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Textbook of Psychiatric Nursing



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Contents

1.	Introduction	1
2.	Principles and Concepts of Mental Health Nursing	34
3.	The Nursing Process: Assessment and Evaluation of Psychiatric Clients	98
4.	Therapeutic Communication	114
5.	Treatment Modalities and Therapies in Mental Disorders	129
6.	Schizophrenia and Psychotic Disorders	217
7.	Mood Disorders	246
8.	Nursing Management of Patient with Neurotic, Stress-related and Somatization Disorders	270
9.	Substance Use Disorders and its Management	317
10.	Nursing Management of Patients with Personality, Sexual and Eating Disorders	346
11.	Nursing Management of Childhood and Adolescent Disorders including Mental Deficiency	372
12.	Nursing Management of Organic Brain Disorders	430
13.	Psychiatric Emergencies and Crisis Intervention	448
14.	Legal Issues in Mental Health Nursing	493
15.	Community Mental Health Nursing	515
Glossary		555
Index		565

4 Therapeutic Communication

INTRODUCTION

According to Webster, an interaction is a mutual or reciprocal action that can occur between or among people. Interaction that facilitates growth, development, maturity, improved functioning and improved coping is considered therapeutic (Rogers, 1961).

Therapeutic communication, relationship, interventions, environment and milieu all are terms that refer to nurse patient interaction. The focus of this unit is to discuss in detail about a therapeutic relationship through communication and interaction.

Communication

In simple way, communication is imparting or interchange of thoughts, opinions or information by speech, writings or signs. The process of communication includes three elements. The sender, the message and the receiver. Communication is the giving and receiving of information. The sender prepares or creates a message when need occurs and sends the message to a receiver or listener, who then decodes it. The receiver may then return a message or feedback to the sender of the message. Communication is a learned concept process influenced by one's attitudes, sociocultural or ethnic background, past experiences, knowledge of subject matter and ability to relate to others. Interpersonal perceptions also affect one's ability to communicate because they influence the initiation and response of communication. Such perception occurs through the senses of sight, sound, touch and smell. Environmental factors that influence communication include time, place/context and the presence of one or more person.

The factors influencing communication are listed below:

- *Attitude:* Attitudes are developed in various ways and maybe the result of interaction with the environment, assimilation of other's attitudes, life experiences, intellectual processes or a traumatic experience. The terms like accepting, caring, judgmental, open or closed minded and prejudiced are used.
- *Sociocultural background:* Communication is vastly influenced by sociocultural philosophy and fabric of the society.

  Past experiences: Previous positive or negative experiences influence one's ability to communicate.

  For example, children who have been told continually to be quiet, or to speak only when spoken to, may become withdrawn and more communicative. Teenagers who have been put down by their parents or teachers whenever attempting to express any feelings may develop a poor self-image and feel their opinions are not worthy. As a result they avoid interacting with others.

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- *Knowledge of subject matter:* A person who is well educated or knowledgeable about certain topics may feel more secure when discussing topics with others.
- *Ability to relate to others:* Expressing relevant information to others is an art. This ability is an learned process, the result of practicing communicative skills over a period of time.
- *Interpersonal perceptions:* Interpersonal perceptions like feeling, moving, speaking, etc. all influence the communication process.
- Environmental factors such as time, place and the presence of people. Timing is quite important factor during a conversation. Place and presence of strange people also influences communication.

Types of Communication

Communication takes place at two levels:

a. **Verbal communication:** It occurs through words, spoken or written.
b. **Nonverbal communication:** It occurs through gestures or behavior that do not involve the spoken or written words. This occurs through vocal, gestures, physical appearance, space, gesture, posture, touch and facial expression.

