

# One

## *Chapter One*

# **Perspectives and Principles of Therapeutic Communication**

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### **LEARNING OBJECTIVES**

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

- Define communication and its significance to nursing
- Discuss communication theories and their relevance to nurse–client interactions
- Analyze major factors and trends associated with communication
- Describe communication across the life span and how it applies to nursing
- Analyze major components of effective communication

## KEY TERMS

**Aphasia**—The loss of the ability to comprehend or generate language.

**Attachment**—A lasting affectional tie or emotional bond, initially between the infant and primary caregivers; it involves seeking closeness to one or more caregivers to feel safe and secure and as a means of understanding the world.

**Attachment theory**—Based on the classic works of Bowlby and Ainsworth that describe attachment or bonding as an adaptive evolutionary and biological process of eliciting and governing physical closeness between an infant and primary caregiver or parent. The integrity of these early child–parent interactions is believed to influence future relationships, trust, and reliance on others.

**Body language**—Nonverbal communication or transmission of a message by way of physical gestures or behaviors.

**Broca's area**—Located in the temporal region of the brain, it is involved in the production of speech; it processes information received from Wernicke's area into a complex and synchronized pattern for vocalization and projects the pattern through a speech articulation region to the motor cortex.

**Communication**—The act or reciprocal process of imparting or interchanging thoughts, attitudes, emotions, opinions, or information by speech, writing, or signs.

**Emotional competence**—An individual's ideas, thoughts, motivations, and adeptness for establishing interpersonal relationships.

**Empathy**—The experience of sharing the feelings, thoughts, and ideas of another. It is a process in which the nurse "puts him- or herself in the client's shoes" without the experience becoming his or her own. It allows for emotional connectedness and understanding without becoming the nurse's experience. It is the opposite of sympathy.

**Language**—A complex process and mechanism used to communicate.

**Personal space**—One's comfort zone or space or space surrounding a person's body in interpersonal relationships. It is often influenced by cultural factors and trust.

**Professional boundaries**—Rules that define who participates in the interpersonal relationship and how they interact; they define the nature of interactions and roles in relationships, and protect the separateness of the nurse–client relationship.

**Rapport**—A harmonious, empathetic, and mutually respectful relationship between the nurse and client.

**Self-awareness**—Personal insight or recognition of one's attitudes, biases, values, beliefs, and ideas and the impact they have on relationships with others.

**Speech**—The motor act of communicating through articulation and verbal expression.

**Sympathy**—Identification with the client's situation, feelings, and thoughts; difficulty removing oneself from a client's experience. It is the opposite of empathy.

**Therapeutic communication**—A healing or curative interaction between individuals.

**Transactions**—Patterns of interactions or communication between people.

**Wernicke's area**—Located in the temporal brain region; it is involved with comprehension of auditory and visual information and is necessary for the decoding and encoding of language.

## INTRODUCTION

**Communication** stems from the Latin word *communicare*, “to impart, participate, convey and share information about” (*Webster’s New Collegiate Dictionary*, 1974, p. 228). It is the act or reciprocal process of imparting or interchanging thoughts, attitudes, emotions, opinions, or information by speech, writing, or signs. Communication is so greatly rooted in human behaviors and the contexts of society that it is difficult to imagine social or behavioral **transactions** without it. For these reasons communication is fundamental to all nursing and interpersonal relationships. Nurses can use this dynamic and interactive process to motivate, influence, educate, facilitate mutual support, and acquire essential information necessary for survival, growth, and an overall sense of well-being (Howells, 1975; Kleinman, 2004).

Communication also involves performing designated tasks and displaying behaviors such as establishing shared meaning, offering therapeutic instructions, performing client interviews, eliciting relevant data, explaining procedures, educating clients and families, discussing treatment options, describing adverse effects from medications, and providing crisis intervention. Interpersonal skills are by nature relational and process driven, and the consequences of effective communication are **rappport** and trust, acceptance, warmth, **empathy**, support, and stress and anxiety reduction (Duffy et al., 2004).

It is essential for nurses to develop and maintain competent communication and interpersonal skills. As a nurse you must listen empathetically and have a clear understanding of nonverbal and verbal communication skills. Effective communication skills are required to facilitate therapeutic interactions, assess client needs, and implement interventions that promote an optimal level of functioning. This process begins with understanding the instinctive nature of people. Human beings are social and depend on verbal and nonverbal communication to survive and understand internal and external environments. The newborn learns to distinguish and relate to caregivers through facial expression, touching, and feeding. Early forms of communication and interactions with primary caregivers are the origin of trust, security and safety, and lifelong interpersonal relationships and communication patterns (Antai-Otong & Wasserman, 2003). Over time, early interactions with primary caregivers become the foundation of adult relationships, self-esteem, and trust in others. Understanding major principles of effective communication is essential for the nurse because clients and families depend upon these relationships for empathy, reassurance, and quality care to maximize resources and champion positive treatment outcomes.

Increasingly, nurses experience difficulties forming these relationships in today's fast-paced and hurried society. Technological advances in communication processes challenge people to converse through various modes including cellular phones, pagers, various informatics such as video recoding and telehealth, and conference calls, emails, fax technology, chat rooms, and telemedicine. We are frequently inundated with information and communications that must be quickly assimilated, synthesized, analyzed, and correctly interpreted to ensure accurate diagnoses and treatment. Despite efforts to immediately access information, communicate instantaneously, and strive for more efficiency through technological advances, there are growing concerns that information is being shared, but less is communicated. A lack of personal contact or face-to-face interactions contributes to misunderstanding of verbal and written cues. Unquestionably, today's nurse must possess skills that enable her or him to integrate technological advances and computer literacy to ensure effective verbal and nonverbal communication skills. Healthy interactions with clients, families, and other staff are critical in today's fast-paced and information-driven society.

Effective partnerships extend beyond the nurse–client relationship and include collaborative encounters with the interdisciplinary team including physicians, other health care providers, and internal and external customers. Interdisciplinary collaboration has been highlighted as a critical element of quality health care and staff satisfaction. Of particular importance is the nurse–physician relationship. Research findings indicate that effective communication between the nurse and physician enhances problem solving and decision making and improves treatment outcomes (Boyle & Kochinda, 2004; Schmidt & Svarstad, 2002). In contrast, negative or poor communication between the nurse and physician has a deleterious impact on staff morale, staff and client satisfaction, treatment outcomes, and quality of care (Larson, 1999; Rosenstein, 2002; Rosenstein & O'Daniel, 2005). Attempts to maintain effective communication between physicians and nurses must be a priority. Partnerships during a time of dwindling resources, time constraints, and demands for quality care across the continuum just make sense.

In a large survey that examined the prevalence and impact of physicians' disruptive behavior on the job satisfaction and retention of nurses (Rosenstein, 2002; Rosenstein & O'Daniel, 2005), involving 50 Veterans Health-care Administration hospitals across the country that targeted nurses, physicians, and administrators, researchers discovered that staff had negative perceptions of the impact of physicians' and nurses' disruptive behavior

on staff and client satisfaction and treatment outcomes. Data indicated most respondents perceived that disruptive behavior increased workplace stress and worsened nurse–physician communication, information sharing, and workplace relationships. Even more daunting were the respondents’ negative perceptions of the effects of these damaging interactions on job satisfaction and staff morale, medication errors, client safety and mortality, and ultimately client satisfaction, clinical outcomes, and quality of care (Rosenstein & O’Daniel). All in all, these data strengthen the argument that healthy nurse–physician relationships are crucial to advancing health care, as well as improving staff morale and treatment outcomes.

The following section focuses on communication theories, modes of communication, and factors that influence communication. It also provides a litany of **therapeutic communication** techniques that enable the nurse to establish rapport, recognize barriers to communication, and develop the mutual trust necessary to gather relevant data, make accurate diagnoses, establish goals, implement client-centered interventions, and facilitate positive treatment outcomes.

## COMMUNICATION THEORIES

Effective communicators tailor their message to the knowledge, interest, and abilities of their recipients. They create a climate of openness and trust to facilitate relationships. They are actively engaged and utilize all senses to assess and evaluate verbal and nonverbal cues to ensure accurate understanding of the message. This reciprocal process involves both the nurse and the client as both senders and receivers of messages throughout the interaction. Astute observational and active listening skills enable the nurse to accurately analyze verbal and nonverbal cues and respond appropriately.

Although many people associate communication with verbal messages or words, nonverbal communication has the most powerful influence on interpersonal relationships. For instance, when the client tells the nurse that he is fine and has no complaints, yet his facial expression such as frowning communicates discomfort, an incongruent message is transmitted. Words must be understood within the context of feelings, emotions, attitudes, and body language. **Body language** refers to nonverbal communication or transmission of a message by way of physical gestures or behaviors. It is imperative to clarify verbal and nonverbal communication even when they are congruent to ensure accurate understanding of the client’s message. Further discussion of these concepts is forthcoming in this chapter.

## Peplau's Interpersonal Relations Theory

Peplau's seminal publication, *Interpersonal Relations in Nursing* (1952), presented a conceptual framework on the therapeutic process between the nurse and the client. Her work has influenced every aspect of nursing. It is considered the cornerstone of interpersonal relationship theories and the basis of all nurse–client communications. Communication occurs within nurse–client relationships and is influenced by complex factors including environment and early interactions with caregivers or parents, and is based on attitudes, beliefs, and practices within the dominant culture.

Peplau's theory (1952) delineated four phases of the nurse–client relationship. These phases are interrelated and each describes the responsibilities and task of the nurse and the client as one of the following:

- *Orientation*—The client's willingness to seek treatment and trust the nurse is an important aspect of this phase. The client communicates his or her needs as the nurse conveys empathy and caring and attempts to understand the client's experience. Through clarification of the client's problem and situation the nurse listens attentively as he or she reviews events that require attention. Information sharing, questioning, clarification, attentive listening, and exploration of treatment options provide the basis of the nurse–client relationship. First impressions about the nurse and health care system evolve during the orientation phase and transition through subsequent phases.
- *Identification*—Nurse–client interactions provide the basis for trust, acceptance, understanding, and a helping relationship. Through effective communication the nurse identifies client problems and experiences. This process also enables the client to become an active participant in treatment, minimizes feelings of powerlessness and helplessness, and assures that things will improve. Ultimately, through the nurse–client relationship, the client identifies with and trusts the nurse and other staff to assist during times of anxiety and stress.
- *Exploitation*—Through the nurse–client relationship the client gains a sense of independence and navigates the health care system as an active participant in his or her care. The client learns to exploit the nurse–client relationship to identify treatment goals, galvanize health care resources, and attain an optimal level of functioning.
- *Resolution*—As the client's needs are met through nurse–client partnerships and effective communication, the client moves towards full independence and resolution of health care problems or needs.

