1 Core communication skills in mental health nursing

Introduction

Communication in mental health nursing is an essential component of all therapeutic interventions. The knowledge and interpersonal skills that a nurse uses to communicate are essential aspects of helping the person who is experiencing mental health problems or distress, as well as facilitating the development of a positive nurse–client relationship. This requires the mental health nurse to use a range of appropriate and effective communication and engagement skills with individuals, their carers and other significant people involved in their care. This chapter examines the verbal and non-verbal communication skills that are most relevant to mental health nursing, and illustrates how each skill can be used in practice.

Learning outcomes

By the end of this chapter, you should be better able to:

1 describe the components of therapeutic communication skills
2 demonstrate an understanding of how the different communication skills can be used in clinical practice
3 use interpersonal skills in clinical practice.

Interpersonal skills

Effective interpersonal skills are central to a mental health nurse's ability to form a sound therapeutic alliance and to the role of mental health nurses (Peplau, 1952). In mental health nursing, communication skills form the basis of every intervention. Good interpersonal skills are what each mental health nurse needs to make nursing happen. These skills are the building blocks or, as Stevenson (2008, p.109) describes them, 'the nuts and bolts – the basic techniques and principles in which everyone engaging in clinical practice in mental health needs to be fluent'. In order to communicate effectively the mental health nurse needs to work towards being proficient in using the basic

communication tools; this means knowing what skill s/he is using and why, and being able to move skilfully from one skill to another as and when the purpose of the interaction requires. In addition, given that different clients have different needs, it is inevitable that mental health nurses will use different skills with different clients in various mental health settings. As Stevenson (2008, p.109) points out, 'one size does not fit all'.

Interpersonal skills that are commonly used in mental health practice are described below. Each skill is explained and supported with specific examples and exercises. These descriptions are by no means intended to be exhaustive or prescriptive but instead we aim to provide the general principles for the use of each skill presented. Each skill is described as a stand-alone piece of communication; however, it is important to remember that when used in practice, these skills will be used interdependently. Furthermore, 'when all the skills are being used together, the mental health nurse provides the proper, respectful conditions that facilitate a positive change to occur' (Stickley and Stacey, 2009, p.47). The following communication skills will be explained:

- listening
- paraphrasing
- summarizing
- questioning
- non-verbal communication.

Listening

Listening is the most important skill and often the most challenging. In our experience, mental health nurses often worry about what they are going to say, what questions they should ask, or whether they have asked the *right* question. While such concerns are common and understandable for the newcomer to mental health nursing, these thoughts can distract the mental health nurse from listening to the person who is talking. One of the common mistakes made by novice mental health nurses as well as experienced nurses is to talk too much. When we are talking, we are not listening! The best and the most therapeutic thing to do is to say less and listen more. Mental health nurses and indeed other helping practitioners, however, often find this difficult. One common reason for this is that many mental health nurses believe they are not doing anything when they are *just* listening (Bonham, 2004) and as a result they underestimate the value of simply listening and more importantly its therapeutic effect. Listening to a client does not mean that you are doing nothing; instead, you are allowing a space for the person to talk. Stevenson (2008, p.110) echoes this and states that 'even if the mental health nurse does nothing but listen, there is likely to be a therapeutic effect'. Several studies have also reported that people who used mental health services value having the opportunity to tell their story and more importantly being heard (Jensen, 2000; Kai and Crosland, 2001; Moyle, 2003; Koivisto et al., 2004; Gilburt et al., 2008; Hopkins et al., 2009).

Listening helps clients to:

- feel cared about and accepted
- feel significant and respected
- feel heard and understood
- connect with other people
- establish a sense of trust with helper(s)
- feel less isolated and alone
- make sense of their current situations and/or past experiences
- ask for help
- give feedback about their care
- express emotions and release tensions
- participate in their care planning.