- *Position or posture***:** The position one assumes can designate authority, cowardice, boredom or indifference. For example, a nurse standing at the foot of a client's bed with arms folded across chest gives the impression that the nurse is in charge of any interaction that may occur.
- *Gesture:* Pointing out, finger tapping, winking, and clapping, eyebrow raising, palm rubbing, hand wringing and beard stroking are examples of nonverbal gestures that communicate various thoughts and feelings. Reflect on these gestures and your reactions to them. What gestures are common in your nonverbal therapeutic communication. Do they betray feelings of insecurity, anxiety, eagerness or genuine interest?
- *Touch:* Touch conveys many messages. Handshaking, hugging, holding hands and patting all denote positive feelings for another person. Reactions to touch depend on one's age, gender, sociocultural background, interpretation of the gesture and appropriateness of the touch. The nurse should exercise caution when touching people. Before touching any psychiatric client, nurse should take consent. The depressed or grieving client may respond to touch as a gesture of concern; whereas the sexually promiscuous person may consider touching an invitation to sexual advances. An abused child may recoil from the nurse's attempt to comfort, whereas the dying patient maybe comforted by the presence of a nurse sitting by the bedside silently holding the client's hand.
- *Physical appearance:* People who are depressed may pay little attention to their appearance. They may appear unkempt and unconsciously wear dark-colored clothing; reflecting their depressed feelings, confused or disoriented persons may forget to put on items of clothing, put them on inside out, or dress inappropriately. Weight gain or weight loss also maybe form of nonverbal communication. People who exhibit either maybe experiencing a low self a concept or feelings of anxiety, depression or loneliness. The manic client may dress in brightly colored clothes and with many items of jewelry and excessive make-up. People with a positive self-concept may communicate such feelings by appearing neat, clean and well dressed appropriately.
- *Facial expressions:* A blank stare, startled expression, sneer, grimace and broad smile are examples of facial expression denoting one's innermost feelings.

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- *Vocal cues:* Pausing or hesitating while speaking, talking in a tense or flat tone, or speaking tremously are vocal cues that can agree with or contradict one's verbalization. Speaking softly may be the result of feelings of anger or hostility. For example, a person who is admitted to the hospital for emergency surgery may speak softly but tremulously, stating 'I' am okay. I just want to get better and go home as soon as possible. The nonverbal cues should indicate to the nurse that the client is not feeling well and the client's feelings should be explored.
- *Distance or spatial territory:* Hall (1966) describes four zones of distance awareness in people. They include the intimate, personal, social and public zones. Actions that involve touching to another body, such as love-making and wrestling, occur in the intimate distance zone. The personal zone refers to an arm's length distance of approximately 1.5 to 4 feet. Physical contact, such as hand holding, still can occur. The social zone, in which formal business and social discourse occurs, occupies a space of 4 to 12 feet. The public zone, in which no physical contact and little eye contact occurs; ranges from 12 to 25 feet. People who maintain communication in this zone remain strangers.

Communication Skills

The following are the effective points to consider and to develop good communication skills for effective therapeutic interactions:

- *Know yourself:* What motivates your interest in helping other. Identify your emotional needs to that they do not interfere with the ability to relate to others. Be aware of any mood swings that you may show. Clients are very sensitive to the emotions of helping individuals.
- *Be honest with your feelings:* The nurses body language, gestures and tone of voice can reveal true feelings or reactions to client behavior. Honesty is the key factor for communication. Your nonverbal communication may contradict your spoken word if you are not honest with the client. For nurses who work with cancer clients often find it hard to relate to terminally ill person. They may avoid contact as much as possible, so that their emotions are not revealed to the clients when they are asked questions such as will I be getting better?, Is it cancer? or Am I going to die?, etc.
- *Be secure in your ability to relate to people:* Do not allow the behavior of others to threaten or intimidate you. Remember that all behavior has meaning. Ask yourself 'what is the client trying to communicate'?
- *Be sensitive to the needs of other:* Listen attentively by using eye to eye contact; focusing your attention on the speaker and assuming a personal distance of 1.5 to 4 feet. Use tact and diplomacy while conversing with others.
- *Be consistent:* Consistency in what you speak and do encourages the development of trust.
- *Recognize symptoms of anxiety:* Knowing anxiety when it appears in yourself and those you relate to it is important. Anxiety impairs communication if the person is unable to concentrate or express feelings.
- *Watch your nonverbal reactions:* Be aware of your body language because it punctuate and modifies verbal messages. Use gestures cautiously to emphasize meanings, reactions or emotions.
- *Use words carefully:* When relating to others, these words should be used continuously. Example, I, you, but, if, then, always, should and ought. Satir (1976) refers to these words as 'powerful words' that may be used thoughtlessly, appear to be accusations, be easily misunderstood, or cause confusion and ambivalence.