Overall, Peplau's theory asserts that the goal of communication is to use symbols or concepts that convey meaning and ease the struggle towards a greater understanding between the nurse and client. The nurse–client relationship challenges the nurse to clarify the meaning or expression of the client's problems and distress and maintain continuity during the conversation when the nurse picks up threads of conversation the client offers during nurse–client interactions. This work will be discussed in depth in Chapter 3.

### Dyadic Interpersonal Communication Model

Berlo (1960) coined the term *dyadic interpersonal communication* to describe a dynamic interactive process that comprises a source or sender (encoder), whose aim is to be understood by another person or recipient (decoder), who processes, analyzes and decodes, and comprehends the message. The recipient responds to the message based on his or her interpretation of the message. The feedback process in this model enables the sender to validate or modify messages. Communication occurs within a context influenced by the situation, the message's content, attitude, perception, and the emotional and physical state of the sender and recipient. The clearer the message the more likely it will be understood. This is a very useful model that can help both the novice and experienced nurse (encoder) to communicate using the feedback process to validate accuracy and congruence of verbal and nonverbal messages (see Figure 1-1).

### Experiential Communication Theories

An example of experiential communication theory is described in the next by Virginia Satir (1967). Satir (1967), a distinguished family therapist, defined communication as a process of giving and getting information. She further noted that individuals must clearly communicate if they expect others to



**Figure 1-1** Berlo's dyadic interpersonal communication model.

meet their needs. She stressed the importance of getting one's needs met as essential for survival. Communication must be clear, honest, and direct. This process is defined as **transactions** or interactions, which involve verbal and nonverbal messages. Diverse means are employed to communicate, such as using symbols and clues to transmit and receive messages. Although the intention of communication is clarity, it is impossible to achieve absolutely clear communication. Apart from using communication to meet one's needs and survive, it is also a reliable indicator of psychosocial functioning. Satir's communication theory is similar to other theorists whose work is described as effective or *functional*; this type of communication involves the following steps:

1. Clearly state the message. (Sender sends a message.)
2. Receive verbal responses and nonverbal behavior. (Receiver receives and deciphers the message.)
3. Ask for feedback. (Sender validates the message by conversing with receiver.)
4. Be receptive to feedback. (Sender is willing to clarify message if it is misunderstood or unclear.)

According to Satir, both the sender and the recipient of the message are responsible for clarifying the message. Mutual clarification between parties reduces miscommunication and generalizations and enables them to give evidence of their assumptions and validate the meaning of the message.

Communication occurs within the context of people, places, situations, and other social and interpersonal conditions. Clear and effective communication requires *congruency* between physical gestures or behaviors, such as tone of voice or facial expression, and the spoken language. For example, a wife who says "I love you" in a pleasant tone of voice while smiling and embracing her spouse is sending a congruent message. More than likely the recipient accurately interprets this message. In contrast, *incongruent messages* demonstrate inconsistency between what is said and body language. For instance, a husband who states, "I am fine," yet frowns, grimaces, and avoids eye contact. Clearly, he is not fine and the spouse is unsure what he is communicating.

Ineffective or dysfunctional communicators tend to overgeneralize and fail to send complete messages as noted in the following statements:

I am very . . . you know.

They always . . . well, it's clear what they do.



These speakers rely on the receiver to complete the sentence. Incongruent communicators place an immense burden on the receiver and ultimately impede the feedback process. This enables the ineffective communicator to let others take responsibility for clarifying the message. This often results in miscommunication and jeopardizes the quality of interpersonal relationships.

Communication theories provide a guide to assist the student in understanding the basis of how nurse–client interactions and interventions can engender trust, facilitate problem solving, and stimulate holistic interventions. Today’s students and nurses are challenged to integrate various communication theories, including Satir’s into changing trends that impact communication through diverse venues and demographics.

The following section focuses on factors and trends associated with communication patterns that facilitate a greater understanding of the human experience of illness and health. The contributions of biological issues, psychosocial and cultural influences, life span and developmental factors, technological advances, and societal and health care trends will also be presented.

## **FACTORS AND TRENDS ASSOCIATED WITH COMMUNICATION**

Communication involves complex biological processes, psychosocial influences, and developmental milestones that occur within the context of societal and health care trends and an explosion of technological advances. Combined, these factors influence how one speaks, what one says, and how people relate to each other both verbally and nonverbally.

The nurse is a matrix of biological, psychosocial, and developmental factors that challenge her or him to interact with clients—who also bring a matrix of lifelong psychosocial experiences and emotional and biological needs—within a social climate that expects them to form therapeutic communication. **Therapeutic communication** refers to a healing or curative relationship between the nurse and others. This concept is consistent with Peplau’s classic work (1952), which affirms that both the nurse and client bring with them unique experiences, values, beliefs, and expectations regarding interpersonal relationships. During their encounters communication is both verbal and nonverbal and reflects their core assumptions (Peplau, 1952). Therapeutic interactions afford the nurse and client opportunities to clarify communication and facilitate an optimal state of health. Clarity of communication engenders mutual respect and commitment between the nurse and client. Furthermore, nurse–client encounters facilitate data gathering; analysis, synthesis, and validation of clinical findings; accurate diagno-

sis; and appropriate treatment. More significantly it promotes understanding and recovery.

Mounting evidence shows that effective communication and mutual sharing are the most important determinants of client satisfaction with care, and that they improve the clinician's sense of competence and confidence. Both adults and children value effective communication because it facilitates mutual trust, respect, and candid discussion that guide staff, clients, and families in challenging care choices (Boise & White, 2004; Winn, Cook, & Bonnel, 2004). Effective communication also is linked to improved adherence to treatment and positive clinical outcomes (Harms et al., 2004; Roter et al., 1997) as well as client recall of information, and it may safeguard against malpractice suits (Levinson & Chaumeton, 1999).

On the whole, communication is a complex process, and now more than ever is requisite to successful nurse–client relationships, client satisfaction, and positive clinical outcomes. Understanding the complexity of communication is critical to recognizing diverse influences that promote and impede healthy nurse–client interactions. Communication is often seen as a natural process, but complex biological processes mediated by psychosocial and cultural influences within a changing society and health care system place inordinate pressure and challenges on today's nurse. The following sections provide an overview of a variety of factors that impact communication and nurse–client relationships.

## Biological Issues

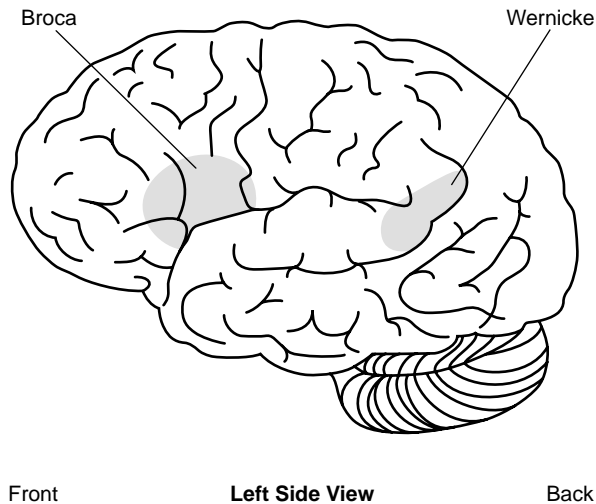
### *Neurobiology of Language and Communication*

Although communication extends beyond spoken words or speech, language is an integral part of this process. **Speech** is the motor act of communicating through articulation and verbal expression, whereas **language** is the primary venue of communicating ideas and thoughts. It links nations, societies, cultures, communities, individuals, and history and is the foundation of human intelligence. Language involves both production and comprehension. It is governed by cerebral hemispheric dominance, which is associated with handedness, a trait that seems to be genetically determined. Right-handed individuals show an overwhelming bias towards left-hemispheric speech lateralization (Flagg, Cardy, Roberts, & Roberts, 2005). The left hemisphere controls written and spoken language and math calculations and plays a role in comprehension of sentences and processing information, whereas the right hemisphere comprehends only simple language and primarily is

involved in spatial construction and patterns. Generally, areas involved in comprehending speech and written words are housed in the left hemisphere. Damage or lesions in these brain regions often leads to speech-language deficits. For instance, a client who suffers a stroke in the left hemisphere is more likely to experience significantly more language and speech deficits or aphasias than one with a lesion in the right hemisphere.

### **Speech Centers**

Neuroimaging studies from the last 20 years and neuroscientists' investigations have demonstrated that vast, complex, and overlapping brain regions underlie the elements of language and speech (Alberca, Montes, Russell, Gil-Néciga, & Mesulam, 2004; Mesulam, 1990). Primary brain regions involved in speech are located in the sylvian fissure or lateral cerebral sulcus of the categorical hemisphere (see Illustration 1.1). One of these regions is the Wernicke area, which is located at the posterior end of the superior temporal gyrus. The superior temporal gyrus is generally larger on the left side and plays a critical role in supporting language in humans (Foundas, Leonard, Gilmore, Fennell, & Heilman, 1996; Pugh et al., 2001). Neuroimaging studies implicate alterations and abnormal lateralization in the superior temporal



**Illustration 1-1** Primary brain regions involved in speech

gyrus as a source of auditory hallucinations in persons with schizophrenia (Levitan, Ward, & Catts, 1999). Wernicke's area is involved with comprehension of auditory and visual information and is necessary for decoding and encoding language. It extends to **Broca's area** in the frontal lobe. Broca's area is involved in the production of speech and articulation and processes information received from Wernicke's area into a complex and synchronized pattern for vocalization; it then projects the pattern through a speech articulation region to the motor cortex, which generates appropriate movements of the lips, tongue, and larynx to initiate speech. In essence, the Wernicke area is responsible for processing incoming speech and the Broca area is responsible for processing outgoing speech.

The auditory cortex also plays a significant role in processing complex sensory information and determines how it is interpreted and integrated. Auditory input is interpreted in the superior temporal gyri and in the inferior parietal lobule and temporal regions previously mentioned. Damage to or deficits in specific brain regions contribute to language deficits and impair one's ability to interpret, understand, or make sense of spoken communication. These conditions interfere with language development and pose significant barriers to the communication process (Alberca et al., 2004; Mesulam, 1990).