Listening is clearly an essential component of effective communication as well as being one of the most important interventions the mental health nurse can offer to a service user. However, listening means more than just hearing the words spoken by the person, it involves *active* listening (McCabe and Timmins, 2006). Listening actively means giving your full attention – that is physically, mentally and emotionally – which needs to be communicated to the person who is talking. Effective listening is therefore a cognitive, behavioural and an affective process (Arnold and Underman Boggs, 2003). Developing a capacity to listen, and trying to understand the client's experience is a challenge for the novice mental health nurse. Similar to acquiring any new skill, learning how to listen effectively takes time and plenty of practice.

Listening involves the following:

- providing time for the person to tell his/her story
- offering a quiet and private space, free from distractions to listen to the person
- listening with the purpose of understanding the person's message
- giving full attention by focusing on what the person is saying
- tuning out external distractions, such as background noises
- tuning out internal distractions, such as thoughts about what to say next.

Listening skills involve using a range of verbal and non-verbal continuation prompts – for example, verbal prompts include:

- 'Mmm' 'Yes'
- 'Absolutely' 'I see'
- 'Please continue' 'Oh'
- 'Say more about' 'Really'
- 'Go on' 'So'.

Non-verbal behaviours include:

- showing it in your face, for example facial expression, looking interested and concerned; maintaining good eye contact

- showing it in your body movements, for example nodding of head, leaning forward.

Listening to non-verbal communication

Much of the communication that takes place between people is non-verbal. Our faces and bodies are extremely communicative. Being able to read non-verbal messages or body language is an important factor in establishing and maintaining relationships (Carton et al., 1999).

Body language includes many different aspects of non-verbal behaviour, including:

- eye contact such as staring, avoiding eye contact
- facial expressions such as frowning, smiling, clenching or 'biting' lips, raising eyebrows
- voice, such as tone, volume, accent, inflection, pauses
- body movement, such as posture, gestures, fidgeting
- physiological responses, such as perspiring, breathing rapidly, blushing
- appearance, such as dress.

In practice, both clients and mental health nurses send many messages and clues through their non-verbal behaviour. It is therefore important that mental health nurses are aware of their own non-verbal body language before they can explore clients' non-verbal behaviour. In practice, however, we may not always be aware of the non-verbal messages that we communicate and, more importantly, how they might affect our interactions and relationship with clients, their families and work colleagues. For example, how often have you said '*It's not what s/he said, but it's the way it was said'* or alternatively someone has said to you '*it's not what you said, but it's how you said it*'?

Effective helpers therefore need to learn 'body language' and how to use it effectively in their interactions with clients, while at the same time being careful not to over-interpret non-verbal communication (Egan, 2010, p.147). Also, when working with clients from different cultural backgrounds, it is important that the mental health nurse is mindful of and sensitive to different practices concerning the use of eye contact and gender, and modify his/her body language accordingly. For example in a number of cultures, including African and Asian, maintaining eye contact with someone who is in a position of authority is likely to be 'interpreted as a demonstration of an equality that is disrespectful and inappropriate' (Sully and Dallas, 2005, p.5).

Non-verbal communication either on its own or together can influence verbal communication in the following ways:

- confirm what is being said verbally, for example when talking about the recent death of her father, the client looked sad and became tearful
- confuse what is being said, for example when telling the client she wanted to hear his story, the nurse kept looking at her watch and fidgeting with her pen

- emphasize what is being said verbally, for example when talking about his anger towards his family for 'forcing him to come into hospital', the client clenched his fist and banged the table
- add intensity to the verbal message, for example when asking for extra medication to stop the voices, the client stood up and put his hands over his ears and shouted 'I want them to stop, I want them to stop.'

The SOLER position

Egan (2010, p.135) identifies certain non-verbal skills summarized in the acronym SOLER that can help the mental health nurse to create the therapeutic space and tune in to what the client is saying. These are:

S: sitting facing the client squarely, at an angle
O: adopting an open posture, arms and legs uncrossed
L: leaning (at times) towards the person
E: maintaining good eye contact, without staring
R: relaxed posture.