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- *Recognize differences:* While communication, note the fact of age differences or may have conflicting loyalties can impair communication.
- *Recognize and evaluate your own actions and responses:* Evaluate your own mind, i.e. open or closed-minded, cooperative or incooperative, supportive, or nonsupportive when you converse with someone. Are you available when needed or do you tend to put someone on hold if you are busy? Never cut short a conversation short in the middle of a self-disclosing interaction. Refer the person to someone whom you feel can be supportive regarding the issues at hand.

Ineffective Communication

Disturbances can occur during the process of communication. The nurse needs to be aware of the various reasons for ineffective communication.

These reasons include:

- Ineffective communication skills used by the helping person. The psychiatric nurse may not send the message what is intended.
- Failure to listen on the part of the helping person. Some individuals are doer rather than listeners. They focus on task oriented nursing instead of therapeutic communication. The client also may not hear the message sent because of many reasons, such as stress, anxiety, fear, denial or anger.
- *Conflicting verbal and nonverbal messages:* Ambivalence on the part of the sender may confuse the receiver, who senses conflicting signals and doubts the helping person's interest in him or her.
- *A judgmental attitude:* Anyone who displays prejudice or a judgmental attitude when relating to others may never really get to know the person. A sensitive person may pick-up on judgmental attitudes and refuse to relate to others, thinking that all people are judgmental.
- Misunderstanding because of multiple meaning of language words. Consider the word 'cup'. It may mean a drinking vessel, a hole in a golf green, or a winner's trophy. The sender should select words that are not confusing in meaning.
- *False reassurance:* Sayings such as 'Everything will be okay' or 'Don't worry, the doctor will make you well' are considered examples of false reassurance. No one can always predict or guarantee the outcome of a situation. There are too many variables, such as persons who desires to maintain a sick role, nonsupportive families or an illness that is irreversible (e.g. cancer or multiple sclerosis) clients who receive false reassurance quickly learn not to trust people if they do not respond to treatment as predicted.
- Providing advice rather than encouraging the person to make decision, however small they maybe. Giving advice may facilitate dependency and may also cause the client to feel inadequate because he or she is not given the opportunity to make choices pertaining to personal care. The client will accept advice when wanted. Feelings of dependency and inadequacy may occur and impair therapeutic communication; if the client fails to receive positive feedback during nurse-client interactions. It is much more constructive to encourage problem-solving by the client.
- Disagreeing with or criticizing a person who is seeking support. Belitting a person may result in the development of low self-concept and inability to cope with different stressors. Consider both thoughts and feelings during conversation.
- The inability to receive information because of a preoccupied or impaired thought process. The receiver maybe prepared to hear a different message from the one sent. Someone who is

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preoccupied with thoughts is not as receptive to message as a person with a clear mind. Impaired thought process, such as delusions or hallucinations also interfere with communication. A client who hears voices saying he or she is being poisoned by others is not receptive to a nurse's, request to take medication.

- Changing the subject if one becomes uncomfortable with the topic being discussed.

Nurse Client Interactions

We find two types of interactions—social and therapeutic may occur when the nurse is working with clients or families who seek help for physical or emotional needs. Social interactions occur daily as the nurse greets the client and passes the time of day; so to speak, with what is referred as short or small talk. Saying 'Good morning', It's a beautiful day and have you heard any jokes are examples of socializing.

During a therapeutic interaction the nurse helps or encourages the patient to ventilate feelings of perceptions, the nurse helps or encourage the patient to ventilate feeling of perceptions, fears, anxieties, frustrations, expectations and increased dependency needs. For example, you look upset, would you like to share your feelings with someone.