### *Language, Speech, and Learning Disorders*

Common language disorders include stuttering, autism, and aphasia. Stuttering is linked to right cerebral dominance and pervasive overactivity of the cerebral cortex and cerebellum. Activation of this region is also associated with the production of laughter—both its duration and its intensity. Clinical features of autism, a neurodevelopmental disorder, include social and communicative deficits that affect the individual's ability to relate to or understand others or to establish reciprocal relationships, as well as repetitive and stereotypical behaviors that emerge in the first 3 years of life and persist throughout adulthood (American Psychiatric Association [APA], 2000).

**Aphasias** refer to the loss of the ability to comprehend or generate language. Although most aphasias stem from neurological conditions such as cerebral vascular accidents or strokes, other conditions such as brain trauma or injury can also produce these disorders. Symptoms emerge from blockage of a cerebral blood vessel caused by a blood clot or thrombosis. Language deficits are linked to lesion location—whether the lesion is in the dominant or nondominant hemisphere. Aphasias can be classified into two simple types: fluent and nonfluent (Faroqi-Shah & Thompson, 2003; Prather, Zurif, Love, & Brownell, 1997). In *nonfluent* or *expressive* aphasia, the lesion is found in

Broca's area. Clients with this type of aphasia speak slowly and have difficulty generating words and writing. Their verbal comprehension, however, is relatively intact. In comparison, lesions associated with *fluent aphasia* are located in Wernicke's area. Clients with fluent aphasia have normal speech and speak incessantly using neologisms, but the quality of their speech is meaningless; words are often inappropriate and make little sense. These people have disturbance in understanding all language—they fail to comprehend the meaning of spoken or written words (Faroqi-Shah & Thompson; Prather et al.).

The inability to communicate is devastating, and treatment to restore function is valued. Current treatment of aphasia is based on the condition's etiology and includes a holistic approach that integrates cognitive neurorehabilitation, computer-aided techniques, and psychosocial interventions. Major nursing goals for the client with aphasia include supporting physiologic function and working with the interdisciplinary team to ensure holistic interventions that focus on regaining conversational skills and alternative communication. Emotional and psychosocial support and patience are integral elements of treatment. Because of the high incidence of depression due to damage to emotional centers and emotional response in persons with strokes, it is imperative to assess for signs and symptoms of suicide risk.

*Dyslexia*, a learning disability, is an inability to learn to read. It is found 12 times more often in left-handers, seemingly due to an abnormality in the left hemisphere of the brain that led to a switch in handedness during early development (Ganong, 1999; Shaywitz et al., 2003; Simos, Breier, Fletcher, Bergman, & Papanicolaou, 2000). Findings from a neuroimaging study conducted by Pugh and colleagues (2001) indicated that skilled word identification in reading is associated with the functional integrity of the left hemisphere posterior systems—a dorsal and ventral circuit that comprise temporoparietal and occipitotemporal regions, respectively. Scientists submit that individuals with developmental dyslexia have functional disturbances in these brain regions. In comparison to persons with normal function, persons with dyslexia rely more on both inferior frontal and right hemisphere posterior regions than normally developing readers, probably to compensate for left hemisphere deficits (Pugh et al.; Shaywitz et al.; Simos et al.).

### ***Sensory-Perceptual Influences***

Sensations and perceptions are integral aspects of communication and serve as filters for external cues and internal responses. Intact processes facilitate accurate interpretation of verbal and nonverbal communication. Effective listening is often governed by what is in one's head rather than the external

world. *Sensory systems* convert external stimuli into neural impulses and then filter irrelevant information to generate an internal image of the external environment, which requires logical reasoning or thinking in higher brain processing regions. These interpretations govern emotions and responses. *Perception* refers to a mental process by which sensory stimuli are brought to consciousness or awareness. The value and degree of comprehension that directs communication determines the ability to synthesize information. Hence, it is imperative for the nurse to have some understanding of the client's functional, mental, and physical status and ability to communicate. Factors such as mental and physical condition, anxiety, stress, and poor listening skills impede accurate interpretation of verbal and nonverbal cues. In addition, conditions that impair attention and concentration play key roles in sensory and perceptual function.

As a rule, the frontal cortex is believed to participate in executive functions, working memory and attention, motivation, cognition, and sensory-perceptual cues. The preservation of attention requires an intact frontal lobe, particularly the right frontal lobe. It mediates and facilitates attention to internal stimuli from key sensory regions, ascribes the relevance of stimuli, and is important for designating appropriate behavioral responses to external and internal stimuli (Buschsbaum, 2004). It also incorporates data from parietal and temporal brain regions with intricate perceptual data from sensory and motor systems to execute cognitive tasks (Buschsbaum).

Damage to or deficits in frontal cortex function impair attention, concentration, and cognitive and communication function. Schizophrenia, depression, attention deficit/hyperactivity disorder (ADHD), and various anxiety disorders such as obsessive-compulsive disorder are examples of psychiatric conditions linked with alterations in frontal lobe function. Alzheimer's disease is also associated with damage or deterioration of the frontal lobe and other brain regions, which causes subsequent sensory-perceptual disturbances (e.g., hallucinations, delusions) as well as problems with speech, attention, concentration, and motor and sensory function including verbal and nonverbal communication. Of these diagnoses, schizophrenia has probably been the most extensively researched. Of particular interest to this discussion are sensory-perceptual symptoms associated with hallucinations in persons with schizophrenia.

Although the precise cause of auditory hallucinations, a cardinal feature of schizophrenia, continues to be debated, mounting evidence from neuroimaging studies indicate that alterations in connectivity between the frontal lobe and temporoparietal speech regions (e.g., superior temporal gyri [Wernicke's area]) may contribute to the pathophysiology of auditory

hallucinations (David, 1999; Hubl et al., 2004; Levitan et al., 1999; Slade & Bentall, 2002). Purportedly, during inner speech, persons with schizophrenia experience abnormal coactivation in brain regions associated with language and auditory processing of external stimuli because they are unable to differentiate self-generated thoughts from external stimuli (David; Hubl et al.; Levitan et al.; Slade & Bentall). Alterations in these regions and subsequent sensory-perceptual deficits associated with hallucinations continue to be investigated.

### ***Neurodevelopmental Disorders***

Neurodevelopmental disorders, such as autism, produce lifelong disabilities that impact quality of life and ability to communicate and to form meaningful relationships. The exact cause of autism continues to be studied. Although most findings from neuroimaging, behavioral, and neuropsychological studies are tentative, most implicate alterations in genetic vulnerabilities and intricate neuroanatomical regions as contributing to social and behavioral dysfunction distinct to this population (Klin, Jones, Schultz, Volkmar, & Cohen, 2002; Rutter, 2000). Early childhood onset of autism is marked by profound social disability due to poor executive functioning (such as poor attention span and emotional control, reduced impulse control, poor planning, and difficulty moving from one activity to another). Collectively, these behaviors impact the child's capacity to understand or relate to others, express feelings, and establish interpersonal relationships due to social dysfunction and problems with language and communication, learning, and unusual behaviors (APA, 2000).

Biological factors associated with one's ability to speak, express feelings, and form interpersonal relationships are vast. A discussion of these factors is beyond the breadth of this book; however, nurses must be able to distinguish normal versus abnormal factors that promote or impede communication across the life span and implement interventions that facilitate healthy nurse–client interactions and optimal functional status.

### ***Psychosocial Issues***

Humans are social beings. There is substantial evidence that adaptation and health status and outcomes are associated with the quality and accessibility of personal relationships. This is particularly relevant to nurses who interact with clients daily and base their interventions and goal setting on the quality of nurse–client relationships. Purportedly, the quality of early infant and

child interactions with primary caregivers and ultimately attachment style are reflected in the quality of nurse–client communication patterns and health and adaptation.

Bowlby's (1973) **attachment theory** provides one explanation of normal psychosocial development, adaptation and biological underpinnings, and their potential impact on lifelong communication patterns, people's ability to relate to others, and their willingness to rely on others during stressful periods. His theory suggests that **attachment** is innate and governed by biological processes in the brain that regulate affective or emotionally driven survival behavior.

Simply stated, attachment refers to the interaction and regulation of biological harmony between the infant and primary caregivers. Researchers assert that early secure attachments govern psychobiologic regulatory processes in the infant's developing limbic system—specialized brain areas, mainly in the right hemisphere, adapted to a rapidly developing brain (Schore, 2000). Because the right hemisphere is connected to the limbic and autonomic nervous system, it may play a pivotal role in stress responses and facilitate coping capabilities across the life span (Schore, 2000, 2001). According to attachment theory, cognitive, emotional, and behavioral components underlie secure and insecure attachment styles. The cognitive component is the primary attribute of secure attachments, indicating that the individual has positive concepts of self and trusts others to be responsive during times of need (Bartholomew & Horowitz, 1991; Kidd & Sheffield, 2005). From an emotional perspective, secure attachment style is linked to adaptive coping behaviors, which enable the person to modulate stress and tolerate frustration and other negative emotions. Finally, people with secure attachment styles are at ease with closeness in interpersonal relationships, communicate and express their feelings effectively, and feel comfortable relying on and being comforted by others (Bartholomew & Horowitz; Waters & Cummings, 2000). In contrast, an individual with insecure attachment styles cognitively has negative perceptions of self and others, and has difficulty communicating with and seeking caregiving from others during times of need. Emotionally, these individuals lack the capacity to modulate intense and negative emotions due to maladaptive coping skills, and they are excessively anxious and fearful of closeness. Behaviorally, they tend to be overly clingy or distant and experience fears of abandonment, have difficulty communicating, and find it difficult to form healthy interpersonal relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Bartholomew & Horowitz; Ogilbene & Collins 1998; Waters & Cummings).



Memories of early attachment relationships, positive or negative, are communicated through the language of affect (emotional state) and influence the ability to modulate and relate to others across the life span (Amini et al., 1996; Schore, 1997; 2000). Over time, insecure attachment styles contribute to maladaptive coping behaviors and increase vulnerability to illnesses, such as personality, eating, mood, and anxiety disorders (Brennan & Shaver, 1998; Goldberg, 2003; Schore, 1997; West, Rose, Verhoff, Spreng, & Bobey, 1998).