As with all interpersonal skills there are a host of things that can hinder the ability to listen attentively. Some of these include:

- distractions in the room, for example noise from TV or radio
- seating, for example uncomfortable place to sit and listen
- temperature of room, for example feeling too cold or too hot and stuffy
- lack of time
- listening to self rather than to client, for example worrying about what you are going to say next, how the client might respond to what you say
- hearing the client talk about things that you find difficult to believe, for example that the voices are instructing them to say or do specific things
- hearing the client talk about very painful experiences that you find very emotionally difficult to hear, for example accounts of physical, psychological or sexual abuse.

We will now look at how using a simple framework can help the listener to structure and organize their conversations with service users, their carers and others who care for and support them.

Listening to verbal communication

Having a framework when listening to a person's story helps to develop 'clinical mindfulness' and assists the listener to organize what the person has said (Bricker et al. 2007, p.25). The following provides a framework to help you focus both your listening and attending with a view to gaining a greater understanding of the person and their story.

Framework for listening and attending to clients

Scenario: Louise

Louise: 'So many things have happened since I was discharged from the day hospital two months ago. I broke up with Harry, my boyfriend, and I moved to a new flat. I really like where I live now, it is smaller but the neighbours are very friendly and helpful. There have been a couple of times when I have been upset and cried a lot, but I know I did the right thing. Harry and I were always arguing about money and his drinking. I used to be afraid that he would hit me. He never did but I do not want to be always afraid. He keeps phoning me, he wants us to get back together. I miss him, [eyes fill up with tears] but I told him I do not want him back. I am much happier now; no more arguments and I am looking forward to lots of things. I am going on holidays with my sister Sharon and her family. They are so good to me.'

Nurse: 'Mm . . . mm', leaning forward

- **Experiences:** The client may talk about their experiences, such as what has happened, for example Louise was discharged from the day hospital two months ago. She broke up with Harry, her boyfriend, and moved to a new flat; or what is currently happening in their life, for example Louise is going on holidays with her sister Sharon and her family.
- **Behaviours and patterns of behaviour:** The client may talk about how they behaved or responded to a certain situation(s). The mental health nurse may also be interested in observing how the person is responding while telling his/her story. For example, Harry keeps phoning Louise, he wants them to get back together. She misses him [eyes fill up with tears] but she told him she doesn't want him back.
- **Thoughts and patterns of thinking:** This may include what beliefs they have about themselves, other people, events in their lives, as well as what sense they make of their own and others' behaviours. For example, there have been a couple of times when Louise has been upset and cried a lot, but she believes she has done the right thing. She and Harry were always arguing about money and his drinking. Louise was afraid that he would hit her. He never did, but she doesn't want to be always afraid.
- **Feelings, emotions and moods:** This refers to the client's description of his/her feelings as well as the feelings they are expressing as they tell their story. For example, there have been a couple of times when Louise has been upset and cried a lot; she misses him [eyes fill up with tears] but she told him she does not want him back. She is much happier now.
- **Strengths and resources:** It is important when listening not to focus only on problems; clients also have strengths and resources.

In the above scenario, Louise's strengths include optimism and determination. Other strengths may include humour and friendliness. Resources include, for example, Louise's helpful neighbours and her sister. Other resources may include family, friends and pets.

- **Non-verbal messages:** As previously discussed, there are non-verbal cues, such as facial expressions, body movements and voice tone, which may confirm or deny what is being spoken. Non-verbal behaviours can mean a number of things and caution needs to be used when reading non-verbal behaviour. For example, on observing the client's behaviour of pacing up and down the ward, the mental health nurse might conclude, incorrectly, that the client is anxious or angry, whereas the client later explains that she feels very cold and is walking up and down to keep herself warm.

Source: Adapted from Cully (1992)

The following box consists of a list of behaviours and characteristics that a good listener might demonstrate (Bonham, 2004, p. 21).

