Chapter

The Nurse-Client Relationship

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“People will forget what you say to them. They will never forget how you make them feel.”

(Anonymous)
Chapter Competencies

Upon completion of this chapter, the reader should be able to:

1. Discuss the process of communication.
2. Identify and explain the components of the communication process.
3. Compare and contrast the different levels of communication.
4. Explain the various modes of communication.
5. Explore the role of therapeutic communication in the nurse-client relationship.
6. Identify the barriers to therapeutic communication.
7. Analyze the impact of communication in the nursing process.

Key Terms

active listening  group communication  paraverbal cue
aphasia  group dynamics  perception
artifact  internal stimuli  receiver
auditory channel  interpersonal communication  sender
channel  intrapersonal communication  therapeutic communication
cohesiveness  jargon  therapeutic relationship
communication  kinesthetic channel  verbal message
external stimuli  message  visual channel
feedback

Communication is not merely the sharing of facts; it is the essence of an innate quest to understand and be understood. People communicate in order to define themselves and find meaning in their interactions with the world around them. The nurse-client relationship depends on effective communication. Nurses must communicate effectively in order to perform their roles as educator, case manager, and active member of the health care team. As fundamental as communication is, it is rarely simple. It takes varied forms, occurs on many levels, and is vulnerable to multiple barriers. This chapter’s goal is to discuss the process of communication and explore the ways in which nurses can use effective communication not only to improve their relationships with clients and thus improve outcomes of care, but also to improve the overall function of the entire health care team.

The Communication Process

Communication is the exchange of thoughts, feelings, and other information. In a sense, it is impossible for people not to communicate (Figure 4-1). Humans are born with not only the capacity, but also the compulsion to self-express. From birth infants communicate with the world, sending and receiving messages upon which their survival may depend. As infants grow, they develop increasingly complex forms of communication, enhancing their ability to understand and be understood. The extent to which infants communicate effectively helps determine their ability to form and maintain healthy relationships.

Nurses endeavor to understand and meet the many needs of a diverse client population. In order to do so, nurses must establish therapeutic relationships with their clients, and the quality of those relationships is directly related to the quality of communication between nurse and client (Desmond & Copeland, 2000).

Components of the Communication Process

When seeking to understand a concept so complex as communication, it may be helpful initially to examine the whole as a sum of the parts that each play a role. In this conceptualization, the parts are sender, message, channel, receiver, and feedback (Figure 4-2). While not intended to encompass all the subtle intricacies of the communication process, the model that follows provides a framework for understanding the basics of how people communicate.
Sender
As illustrated in Figure 4-2, the communication process is described as a line within a circle. Clearly the process is cyclical, and although a linear representation may oversimplify the process, it is helpful to consider communication as having a starting place. In the communication model, the starting place is the sender. The sender initiates the process of communication by generating a message. Messages emerge from people’s need to relate to others and to create meaning from the world around and inside themselves.

Message
The message derives from the sender’s internal and external experiences. External stimuli include physical sensations, sights, sounds, touch, tastes, and smells. Internal stimuli include but are certainly not limited to hunger, fatigue, and cognitive experiences (e.g., thoughts, fantasies).

These internal and external stimuli generate messages that the sender then communicates to a receiver verbally, nonverbally, or in some other symbolic form (e.g., art). Verbal and nonverbal messages, as well as the influence of cognitive factors on communication, are discussed in detail later in this chapter.

Channel
The channel is the medium through which the sender transmits the message. The three main communication channels are auditory, visual, and kinesthetic. The visual channel involves sight, which in turn allows for visual observation and perception. The auditory channel consists of spoken words and other verbal cues. The kinesthetic channel refers to physical sensations mediated by touch. Many people are aware of having a dominant channel—one that they subconsciously rely upon more than the others to send and receive messages—which influences the ways in which each individual communicates.

Receiver
In addition to receiving the sender’s message, the receiver interprets the message, infusing it with meaning specific to his personal experience. Different receivers may glean various meanings from the same message (see discussion on perception). Many factors influence each phase of the communication process, some of which are discussed in the following section. In terms of the receiver, physiological, psychological, and cognitive processes may have a significant impact. The physiological component involves the senses described above. For example, if the receiver’s hearing is impaired, that person may not be able to hear spoken messages. If vision is affected, important visual cues may go unnoticed. Psychological processes exert a powerful influence on communication. In a mild stress response, for example, the receiver becomes acutely aware of her surroundings—able to perceive and interpret subtle messages rapidly and efficiently. If stress becomes severe or chronic, anxiety may seriously impede the receiver’s ability to understand even the simplest messages. The cognitive processes, or thoughts, that occur within a receiver’s mind help determine for each individual what the message exactly means (see section on intrapersonal communication for further discussion).

Feedback
The receiver’s reaction to the sender’s message is labeled feedback. The function of feedback is to provide the sender with information about the receiver’s perception of the interaction. This sometimes subtle and complicated process occurs constantly, shaping and reshaping the communication process. Feedback can either facilitate or impede effective communication. In the context of the nurse-client relationship, feedback must reflect and support the therapeutic nature of the communication process. Box 4-1 displays characteristics of effective feedback.
Factors Influencing Communication

In terms of this model of communication, the sender, the message, the channel, and the receiver may all exert powerful influences on the process of communication. A discussion of other potentially influential factors includes perception, cultural context, space and distance, and time.

Perception

Perception is an individual’s subjective sense of the world around him. “Rather than hear a story, we construct a story about what we think we are hearing” (Greenhalgh & Hurwitz, 1998, p. xiii). It would be inaccurate to say there are as many different perceptions of the world as there are people. However, each individual, as a function of her social, cultural, family, and individual experience, perceives things in a unique and individual way. People often depend on presumed similarities between the way they see the world and the way they imagine others to see it; they assume commonality of meaning. This is especially true when people speak a common language. It is easy for the sender to assume that when he says “blue,” “delicious,” or “big,” the receiver gets an image in mind similar to the sender. However, these assumptions can and often do lead people to misunderstand each other, as they attempt to fill inevitable gaps between intended meaning and perception.

Cultural Context

Communication varies significantly from culture to culture. Not only may people from different cultures speak different languages, but they also may attach different meanings to other elements of communication, such as touch, personal space, and eye contact (Giger & Davidhizar, 1999). See Chapter 5 for a more in-depth discussion of cultural variations related to communication.

Space and Distance

Each person has an invisible buffer zone, or personal space, which defines for that individual how close others should be when communicating with the individual (Figure 4-3). Table 4-1 describes the types of personal space. This boundary is culturally defined as well as particularly defined per the individual. An individual whose personal space has been invaded may experience discomfort, anxiety, and perhaps a strong desire to flee or defend himself (the fight-or-flight response). The nurse must consider and respect each client’s right to personal space. This is especially important when the nurse is examining or touching the client. Before making contact, the nurse should explain the procedure and allow the client to ask questions. During the procedure, the nurse should communicate constantly with the client, explaining what she is doing and why.

Time

Time is an increasingly challenging aspect of the nurse-client relationship. Today’s nurses care for a greater number of clients with complex medical conditions than ever before. Nurses must learn to manage time effectively in order to complete the many and varied tasks that fall under their responsibility. By spending time with the client, the nurse allows the client to feel cared for, valued, and ideally, understood. When the busy nurse is unable to spend time with the client, that client may feel that he is not important and his needs may not be met. Finding ample time to avoid appearing rushed, to gather important diagnostic facts, to educate clients, and to establish therapeutic relationships remains a significant challenge for every nurse.