The nurse can help the client communicate more effectively by understanding the reasons underlying cognitive, emotional, and behavioral problems associated with maladaptive coping styles. One approach involves assessing these behaviors and using assertive communication skills to role model emotional competence, foster trust, and form therapeutic interactions. This process begins with **self-awareness** of how one sees oneself and others, and the competence to navigate in the world through positive and healthy relationships. It is imperative to avoid personalizing negative comments or responses because they reflect a repertoire of experiences and perceptions brought in by the client. Negative or rejecting responses reinforce negative perceptions and need to be avoided. The nurse also must be emotionally competent in order to be responsive to the client's emotional and medical needs. **Emotional competence** governs communicative and social functions concerning the individual's ideas, thoughts, motivations, and adeptness at establishing interpersonal relationships (Furr & Funder, 1998; Keltner & Haidt, 2001; Smith & Pope, 1992). Effective modulation or control of negative feelings or emotions is required in order to initiate and maintain close interpersonal relationships and communication. It enables the nurse to listen attentively to the client without bias and remain emotionally present to ensure appropriate responsiveness. A failure to effectively manage one's emotions and adapt to stressful situations threatens the communication process and interpersonal interactions. For example, when an individual is angry and unable to manage the physiological and emotional processes associated with the situation that evoked the anger, he is likely to be controlled by his emotional state and become irrational and out of control, resulting in aggressive and threatening communication. In contrast, the individual who gets angry and controls her emotions—through self-awareness, appropriate control of physiologic and emotional responses, and assertive communication skills—can focus on the issues from an intellectual rather than an emotional perspective and communicate thoughts, feelings, and ideas in a nonthreatening and socially appropriate manner.

Obviously, communication is vital to healthy human interactions. Understanding various psychosocial factors—including the impact of early relationships with primary caregivers on perceptions of self and others, on the ability to modulate intense and negative emotions, and on the ability to rely on others during times of need—is requisite for effective communication and interpersonal relationships. The nurse must recognize adaptive and maladaptive behaviors within a social context and use nurse–client relationships to enrich and role model healthy interactions. Nurses, like their clients, must recognize the role of their early childhood relationships as well as their attachment styles and their potential impact on nurse–client relationships. Personal awareness enables the nurse to respect and recognize the potential and actual impact of psychosocial issues, coping and attachment styles, emotional responsiveness, and communication with clients across the life span.

### **The Role of Culture in Communication**

The 2000 U.S. Census confirmed that this country is more diverse than ever before (U.S. Census Bureau, 2000). More than ever, the client’s perception of health and expectations for care, treatment options, and health practices parallel his or her socioeconomic status, culture, ethnicity, gender, and religious beliefs.

Communication and language are initial challenges when client interactions involve diversity (Kavanagh & Kennedy, 1992). Converging evidence also indicates that the sociocultural differences between clinicians and clients influence communication, diagnosis, and clinical decision making (Berger, 1998; Einbinder & Schulman, 2000; Flores, 2000; Office of Minority Health, 2001; Street, 2002). It is important to note, however, that cultures are not homogeneous. Assorted factors, such as degree of acculturation, age, education, socioeconomic status, family structure, religion, spirituality, gender, and country of origin modify the impact of one’s culture and ethnicity and influence expression of distress, health beliefs and practices, and perception of health and illness (Kagawa-Singer & Kassim-Lakha, 2003).

Appreciation of the impact of culture on the client and treatment outcomes is “essential for well-being, growth, survival . . .” (Leininger, 2002, p. 192). Nurses must bridge the gap between themselves and their clients through cultural competence. Every culture characterizes health for its members; delineates acceptable health practices, communication patterns, and language and expression; and defines how to adapt to distress (Leininger, 2002). It also enables individuals to restore and maintain a sense of well-

being. The communication process becomes more significant during distressful situations because they often require health education, appreciation of diversity, partnerships with the client and family, and accurate explanations of procedures and their psychological and physical ramifications. The nurse must also take into account educational level, language, and literacy when communicating with clients and families from diverse cultural and ethnic backgrounds (Munet-Vilaró, 2004).

Failure to consider sociocultural factors when communicating with *all* clients may result in stereotyping, mistrust, biased and inaccurate diagnoses, and inappropriate treatment of clients based on culture, ethnicity, language, race, or social status (Antai-Otong, 2002; van Ryn & Burke, 2000). Numerous studies show that clients from racial and ethnic minority groups are less likely to have a positive perception of providers or to trust providers than are other groups (Cooper-Patrick et al., 1999; Murray-Garcia, Selby, Schmittsiehl, Grumbach, & Quesenberry, 2000; Taira et al., 1997). A lack of trust erodes the nurse–client relationship. Trust is nurtured through acceptance, empathy, sensitivity, and a willingness to glean a greater understanding of client symptoms, communication patterns, health practices, and belief systems. The nurse can further strengthen trust and rapport by embracing family strengths and uniqueness and appreciating their level of distress, as reflected by client-centered care (Antai-Otong; Cioffi, 2003).

Culturally sensitive communication is every client's right. It requires empathy, self-awareness, respect, concern, and humility. These are basic aspects of nursing. Regardless of the client's culture, race, socioeconomic status, or ethnicity, *all* require individualized health care free of bias and stereotyping and an approach that encourages expression of feelings, thoughts, and attitudes and participation in client-centered care.

As previously mentioned, positive health outcomes and client satisfaction are closely linked with responsiveness to the client's wishes, preferences, and needs (Brown, Boles, Mullooly, & Levinson, 1999). Owing to the potential deleterious impact of biased and inappropriate care on treatment outcomes, efforts to use culturally sensitive communication skills are a priority. Although there is tentative data that indicate a failure to provide culturally sensitive communication and health care is likely to result in negative outcomes and distrust, it is vital for researchers to move beyond awareness to identifying and implementing communication strategies that help nurses respond more effectively to culturally diverse populations. An in-depth discussion of nurse–client interactions will be discussed in Chapter 4, Cultural Aspects of Communication Partnerships.

## Developmental/Life Span Issues

### *Infancy and Childhood*

Communication throughout the life span is essential for health and survival. It is well-documented that infants given minimal physical care in institutions or homes fail to thrive and their development and well-being are compromised. In comparison, holding, stroking, smiling, feeding, soothing, and caring for babies promote normal growth and development and a sense of well-being. Neuroimaging studies strengthen this premise and indicate early environmental sensory input shapes the brain's neural structures, which serve as the underpinnings of the mind and personality. Purportedly, within hours after birth the infant is visually sensitive to the caretaker's face; within days he or she recognizes the mother's voice and within weeks he or she favors the mother's face. Parents and caregivers who create sensory environments using various means of communication may be able to shape vast high-level cognitive and motor structures associated with thinking, planning, coping, and modulating anxiety and stress. A failure to shape these neural structures through positive early sensory communication may result in lifelong difficulty modulating anxiety and stress (Sinha, Lacadie, Skudlarski, & Wexler, 2004).

Because of the potential positive and negative impacts of early interactions between the infant and primary caregivers, it is useful to use John Bowlby's attachment theory, discussed earlier in the chapter, to explain the infant's developmental perspective. Attachment refers to a lasting affectional tie or emotional bond initially between the infant and primary caregivers, and involves seeking closeness to one or more caregivers to feel safe and secure, and provide a means of understanding the world (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1973, 1980). Secure attachment fosters independence and mastery of the environment and exploration of the child's surroundings from a stable foundation provided by primary caregivers.

*Secure attachments styles* during infancy generally result in healthy communication and interpersonal skills in adulthood. The attachment theory links secure attachment styles in adults to specific positive interactions during infancy with primary caregivers (Collins & Feeney, 2000; Ognibene & Collins, 1998). Early secure attachments also contribute to the neurophysiology of the developing brain, specifically the right hemisphere, during its peak growth period (Amini et al., 1996; Schore, 2001). Secure attachment styles and communication are demonstrated in children who are sensitive and receptive to caregiving (Ainsworth et al., 1978). They are playful, happy, and

receptive to affection expressed by primary caregivers. In comparison, failure to form close and secure attachments during early infancy interferes with establishing close, secure, and safe interpersonal relationships and results in *insecure attachments styles* in adulthood (Bowlby, 1973). Infants and children exposed to inconsistent, harsh, neglectful primary caregivers often experience fears of abandonment and appear frightened, excessively clingy, and anxious and have difficulty communicating their needs.

The enormous task of language development and communication varies throughout the life span, but never more than during early childhood. Language plays a vital role in human learning, communication, and memory. It also is the core of all interpersonal relationships and is reinforced through early interactions with and imitation of parents and primary caregivers. Through early interactions children learn to communicate feelings, attitudes, and ideas; allay fears; understand themselves and others; and form common bonds between themselves and others.

Early speech and communication during infancy occurs with various sensory and perceptual stimuli. The voice and touch of caregivers or parents are crucial for emotional and central nervous system development. Feeding provides nourishment and fulfills oral needs during early infancy and childhood and builds trust, closeness, and a sense of well-being—key factors that promote mental and physical health as well as communication between the child and parents or caregivers. Early interactions foster trust and love and underlie communication across the life span. During the early developmental stages infants and adults also communicate with eye tracking that evokes various nonverbal and verbal communication forms such as smiles, cooing, facial expressions, suckling, crying, grabbing, and kicking. Language production during the first year of life involves coos in response to voice babbling and imitation of sounds (Schwartz, 1990). Towards the end of the first year, the child uses words such as mama/dada meaningfully, and in time true speech emerges. By age 2, 20% of speech is understandable by strangers (Schwartz). Most children across various cultures master all levels of language by age 4 to 5 years.

Adults process speech incrementally, promptly distinguishing spoken words based on initial phonetic information sufficient to discerning them from alternatives. Some researchers submit that during the second year of life infants are capable of incremental speech processing even prior to developing a large vocabulary (Fernald, Swingley, & Pinto, 2001). Lexical or vocabulary growth is also associated with increased speed and efficiency in comprehending oral speech.

Language and communication problems that occur during childhood require knowledge of complex underlying neurobiologic, social, cultural, and family issues. These factors provide a frame of reference of trust, communication and interpersonal skills, self-esteem, and learning. Major challenges emerge when children present in various clinical settings with their parents or caregivers and are unable to express their feelings, communicate effectively, form interactions with family members and peers, maintain attention, manage impulses, and appropriately modulate emotions.