Therapeutic Communication

Therapeutic communication is an interpersonal interaction between the nurse and the client during which the nurse focuses on the clients' specific need to promote an effective exchange of information.

A comparison of social interactions and therapeutic interaction is given below (Purtilo 1978). He also recommends the following approaches when communicating in a therapeutic ways.

Social vs Therapeutic Interaction

Social interaction	Therapeutic interaction
• Social interaction maybe referred as doing a help or favor for another person such as giving someone money, etc.	• Therapeutic interaction promotes the functional use of one's latent inner resources. Encouraging verbalization of feelings following the death ones child or exploring ways to cope with excessive stress are examples of therapeutic help.
• A personal or intimate relationship occurs.	• A personal, but not intimate relationship occurs.
• Not necessarily concerned with the identification of needs.	• Needs are identified by the person with the help of the nurse.
• Personal goals may or may not be discussed.	• Personal goals are set by the client.
• May create constructive or destructive dependency.	• Promotes constructive dependency, interdependency and independency.
• May use a variety of resources during socialization.	• Uses specialized professional skills while employing nursing interventions.

Approaches to Therapeutic Communication (Purtilo, 1978)

- Translate any technical information into simple terms.
- Clarify and restate any instructions or information given. Clients usually do not ask doctors or nurses to repeat themselves.
- Display a caring attitude.

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- Exercise effective listening.
- Do not overload the listener with information.

Roger's (1961) lists eight conditions essential for a therapeutic relationship to occur. They include:

- *Empathy:* The helper is able to understand and feel on the feeling of another person. He/she has to 'walk in another's shoes' shows empathetic understanding because such actions enables one to experience the feelings of another and respond to them. A person seeking help feels understood and accepted. The person is able to relate to another, to explore feelings and to try new behaviors.
- *Respect:* The helper considers the person to be deserving of high regard and cares deeply for the person as a human being. Consistency on the part of the helper conveys respect.
- *Genuineness:* The helper is sincere, honest, and authentic in responses. The helper becomes a role model as he/she meets the patient's needs rather than wants.
- *Self-disclosure:* Exposing a view of one's attitudes, feelings and belief is self-disclosure. It can occur on the part of the helper as well as the client. Appropriate self-disclosure by the helper provides a role for the other person to model, allowing the person to become more open, reveal more about self and feel more secure.
- *Concreteness and specificity:* The ability to identify feelings by skillful listening requires the helper to be realistic, not theoretical; while assisting the person in expressing specific feelings.
- *Confrontation:* Discussing misunderstandings in the person's thought and behavior must be done in an acceptable manner after good establishment of rapport. Those with emotional problems may perceive themselves differently than they think others regard them. Such feelings may result in anxiety and inappropriate behavior in an attempt to reconcile these perceived misunderstandings.
- *Immediacy of relationship:* Recognizing one's own feelings and sharing with the client is essential to a therapeutic relationship. The helper needs to be able to share spontaneous feelings but not necessarily all of them. The sharing of too many negative expressions can be detrimental during the beginning of a relationship. Once a relationship exists, the helper shares immediate feelings when the helper feels the patient will benefit from communication.
- *Self exploration:* If the client is to make progress, he or she needs to engage in self-exploration. Feelings of discomfort or fear may initially emerge; however; the more the client investigates feelings, the more the client learns to adapt and cope with the problem.

Confidentiality

Confidentiality is very important during a nurse client interaction. The client has a right to privacy. All information concerning the client is considered personal property and is not to be discussed with other clients or outside the hospital setting. When discussing any information with a client, as in nursing conference, the client's name and identity should be kept secret. It may be necessary for a student nurse to reassure a client that confidentiality will be maintained except when:

- The information maybe harmful to the client or others.
- The client does not intend to comply with the treatment plan.
- The patient threatens self-harm. One way to convey this is simply to state 'only information that will be helpful in management to others on the staff'. Family members should be informed to get permission from clients 18 years old and older before seeking any health team member.