One important time-saving strategy is to take the time up front to do the job right the first time around. Many nurses may feel they don’t have the time to communicate fully and effectively with a client during the initial assessment. However, studies indicate that the time invested in establishing rapport and listening to the

**BOX 4-1 CHARACTERISTICS OF EFFECTIVE FEEDBACK**

- Specific rather than general
- Descriptive
- Provided in a supportive, nonthreatening manner
- Given in a timely manner
- Practical and appropriate for the individual client
- Clear and unambiguous
- Direct and honest

**Figure 4-3** Appropriate distance between the nurse and the client during an interview creates a more comfortable setting.
TABLE 4-1  TYPES OF PERSONAL SPACE

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Nursing Implications</th>
</tr>
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</table>
| Intimate distance (0 to 18 inches around the person’s body) | • Reserved for people who feel close
• Vision is affected in that it is restricted to one portion of the other’s body; may be distorted
• Tone of voice may seem louder
• Body smells are noticeable
• Increased sensation of body heat | • Nurses often must intrude on this space to provide care
• Explain intention to client
• Respect client’s space as much as possible
• This space may be used for comforting and protecting
• Therapeutic examples:
  — Rocking a toddler
  — Administering a massage
  — Checking vital signs (temperature, pulse, respiratory rate, and blood pressure) |
| Personal distance (zone extends 1.5 to 4 feet around the person’s body) | • Usually maintained with friends
• Vision is clear since more of the other person is visible
• Tone of voice is moderate
• Sensations of body smells and heat are lessened | • Better able to read nonverbal communication at this distance
• Therapeutic examples:
  — Conversation between client and nurse usually occurs in this zone
  — One-to-one teaching
  — Counseling |
| Social or public distance (zone extends from 4 feet and beyond) | • Generally used when conducting impersonal business
• Communication is more formal and less intense
• Sensory involvement is less intense
• Increased eye contact | • Therapeutic examples:
  — Making rounds
  — Leading a group
  — Teaching a class |


client is invaluable. The nurse can avoid mistakes and complaints that arise later due to incomplete or inaccurate assessments and diagnoses. In addition, the nurse must establish a therapeutic relationship (i.e., a relationship that benefits the client’s health status) with the client. A client who is fully informed is a more effective partner in the health care team (Hubert, 1998).

Levels of Communication

Communication occurs at various levels, with each level influencing the others. Examples of different levels of communication include intrapersonal, interpersonal, group, and interdisciplinary, which are discussed below.

Intrapersonal Level

Intrapersonal communication, also known as self-talk, is the deluge of thoughts, feelings, and information that circulate inside one’s own mind. Everyone organizes,
interprets, and assigns meaning to every communication. Like perception, self-talk influences the way individuals understand the messages they receive from others. Figure 4-4 illustrates some of the elements involved in the process of self-talk. This process subtly but inevitably influences each individual’s perception of a given message.

The speaker’s intended message may vary dramatically from the message the receiver perceives, because of the intrapersonal communication process of the sender and receiver. For example, a client may determine in her self-talk process that she dislikes health care providers asking questions about her past. Then when the nurse asks questions in the interview process about the client’s past, the client is negative toward the nurse’s questions. At its worst, self-talk can interfere with attention to others and widen the gap between communicators during interpersonal exchanges. The more the nurse is aware of self-talk and the influence it may have on perception and the communication process as a whole, the more effectively the nurse can minimize the potentially disruptive nature of intrapersonal communication.

**Interpersonal Level**

Interpersonal communication is the process that occurs between two individuals either in face-to-face encounters, over the telephone, or through other communication media. Interpersonal communication builds on the intrapersonal level in that each person communicates with himself in the process of communicating with others. Interpersonal communication represents an essential element in the development and maintenance of any interpersonal relationship, and without skillful interpersonal communication, the nurse-client relationship is in serious jeopardy.

**Group Communication Level**

Communication between three or more individuals is defined as group communication. Because each member in a group engages in intrapersonal and interpersonal communication, the number of participants in the communication process is often directly related to increased complexity: the more communicators, the more challenges.

Group dynamics is the study of events that occurs in the context of group interaction. The dynamics of any group inevitably impact the productivity of the group. Nurses deal with groups constantly as they interact with families of clients, treatment teams, therapy groups, and committees within the health care setting. Groups represent potentially powerful therapeutic interventions, and nurses can participate not only by sharing professional insights, but also by listening actively and collaborating with multidisciplinary team members (e.g., social workers, clergy) to initiate the referral process.

Cohesiveness refers to bonding between and among members of a group (Figure 4-5). Groups often are formed around a common purpose or goal. Table 4-2 describes several different types of groups in which nurses are likely to participate. Nurses’ participation in groups depends on educational background and professional licensing. According to the American Nurses Association (2000), nurse generalists, those prepared at the baccalaureate level or lower, may lead and colead all types of groups except for psychotherapy groups. Only nurse specialists with graduate degrees may lead psychotherapy groups.

**Interdisciplinary Communication**

The health care team consists of the client (and family) and all health care personnel (e.g., social workers, physical therapists, occupational therapists) involved in providing care. Each member of the team performs important roles in the health care delivery system. It is essential that all health care team members communicate effectively with each other regarding assessment, intervention outcomes, and client status. The interdependent nature of the health care team requires especially skillful communication; breakdown of communication between team members could interfere with the client’s treatment and ultimate outcomes.
Modes of Communication

People communicate not only with verbal messages (words), but through nonverbal actions as well. Communication can therefore be categorized as either verbal or nonverbal.

Verbal Messages

Verbal messages are communicated through words or language. Spoken and written language is comprised of verbal cues. Often paraverbal (or paralinguistic) cues accompany verbal messages. These cues include pitch and tone of voice; speed, inflection, and volume; grunts and other nonlanguage vocalizations. Paraverbal cues add meaning to verbal messages and can influence the listener as much as, if not more than, words do. Regardless of the words a person uses, concurrent paraverbal cues will likely significantly impact the listener’s understanding of what is said.

Cultural differences may lead to challenges in accurately interpreting verbal messages, most obviously because of difficulties understanding spoken language. No less confounding, however, are the culturally idiosyncratic paraverbal cues. Tone of voice, volume, and inflection varies from language to language and may easily be misinterpreted. On the other hand, other paraverbal messages like a friendly smile or tears during a period of grief seem practically universal and help to bridge the language gap.

The advent of Internet communication has given rise to a new set of challenges. Electronic mail (e-mail), for example, has become a pervasive form of modern communication technology. Though similar in some ways to traditional written communication (e.g., letters), certain elements of e-mail make it a unique form of communication with unique benefits as well as challenges. First, e-mail is immediate, allowing participants in an e-mail “conversation” to exchange information much more rapidly than would be possible using other forms of written communication. On the other hand, very much like a letter sent via traditional mail, the writer need not be immediately present to face the consequences of her message. Also like traditional mail, and seemingly incongruous in light of the speed of the Internet, e-mail confers upon the recipient of a message the advantage of time and forethought in drafting a response. A disadvantage is the lack of nonverbal communication and that the message may be more easily misinterpreted. For all its advantages and disadvantages, it seems clear that e-mail is here to stay. Nurses must therefore join other health care professionals in becoming proficient in using this technology and developing applications to benefit client care.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task group</td>
<td>Focuses on achievement of a specific goal</td>
<td>Diabetes education group</td>
</tr>
<tr>
<td></td>
<td>Emphasizes problem-solving and decision-making</td>
<td>Committee to study staffing issues</td>
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<tr>
<td></td>
<td></td>
<td>Student Nurses Association</td>
</tr>
<tr>
<td>Therapeutic group</td>
<td>Increases members’ coping abilities</td>
<td>Stress management class</td>
</tr>
<tr>
<td></td>
<td>Offers support</td>
<td>Bereavement and grieving</td>
</tr>
<tr>
<td></td>
<td>Provides education and information</td>
<td>Exercise group (e.g., mall-walkers club)</td>
</tr>
<tr>
<td>Therapy group</td>
<td>Helps members learn about and change</td>
<td>Psychotherapy group</td>
</tr>
<tr>
<td></td>
<td>problematic behaviors</td>
<td>Cognitive-behavioral group</td>
</tr>
<tr>
<td></td>
<td>Focuses on emotional and behavioral disorders</td>
<td></td>
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<tr>
<td>Self-help group</td>
<td>Focuses on a common experience of all members</td>
<td>Weight Watchers</td>
</tr>
<tr>
<td></td>
<td>Often led by nonprofessionals</td>
<td>Reach for Recovery (a group for women who have had mastectomies)</td>
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<tr>
<td></td>
<td></td>
<td>Alcoholics Anonymous</td>
</tr>
</tbody>
</table>
Nonverbal Messages