Language difficulties or disorders during this developmental stage may go unrecognized because parents often complete sentences and interpret for the child. Sometimes asking closed-ended sentences elicit yes or no answers. Children presenting with language and speech disorders often misunderstand questions or may expect the nurse to fill in gaps as parents have to make sense of their responses or communication. Treatment issues involving children with language and communication disorders or problems require accurate comprehensive psychiatric, academic, and developmental evaluation to rule out psychiatric conditions, including family history of psychiatric and medical conditions, health practices, and family dynamics.

Clearly, early speech and language delay should cause concern for parents and nurses because it may be a manifestation of comorbid conditions, such as hearing loss, developmental and behavioral disorders, and psychosocial deprivation (Noterdaeme, Mildemberger, Minow, & Amorosa, 2002; Weisbrot & Carlson, 2005). Early identification of speech and language problems is crucial, and with appropriate interventions may allay the emotional, social, behavioral, and cognitive deficits of these disabilities and increase quality of life and self-esteem (Weisbrot & Carlson).

### ***Adolescence***

Like childhood, adolescence is an overtaking period of great transition and reorganization. Adolescents struggle to resolve tremendous biologic changes, psychosocial pressures, and developmental milestones. Peer pressure, the need to belong, and a struggle for self-identity separate the adolescent from parents or caregivers; influence self-image, self-esteem, and sexual identity; and contribute to emotional turbulence. Communication during this period often reflects the language of peers, society, and family. Feelings and thoughts may be communicated through various venues such as music, clothes or fashion, computer games, emails, chat rooms, cellular phones, text messages, snail mail, and family gatherings.

Adolescents are often challenging because of trust issues with adults and the need to separate from family of origin, reflective of interpersonal relationships with parents. Baffled at being between childhood and adulthood, adolescents are usually overly sensitive to criticism and worry that others will disapprove of them, particularly if they have a problem. Poor impulse control, immature thinking processes, and “here and now” thinking make it arduous for the youth to see beyond today. Successful communication with the adolescent requires patience, understanding of developmental milestones including infancy and childhood issues, and a knowledge of the history of the client’s and family’s medical and psychiatric conditions and family dynamics (see Table 1-1).

### **Adulthood**

Adulthood has been discussed throughout this chapter, and so will not be discussed again in this section.

### **Older Adulthood**

The aging process vastly impacts communication. Normal age-related changes and developmental issues impact the older adult’s ability to form nurse–client relationships and cope with aging. Age-related changes in sensory and perceptual processes such as hearing and seeing impact communication because they also influence interpretation of external cues and internal responses. An older adult with visual deficits is likely to misinterpret environmental stimuli and experience more illusions and fears. Illusions are misinterpretations of environmental stimuli—such as when an older person with visual deficits enters a dimly lit room and thinks that a shadow is a person or ghost. In reality the individual is not “seeing things,” but misinterpreting environmental stimuli. Adequate lighting and glasses are likely to reveal a shadow versus a ghost or person. When older adults communicate these events and express anxiety and

**Table 1-1** Essential Nurse Characteristics

<ul style="list-style-type: none"> <li>• Establish trust</li> <li>• Be honest and nonjudgmental</li> <li>• Convey empathy and concern</li> <li>• Use congruent verbal and nonverbal cues</li> <li>• Discuss confidentiality</li> <li>• Use nonthreatening questions</li> </ul>	<ul style="list-style-type: none"> <li>• Provide explanations for questions</li> <li>• Praise for healthy behaviors and adaptive</li> <li>• Assess level of dangerousness to self and others</li> <li>• Talk to parents or caregivers</li> </ul>
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fears, it is imperative for the nurse to reassure and educate about age-related changes and their impact on sensory-perceptual processes. They often require devices that enhance declining sensory function, including prescription eye-glasses and hearing aids. In addition to sensory-perceptual changes, some older adults may process information more slowly and respond less spontaneously than younger age groups, and also feel threatened by these changes. Communication with older adults requires patience and sensory-enhancing tools or strategies, such as speaking loud, without yelling; using short explanations for those with short-term memory problems; pausing for responses; and using touch and respectful mannerisms appropriately (see Table 1-2).

Lifelong positive experiences, achievements, coping styles, and self-esteem influence developmental issues in older adults and play pivotal roles in their ability to communicate with others during stressful and nonstressful periods. Normal developmental issues impacting communication in the older adult are mediated by age-related changes, cultural influences, values, health practices, and belief systems. Culture and ethnicity impact the older adult's communication skills and language and parallel generational issues such as the need for independence, a sense of "weakness" or dependence, and a need for integrity, dignity, meaningfulness of life, and self-worth (Erikson, 1963). A sense of despair and disgust (Erikson) stems from unsuccessful coping skills related to early childhood issues and ineffective coping styles across the life span, which are detrimental to the client's ability to express feelings, seek help, and communicate with the nurse and other staff.

Intergenerational communication involving older adults is likely to be influenced by the nurse's assumptions about aging, culture and ethnicity, and economic, social, and political systems. It is important to address clients respectfully and avoid using patronizing words such as "sweetie" or "honey" when working with older adults. Cultural influences also determine which personal experiences are communicated and shared with the nurse, and how they are shared. Story-telling is an example of a common form of communication among various cultures, particularly among elder members of the family. Story-telling enables older adults to link the present with the past and

**Table 1-2** Major Barriers to Effective Communication with Older Adults

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• Ageism or stereotyping	• Sense of futility
• Lack of appreciation for lifelong experiences and meaningfulness in life	• Over identification
• Hurried unconcerned approach	• An overall lack of respect for older adults

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ascribe significance to the family legacy. It provides important information about family history, roles, customs, coping styles, and health practices. Taking the time to listen and approaching the client in an unhurried manner are important interventions for the client who needs extra time to respond to queries and are crucial to the nurse–client interaction in this age group. Culture and ethnicity play key roles in how older adults are viewed by family members and communities. It is imperative to respect each older adult as an individual and create relationships that convey respect, appreciation of age-related physical changes, and dignity and preserve integrity.

Communication with older adults is further complicated by various non-age-related medical conditions that cause severe cognitive deficits, such as Alzheimer's disease (AD). Because of deterioration of various brain regions and alteration in biochemistry, the client is unable to process or integrate information and suffers from complex language difficulties including aphasia and/or inability to generate speech.

Data from several studies indicate that despite severe cognitive deficits associated with AD, the client still has a sense of self-awareness (Mayhew, Acton, Yauk, & Hopkins, 2001; Moore & Hollett, 2003; Tappen, Williams, Fishman, & Touhy, 1999). Because it is impossible to ascertain the degree of mental capacity and cognitive deficits of persons with AD it is imperative to treat the client as though he or she understands. Normally, this requires tailoring communication to meet the needs of the client based on mental status and physical findings. Basic communication guidelines include introducing yourself, explaining procedures, making eye contact, calling the person by name, being comfortable with long pauses, orienting the client, and using a warm and pleasant tone of voice. In general, these interventions preserve dignity and convey respect, reverence, compassion, and caring. Nurses must educate families and caregivers about the importance of talking, listening, and respecting the client despite communication and language difficulties. Additional suggestions for improving communication between the caregiver and the client with severe dementia include simplifying vocabulary, using concrete content, speaking slowly, keeping a congenial and pleasant voice tone, and using closed-ended questions (Frank, 1994; Shulman & Mandel, 1993; Tappen, Williams-Burgess, Edelstein, Touhy, & Fishman, 1997).

Communication with persons with severe dementia such as AD is often regarded as incoherent and meaningless. This is particularly devastating to clients and their families. Studies illustrate that the family or caregiver's inability to communicate with clients with cognitive deficits generates feelings of helplessness and purposelessness and suggest that improved commu-

nication could diminish or prevent the meaninglessness associated with caring for older adults with severe dementia (Mayhew, Acton, Yauk, & Hopkins, 2001; Sheldon, 1994; Shulman & Mandel, 1993). Negative assumptions about the inability of persons with AD to communicate also threaten their integrity and sense of self and well-being.

### **Societal and Health Care Trends**

Societal trends involving reduced staff, dwindling health care resources, and pressures to provide quality care with fewer dollars challenge nurses to create innovative strategies to communicate effectively with clients. Nurses are the chief providers of health care and are in pivotal positions to advance these strategies and promote healthy interactions. Healthy nurse–client relationships are essential to successful utilization of resources, client satisfaction, and quality care. Through effective interdisciplinary teamwork the nurse orchestrates health care, advocates for quality health care and client rights, and allocates resources and implements interventions that facilitate positive treatment outcomes.

### **Technological and Information Systems**

In 2001, the Institute of Medicine (IOM) felt the growing complexity of science and technology were becoming an essential aspect of quality and safe health care (IOM, 2001). The past few years have seen a plethora of information technologies introduced into hospitals, communities, and homes. Numerous outcome studies show that some technologies improve communication among providers (Bernstein, Farinelli, & Merkatz, 2005), disease management, and self-care management via home monitoring devices and telephone contact (Papazissis, 2004). One such telecommunication technology is telemedicine, which is the use of telecommunication technology to diagnose, monitor, and provide therapeutic intervention when distance separates the client and care provider. This telecommunication approach captures and quickly transmits textual, audio, and video data in rural areas, homes, and other sites where nurses and other staff are not readily accessible (Agency for Healthcare Research and Quality [AHRQ], 2001). Because rapid advances in technology may have the potential to deteriorate the nurse–client relationship, the nurse must be proactive and implement interventions that maintain the quality of these relationships.

Technological advances and the Internet continue to afford opportunities for communication. Nowadays, clients are more knowledgeable about their health care needs, preferences, and alternative therapies and demand nurse–client interactions that are safe, client-centered, culturally and developmentally sensitive, and cost-effective. As a result of technology and Internet access, clients can go online and access various tests, and provide input that allows clinicians to monitor and trend vital signs, weight, wounds, oxygen saturation, and glucose levels and important various medical aspects of chronic disease management. Through diverse interactive communication modalities they can let the nurse know how they are doing, receive psychoeducation, and participate in self-help groups. Overall, researchers submit that the Internet offers numerous opportunities to enhance communication and access to information for clinicians, clients, and other stakeholders (National Research Council, 2000). Meanwhile, privacy and confidentiality, ethical issues, and legal concerns involving access to data via the Internet continue to be debated.

Even as societal and health care trends and technological advances challenge today's nurses, effective communication remains the basis of nursing care. It facilitates trust and understanding and increases sensitivity to the client's experiences and responses across the life span. Linking these changes to diverse modes of communication enhances the quality of nurse–client interactions and facilitates holistic and individualized health care.