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THERAPEUTIC RELATIONSHIPS: ESTABLISHING AND MANAGEMENT OF ROLES

Peplau (1952) describes six subroles of the psychiatric nurse during a therapeutic relationship. They are teacher, mother, surrogate, technical nurse expert, manager, socializing agent and counselor or nurse therapist. For example, the nurse-manager is accountable for creating a therapeutic environment in which the clients feel safe and accepted. The subrole of teacher enables the nurse to educate client about specific illnesses and medication prescribed to promote early recovery. Social skills such as participating in groups are promoted by the nurse who acts as a socializing agent. The nurturing needs of clients who are unable to carry-out simple tasks are met by mother surrogate. Recording vital signs, medical or surgical procedures, administration of medication and physical assessment are generally carried out by the technical nurse. Lastly, the nurse therapist or nurse counselor employs therapeutic skills to help patients identify and deal with various stressors or problems that have resulted in dysfunctional coping. Each of these roles can be effective during the various phases of the therapeutic relationship.

During the therapeutic relationship, clients try to distort their perceptions of others. Therefore, they may relate to the nurse not on the basis of the nurse's realistic attributes but wholly or chiefly on the basis of interpersonal relationships existing in their environment. This is termed as transference or paratoxic distortion (Yalom 1985). Countertransference occurs when the nurse responds unrealistically to the client's behavior of interaction. Negative transference can interfere with the development of a therapeutic relationship.

THE ONE-TO-ONE NURSE CLIENT RELATIONSHIP

Peplau (1952) discusses the phases of one-to-one nurse client relationships established in psychiatric mental health nursing. Such relationships can be divided into three phases. Initiating or orientation phase, working and terminating phases. These phases are important and effective in both inpatient and outpatient setting. Following is a description of each of the phases, including therapeutic tasks or goals to be fulfilled.

Orientation Phase/Initiating Phase

This is the first step in therapeutic relationship. During this phase the nurses set the stage for a one-to-one relationship by becoming acquainted with the client. Both the nurse and the client may experience anxiety when they met first time. Very little it exists. Assessment of the client occurs as the nurse and client agree on the time, place and duration of each setting of the meeting. Communication styles of the nurse and the client are explored to facilitate rapport and open communication as the client begins to share innermost feelings, anxieties and conflicts. Client must feel accepted as he or she develops a feeling of trust toward the nurse. Allow the client to set the pace of the relationship. The client is a unique person who is ill and maybe experiencing feelings of loneliness, fear, anger, disgust, despair, frustration and rejection. As a client, the person seeks comfort and help in handling various stressors. In doing so the client accepts another assistance in problem-solving or goal setting.

The following tasks to be accomplished during the first phase

- Building trust and rapport by acceptance.
- Establishing a therapeutic environment.
- Establishing a mode of communication acceptable to both the client and nurse.

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- Initiating a therapeutic contract by establishing a time, place and duration of each meeting as well as the length of time the relationship will be in effect.
- Assessing the client's strengths and weaknesses.

Working Phase/Middle Phase

The second phase of therapeutic relationship is known as the working or middle phase. In this phase, the client begins to relax, starts to trust the nurse, and is able to discuss mutually agreed upon goals with the nurse as the assessment process continues and a plan of care action develops. Perceptions of reality, coping mechanisms and support systems are identified at this time. Alternative behaviors and techniques are identified at this time. The nurse are explored to replace those that maladaptive. The nurse and the client, both discuss the meaning behind behavior the working as well as any reactions by the nurse such as fear, embarrassment, anger or intimidation. During the working phase, the client is able to focus on unpleasant, painful aspects of life with the nurse's support and help.

Therapeutic tasks accomplished during the working phase include:

- Exploring perception of reality
- Developing positive coping behaviors
- Identifying available support systems
- Promoting a positive self-concept
- Encouraging verbalization of feelings
- Developing a realistic plan of action
- Implementing the plan of action
- Evaluating the results of the plan of action
- Promoting independence.

Terminating Phase

The last step of the therapeutic relationship is the termination phase. The nurse terminates the relationship when the mutually agreed-upon goals are reached, the patient is transferred or discharged. As separation occurs, the client may exhibit symptoms like regressive behavior, hostility or experience sadness. The client may attempt to prolong the relationship as clinical symptoms of separation anxiety are experienced.