Just as paraverbal cues often confer more meaning than their accompanying words, so do nonverbal messages carry great meaning in human communication. People send **nonverbal messages** via body language rather than words, though the two very often coexist. Communication experts estimate that the majority of communication occurs through nonverbal messages. Nurses must pay close attention to nonverbal cues in order to accurately interpret changes in client behavior. Following is a brief discussion of specific types of nonverbal communication.

**Facial Expressions**
The face is the ultimate conveyor of nonverbal messages (Figure 4-6). Unlike anywhere else in the body, the muscles of the face are connected directly to the skin, allowing for fine motor control of facial expressions to communicate the subtlest of messages. Facial expressions give clues that betray feelings and reactions not expressed in words. In addition, facial expressions support, contradict, or disguise the verbal message. Nurses attuned to changes in clients' facial expressions may be aware of emotional reactions and needs that a client might be reticent to express verbally, leading not only to better client care, but also to helping the client feel understood.

In addition to its central role in verbal communication, the mouth speaks volumes nonverbally as well. The lips smile (warmth, friendliness), frown (sadness, disapproval), quiver (fear, impending tears), and snarl or pout (malevolence, anger).

The eyes and surrounding structures (eyebrows and eyelashes) demonstrate interest, concern, sadness, dishonesty, or sincerity, and they are the windows into emotions such as anger, happiness, sadness, and fear. The French neurologist G. B. Duchenne discovered in his 19th century experiments that there are certain muscles that control movement of the facial structures surrounding the eyes and mouth that do not respond to conscious control, but rather are “only put into play by the sweet emotions of the soul,” (Purves, Augustine, Fitzpatrick, Katz, LaMantia, McNamara, & Williams, 2001, p. 628).

**Posture**
The nurse can learn much about the client and the client’s family by observing and accurately interpreting posture. Posture may indicate anxiety, relaxation, and positive or negative self-image. Standing straight and tall usually indicates confidence, while slumping often indicates depressed, tired, or bored individuals. Leaning forward usually indicates interest; leaning backward might point to aversion, rejection, or a lack of engagement. On the other hand, a client who is very relaxed and self-assured might lean back during communication as well, illustrating the fact that just as verbal communication is subject to interpretation and vulnerable to inadvertent misunderstanding, so too is nonverbal communication potentially ambiguous.

**Gestures**
Gestures like shrugging the shoulders, waving the hands, tapping the feet, and shaking the head all add to verbal communication. The nurse communicates openness and a willingness to listen by facing the client in a relaxed position. Crossed arms, for example, might indicate to the client that the nurse does not accept or has no interest in.
what the client has to say. Looking repeatedly at a watch or clock tells the client the nurse does not have time to spend, regardless of what the nurse says.

**Touch**

Touch is a powerful vehicle for communication, and is arguably underutilized in today’s modern medical world, where machines and medications are the order of the day (Figure 4-7). Touch can be used to soothe, comfort, and establish rapport and a therapeutic bond between nurse and client. Touching someone is an age-old demonstration of caring, as in the case when a nurse holds a client’s hand during a painful procedure or when delivering bad news. Despite the nurse’s best intentions, touch can also be perceived as intrusive or hostile. It is especially important to use touch cautiously with clients who are confused, suspicious, or aggressive, and with clients who have been victims of abuse. In addition, the nurse must understand the cultural significance of touch in order to prevent potential problems. See Chapter 5 for a discussion of various cultural perceptions of touch.

**Physical Appearance**

Physical appearance and artifacts (items in the client’s environment, grooming, clothing, jewelry) may convey important nonverbal messages. Uniforms can demonstrate professionalism and inspire confidence, but at the same time they may be perceived as symbols of superiority, hindering interpersonal connections. For this reason, nursing uniforms are not worn in certain areas, such as pediatrics, psychiatry, and some home health care settings.

**Therapeutic Communication**

Therapeutic communication, using communication for the purpose of creating a beneficial outcome for the client, is the hallmark of the nurse-client relationship. Like touch, therapeutic communication may seem almost trivial in the context of the modern medical miracles that technology makes possible for today’s clients. However, while every client deserves and presumably desires to benefit from these technological advances, it is equally if not more important to every individual to feel cared for and understood; this is the goal of therapeutic communication. Brain scans, biochemistry, and other technology cannot replace dialogue; with its use nurses have a unique, demanding, and irreplaceable role in caring for clients. Table 4-3 presents the essential elements of therapeutic communication: empathy, trust, honesty, validation, caring, a nonjudgmental approach, and the use of active listening.

**Principles of Therapeutic Communication**

Generally speaking, therapeutic communication is purposeful, in that it is directed toward a specific outcome. Most important, therapeutic communication is nonjudgmental and client-centered. While a therapeutic approach to communication may come somewhat naturally to many nurses, it behooves all nurses to practice techniques specifically designed to enhance the therapeutic value of communication. A discussion of basic principles for guiding therapeutic communication follows.

**Time and Place**

Time and place are important to the elements of therapeutic communication. Not only the amount of time the nurse spends with each client, but also the timing of an interaction may have a significant impact on the outcome of the interaction. If the client is distracted by visitors or fatigued from a recently completed procedure or even a favorite television show, he may be too preoccupied to participate actively in the nurse-client interaction. Taking into consideration the timing of the interaction will also show the client that the nurse has the client’s needs in mind.
The physical environment should be as comfortable and private as possible. The nurse can help ensure the client is comfortable by inquiring about the temperature, ventilation, and positioning of the client, and making any necessary adjustments. In addition, if pain is an issue, the nurse can intervene as appropriate. However, it should be noted that pain medication might have a sedative effect on the client and thereby render active participation by the client more difficult.

The client must be assured of confidentiality in order to feel safe in sharing information of a very private nature. This includes securing as private a location as possible for the interaction, as well as reiterating to the client that the conversation is confidential and information will be shared only with those directly involved in the client’s care.

**Setting the Stage**

Setting the stage for therapeutic communication is important. Having established an appropriate time and place, the nurse should introduce herself and clarify the purpose of the interaction and the expected duration. Setting the stage in this way allows the client to begin the interaction on a more equal footing with the nurse; each knows who the other is, as well as why and how long they will be there.

