is externalized, the patient may become critical, defiant, and irritable and may express doubts about nurse's training, experience or competence. Patient may attempt to compete with the nurse by reading books on psychology and debating intellectual issues rather than working on real life problems.

Dependent Reaction Transference

This resistance is characterized by patient who are submissive, subordinate, and irritating and who regard nurse as godlike figure. Patient continues to demand more of the nurse.

Management of Transference and Resistance

- Resistance and transference can be difficult problems for the nurse. The psychiatric nurse must be ready to be exposed to such powerful positive and negative emotional responses from the patient.
- Resistance may be due to the nurse and patient have not arrived a mutually acceptable goals or plans of action. The appropriate action here is to return to the goals, purposes and roles of the nurse and patient relationship.
- The analysis of the resistance or transference should be directed toward the patient gaining awareness of these motivations and learning about being completely responsible for all actions or behavior.
- The first thing nurse must listen to the patient.
- When transference or resistance is recognized clarification and reflection of feelings can be used. Clarification gives the nurse a more focussed idea of what is happening. Reflection of the content may help patients become aware of what has been going on their own mind.

For example, nurse may say "I sense you are struggling with yourself. Part of you want to explore the issue of your marriage and another part says 'No Iam not ready yet' ".

Countertransference

It is a therapeutic impasse created by the nurse's specific emotional response to the qualities of the patient. This is inappropriate to the content and context of

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therapeutic nurse-patient relationship. It is transference applied to the nurse. It is natural that nurse feels warmth toward or liking for some patients more than others. The nurse also will be genuinely angry about the actions of some patient. But in countertransference, the nurse's responses are not justified by reality. Here nurse identify the patient with individuals from their past, and personal needs interfere with their therapeutic relationship.

Types
1. Reactions of intense love or caring
2. Reactions of intense disgust or hostility
3. Reactions of intense anxiety often in response to resistance by the patient.

Examples:
- Difficulty in empathizing with the patient in certain problem areas
- Feeling of depression during or after a session
- Feeling or anger or impatience because of the patient's unwillingness to change
- Argument with the patient or a tendency to push before the patient is ready
- Personal or social involvement with the patient
- Dreams about or preoccupation with the patient
- Sexual or aggressive fantasies about the patient

Other forms include staff involve in countertransfernce
- When they over-react the patient's aggressive behavior, ignore available patient data that would promote understanding
- Ignoring patient's behavior that does not fit the staff's diagnosis, minimizing a patient's behavior, joking about or criticizing a patient or becoming in caught up in intimidation.

The nurse must be constant look out for countertransfernce, become aware when it occurs and work with it to promote therapeutic goals. The nurse must use self-examination throughout the relationship. Following questions are helpful:
- How do I feel about the patient?
- Do I feel sorry or sympathetic for the patient?
- Am I afraid of the patient?
- Do I get extreme pressure out of seeing the patient?
- Do I want to protect, reject, or punish the patient?

Countertransfernce can be harmful to the relationship; it should be dealt as soon as possible. The nurse should discover the source of the problem. When it is recognized the nurse can exercise control over it. If required help, the nurse can seek individual or group supervision.

'Problem patients' may elicit strong negative feelings such as anger, fear and helplessness in the mind of nurse. Such patients should be dealt with patience and action should be directed to making patient responsible for his own behavior. Nurse should review patient's needs and problems and use responsive dimensions of genuineness, respect, empathetic understanding, and concreteness.

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Boundary Violations

Here the nurse goes beyond the boundaries of therapeutic relationship and establishes a social, economic, or personal relationship with a patient. Boundary violation is involved whenever a nurse is doing or thinking of doing something special, different or unusual for a patient. Situations where possible boundary violations can happen:

- The patient takes the nurse to a lunch or dinner
- The nurse regularly reveals personal information to the patient
- The nurse accepts free gifts from the patient
- The nurse agrees to meet the patient for treatment outside the usual therapeutic setting without therapeutic justification.

Types

- Role boundaries—problems with role boundaries require the insight of the nurse and the setting of firm therapeutic limits with the patient.
- Time boundaries—odd and unusual hours that have no therapeutic necessity.
- Place and space boundaries—usually in an office or a hospital unit, outside that requires strong therapeutic rationale.
- Money boundaries—regarding fee.
- Gift and service boundaries—gift acceptance may place undue obligations to the patient.
- Clothing boundaries—dress appropriately in a therapeutic manner.
- Language boundaries—addressing the patient and nurse's choice of words in implementing care. Too familiar, sexual, off-color or leading language are boundary violations.
- Self-disclosure boundaries—inappropriately timed self-disclosure and that lacking therapeutic value.
- Post-discharge social boundaries—post-discharge social contact raise the question of boundary violation.
- Physical contact boundaries—sexual contact.

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PSYCHIATRY Made Easy®

Salient Features

- A comprehensive and yet concise book
- Written in a lucid and easy-to-read style
- Covers most of the psychiatric disorders
- Prepared systematically and in logical manner
- Perfect teaching guide.



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