The helpful person

- is quiet for most of the conversation, for example allowed you to do most of the talking
- is encouraging, for example demonstrates by their body language that they understand what you are saying. They nod and maintain eye contact without staring and appear interested
- sits or stands in a similar way to you and at a comfortable distance from you, not too close or not too far away.
- appears relaxed to what you are saying, asks to repeat or clarify something to make sure that they understand you
- might sometimes repeat back to you what you have said or summarise what you have said to ensure sure that they understand you
- might convey a sense that they are 'in tune' with what you are saying or experiencing
- does not judge you
- gives you ample time to talk
- leaves you feeling respected

Practice exercise

- Think of a time when you experienced or observed someone to be very helpful in practice.
- Identify which of the above behaviours were used.

Touch

Touch, as a form of non-verbal communication, is an important component of therapeutic communication. In mental health nursing, touch can be used as a means of reassuring and/or breaking down barriers between nurse and client (Gleeson and Higgins, 2009). Touch can be instrumental or procedural, whereby the use of touch is necessary or deliberate, for example administering an injection, taking a client's pulse or blood pressure, bathing or dressing a client. In contrast, 'expressive' touch is non-procedural, more spontaneous and a demonstration of affection, for example holding a client's hand, placing a hand on a client's shoulder (Watson, 1975). As with all communication skills, touch needs to be used with care and respect. Before using touch, mental health nurses need to consider the following points.

- Offer touch respectfully based on the needs of the person as opposed to your own needs. For example the nurse asks the distressed client 'Would you like me to hold your hand?', rather than the nurse initiating holding the client's hand to allay his/her own feelings of discomfort and/or assuming that the client wants or needs to be touched.
- Respect the client's culture, age, ethnicity and gender; for example do not assume that it is OK to touch older clients or children without their permission. Also, in some cultures, it is unacceptable to be touched by people who are not intimate unless it is in the administration of specific physical care.
- Be mindful that clients who experience mental health problems or distress may require special consideration when using touch, as their responses may not always be predictable, for example if a client believes that 'all females want to harm him' it is important that the client's personal space is respected, particularly by female nurses.
- Be aware of your own level of (dis)comfort and be genuine when using touch, for example if you are uncomfortable about using touch then it is better for the client and yourself that you do not force or impose the use of touch without seeking permission.
- Similar to other therapeutic interventions, touch should always be used genuinely and for the client's best interest.

Silence

Being able to be silent and still with the client, particularly when s/he is distressed, demonstrates the ability to be present and with the person (Benner, 2001, p.50). However, this can often evoke some discomfort for both the mental health nurse and the person in distress. As a result, silences can often feel longer than they actually are, especially if the person finds them uncomfortable. Learning to '*sit with*' silence requires practice. One way of learning this skill is for the mental health nurse to practise pausing for five seconds before making an intervention (Stickley and Stacey, 2009). This can help the mental

health nurse to refrain from *filling the space* by speaking and yet not allow the silence to be too long to cause possible distress for the client. With time and much practice, learning to be comfortable with silence becomes easier and you will begin to notice the positive impact it has on your interventions. As a therapeutic intervention, the use of silence is a way of communicating respect to the client and, as a result, can convey the following messages, as outlined by Stickley and Stacey (2009, p.51):

- the person is important to you
- you have time for the person
- this interaction is more than a normal conversation
- your interventions are considered
- it is OK to be with the person without feeling the need to do something.

While listening is important, it is usually not enough – the client also wants a response. The following refers to the skills of responding verbally to service users. These are called reflecting and probing skills.

Reflecting skills

Reflecting skills are those skills that help the mental health nurse to focus on the client's perspective, and as such encourage person-centred communication. The main principle in using reflective skills involves identifying the person's core message and offering it back to them in your own words. When using reflective skills, the mental health nurse follows what the client is saying – that is, aiming to be person-centred rather than directing the interaction and imposing what s/he believes to be important, which is nurse-centred communication. Effective use of reflective skills can facilitate exploration, build trust, and communicate acceptance and understanding to the client.

Paraphrasing

Paraphrasing involves expressing the person's core message in your own words. When using paraphrasing, essentially the meaning is not changed but the words are different. Paraphrasing is a valuable tool in that it demonstrates to the client that the mental health nurse is listening and has heard what s/he has said, which can feel very supportive and therefore therapeutic. Paraphrasing can also be used to check clarity and understanding rather than using questions, as illustrated in the following examples.