**Accepting the Client**

Accepting the client “as is” is important to therapeutic communication. A judgmental approach to any interaction will limit the ability for mutual understanding. It is essential for every nurse to remain aware of his own biases and to approach each client from a perspective of acceptance. Often it is difficult for nurses to understand why clients behave in certain ways, especially when this behavior endangers the client’s health. While the nurse’s feelings may stem from the best of intentions for the client’s wellbeing, these feelings often drive a wedge between the nurse and client, rendering effective therapeutic communication nearly impossible. The nurse serves the client best by reserving judgment and trying to accept and understand the client as she is.

**Active Listening**

Active listening is an important element to therapeutic communication. Thomas Gordon defines *active listening* as “a method of listening where you reflect back your understanding of what a person says to you.” This is meant to confirm to the person that you understand his message, and to give him a chance to correct you if you don’t. More important, however, active listening communicates your acceptance of the person’s thoughts and emotions. Clearly understanding the client requires more than just hearing what she is saying. In addition to paying careful attention to what is said as well as what is not said (i.e.,

**COMMUNITY/HOME CARE**

**Incorporating Family Members into Communication**

It may be very challenging for the nurse to balance the need to include the client’s family members with having to provide ample opportunity for private nurse-client interaction. The nurse should consult clients (privately) and ask how they want their family members involved in their care. The nurse can obtain a sense for a client’s preference regarding how much the family is to be included in the nurse-client interactions. The nurse should ensure at least some one-to-one communication with the client.

**LEGAL AND ETHICAL ISSUES**

**Confidentiality**

One of the nurse’s primary duties is to protect the client’s right to confidentiality. However, should the client divulge information that indicates a real and present danger to the client or another individual, the nurse may be required by law to intervene by reporting this information to the appropriate authorities. *Tarasoff v. Regents of the University of California* describes a case in which a psychiatric patient shared with his therapist his intention to kill Tatiana Tarasoff, a young woman who had spurned the patient’s affections. When the patient eventually followed through with his plan, Tatiana’s parents sued the system for neglecting to better protect their daughter. The Tarasoff case has inspired two decades of debate regarding health care providers’ obligations to the safety of third parties, and each state currently defines these obligations differently. Needless to say, it is essential that each nurse be aware of his state’s regulations. While breaching client confidentiality may in rare situations be warranted or even required, nurses should never discuss clients casually or in settings or contexts outside the clients’ direct care.

TABLE 4-3 THE ELEMENTS OF THERAPEUTIC COMMUNICATION

<table>
<thead>
<tr>
<th>Definition</th>
<th>Behaviors of the Nurse</th>
<th>Outcomes</th>
</tr>
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</table>
| **Empathy:** An emotional linkage between two or more people through which feelings are communicated; involves trying to imagine what it must be like to be in another person’s situation | **Verbal comments:**  
• “This must make you feel sad.”  
**Nonverbal actions:**  
• A nod of the head to indicate understanding.  
• Mirroring the client’s facial expression in a genuine way. | • Promotes understanding of the client’s feelings and condition.  
• Enables the nurse and client to relate better.  
• Provides the client with clues that the nurse is following and understanding what is being said.  
• Provides the basis for progress during future encounters.  
• Sets up the foundation of the therapeutic relationship.  
• Makes the client feel comfortable with the nurse, rather than guarded or afraid.  
• Promotes the development of trust.  
• Enables the nurse to gain personal insight. Consequently, behavior with the client can be modified as needed.  
• Clarifies communication.  
• Helps the client to feel accepted, respected, and understood. |
| **Trust:** The client’s belief that the nurse will behave predictably and competently while respecting the client’s needs | **Verbal comments:**  
• “So you are saying that . . .”  
• “Let me be sure I understand what you are saying.”  
• “Tell me what you understand about what I just said.”  
**Nonverbal actions:**  
• Ensure confidentiality.  
• Be consistent.  
• Do exactly what you say you will do for the client.  
• Arrive on time.  
• End the session on time.  
• Return when you say you will.  
• Be consistently friendly, open, and honest. | • Makes the client feel accepted.  
• Provides the client with the knowledge that the nurse is willing to help.  
• Promotes understanding of the client.  
• Allows the client to express self more freely.  
• Helps the client gain a better understanding of the problem(s).  
• Promotes problem solving by the client.  
• Enhances the client’s self-esteem. |
| **Honesty:** The ability to be truthful, frank, and sincere | **Verbal comments:**  
• Provide realistic reassurance.  
• Avoid false reassurance.  
• Develop insight into the way your feelings and reactions affect the client.  
• Accept yourself.  
**Nonverbal actions:**  
• Ensure confidentiality.  
• Be consistent.  
• Do exactly what you say you will do for the client.  
• Arrive on time.  
• End the session on time.  
• Return when you say you will.  
• Be consistently friendly, open, and honest. | • Makes the client feel accepted.  
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• Helps the client gain a better understanding of the problem(s).  
• Promotes problem solving by the client.  
• Enhances the client’s self-esteem. |
| **Validation:** Listening to the client and responding congruently in order to be sure that the nurse and client have the same understanding of a problem or issue | **Verbal comments:**  
• “This must make you feel sad.”  
• “So you are saying that . . .”  
• “Let me be sure I understand what you are saying.”  
• “Tell me what you understand about what I just said.”  
**Nonverbal actions:**  
• Seek the client out each day.  
• Spend quality time with the client.  
• Paying attention to the client’s needs.  
• Using tactile messages, such as a pat on the back, to show support.  
**Verbal comments:**  
• “You are feeling sad today.”  
• “You are very concerned about your situation.” | • Promotes understanding of the client.  
• Enables the nurse and client to relate better.  
• Provides the client with clues that the nurse is following and understanding what is being said.  
• Provides the basis for progress during future encounters.  
• Sets up the foundation of the therapeutic relationship.  
• Makes the client feel comfortable with the nurse, rather than guarded or afraid.  
• Promotes the development of trust.  
• Enables the nurse to gain personal insight. Consequently, behavior with the client can be modified as needed.  
• Clarifies communication.  
• Helps the client to feel accepted, respected, and understood. |
| **Caring:** The level of emotional involvement between the nurse and the client | **Verbal comments:**  
• “This must make you feel sad.”  
• “I understand how you feel.”  
• “I can see that you are really upset.”  
• “You are having a very hard time.”  
• “You must be very angry.”  
**Nonverbal actions:**  
• Seek the client out each day.  
• Spend quality time with the client.  
• Paying attention to the client’s needs.  
• Using tactile messages, such as a pat on the back, to show support.  
**Verbal comments:**  
• “You are feeling sad today.”  
• “You are very concerned about your situation.”  
**Nonverbal actions:**  
• Provide realistic reassurance.  
• Avoid false reassurance.  
• Develop insight into the way your feelings and reactions affect the client.  
• Accept yourself.  | • Makes the client feel accepted.  
• Provides the client with the knowledge that the nurse is willing to help.  
• Promotes understanding of the client.  
• Allows the client to express self more freely.  
• Helps the client gain a better understanding of the problem(s).  
• Promotes problem solving by the client.  
• Enhances the client’s self-esteem. |
| **Active listening:** Hearing and interpreting language, noticing nonverbal and paraverbal enhancements, and identifying underlying feelings | **Verbal comments:**  
• “This must make you feel sad.”  
• “I understand how you feel.”  
• “I can see that you are really upset.”  
• “You are having a very hard time.”  
• “You must be very angry.”  
**Nonverbal actions:**  
• Seek the client out each day.  
• Spend quality time with the client.  
• Paying attention to the client’s needs.  
• Using tactile messages, such as a pat on the back, to show support.  
**Verbal comments:**  
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• Allows the client to express self more freely.  
• Helps the client gain a better understanding of the problem(s).  
• Promotes problem solving by the client.  
• Enhances the client’s self-esteem. |
facial expressions, body language), nurses can encourage clients to engage in interaction by practicing the elements of active listening in Box 4-2.