Termination needs to occur if a therapeutic relationship is to be a complete process. Preparation for last step begins during the initiating phase.

There are some mutually accepted goals resulting in the termination of a therapeutic relationship include the ability to:

- Provide self-care and maintain one's environment
- Demonstrate independence and work independently with others
- Recognize signs of increased stress or anxiety
- Cope positively when experiencing feelings of anxiety, anger or hostility
- Demonstrate emotional stability and equality.

Therapeutic Communication Techniques

Therapeutic communication is used to encourage the expression of feelings and ideas.

- *Active listening:* It is being attentive to what the client is saying; verbally as well as nonverbally. Sit facing the client, open posture, lean toward the client, keeping eye contact and relax.

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It is an active process of receiving information responses on and other forms of receptive nonverbal communication convey to the client he/she is being listened to understand.
*Therapeutic value***:** Nonverbally communicates to the client the nurse's interest and acceptance.

- *Making observations:* It is done by commenting on how the other person looks, sounds or acts. For example, 'You look tired' or 'I have not you eating anything today'.
- *Broad opening:* Encouraging the client to select topics for discussions. For example, 'what are you thinking about'?
- *Restating:* Repeating the main thought expressed by the client. For example, 'you say that your mother left you when you were five years old'.
  Therapeutic value: It indicates that the nurse is listening and validates, reinforce or calls attention to something important that has been said'.
- *Using touch:* This is most potent form of communication. Comfort touch such as holding a hand, is especially important for vulnerable clients who are experiencing severe illnesses.
- *Clarifying:* To check whether understanding is accurate, or to better understand, the nurse restates an unclear or ambiguous message to classify the sender's meaning 'I' am not sure what you mean. Could you tell me about that again?
  Therapeutic value: It helps to clarify feelings, ideas and perception of the client and provides an explicit correlation between them and the client's action.
- *Reflection:* It is directing back the client's ideas, feelings, questions and content. For example, you are feeling tense and anxious and it is related to a conversation you had with your husband at night.
  Therapeutic value: It validates the nurse's understanding of what the client is saying and signifies empathy, interest and respect for the client.
- *Sharing Humor:* Sharing humor contributes to feelings, of togetherness, closeness and friendliness. It promotes positive communication in prevention, and perception. Here the discharge of energy through comic enjoyment of the imperfect. For example, that gives a whole new meaning to the word 'nervous' said with shared kidding between the psychiatric nurse and the client.
  Therapeutic value: Care promote insight by making repressed material conscious, resolving paradoxes, tempering aggression and revealing new options and is socially acceptable form of sublimation.
- *Informing:* The skill of information-giving. For example, I think you need to know about your medications.
  Therapeutic value: Helpful in health teaching or client education about relevant aspects of client's well-being and self-care.
- *Focusing:* Taking note of a single idea expressed or even a single word. An example is: On a scale of 0 to 10, tell me the level of the pain you are experiencing in your great to right now. Questions or statements that help the client expand on a topic of importance. For example, I think that we should discuss more about your relationships with your father.
  Therapeutic value: It allows the client to discuss central issues and keeps the communication process goal directed.
- *Sharing perceptions:* Asking the client to verify the nurses understanding of what the client is thinking or feeling. For examples, You are smiling but I sense that you are really very angry with me.

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Therapeutic value: Conveys the nurse understands to the client and has the potential for clearing up confusing communication.