## **MODES OF COMMUNICATION**

When we think of communicating, we often envision ourselves talking. Of course, real communication means talking, listening, thinking, interacting, planning, and responding, simultaneously. It means understanding from another person's perspective and interpreting and responding based on personal experiences. The nurse–client interaction requires all the nurse's senses, attention, interest, and competence to analyze behavioral and emotional responses within the context of a given interaction. Modes of communication are influenced by the nurse's adeptness at establishing rapport, trust, and empathy and using active listening as a means of facilitating healthy nurse–client relationships.

The following factors influence effective communication:

- Rapport
- Trust
- Empathy

- The manner in which the message is delivered
- Anxiety and stress
- Language (spoken or verbal communication)
- Body language (nonverbal communications)
- Space

## Rapport

**Rapport** is a harmonious, empathetic, and mutually respectful relationship between the nurse and client. Generally, the nurse is the helping part of the nurse–client relationship. Rapport requires a warm, accepting, confidential, and secure environment that engenders trust, encourages expression of feelings, improves decision-making skills, requires active listening, and promotes healthy and adaptive lifestyle changes. Rapport is necessary for the client to feel comfortable and less anxious and fearful, so he or she can freely express feelings.

The following statement is an example of what a nurse may say to initiate rapport:

Good morning Mr. Jones, my name is Lisa and I am your nurse today. I understand that this is your first visit. How can I help you today?

The nurse's introduction and subsequent question convey a genuine interest in the client's well-being. Addressing the client by name conveys respect, thoughtfulness, and empathy. This unhurried and caring approach mitigates the client's fears and normal anxiety associated with a first visit, opens lines of communication, and facilitates expression of feelings.

The following is an example of a dialogue that can foster rapport:

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**Nurse:** Good afternoon, Mrs. Chamberlain, my name is Ken; I understand you're upset about the delay in getting your prescription. I'm sorry for the delay and I am waiting for a call from pharmacy. How can I help you right now?

**Client:** This is the second time this has happened and I am tired of waiting several hours each time I come to the clinic.

**Nurse:** I understand. I can see you're pretty upset. As soon as I hear from the pharmacist I can tell you how long you have to wait. We will get your prescription as soon as possible.

**Client:** I feel better knowing that someone is at least trying to help me. I really appreciate your time. I'll just wait until you return. Thank you very much.

---

The nurse established rapport with this angry client by approaching her in an unhurried manner, immediately expressed understanding, communicated empathy, and avoided defensiveness. The use of active listening skills is a vital component of rapport. Active listening with empathy and impartiality helped the client stay calm and develop a positive relationship with the nurse and staff. A failure to communicate or establish rapport, especially in challenging situations, may escalate the situation and reduce both confidence in the nurse and staff and client satisfaction.

## Trust

Trust is germane to therapeutic and authentic nurse–client relationships. Frequently nursing research links trust to human development and healthy ego formation, referring to the contributions of Erikson (1963). Carl Rogers (1977) coupled trust with power, and an environment of openness. Trust indicates that one person can rely or depend on another to follow through on a promise or obligation. Trust stems from consistent, reliable, and positive experiences with early childhood primary caregivers and subsequent adult relationships. Trust is very difficult to engender when the client has a history of poor interpersonal relationships. Normally, nurses experience a high degree of trust in their interactions with clients they serve. This unique position can be used to strengthen trust, foster hope, empower clients to make adaptive changes, and influence quality of life throughout the life span.

As just mentioned, the client's capacity to trust is governed by early interactions with parents and caregivers. However, trust evolves through nurse–client relationships that convey acceptance, empathy, caring, and understanding. As the nurse approaches the client, she or he must use congruent body language and verbal communication, such as good eye contact, extension of hand to greet the client, calmness, and a normal voice tone. For example, when you take a client's vital signs, this process involves greeting the client with good eye contact, calling the client by name, displaying competence to perform the task, and asking him or her which arm he or she prefers for blood pressure. This brief interaction demonstrates respect, acceptance, and caring. Through eye contact and greeting the client by name, the nurse conveys "I accept and respect you as an individual and I am here to help you." By asking which arm he or she prefers for blood pressure reading,

the nurse allows the client to participate in decision making. Each nurse–client encounter must be used to convey competence, acceptance, caring, and understanding—the basis of trust. Major nursing attributes that engender trust include:

- Competence
- Reliability
- Confidence
- Hope
- Motivation
- Predictability
- Empathy
- Trustworthiness
- Genuineness and authenticity
- Consistency
- Responsibility
- Conscientiousness
- Kindness
- Fairness

Overall, trust facilitates healthy and effective communication through rapport and nurse–client interactions. It conveys competence and confidence and creates a caring, compassionate, and therapeutic environment of mutual respect, empathy, cooperation, and sincerity.

## Empathy

**Empathy** refers to sharing the feelings, thoughts, and ideas of another. It allows for emotional connectedness and understanding without the experience becoming the nurse’s. It is the cornerstone of nursing and determines how the nurse accepts, values, and seeks to understand the client’s experiences. It allows the nurse to glean the client’s experiences and world through the client’s lens. Empathy engenders understanding of the client’s feelings and communicates this understanding to the client. By embracing the client’s viewpoint the nurse is more likely to see situations or problems as the client does. It is being able to “walk a mile in someone’s shoes” without their experience becoming your own. Empathy differs from **sympathy**, in that the latter involves taking on another’s experiences and making them yours. For example, after the loss of his wife of 45 years, Mr. Jones feels sad and lost. He talks to you and expresses sadness and grief. *Empathy* enables you to respond to his grief by saying “I understand this is a very difficult time for you.” In comparison, *sympathy* is displayed by saying “I feel sad too and want to cry with you.” In the latter case the nurse has problems distinguishing her grief from the client’s, and hence becomes less effective and objective in facilitating the grief process. Characteristics of sympathy include over-identification with the client’s situation, feelings, and thoughts; difficulty removing oneself from the client’s experience; and rescuing the client instead

of encouraging the client to resolve grief or problems. Although both concepts convey compassion, sympathy is nontherapeutic and compromises the client's grief process and the nurse–client relationship.

The therapeutic nature of empathy lies in “being with the client” but not “becoming the client.” This is often difficult for the novice nurse, due to a lack of self-awareness and problems distinguishing personal reactions from the client's. Fortunately, with time, personal development, and self-awareness or insight, the novice nurse will master this essential nursing skill.

### **The Manner in Which the Message Is Delivered**

Communication is a complex process mediated by emotions, attentiveness, understanding, and empathy. It involves both verbal and nonverbal processes that must be congruent; otherwise, the recipient may misinterpret the message and respond accordingly. Self-awareness of our communication styles and patterns and how others perceive us is crucial to understanding ourselves. For instance, if the client asks, “Why are you so angry today?” and your response is “I am not angry” it is essential for you to assess why the client perceived you as being angry. You may not be angry, but something about your tone of voice, use of words, or nonverbal communication led the client to believe you were angry. This is particularly significant if more than one person asks the same question, which generally means that the queries are justifiable. During these occasions it is important to ask reasons for these perceptions, to explore reasons why you may or may not be angry, or just to look in the mirror and assess for cues that may indicate anger. Acknowledging anger is not a sign of weakness because it indicates that strong emotions were outside your radar screen (**self-awareness**). Situations like this also expand self-awareness, decrease defensiveness, and enable you to understand your own emotions and nonverbal cues and determine ways to acknowledge and manage them effectively. Self-awareness refers to personal recognition of one's attitudes, ideas, biases, values, and beliefs that affect relationships with others.

### **Anxiety and Stress**

Emotions play a pivotal role in how a message is delivered. Anxiety and stress can be overwhelming in some cases and interfere with the ability to process information accurately, resulting in the receiver tuning out the message. Anxiety and other emotions are often expressed by gestures, attitude, eye contact, tone of voice, touch, emotional state, facial expressions, and posture. The

higher the emotional state the less accurately one hears or communicates messages. An inability to understand messages due to anxiety and stress impedes effective communication, compromises decision making, and prevents appropriate behavioral and verbal responses. For instance, if a nurse is upset or fearful or experiences overwhelming stressors, although she may use appropriate spoken words, the message is likely to be overshadowed or diluted by her emotional state and an incorrect message will be conveyed. Another example is when a client walks into a primary care clinic or is admitted to a surgical unit and feels frightened about his condition; he may appear angry and respond abruptly. If the nurse fails to recognize underlying fears or anxiety, she or he may respond similarly, by speaking loudly or abruptly, hence losing an opportunity to establish rapport, remain calm, reassure the client, and assess the client's needs. During stressful encounters it is imperative for the nurse to:

- Pay close attention to the message.
- Focus on themes and content rather than on how the message is delivered.
- Remain open-minded and objective.
- Clarify and restate what he or she hears before responding.

Equally important, the nurse needs to examine personal feelings toward specific clients and recognize their potential impact on verbal and nonverbal communication with them. Obviously, certain situations and client behaviors make it arduous to create these environments because they are threatening and require patience, self-control, perseverance, knowledge, and maintenance of personal safety.

The following scenario demonstrates the impact of emotions on the nurse–client relationship when the client uses threatening or aggressive behaviors that engender fear in the nurse. Clearly the nurse is frightened, but it is essential for her to respond assertively and set limits to prevent escalation and maintain personal safety.

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**Client (yelling):** No one cares how long it's taken me to drive to this hospital because everyone is busy!

**Nurse:** Mr. Irvin, I understand you are upset, but it is difficult for me to help when you are yelling and threatening. I will do whatever I can to assist you, but it is important for you to lower your voice.

**Client:** I'm sorry, but this is the third time I've had to come to the emergency room this month and I don't know what's wrong with me.



**Nurse:** Mr. Jones, I understand and believe you have reasons to be upset. What brought you in today or what can I do to assist you now?

---

The client now settles down and becomes more conciliatory. Obviously he was unable to convey his feelings appropriately because of underlying fears and high anxiety levels. The nurse's response and tone of voice were instrumental in mitigating the client's fears and anxiety. Her reassuring mannerisms, assertive communication, and firm and clear limit setting enabled her to ensure personal safety and form a trusting nurse–client interaction. Personal safety must be a priority in situations involving threatening or potentially dangerous situations.