Table 4-4 describes a number of specific techniques to enhance therapeutic communication. Every nurse should be aware of these techniques, but in the end each nurse must find a style of communication that fits his own unique personality.

**Barriers to Therapeutic Communication**

Communication is challenging even under the most ideal circumstances. The situations in which nurses and clients must communicate often present obstacles, which the nurse and client must navigate in order to communicate effectively. Common barriers to effective communication are discussed below, followed by suggestions to help nurses overcome these barriers.

**Language**

Even when two people speak the same language, it may be difficult for them to understand each other. In addition to linguistic barriers, such as discrepancies in sophistication of vocabulary, for example, intrusive self-talk, preconceptions, and individual differences in the use of certain words and expressions can render messages unintelligible despite a shared dialect. Imagine the potential barriers when two people do not speak the same language!

When English is the nurse or client’s second language, the nurse can enhance the client’s understanding by seeking common ground. Nurses can endeavor to learn some of the client’s language. When this is not practical, nurses must bridge language gaps by thinking critically and creatively. Interpreters, foreign language dictionaries, pictures, and symbols are some potentially effective tools the nurse can use to enhance communication with a client who speaks a different language.

**Culture**

Cultural differences in communication transcend spoken language. For example, while people from one culture may consider it perfectly appropriate to express thoughts and feelings with spontaneity and exuberance, people from another culture may value stoicism and reservation in verbal communication. Eye contact, physical proximity and contact, and the role of small talk are but a few examples of culturally idiosyncratic elements of communication. See Chapter 5 for a more in-depth discussion of cultural influence on communication.

**Gender**

While it is certainly a generalization with many evident exceptions, men and women sometimes differ in their communication styles. Many people believe, for example, that women tend to be more adept at reading nonverbal cues and are more comfortable than men are with close physical proximity when communicating with another individual. Recent developments in brain imaging techniques indicate possible gender-based differences in the speech centers of men and women, and it will be interesting to follow this science as it develops (Williams, 2001). That said, as with any generalization, it is important to avoid relying on rigid preconceptions based on stereotypical gender-based differences.

**Health Status**

The client who is in pain or is preoccupied with her condition may have difficulty communicating effectively.

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**BOX 4-2 ELEMENTS OF ACTIVE LISTENING**

- **Let the client take the lead.** The nurse may need to gather important information in a short period of time, but it is essential to allow the client to initiate. This helps the client maintain some control in a situation (illness, hospitalization) that may have significantly attenuated his sense of control.

- **Seek clarification.** It can be very useful for the nurse to pause occasionally in order to verify that she has understood what the client has said. One very effective technique is reflection and restating (see Table 4-5). The nurse rephrases that which she believes the client has said. This not only allows the client to clarify his message, but hearing it in different words may also help the client to better understand and identify her own thought process. Not insignificantly, it also helps the nurse demonstrate to the client that she is fully engaged in the interaction.

- **When in doubt, listen.** Nurses’ sincere desire to help clients can inadvertently sabotage the therapeutic communication process. By focusing on the myriad ways she can help, the nurse may forget to actually listen to the client. As tempting as it is to solve the client’s problems, it is essential to hear the client out and, if possible, to guide him into playing a role in solving his own problems. This is the key to active listening.
## TABLE 4-4  TECHNIQUES OF THERAPEUTIC COMMUNICATION

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Techniques that allow the client to set the pace</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Offering self</strong></td>
<td>Nurse is available, physically and emotionally</td>
<td>“I’ll sit with you awhile.”</td>
</tr>
<tr>
<td></td>
<td>Indicates nurse’s willingness/intent to help</td>
<td>“Go on.”</td>
</tr>
<tr>
<td></td>
<td>Nurse’s presence is reassuring; may prompt client to continue</td>
<td>“Uh-huh.”</td>
</tr>
<tr>
<td></td>
<td>Indicates nurse’s attention and interest</td>
<td>Head nodding</td>
</tr>
<tr>
<td><strong>Broad openings</strong></td>
<td>Encourages client to choose topic for discussion</td>
<td>“What do you want to talk about?”</td>
</tr>
<tr>
<td></td>
<td>Demonstrates respect for client’s thoughts</td>
<td>“Can you tell me more about that?”</td>
</tr>
<tr>
<td></td>
<td>Emphasizes importance of client’s needs</td>
<td>“How have things been going?”</td>
</tr>
<tr>
<td><strong>Silence</strong></td>
<td>Gives client time to reflect</td>
<td>Sit quietly and observe client’s behavior</td>
</tr>
<tr>
<td></td>
<td>Encourages client to express self</td>
<td>Use appropriate eye contact</td>
</tr>
<tr>
<td></td>
<td>Indicates interest in what client has to say</td>
<td>Employ attending behaviors</td>
</tr>
<tr>
<td></td>
<td>Increases nurse’s understanding of client’s message</td>
<td>Control own discomfort during quiet periods or conversation lulls</td>
</tr>
<tr>
<td></td>
<td>Helps to structure and pace the interaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conveys respect and acceptance</td>
<td></td>
</tr>
<tr>
<td><strong>Techniques that encourage spontaneity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Open-ended comments</strong></td>
<td>Unfinished sentences that prompt client to continue</td>
<td>“Tell me about your pain?” instead of “Are you in pain?”</td>
</tr>
<tr>
<td></td>
<td>Questions that cannot be answered with a one-word answer</td>
<td>“Tell me about your family” rather than “How many children do you have?”</td>
</tr>
<tr>
<td></td>
<td>Allows client to decide what content is relevant</td>
<td></td>
</tr>
<tr>
<td><strong>Reflection</strong></td>
<td>Focuses on content of client’s message and feelings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repeating client’s last words in order to prompt further expression</td>
<td>Client: “Do you think I should tell the doctor I stopped taking my medication?”</td>
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<tr>
<td></td>
<td>Communicates nurse’s interest</td>
<td>Nurse: “What do you think about that?”</td>
</tr>
<tr>
<td></td>
<td>Lets client know the nurse is actively listening</td>
<td>Client: “I probably should. But the medicine makes me so tearful and agitated.”</td>
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<tr>
<td></td>
<td></td>
<td>Nurse: “You sound a bit agitated now.”</td>
</tr>
<tr>
<td><strong>Restating</strong></td>
<td>Repeating or paraphrasing client’s main idea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicates nurse is listening to client</td>
<td>Client: “I told the doctor that I had problems with this medicine, but he just didn’t listen to me!”</td>
</tr>
<tr>
<td></td>
<td>Encourages further dialogue</td>
<td>Nurse: “Sounds like you’re pretty angry at him.”</td>
</tr>
<tr>
<td></td>
<td>Gives client an opportunity to explain or elaborate</td>
<td>Client: “I don’t sleep well anymore.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse: “You’re having problems sleeping?”</td>
</tr>
<tr>
<td><strong>Techniques that focus on the client by responding to verbal, paraverbal, and nonverbal cues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exploring</strong></td>
<td>Attempts to develop in more detail a specific area of concern to client</td>
<td>“Tell me more about how you feel when you do not take your medication.”</td>
</tr>
<tr>
<td></td>
<td>Identifies patterns or themes</td>
<td>“Could you tell me about one of those times when you felt so upset?”</td>
</tr>
<tr>
<td><strong>Recognition</strong></td>
<td>Nurse points out observed cues to client</td>
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<tr>
<td></td>
<td></td>
<td>“I notice that you became embarrassed when . . .”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I see that you have some pictures of the new baby.”</td>
</tr>
<tr>
<td><strong>Focusing</strong></td>
<td>Questions or statements that help client develop or expand an idea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Directs conversation toward key topics</td>
<td>“You mentioned that you are having a problem with . . .”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“You say you feel nauseous a lot.”</td>
</tr>
</tbody>
</table>