Example 1

Zoe: Mm. [Pause] I don't know really, I mean, I suppose if there is something you would like me to talk about I would be happy to do that, but as I said, it does feel hard to focus and be here.

Nurse: It seems that it is easier to follow instructions now.

Zoe: Mm, yes, yes, I think that is right. I do not feel very able to think very clearly now, and I have been a bit forgetful over the last couple of weeks. I forgot my keys the other day, which is very unusual for me.

Example 2

Dylan: [with an angry tone] I suppose I felt uncomfortable when my brother asked me to lend him the money. It is not because I do not have the money, I can afford it. I don't know why I was angry, but I, don't want to seem miserly.

Nurse: You felt annoyed when he asked you and didn't want him to think you were mean.

Dylan: Yes, that's right I did feel annoyed … but I also felt guilty … He is my youngest brother and he has no one else.

Summarizing

This skill involves offering the client a précis or summary of the information that s/he has given. A summary is essentially a longer paraphrase, however it should not be presented as a list of facts. Summarizing can be a very useful intervention, particularly if the person in distress has given you a lot of information. For the client, hearing a summary of what s/he has said can help to clarify and reassure them that the nurse has heard correctly. It also gives the client the opportunity to correct any misunderstandings, elaborate further as well as hear the main points of their story. When using a summary you may begin by saying something like 'So, to sum up, you have mentioned several issues concerning … '

Probing skills

Probing skills involve questioning. The most useful forms of questions are open ended and begin with 'when', 'what', 'how', 'who' or 'where'. Asking an open-ended question invites a full descriptive response. For example, if you were exploring a person's experience of hearing voices, you might use some of the following open questions.

Examples of open questions

- When did you first hear the voices?
- How many voices do you hear?
- What do the voices say to you?
- When are the voices loudest?
- Who knows that you hear voices?
- How do you feel, when the voices say … ?
- What were you doing when the voices became louder?
- What helps you to cope with the voices?

The following illustrates examples of other categories of questions, which can be used when working with clients and their families/carers. These include the following:

- cognitive questions; these focus on the person's thoughts or beliefs
- affective questions; these focus on the person's feelings, mood or affect
- behavioural questions; these focus on the person's behaviour or actions
- time-orientated questions focus on issues relating to time, such as past, present and future.

Other useful open questions

Cognitive questions:	What do you think about when you have a panic attack? What did you think would happen when you took the overdose? What do you think causes the voices to say those things?
Affective questions:	When you were told about your son's diagnosis, how did you feel? How do you feel when the voices call you names? How do you feel after you have injured (cut) yourself?
Behavioural questions:	What did you do when you had the panic attack? What does your son do when he gets angry? What can you do to reduce the stress caused by the voices?
Time-orientated questions:	What did you do in the past that helped you to manage the voices? What can you do now to reduce the urge to cut yourself? What could you do in the next two hours to keep yourself safe?

Unhelpful questions

Unhelpful questions include the following.

Closed questions

These are questions that limit the other person's options and often only give the option of a 'yes' or 'no' response, for example:

- Did you take your medication?
- Have you seen the doctor?
- Do you hear voices?
- Did you go to the hospital?
- Do you like your parents?

Although closed questions are useful when gathering information, they have limited value and do not encourage dialogue, and as a result reduce the opportunity to engage with the client. Overuse of closed questions can also set up a pattern of 'questions and answers', which can be hard to break.

Other questions, which are unhelpful in encouraging dialogue and person-centred communication, include the following.

Leading questions

As the name suggests, these questions involve imposing your own perspective or being suggestive, for example 'I don't think you are very happy with your husband?' rather than, 'How do you feel towards your husband?', which encourages person-centred communication rather than nurse-led communication.

Multiple questions

These involve asking two or more questions at once, for example 'What did the doctor say when you told him about your panic attacks; did he suggest reviewing your medication and did he refer you to the anxiety management group?' It is not surprising that this can be confusing and unhelpful for the client. In addition, when the client answers, the mental health nurse will not know which question the client has answered.