### Verbal and Nonverbal Behaviors

Spoken or oral communication has been extensively discussed in this chapter. It is an important part of communication, but has less impact on the meaning of what is said than nonverbal behaviors or cues. For the purposes of this discussion, nonverbal behavior or communication will be referred to as **body language**. The more congruency between verbal and nonverbal communication, the more accurately the message will be interpreted or understood.

Often body language or nonverbal behaviors convey what the person has difficulty saying or articulating. Common body language gestures include eye contact, facial expressions such as frowning or grimacing, tone of voice, hand waving or pointing, head movements, physical appearance and hygiene, general posture and gait, laughter, smiling, and head nodding. The body is a mediator of messages and often uses muscle tone and posture as modes of nonverbal communication (Sloan, Bradley, Dimoulas, & Lang, 2002). For example, the extent one allows oneself to relax during conversations communicates a message. Tense muscles and posture indicate dislike, anxiety, or stress; in contrast, a person who leans toward the respondent and has relaxed facial muscles and a firm handshake indicates he or she is at ease.

Sometimes nonverbal communication occurs simultaneously with verbal communication, and at times the speaker is unaware of these nonverbal signals. Common consequences of incongruent verbal and nonverbal behaviors are miscommunication or misinterpretation of cues. Just because someone smiles does not necessarily mean she or he is happy. In fact, smiling often masks negative or overwhelming emotions, such as fear and anxiety. It is imperative to validate or clarify one's interpretation of these gestures to ensure accuracy of their meaning and avoid responding inappropriately; for

example, it is imperative to refrain from smiling inappropriately during interactions because when the client shares important information and the nurse smiles this could be mistaken as “being funny” and belittling or devaluing. Again, self-awareness and how one responds with nonverbal cues is just as important as validating the client’s behaviors.

## Space

We all know what it feels like when someone invades our **personal space** or “comfort zone.” If we feel anxious and uncomfortable when this occurs, just imagine how our clients feel, particularly those who are already anxious and feel threatened. The need for personal distance and space must be recognized and afforded by the nurse. Hall (1966) coined the concept of personal space in interpersonal interactions in his book *The Hidden Dimension*. He asserted that the distance and relevance of space between people is governed by cultural influences. He delineated four principal space distance zones maintained by healthy middle-class Americans, acknowledging that the distance zones are not applicable to all cultures or ethnic populations. He further posited that the specific distance selected is governed by the nature of transactions and relationships between parties—their feelings and actions.

The four distance zones are:

1. *Intimate distance*—Close range and the presence of another person is unmistakable. This is illustrated in love-making, hugging a child, friend, or relative, or holding an infant.
2. *Personal distance*—Ranges from 1½ to 4 feet. Normally this is arm’s length.
3. *Social distance*—Ranges from 4 to 12 feet. At this distance parties have minimum if any physical contact and are at a more formal business distance, which is maintained at a staff meeting, supermarket cashier, conference table, or receptionist area.
4. *Public distance*—Ranges from 12 to 25 feet or more, with minimal eye contact. This takes place when walking through a shopping mall or passing someone in the hallway. There is mutual respect to maintain distance and remain strangers. (Hall 1966, 1989)

Caring for clients often forces the nurse to invade the client’s personal space (e.g., taking vital signs, changing dressings, providing treatment). It is important to note that the closer the proximity between the nurse and client,

the higher the risk of violence or difficulty escaping if necessary. It is imperative for the nurse to be cognizant of his or her own comfort distance zones and appreciate and respect those of clients and staff. Although cultural influences govern people's comfort zones, medical and psychiatric conditions may also influence how one defines one's personal space. Persons with schizophrenia and other severe psychiatric conditions often feel anxious and uncomfortable when the nurse invades their personal space. Increased anxiety also increases the risk of violence—a gesture to protect oneself from harm. In comparison, persons with bipolar disorder during a manic phase may be intrusive and invade the nurse's personal space, requiring the nurse to step back and set limits. Maintain leg's length distance and avoid touching or making sudden movements when caring for clients who are cognitively impaired, suspicious, paranoid, or psychotic. Invading their personal space increases the risk of physical harm and danger. Maintaining a safe distance ensures quick and safe escape. The personal meaning of space is individual, but the nurse must be aware of her comfort distance zone and value and respect those of clients and colleagues.

### CRITICAL THINKING QUESTION

**Question:** What do you do when a client invades your personal space by either hugging or embracing you?

**Answer:** Your response will vary and depend upon the nature of your relationship with the client or staff. For example, if you have worked with a client and family for several months or years and established a therapeutic relationship, and everyone understands and respects personal boundaries, during a death or very stressful event hugging may be appropriate. There must be mutual acceptance of the behaviors, however. In another situation where the nurse does not know the client or the client is threatening or overly seductive, it is imperative to maintain a safe distance and set firm verbal limits to ensure easy access to an exit to maintain personal safety.

In conclusion, modes of communication are vast. Each nurse must understand him- or herself in order to relate to and understand the client's experience and behavior. A further discussion of the nurse–client relationship will be included in Chapter 3.

## LEGAL AND ETHICAL CONSIDERATIONS

Legal and ethical considerations are an integral part of nursing. All information or data gathered during client encounters and interventions with clients is confidential. This includes ensuring confidentiality and privacy, maintaining secure medical records, documenting accurate information in the client's record that can be supported by observations and interpretation, assuring third-party safety, and maintaining professional nurse–client boundaries.

### Confidentiality

Nurses are responsible for maintaining confidentiality of information shared by clients and families with the nurse and treatment planning team (Barloon, 2003). The American Nurses Association (ANA) *Code of Ethics for Nurses* (ANA, 2000) states nurse practice acts, and institutions have statements about confidentiality. The registered nurse is encouraged to practice under the auspices of the ANA *Code of Ethics* to guide practice and to:

- Deliver nursing care that preserves and protects client autonomy, dignity, rights, and respect.
- Ensure client confidentiality.
- Demonstrate self-care.
- Serve as client advocate and contribute to resolving ethical issues.
- Maintain a professional client–nurse relationship with appropriate boundaries.

Such statements represent a consensus of general standards of professional conduct. Clients trust the nurse to listen attentively; document in the medical record, and safeguard shared information. It is imperative to keep records out of public reach, including loose papers that need to be shredded rather than tossed in the wastebasket; to avoid discussing a client on the elevator, in a waiting room, or at a work station; and to not leave a computer unlocked or unattended.

Information shared must be used for treatment purposes only unless the client provides written permission to do otherwise. Only when the client provides written permission that specifies what information and how it will be used and to whom it will be shared, usually on a specific form that is dated and signed by the client, should the nurse waive confidentiality. The client must also be competent to make such a decision. In the event a client is obviously unable to make an informed decision or has been legally declared incompetent, the nurse must implement measures that reflect local,

state, and federal regulations to ensure confidentiality. Clients are considered competent unless the client's behavior calls it into question (e.g., strange or aberrant behavior) (Barloon, 2003).

In the case of a minor, a parent or legal guardian has the right to consent for treatment based on age, the nature of the child's diagnosis, or other considerations delineated by state or federal law (American Academy of Pediatrics, 1999). Adolescents may be concerned about confidentiality when sharing information with the nurse. It is imperative to reassure the youth that information shared with his or her parents will be limited by the contents of his or her signed consent form, except in circumstances involving danger to self or others. Some jurisdictions make an exception for adolescents to consent for treatment of substance use disorders, including prescribing contraceptives and treating sexually transmitted diseases, allowing maintenance of confidentiality between the youth and nurse (Muscari, 1998; National Clearinghouse for Alcohol and Drug Information [NCADI]). Federal regulations permit disclosure without the adolescent's consent in several situations, including medical emergencies, reporting child abuse, and communications among health care providers. Nurses must be cognizant of local regulations and statutes and federal regulations that address privacy and confidentiality issues. Family circumstances; the nature, severity, and complexity of the adolescent's problems; age; and emotional, cognitive, and social maturity must also be considered when issues concerning confidentiality exist.

Efforts to maintain confidentiality are important; however, certain circumstances may make it necessary to share information with others, particularly when a person's life or safety are at risk. The duty to protect life often outweighs the duty for confidentiality. Clearly the issues of confidentiality challenge nurses on a daily basis (see Research Study 1-1 on page 44).

### CRITICAL THINKING QUESTION

During an interview with a 15-year-old adolescent at a high school health fair, he mentions that he wants to discuss something with you, but you must promise not to share it with his parents. What is the most appropriate response?

1. Make the promise and *only* share it if warranted due to threats to harm himself or others.
2. Inform him that his permission will be requested before specific information is shared with parents, except in situations that involve danger to himself or others.

3. Ask his parents to come into the room so you are not caught in the middle of the youth's and parents' problems.
4. Let him know that his parents have a right to read his record because he is a minor.

### **Information Technology and Security**

Increasingly, identifiable personal information about clients and general health care data are available in electronic form in health databases and online servers. Although access to this information benefits clients and health care providers, enhances client autonomy, improves treatment outcomes, and advances health research, it also has the potential to jeopardize client rights and confidentiality and heightens the risk of abuse or use of information other than for medical purposes.

Technologies have the capacity to transform communication between nurses and their clients and nursing care (Phillips, 2005). Electronic health records and health information can be obtained from handheld computers. A handheld computer is an example of a technology that can help nurses to access electronic progress notes, laboratory and diagnostic results, and orders, which are important communication venues that improve nursing care to clients (Thompson, 2005). Cell phones and pagers can be used to communicate with clients and their families in emergency departments, busy urgent clinic and ambulatory care settings concerning when they will be seen. During these waiting periods, clients and families have the option of getting a meal or staying in the waiting area.

As previously mentioned the spectrum and technologies, including telemedicine, provide vast opportunities for the nurse to communicate and work with clients and families in their homes and communities. Frequently, telemedicine is welcomed by clients who live in rural areas or urban areas in which the client with comorbid chronic diseases is dependent on public transportation. It provides contact with clients who are isolated from their families; psychoeducation about disease management; and emotional support through telehealth monitoring devices and telephonic follow-up.

### **Documentation**

Based on legal and ethical principles, documentation of written communication must be accurate, completed in a timely manner, succinct, unbiased,

based on a comprehensive and accurate assessment, and provide evidence to support observations and interpretations (Mohr, 1999). It must also be evidence-based, and reflect professional practice standards and state and federal regulations.

Nowadays documentation is the basis of reimbursement for health care. Numerous agencies depend upon accurate and timely written communication.