(continues)
TABLE 4-4  TECHNIQUES OF THERAPEUTIC COMMUNICATION (continued)

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directing</td>
<td>Comments that elicit specific information from the client</td>
<td>Client: “They told me I needed to see a specialist.” Nurse: “What made them say that to you?” or “When were you told this?” or “Where were you when they told you?” or “How do you feel about seeing another doctor?”</td>
</tr>
<tr>
<td></td>
<td>Is used to collect assessment data, not to satisfy nurse’s curiosity</td>
<td></td>
</tr>
<tr>
<td>Techniques that encourage expression of feelings</td>
<td>Verbalizing the implied messages</td>
<td>Client: “How much is this x-ray going to cost?” Nurse: “You’re worried about your medical bills?”</td>
</tr>
<tr>
<td></td>
<td>Making observations of feelings</td>
<td>“You seem sad today.” “You’re limping as if your leg hurts.”</td>
</tr>
<tr>
<td>Clarifying</td>
<td>Makes the meaning of client’s message clear</td>
<td>Client: “Whenever I talk to my doctor, I feel upset.” Nurse: “Tell me what you mean by upset.”</td>
</tr>
<tr>
<td></td>
<td>Prevents nurse from making assumptions about client’s message</td>
<td>Client: “They said I could be discharged tomorrow.” Nurse: “Who told you this?”</td>
</tr>
<tr>
<td>Techniques that encourage the client to make some changes</td>
<td>Confronting Nurse’s verbal response to incongruence</td>
<td>Client: “I am so angry at her” (stated while smiling). Nurse: “You say you’re angry, yet you’re smiling.”</td>
</tr>
<tr>
<td></td>
<td>Encourages client to recognize potential areas for change</td>
<td>Client: “I never know which of my symptoms to pay attention to. I think maybe I’m just a hypochondriac.” Nurse: “You say you’re not sure which symptoms are important, yet you knew when to come to the clinic for help.”</td>
</tr>
<tr>
<td>Limit setting</td>
<td>Stating expectations for appropriate behavior</td>
<td>Nurse: “It seems that you are feeling unsure of how to behave right now.”</td>
</tr>
<tr>
<td></td>
<td>Establishing behavioral parameters</td>
<td>Client: “What do you mean?” Nurse: “Well, you’re asking me a lot of personal questions. The reason you’re here is because you have some health problems. How can I help you tell me more clearly what brought you here to the clinic?”</td>
</tr>
</tbody>
</table>


Similarly, confusion and perceptual alterations such as loss of hearing or vision may impact the communication process. See Table 4-5 for a description of techniques that may be helpful when communicating with clients whose physical and/or cognitive condition might potentially impede effective communication.

**Developmental Level**

Failure to communicate at the client’s individual developmental level can represent a significant roadblock to effective communication. Young children, for example, are generally incapable of abstract thought. Knowing this, the nurse will communicate with the child in relatively concrete terms. It is important that the nurse consider not only the age but also the developmental stage of the client, which may be affected by preexisting diseases.

**Emotions**

In the health care setting, providers are sometimes guilty of treating the client as a curiosity, a problem, or a disease.
### TABLE 4-5  COMMUNICATING WITH VULNERABLE POPULATIONS

<table>
<thead>
<tr>
<th>Vulnerable Population</th>
<th>Communication Strategies</th>
</tr>
</thead>
</table>
| Clients who are hearing impaired      | Determine if the client reads lips. If so, face the client and reduce background noise to a minimum.  
                                      | If client is using a hearing aid, check to see that it is in working order.  
                                      | Always face the client.  
                                      | Speak at a normal pace in a normal tone of voice.  
                                      | Focus on nonverbal cues from the client.  
                                      | Use gestures and facial expressions to reinforce verbal messages.  
                                      | Provide pen and paper to facilitate communication if client is literate. |
| Clients who are visually impaired     | When speaking to visually impaired clients, always face them as if they were sighted.  
                                      | Follow the cues of the clients in order to allow as much independence as possible.  
                                      | Look directly at the client.  
                                      | Speak in a normal tone of voice; it is demeaning to yell.  
                                      | Ask for permission before touching the client.  
                                      | Orient the client to the immediate environment. |
| Clients who are aphasic                | Assess the client’s usual method of communication; adapt the interaction to accommodate the client’s abilities.  
                                      | Use a written interview format, letter boards, or yes/no cards.  
                                      | Allow additional time for client’s responses.  
                                      | Do not answer for the client.  
                                      | Use closed (one-word response) questions when possible.  
                                      | Repeat or rephrase the comment if client does not understand.  
                                      | Speak directly to the client, not to the intermediary.  
                                      | To reinforce verbal messages, use facial expressions, gestures, and voice tone. |
| Unconscious clients                    | Assume the client can hear.  
                                      | Talk to the client in a normal tone of voice.  
                                      | Engage in normal conversational topics as with any client.  
                                      | Speak to the client before touching.  
                                      | Use touch to communicate a sense of presence.  
                                      | Decrease environmental stimuli (especially auditory). |
| Confused clients                       | Maintain appropriate eye contact.  
                                      | Keep background noises to a minimum.  
                                      | Use simple, concrete words and sentences.  
                                      | Use pictures and symbols.  
                                      | Use closed rather than open-ended questions.  
                                      | Give the client time to respond. |
| Angry clients                          | Use caution when communicating with a client who has a history of violent behavior or poor impulse control.  
                                      | Do not turn your back on the client. Arrange the setting so that the client is not between you and the door to the room.  
                                      | Focus on the client’s body language.  
                                      | Be alert for physical indicators of impending aggression: narrowed eyes, clenched jaw, clenched fist, or a loud tone of voice.  
                                      | Model the expected behavior by lowering your tone of voice.  
                                      | Stay within the client’s line of vision.  
                                      | Do not use touch. |
This stance may engender emotional distance, an unwillingness to “be there” with the client. Despite the need to focus on the client’s alterations, the nurse must remember that the client is, first and foremost, a human being in need of empathy and understanding. Emotional distance precludes any modicum of therapeutic communication.

On the other hand, excessive emotional involvement on the part of the client or the nurse may prove equally disruptive to the communication process. The client may be so emotionally distraught that the nurse would do best to allow the client time to experience the emotions, without trying to intervene. In the interest of the client, the nurse, too, must maintain some control over his own emotions. A saying in hospice nursing goes, “It’s OK to cry with the client, as long as you don’t cry more than the client.”

The role of emotions in the communication process, and in the overall nurse-client relationship, is complex. This complexity requires the nurse to remain conscious of her own emotional state as well as that of the client, and to ensure that neither emotional distance nor emotional excess derails the communication process.

Using Health Care Jargon

Health care professionals often distance themselves from clients by using jargon, technical language that may be perfectly appropriate when communicating with other providers, but is confusing and potentially frightening to the client. Nurses should use language that is easily understood by the average layperson, explaining medical terminology in “plain English” at every opportunity. At the same time, nurses must avoid “talking down” to the client. Once again, review of basic therapeutic communication principles will help ensure that the nurse and client understand each other. In addition, nurses must also employ specific considerations when communicating with elderly clients (Figure 4-8).