- *Theme Identification:* This involves identification of underlying issues or problems experienced by the client that emerge repeatedly during the course of the nurse client relationship. For example, I noticed that you said, you have been hurt or rejected by the man. Do you think this is an underlying issue?
  Therapeutic value: It allows the nurse to promote the client's exploration and understanding of important problems silence.
- Time for the nurse and client observe one another, sort out feelings, think of how to say thing and consider what has been verbally communicated. The nurse should allow the client to break the silence. Lack of verbal communication for therapeutic reasons. For example, sitting with the patient and nonverbally communicating shows interest and involvement.
  Therapeutic value: Allows the client, time to think and gain insight, slow pace of the interaction and encourages the client to initiate conversation while enjoying the nurse's support, understanding and acceptance.
- *Suggestions:* Presentations of alternative ideas for the client's consideration relative to problem-solving. For example, have you thought about responding to your boss in a specific problem has occurred.
  Therapeutic value: It increases the client's perceived notions and or choices.
- *Providing information:* Relevant information is important to make decision experience less anxiety and feel safe and secure. For example, Raman is getting an echocardiogram right now which is a test that uses painless soundwaves to create a moving picture of her heart structures and values and should tell us what is causing her murmur.
- *Sharing empathy:* The ability to understand and accept person's reality, to accurately perceive feelings and to communicate understanding. For example, 'It must be very frustrating to know what you want and not be able to do it'.
- *Sharing Hope:* Communicating a 'sense of possibility' to others. Encouragement when appropriate and positive feedback. For example, 'I believe you will find a way to face your situation because I have seen your courage in the past'.
- *Sharing feelings:* Nurses can help clients to express emotions by making observations, acknowledging feelings and encouraging communication, providing permission to express 'negative' feelings and modeling healthy anger.
- *Paraphrasing:* Restating another's message more briefly using one's own words. It consists of repeating in fewer words the essential ideas of the client. For example, the client says, ' I cannot, focus': my mind keeps wandering. The student nurse says' you are having difficulty in concentrating'.
- *Asking relevant questions:* To seek information needed for decision-making. Asking only one question at a time and fully exploring one topic before moving to another area. Open-ended questions allows for taking the conversational lead and introducing pertinent information about a topic. For example, 'what is your biggest problem at the moment or How has your pain affected your life at home'.
- *Summarizing:* It is pulling together information for documentation. It gives a client a sense of closure. For example, it is my understanding that your arm pain is you understand. It is a concise review of key aspects of an interaction. Summarizing brings your arm pain to level 1 since you have taken a vovoran one hour ago. Taking your pain medication before physical therapy seems to help you complete the activities which the doctor wants you to for

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your psychosocial rehabilitation. Is this correct? Client responds 'yes', it really helps to take the medicine before I do my physical therapy, because it helps reduce the pain in my arm.

- *Self-disclosure:* Subjectively true personal experiences about the self, are intentionally revealed to another person for the purpose of emphasizing both the similarities and the differences of experiences. These exchanges are offered as an expression of genuineness and honestly by the nurse and disclosures should be relevant and appropriate. They are used sparingly so the client is the focus to the interaction; 'that happened to me once, too. It was devastating and I had to face about myself that I did not like. I went to counseling and it really helped. What are your thoughts about meeting a counselor?
- *Confrontation:* It is helping the client become more aware of inconsistencies in his or her feelings, attitudes, beliefs and behaviors. Only to be used after trust has been established and should be done gently with sensitivity. For example, 'you say, you have already decided what to do, yet you are still talking a lot about your options.
- *Encouraging formulation of a plan of action:* Encourage the client for therapeutic decision-making, e.g. if this situation occurs again, what options would you have?
- *Asking direct questions:* Ask direct questions to ventilate his/her inner feelings and thoughts, e.g. how does your wife feel about your hospitalization?