### **Duty to Protect Third Parties**

When is it okay to waive the client confidentiality without written consent? There may be several answers to this query, but the most important is when a client threatens to seriously harm or kill a third party or when the nurse suspects child or elder abuse and neglect.

In the first situation, the courts have found that the duty to protect the public, designated as the “duty to warn” or “duty to inform,” outweighs the nurse’s obligation of confidentiality to the client. The landmark decision that provides the basis of the duty to warn was established by the California Supreme Court in *Tarasoff v. Regents of University of California* (1974), in which the court proclaimed that the privilege of confidentiality ceases when danger to the public exists. Health care providers are protected against breach of confidentiality when the warning is in good faith (Walcott, Cerundolo, & Beck, 2001). The debate over this issue continues, and many feel it threatens the integrity of the nurse–client relationship, particularly in the area of trust. However, clients of nurse psychotherapists, who are routinely informed of the limitations of confidentiality, have little difficulty dealing with this issue. It is imperative that the decision to warn be evaluated individually and based on sound clinical judgment, professional responsibility, and state and federal regulations and laws.

In the second situation, when there is suspicion of child or elder abuse or neglect, all states have mandatory reporting laws for health care providers. The decision to report abuse or neglect in these populations must be based on clear evidence of abuse or neglect and astute clinical judgment. It is imperative for the nurse to be cognizant of reporting regulations and report the abuse in a timely manner and in good faith.

### **Professional Boundaries**

Maintaining **professional boundaries** between the nurse and client is an important ethical and legal issue that is often overlooked. Why are profes-

sional boundaries important? Professional boundaries are essential because they define who participates in the interpersonal relationship, nature of relationship, role expectations in the interpersonal relationship, and protect the separateness of the nurse–client relationship.

Boundaries, like space, are defined by numerous factors including culture, ethnicity, stress and anxiety levels, and the ability to form healthy interactions. Persons with certain psychiatric conditions, such as personality disorders, have difficulty discerning boundaries and are likely to test limits by stepping over boundaries. The client will often be excessively clingy and smothering. The inability to form healthy boundaries stems from early childhood relationships that made it difficult to emotionally separate from others and maintain healthy interpersonal boundaries. In these situations it is imperative for the nurse to recognize, develop, and maintain consistent and distinct boundaries between themselves and their clients (see Table 1-3). In contrast, clients with schizophrenia have difficulty feeling close to others and tend to have distant relationships with others. It is imperative to value the need for distance and to create environments that reduce anxiety and tension and the risk of becoming dangerous due to a need to protect self. The client's level of dangerousness is likely to increase when the nurse gets into her or his personal space or touches or makes sudden movements toward clients who prefer aloofness or distant boundaries.

In conclusion, the following strategies can facilitate clear boundaries:

- Be self-aware about your own family systems and clarity regarding the boundaries between self and others and how they continue to influence personal and professional interactions, such as with colleagues and clients.
- Learn to speak for yourself and not others and vice versa.
- Think in terms of what you want and need rather than what others want/need.

**Table 1-3** Strategies that Facilitate Professional Boundaries

- 
- Clearly delineated rules that describe who participates and how
  - Articulated rules and roles in relationships
  - Protected separateness in nurse–client relationship
  - Balanced intellectual and emotional systems
  - Healthy interpersonal and communication skills
  - Recognition and value of cultural factors (both the nurse's and client's), which define boundaries between the nurse and client
-



- Use “I” statements and take responsibility for the way you feel, think, and behave.
- Afford yourself and others privacy and opportunities or tasks that foster differentiation or self-growth.
- Celebrate your attributes or differences in relationships—both personal and professional.
- Seek opportunities for personal growth and successes.
- Establish and maintain clear boundaries between self and others, recognizing your needs and those of others.
- Avoid taking responsibility for others’ feelings, thoughts, and behaviors.
- Avoid speaking for others or propose to know what they are feeling or thinking.

For more information on this topic, see Chapter 5, Professional Development: Leading Through Effective Communication.

## SUMMARY

Clearly, communication is important for survival, expressing feelings, imparting information, and working with others to develop treatment approaches that address the needs of clients, families, colleagues, and stakeholders. However, it is imperative for students, novices, and experienced nurses to understand the complexity and difficulty of being effective communicators. Because of daily interactions with clients and staff, the nurse must deal with each encounter individually because what constitutes effective communication in one situation may be ineffective in another (Zoppi & Epstein, 2002).

Communication is a complex and dynamic interaction that requires active listening skills, personal insight or self-awareness, mindfulness, and the appropriate expression of feelings and anxiety. Nurses must identify their communication patterns and styles and understand their impact on relationships with others. The focal point of this chapter has been communication across the life span and the role of diverse and complex factors that enhance or impede effective communication. Despite the difficulty, nurses must be competent and effective communicators. Effective communication skills are necessary to establish interpersonal relationships with physicians and other staff, clients, and their families; these relationships are essential in today’s fast-paced, information-driven society and health care arena. Collectively, these factors may enhance client adherence, increase staff and client satisfaction, and facilitate positive clinical outcomes.

## SUGGESTIONS FOR CLINICAL AND EXPERIENTIAL ACTIVITIES

1. Use a clinical situation and role play interactions between the nurse and a difficult client. Ask the group to critique and provide constructive feedback.
2. Role-play various types of body language (nonverbal communication) and ask participants to discuss their interpretation and how accurate they are.
3. Provide several scenarios that address life span issues including how to respond to:
  - a. An adolescent who asks for reassurance that information shared remains confidential
  - b. An older adult with cognitive deficits
4. Ask a nurse or other staff member to discuss nurse–physician issues along with strategies used to resolve workplace conflicts and work effectively as a team to ensure quality health care.

## END-OF-CHAPTER QUESTIONS

1. Mr. Johnson, a 79-year-old, is upset because his wife has recently been diagnosed with Alzheimer’s disease. He yells at you and calls you “stupid.” What is the most appropriate response?
  - a. Raise your voice slightly and let him know how it feels when this occurs.
  - b. Maintain your composure and let him yell.
  - c. Let him know you understand he is upset, but it’s difficult to assist when he yells.
  - d. Report him to security.
2. Mary is a 35-year-old physician recently diagnosed with Crohn’s disease. She is openly upset, yet expresses concerns about her illness and treatment options. She talks to her spouse, who is very supportive. Based on your understanding of attachment styles, which one does Mary exhibit?
  - a. Insecure
  - b. Secure
  - c. Adaptive
  - d. Maladaptive
3. Peplau’s interpersonal theory discusses four phases of the nurse–client relationship. Which of the following *best* exemplifies the exploitation phase?
  - a. Encourage the client to seek guidance in decision making.
  - b. Ask the client to identify and discuss personal needs and preferences.

- c. Communicate with significant others about the client's condition.
  - d. Tell the client that you are available if he needs your help.
4. Sonny, the evening nurse, is upset about his client's recent diagnosis of a terminal illness. He reports that he has been unable to sleep the past few days because the client reminds him of his father. He also finds himself overly involved in the client's care. Which of the following *best* describes the nurse's behavior?
  - a. Unclear boundaries
  - b. Empathy
  - c. Sympathy
  - d. Disclosure
5. Mr. Morris, a new client in the ambulatory care clinic, is very distrustful and refuses to share information with the nurse. Which of the following is the *most* appropriate approach or response to the client?
  - a. Avoid talking to him until he is more cooperative.
  - b. Review his record for additional information.
  - c. Refer him to a mental health professional.
  - d. Ask a colleague to talk to him.
6. Which of the following has the greatest impact on communication with adolescents?
  - a. Concerns about confidentiality
  - b. Overly sensitive to criticism
  - c. Poor impulse control
  - d. All of the above
7. Mrs. Smyth, an 81-year-old, has an appointment in the primary care clinic. Based on your understanding about communicating with older adults, what is the *least* effective approach to facilitating the nurse–client relationship?
  - a. “Mrs. Smyth, I will speak loud so you can hear me.”
  - b. “How can I help you today?”
  - c. “I noticed this is your first visit to the clinic.”
  - d. “What's brought you in today?”
8. During an interview with Jasmine, a 17-year-old, she asks you to promise not to tell her parents she is taking birth control pills. What is the *most* appropriate response?
  - a. “Everything you share is confidential and will not be shared with your parents.”
  - b. “Jasmine, I am unwilling to keep a secret from your parents.”
  - c. “Let's bring your parents in so you can share the secret with them, too.”
  - d. “Jasmine, information about birth control pills will not be shared with your parents.”

**Answers**

- p . 8  
 a . 7  
 p . 6  
 b . 5  
 c . 4  
 b . 3  
 b . 2  
 c . 1

## Research Study 1–1

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**Title:** Disclosing Genetic Test Results to Family Members Hamilton, R. J., Bowers, B. J., & Williams, J. K. (2005). *Journal of Nursing Scholarship*, 37, 18–24.

**Purpose:** To describe the experiences of disclosing genetic test results to biological family members of people tested for Huntington’s disease or hereditary diseases (e.g., cancers).

**Design:** Grounded theory technology.

**Methods:** Researchers used open-ended interviews with  $n = 29$  participants, of whom 24 had received genetic tests and 5 had not been tested. Population was from 3 countries, including 15 participants from the United States. Interviews were conducted over a 2-month to 4-year period. Taped interviews were transcribed and analyzed for conceptual categorization to depict personal meanings of disclosing test results.

**Results/Findings:** Participants described the impact of disclosing test results to family members and how they selectively made decisions to disclose. Timing of the disclosure was impacted by the nature of the disease and the participant’s personal need to prepare. Disclosure brought about genetic risk or disease-generated discussion between the participant and family member.

**Implications for Nurses:** Various legal and ethical issues guide disclosure of genetic diseases and risk. The decision to share genetic test results and other health data with families is based on the individual’s consent. Nurses are in key positions to facilitate therapeutic relationships with clients faced with their own issues associated with genetic testing and disclosing them with family members.

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## SELECTED WEB SITES

Access Project (Limited English project): <http://www.accessproject.org>

Autism Spectrum Disorders (Pervasive Developmental Disorders):  
<http://www.nimh.nih.gov/healthinformation/autismmenu.cfm>

National Institute of Mental Health Outreach:

<http://www.nimh.nih.gov/outreach/index.cfm>

National Institute on Deafness and Other Communication Disorders:

<http://www.nidcd.nih.gov>

Office for Civil Rights: <http://www.hhs.gov/ocr/hipaa/finalmaster.html>