Communication Blocks

Certain responses that are acceptable in the context of social conversation may be inappropriate during therapeutic interaction. Communication roadblocks, some of which are described in Table 4-6, can stall the interview process and potentially confuse, intimidate, or even anger the client. Not only must nurses continuously monitor their communication with clients as well as other members of the health care team in order to identify potential roadblocks, but they also should strive to develop strategies and techniques to optimize the therapeutic value of their interactions.

Communication, Critical Thinking, and the Nursing Process

In terms of effective communication, critical thinking refers to the vigilance nurses must use in their ongoing assessment of the communication between themselves, their clients, and their fellow health professionals. Thinking critically about communication helps the nurse to identify and...
### TABLE 4-6 COMMUNICATION ROADBLOCKS

<table>
<thead>
<tr>
<th>Roadblock</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reassuring</td>
<td>Comments that indicate to the client that concerns or fears are unwarranted</td>
<td>• “Everything will be fine.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “You will feel better soon.”</td>
</tr>
<tr>
<td>Agreeing</td>
<td>Comments that indicate that the nurse’s views are those of the client</td>
<td>• “I agree.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “I think you are right.”</td>
</tr>
<tr>
<td>Approving</td>
<td>Comments that indicate that the client’s views, actions, needs, or wishes are “good” rather than</td>
<td>• “That’s good.”</td>
</tr>
<tr>
<td></td>
<td>“bad”</td>
<td>• “I think you did the right thing.”</td>
</tr>
<tr>
<td>Defending</td>
<td>Comments that are aimed at protecting the nurse, someone else, or something from verbal attack</td>
<td>• “I did not say that.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Doctor Jones is a good doctor.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “I am sure your father meant nothing by that comment.”</td>
</tr>
<tr>
<td>Using yes-or-no questions</td>
<td>Questions or comments that can be answered by the client with a Yes or No</td>
<td>• “Are you tired?”</td>
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<tr>
<td></td>
<td></td>
<td>• “Would you like some water?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Could we talk now?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Did you sleep well?”</td>
</tr>
<tr>
<td>Using stereotyped</td>
<td>“Pat” answers or clichés that indicate that the client’s concerns are unimportant or insignificant</td>
<td>• “C’est la vie.”</td>
</tr>
<tr>
<td>comments</td>
<td></td>
<td>• “That’s the way the ball bounces.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “It will all come out in the wash.”</td>
</tr>
<tr>
<td>Changing focus</td>
<td>Switching to a topic that is more comfortable to discuss</td>
<td>• Client: “I wish I were dead.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurse: “Did your wife visit today?”</td>
</tr>
<tr>
<td>Judging</td>
<td>Comments or actions by the nurse that indicate pleasure or displeasure with what the client says</td>
<td>• A stern look</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rolling the eyes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “I like that.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “I do not like that.”</td>
</tr>
<tr>
<td>Blaming</td>
<td>Accusing the client of misconduct; undermines the client’s need to be loved and accepted</td>
<td>• “You should know better than to talk like that.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “If you had not moved, I would have been able to complete this venipuncture.”</td>
</tr>
<tr>
<td>Belittling the</td>
<td>Indicating to the client that feelings expressed are unwarranted or unimportant</td>
<td>• “Don’t feel that way.”</td>
</tr>
<tr>
<td>client’s feelings</td>
<td></td>
<td>• “Be a big boy and stop crying.”</td>
</tr>
<tr>
<td>Advising</td>
<td>Giving the client opinion or direction about solving a problem</td>
<td>• “If I were you, I would talk to your husband about this.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “I think you should do something for yourself for a change.”</td>
</tr>
<tr>
<td>Rejecting</td>
<td>Indicating to the client that certain topics are not open to discussion</td>
<td>• “Let’s not talk about that right now.”</td>
</tr>
<tr>
<td>Disapproving</td>
<td>Indicating displeasure about comments or behaviors and/or placing a value on them</td>
<td>• “That’s bad.”</td>
</tr>
<tr>
<td>Probing</td>
<td>Pressuring the client to discuss something before she is ready.</td>
<td>• “Why do you feel this way?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Why did you come to the hospital?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Why are you angry with your son?”</td>
</tr>
</tbody>
</table>

successfully employ appropriate communication techniques. In addition, critical thinking can yield a deeper understanding of the client’s experience and needs, ideally facilitating better outcomes.

Assessment

The nurse theorist Hildegarde Peplau (1960) once said that, to encourage the client to participate in identifying and assessing his problems is to engage him as an active partner—an enterprise of great importance to him. Peplau’s statement speaks to the importance of therapeutic communication in the quest to engage the client more fully in the healing process. Therapeutic communication is the vehicle for establishing a partnership between client and nurse. When assessing the client, the nurse seeks to understand the client by processing both verbal and nonverbal messages. When the client denies pain, for example, does her facial expression and body language support her words? Is there some incongruity between words and behavior? Refer to the Nursing Strategy box for guidelines that may be helpful in communicating with clients during the assessment process. Following these guidelines facilitates communication and thereby improves the accuracy and usefulness of assessment data.

Ongoing assessment of the client’s ability to communicate involves collecting information regarding both physical and psychological barriers. Several types of aphasia, impairment or absence of language function (Figure 4-9), are described in Table 4-7.

Nursing Diagnosis

“Accurate diagnosis is an art of communication perfected by experience” (Hubert, 1998, p. 16). Accurate diagnosis derives from a therapeutic relationship with the client, one in which the client feels safe to express all relevant concerns. By paying meticulous attention to and correctly interpreting the client’s verbal and nonverbal messages, nurses develop an understanding of the client’s most compelling needs and can use this information to form their diagnostic judgments.

Whenever a client is unable to send, receive, or interpret messages accurately, the diagnosis of Impaired Verbal Communication is applicable. According to the North American Nursing Diagnosis Association (2003), the diagnosis of Impaired Verbal Communication is indicated when the client demonstrates a decreased, delayed, or absent ability to process, receive, or transmit meaning.
Defining characteristics of the client with impaired verbal communication are shown in Box 4-3.

Other potentially relevant nursing diagnoses for the client experiencing communication difficulties include the following: (1) social isolation related to impaired verbal communication, (2) anxiety related to impaired verbal communication, and (3) self-esteem disturbance related to impaired verbal communication.

Planning and Outcome Identification

The nurse and client work together to develop goals and identify appropriate outcomes, a process that relies heavily on effective therapeutic communication. When impaired communication is an issue for the client, the nurse may employ any of the following approaches to overcome language barriers:

- Speak slowly in a normal tone of voice, enunciating clearly.
- Use gestures or pictures, when appropriate, to clarify meaning of words.
- Avoid clichés, medical jargon, and judgmental terms.
- Avoid body language that might appear defensive or frustrated.
- Consider the client’s reading level when providing written material, and whenever possible, offer materials written in the client’s native language.
- Ideally, use a professional interpreter fluent in medical terminology. Speak to the client rather than the interpreter.
- If possible, use the same interpreter for each interaction.

Implementation

According to the National Institutes of Health (2001), it is estimated that communication disorders (including speech, language, and hearing disorders) affect 1 of every 10 people in the United States. Nurses inevitably interact with clients experiencing impaired communication, and these interactions can be very challenging. Box 4-4 describes various methods of communicating with clients who have special needs.