Either/or questions

These questions are both leading and restrictive because the options put forward are what the nurse has chosen and, as with multiple questions, they involve two questions, for example 'What do you want to do, go for a walk or attend the anxiety management group?'

The 'why' question

The 'why' question tends to invite an answer rather than a description or an exploration. In addition, the use of 'why' may appear interrogative and as a result may evoke a defensive answer from the person. For example, how might *you* feel and respond if you were asked the following 'why' questions:

'Why were you late?'; 'Why did you say that?' Such questions may cause the person to feel defensive and/or irritated. Therefore, it may not be surprising that the following why question might evoke such a limited response:

Nurse: 'Why didn't you take your medication?'

Client: 'Because I forgot.'

Poorly timed questions

As with all interpersonal skills, timing is critical to asking effective questions. For example, if a client who is very distressed relates having an argument with his father and the nurses asks, 'What did you say that might have contributed to the argument?' it is unlikely that the client will be willing to explore his own behaviour at this particular time and may feel unheard by the nurse.

Learning to ask questions without using 'why' can be challenging and require patience and plenty of practice. The following illustrates some practice examples of 'why' questions and how these questions might be asked more effectively.

'Why' questions	Alternative phrasings
Why didn't you take your medication?	What stopped you from taking your medication?
Why did you take an overdose?	What made you take an overdose?
Why did you discharge yourself from hospital?	What happened that led you to discharge yourself?
Why do you get anxious?	What do you think causes you to feel anxious?
Why did you say that?	What made you say that?

Using skills in practice

As with most acquired skills, learning how to use the different interpersonal skills and use them effectively takes time, practice, motivation, and the courage to make mistakes and *be imperfect*. There are no verbal formulas or magical sentences that will solve clients' problems. Equally, there are no set 'right or wrong' or 'good or bad' communication skills. Instead, there are useful and non-useful skills and interventions. Learning how to communicate effectively in practice will present mental health nurses with different learning opportunities and challenges; but in order for lifelong learning to take place we strongly encourage you to take some time to think about each interaction, your communication skills and their therapeutic effectiveness. The following

questions provide a simple framework to help you evaluate your interactions in clinical practice.

Practice exercise

Take some time to think about a recent interaction that took place during your clinical practice. Reflect on the following questions and jot down your thoughts, ideas and feelings in your journal. Try to be as specific as possible in your answers, as illustrated below. You may also wish to spend some time reflecting on your answers with a colleague or your mentor.

Reflective questions

1 What did I like best about my use of interpersonal skills?
For example: I liked best that I listened even though at times I was tempted to ask a question.

2 What did I like least about my use of interpersonal skills?
For example: I liked least that I asked a closed and leading question a few times.

3 If I were to do this interaction again, what would I do differently and why?
For example: I would summarize what the client said to me. This would have helped me to stop worrying that I was going to forget what the client said, and as a result I didn't listen to the client.

4 What have I learnt from this interaction?
For example: I learnt that I need to practise the use of summarizing.

Conclusion

This chapter has outlined the different verbal and non-verbal skills that are used in mental health practice. These interpersonal skills can be learnt and used in various clinical encounters. It is not enough, however, simply to learn communication skills and techniques; they must be integrated into your own style of working as a mental health nurse. As with all new learning, this will require time, practise and a willingness to be open to feedback from clients and colleagues about your use of different skills and their therapeutic impact in practice. While we hope that this chapter is useful to you in developing your repertoire of communication skills, it is not intended to be the only source of learning. Nevertheless, we hope it provides a useful framework to identify and clarify what skills you are using and, more importantly, to consider its usefulness in developing your communication skills as a mental health nurse.

Reflective questions

1 What type of questions should *not* be used or at best should be used sparingly, and for what reasons?
2 When using the skill of listening in your practice, identify three things you found rewarding and challenging?
3 What three communication skills do you want to improve and for what reasons?
4 How would you explain to a colleague that 'why' questions should be used sparingly?