NONTHERAPEUTIC TECHNIQUES OF COMMUNICATION

- Nontherapeutic communication 'blocks' to communication of feelings and ideas.
- *Reassuring:* The nurse implies that anxious client has no cause for worry or concern, *e.g. nurse with child:* Do not cry, mummy will come back.
  Nurse with adult: you have nothing to worry about anything.
  Someone will come along who will love you and make you very happy.
- *Promoting:* The nurse mechanically repeats the client's words without thinking, without evaluating what has been said and without helping the client to think things through. It indicates a lack of interest, respects and relatedness on the part of the nurse, *e.g.* adolescent: I hate you.
  Nurse: You hate me.
- *Giving approval:* The nurse provides positive sanction for client's thinking or behavior, thereby setting and maintaining standards of good and bad. The client may work to earn the nurses praise rather than to make progress, *e.g. nurse with child:* You are a good boy.
  Nurse with adult: Your's choice was only the correct one.
- *Rejecting:* The nurse refuse to consider or shows contempt for the client's thinking. Rejection closes the topic of exploration, *e.g. nurse with adult:* Do not let me hear my more about ……
- *Probing:* The nurse digs for information or persistently questions the client even after the client indicates unwillingness to discuss the issues, *e.g. nurse with adult:* Tell me about your history of alcohol abuse.
- *Challenging:* The nurse insists the client provides a rational basis for irrational thinking, the client then becomes defensive, *e.g. Nurse with adult:* If you really have no legs, how can you walk up here to the nurse's station?
- *Requesting an explanation:* The nurse asks 'why' to the client, thereby asking for the reason for feelings and behaviors when the client may not know the reason, *e.g. nurse with client:* Why did you do that?

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- *Using denial:* The nurse refuses to acknowledge that a problem exists, there by cutting of exploration of the problem with the client and denying the validity of the client's perception. *e.g. nurse with adult:* I am not going to be able to stop drinking. *Nurses:* Of course, you will.
- *Blaming:* The nurse inappropriately expresses feelings or anger or impatience with the client as a means of faulting the client because the nurse-patient relationship is not progressing well. This the therapeutic dead end that negates that nurse's role as a client advocate; destroy trust and takes away clients motivation to work with the nurse to identify and explore sensitive topics, *e.g. nurse with adult:* I know the pain is bad when I have to try to turn you, but it was you who climbed up on the ladder and risked breaking a hip, not me.
- *Disapproving:* The nurse makes a negative value judgment about the client's behavior and thinking. *Nurse with the child:* That was bad to do, *e.g. nurse with adult:* I am afraid, I cannot approve of such behavior.
- *Advising:* The nurse literally tells the client what to do. This implies that nurse knows best and the client is incapable of independent problem-solving, *e.g. nurse:* You should use acne medication and stop drinking soft drinks.
- *Interrogating:* The nurse bombards the client with multiple questions that do not allow the client time for a thoughtful response. The question interrupts therapeutic communication, e.g. *Nurse:* How did you feel after the surgery? When they took out the bandage off were you nervous?
  Did you dread looking in the mirror who was with you at that time?
- *Introduction of unrelated topic:* The nurse changes the subject when the clients bring up material the nurse prefers not to discuss, *e.g. adult:* I wish I could die. *Nurse:* What dress you are wearing today?
- *Using jargon:* The nurse excludes the client and makes the interaction incomprehensible by using nursing jargon, e.g. *nurse with adult:* Ingestion of a cholecystocholangiographic medium (gallbladder pill) is necessary.
- *Asking personal questions:* Asking personal questions that are not relevant to the situation is not professional or appropriate. Do not ask question just to satisfy your curiosity, why are not you married to Kamal? It is not appropriate. Instead it can be asked like how would you describe your relationship with Kamal.
- *Giving personal opinions:* Giving personal opinions, takes away decision-making for the client. Remember the problem and solution belongs to the patient not to the nurse. 'If I were you' I would put your father in a nursing home 'can be reframed to say Let us talk about what options are available to your father'.
- *Changing the Subject:* 'Let us not talk about your insurance problems, its time for your walk'. Changing the subject when someone is trying to communicate with you is made and shows a lack of empathy. It tends to block further communication and seems to say that you do not really care about what they are sharing. 'After your walk, let's talk some more about what is going on with your insurance company.
- *Automatic responses:* Saying—Administration does not care about the staff or older adults are always confused. These are generalizations and stereotypes that reflect poor nursing judgment and threaten nurse-client or team relationships.
- *False reassurance:* Do not worry, everything will be all right. When a client is seriously ill or distressed, the nurse may be tempted to offer hope to the client with statements such as 'you will be fine' or 'there's nothing to worry about'. When a patient is reaching for understanding these phrases that are not based on fact or based on reality can do more harm than good.

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