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**TABLE 4-7 CLASSIFICATION OF APHASIAS**

<table>
<thead>
<tr>
<th>Aphasia</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broca’s aphasia</td>
<td>Slow, hesitant speech, difficulty selecting and organizing words, naming, word, and phrase repetition, writing impaired, slight comprehension defects</td>
</tr>
<tr>
<td>Wernicke’s aphasia</td>
<td>Auditory comprehension impaired, impaired speech content, client unaware of deficits</td>
</tr>
<tr>
<td>Anomic aphasia</td>
<td>Unable to name objects or places, comprehension and repetition of words and phrases intact</td>
</tr>
<tr>
<td>Conduction aphasia</td>
<td>Difficulty repeating words, substitutes incorrect sounds for another</td>
</tr>
<tr>
<td>Global aphasia</td>
<td>Severe impairment of oral and written comprehension, impaired naming and repetition of words, impaired writing ability</td>
</tr>
</tbody>
</table>

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**BOX 4-3 CHARACTERISTICS OF IMPAIRED VERBAL COMMUNICATION**

- Disorientation
- Inability or unwillingness to speak
- Difficulty speaking
- Difficulty expressing thoughts verbally
- Partial or total visual defect
- Stuttering or slurring of words
- Willful refusal to speak
- Unable to speak dominant language

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**Inability to Speak**

Mr. Perez is recovering from a stroke and is unable to speak. You enter his room to find him agitated and making every effort to get you to take a piece of paper he has in his hand. In addition, he is making slurring noises, and you know he is trying to talk to you. On the paper he has written in shaky print, “I can’t get anyone to take the time to listen to me. Please help!” What interventions can you suggest for yourself and other members of the health care team?
Evaluation

Communication is an essential tool in evaluating the client’s achievement of expected outcomes. This is especially true when evaluating the effectiveness of the nurse’s efforts to educate the client regarding aspects of self-care. The nurse must pay careful attention to verbal and nonverbal cues and validate that these cues might indicate a need for further teaching. Generally speaking, nurses must ask themselves if communication is impeding this client’s healing process, and if so, what interventions might resolve this problem.

BOX 4-4  CHARACTERISTICS OF IMPAIRED VERBAL COMMUNICATION

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RESEARCH FOCUS

Title of Study: Nursing the patient with severe communication impairment.

Study Purpose: In light of the currently scant research on nurses’ experience caring for clients with severe communication impairment, this study provides descriptive information from interviews with 20 nurses who have cared for clients with severe communication impairment.

Methods: Initially, the authors conducted focus groups and a small pilot study designed to develop an interview protocol. Subsequently, the main study consisted of interviews with 20 nurses (17 women, 3 men) who had cared for at least 2 clients with significantly impaired communication in various in-patient hospital settings in the past 12 months. While one member of the research team conducted the 2-hour interview, another researcher entered responses into a portable computer. Following the interview, the interviewer checked the transcript for accuracy. Both descriptive and quantitative analyses were conducted to generate information regarding how often nurses used augmentative and alternative communication (AAC) strategies, and to explore general themes.

Findings: Not surprisingly, the interviews indicated that significant challenges are inherent in caring for clients with severe communication impairment. Many of these difficulties were attributed to a dearth of readily accessible support systems designed to aid in the nurse-client communication process.

Implications: This study indicates a need to educate nurses in the use of alternative modes of communication. Examples include sign language, gestures, alphabet boards, and electronic communication devices. In addition, nurses might benefit from a more collaborative working relationship with speech pathologists.


CASE STUDY/NURSING CARE PLAN

Mrs. Sinclair brought her 16-year-old daughter to the emergency department (ED), distraught over Jennifer’s plans to kill herself. Jennifer had become sullen and isolated, dropping out of school and refusing to talk to her mother except when they argued, which was daily at this point. Recently, the arguments often ended with Jennifer’s promise to commit suicide, and tonight Mrs. Sinclair had found Jennifer alone in her room cutting her wrist with a pair of scissors. While the cuts were not serious, they frightened Mrs. Sinclair and convinced her that she had to seek help for her daughter. In the ED there were two distinct communicative approaches to this situation.

The nurse practitioner (NP), a longtime veteran of the ED, spoke mainly with Mrs. Sinclair to gather the history, engaging Jennifer only to admonish her for her selfishness. The NP spoke to Jennifer as if she could read (continues)
CASE STUDY/NURSING CARE PLAN (continued)

the young woman’s mind. She labeled character traits and thought patterns that she assumed Jennifer identified with. She also seemed to not register Jennifer’s denials of feeling or thinking as the NP described. Jennifer and her mother became increasingly uncomfortable, and Mrs. Smith eventually asked if there might be someone else they could talk to. An inexperienced registered nurse (RN) approached the situation very differently, speaking directly to Jennifer in a comforting and sincere tone, asking her what she was experiencing and why she thought things had progressed to the point of suicide ideation. Jennifer gradually responded to this approach, eventually agreeing to spend the night in the hospital and to speak to a counselor the following day.

**Assessment**
Client demonstrates suicidal ideation. She presents with minor cuts on her wrists, saying that next time she will use a razor and “finish the job.” She is initially reticent to discuss her situation, feeling as though no one understands. The NP does not use good principles of therapeutic communication, but the young RN communicates very appropriately.

**Nursing Diagnosis #1**
High risk for self-directed violence
**NOC:** Cognitive Ability; Depression Control; Distorted Thought Control; Impulse Control; Suicide Self-Resistant
**NIC:** Anger Control Assistance; Anxiety Reduction; Coping Enhancement; Crisis Intervention; Suicide Prevention

**Expected Outcomes**
The client will:
1. Reside in a safe setting to prevent self-harm while in facility.
2. Attend initial counseling session when scheduled.

**Planning/Interventions/Rationales**
1. Admit client on inpatient basis, and place on 24-hour observation overnight. *Ensure client safety.*
2. Establish referral to counseling service provider. *Provide access to ongoing psychiatric care.*

**Evaluation**
Verify that client is safe and that she has attended initial counseling session.

**Nursing Diagnosis #2**
Impaired verbal communication related to depression
**NOC:** Communication Ability; Communication: Expressive Ability
**NIC:** Active Listening

**Expected Outcomes**
The client will:
1. Receive counseling to address underlying issues within 24 hours.
2. Verbalize that she is being heard and understood by the end of session four.

**Planning/Interventions/Rationales**
2. Employ anxiety reduction techniques. *Allow client to process emotions from a calm and rational perspective.*

**Evaluation**
Verify that the client feels she is being heard and understood.

**Key Concepts**

- The communication process is fundamental to any human relationship.
- The components of the communication process include sender, message, channel, and receiver.
- There are several different levels in which persons communicate with one another, including intrapersonal, interpersonal, group, and interdisciplinary.
- Verbal and nonverbal messages are modes of communication that exist in the nurse-client relationship.
Perception, culture, space, distance, and time influence communication.

The goal of therapeutic communication is for all clients to feel that they are cared for and understood.

Obstacles that must be considered in developing a therapeutic relationship are language, culture, gender, health status, developmental levels, emotions, and use of health care jargon.

The nursing process impacts communication in the nurse-client relationship.

Review Questions and Activities

1. How is effective communication central to the nurse-client relationship?
2. In what ways might poor communication skills hinder the nurse’s ability to work productively within the health care team?
3. What is therapeutic communication?
4. How might a nurse go about communicating with a client who just had a stroke that impaired the client’s ability to speak?
5. In what ways can a nurse communicate with children in order to comfort them during a frightening clinical experience?

Multimedia Links

Christensen Core Concept Videos: Therapeutic Communication

Web Resources

Administration on Aging
http://www.aoa.gov

Center for the Advancement of Health
http://www.cfah.org

Gordon Training International
http://www.activelistening.com

National Institutes of Health
http://www.nih.gov

National Institutes of Mental Health,
http://www.nimh.nih.gov

References


