Learning Objectives

After reading this chapter, you will be able to:

- Describe characteristics of the nurse–client relationship.
- Explain the tasks associated with each phase of the nurse–client relationship.
- Define the conditions that are conducive to the development of a therapeutic relationship.
- Describe strategies for managing issues unique to the professional nature of the nurse–client relationship.
- Identify therapeutic and nontherapeutic communication techniques.

Key Terms

Active listening
Assertive communication
Countertransference
Emotional intelligence
Empathy
Genuineness
Nurse–client relationship
Self-disclosure
Transference

Chapter 3

The Nurse–Client Relationship and Therapeutic Communication

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Introduction

The therapeutic relationship between the nurse and client is the hallmark of psychiatric-mental health nursing.

The therapeutic relationship between nurse and client is the hallmark of psychiatric nursing. In 1952, the publication of *Interpersonal Relations in Nursing*, by Hildegard E. Peplau, essentially revolutionized the teaching and practice of psychiatric nursing in the United States. At a time when the introduction of psychotropic medications was changing the treatment of psychiatric illness, Peplau emphasized the interpersonal relationship of the nurse and client. Peplau defined nursing as "a human relationship between an individual who is sick, or in need of health services, and a nurse especially educated to recognize and to respond to the need for help" (1952, p. 5–6). This chapter will explore the multiple factors that contribute to the development and success of the nurse–client relationship, including the use of therapeutic communication techniques.

Nurses need to understand the difference between professional and social relationships. A relationship exists between the client and nurse only when they become significant to each other.

Critical Thinking Question

What factors contribute to making the therapeutic relationship between the psychiatric nurse and the client the hallmark of psychiatric nursing?

The Nurse–Client Relationship

The **nurse–client relationship** is the context in which the nursing process occurs and is the primary means of providing nursing care. This is true for all nursing practice, not just psychiatric nursing. According to Peplau, nursing's unique focus is the reactions of clients to the circumstances of their illness or health situation. Illness provides an opportunity for learning and growth. The nurse, through careful observation and thoughtfully guided communication, assists the client to identify needs and develop new intellectual and interpersonal skills. The competency of the nurse will substantially affect the quality of the client's experience and the outcome of care. Nursing competence goes beyond the mastery and application of scientific knowledge and technical skills. The vehicle for all nursing action is the nurse–client relationship, and it is the basis for a successful and fulfilling nursing practice as well as for all nursing actions.

Characteristics of the Therapeutic Nurse–Client Relationship

All intentional interactions with clients that are helpful are considered therapeutic. However, not all nurse–client interactions constitute a relationship. A relationship exists between the client and the nurse only when they become significant to each other (i.e., the opinion of the other makes a difference in how one views oneself). When this occurs, the potential for corrective emotional experiences exists. If it is achieved, the relationship becomes therapeutic. There are several characteristics that define the therapeutic nurse–client relationship. They include the following:

- To be therapeutic, the nurse–client relationship must be based on mutual respect.
- The relationship is client focused and designed to meet the client's needs. The emotional needs of the nurse cannot interfere with this process.
- The interactions are goal oriented.
- Goals are mutually established by both the client and the nurse.
- The relationship is collaborative, with both the client and the nurse contributing to the healing, growth, and problem solving.
- The client and nurse engage in shared decision making.
- The relationship promotes the client's independence to the maximum extent possible. The nurse *works with* the client and does *not do for* the client.
- The relationship promotes the expression of the client's feelings.

At the beginning of the relationship, an agreement or contract between the nurse and client should be established. This is an excellent opportunity to establish the rules and behaviors or boundaries that are expected between the nurse and client, such as the time and frequency of meetings; reimbursement for services; contact with family members, significant others, and other therapists; and prohibition against socialization. Nurses need to be aware that boundaries are critical in maintaining a professional therapeutic relationship. Ideally, the nurse and client develop a collaborative and dynamic relationship in which both learn and grow.

Identifying goals and boundaries early in the relationship helps to define the professional nature of the relationship. The nurse does not relate to the client

Table 3-1 Comparison of Professional and Social Relationships

Professional Relationships	Social Relationships
Client focused	Shared focus
Structured	Unstructured
Purposeful and time limited	Open with respect to content and time
Mutually determined goals	No specific goals
Intimate, personal information restricted	Exchange of information not restricted
Nurse is responsible to guide the interaction and meet client's needs	Shared responsibility for the interaction

in the same way as one relates in a social situation. There are clear differences between a professional and a social relationship (**Table 3-1**). If one is angry with a friend, one can choose to ignore the person, argue with the person, or even become verbally loud or aggressive. The nurse does not have these options in the professional nurse–client relationship. The nurse must honor the implicit contract to help the client. Therefore, if something in the client's behavior raises feelings of anger in the nurse, the nurse must recognize and try to understand the response, set firm limits in a calm manner, help identify the client's need at the moment, and help the client meet the need in an acceptable way. This is a large task, and it requires strong communication skills.

Because the relationship is collaborative, the nurse partners with the client in establishing goals, planning interventions, and making decisions about the client's care. Early in psychiatric nursing, the nurse was cast in a custodial role and was seen as taking care of the client. This had the effect of fostering dependency. Rather, in a therapeutic relationship, the nurse encourages the client's participation and growth towards independence. At times, the client's fears, anger, anxiety, or expectations may impede participation in treatment. Through the purposeful use of therapeutic communication techniques, the nurse can promote the client's understanding and acceptance of the situation. **Table 3-2** shows the application and effectiveness of Peplau's interpersonal nursing model in a medical-surgical setting.

There are four phases of the nurse–client relationship: the preinteraction phase, the orientation phase, the working phase, and the termination phase.

Phases of the Nurse–Client Relationship

The nurse and client come to the nurse–client relationship as strangers, and the trust and respect essential to the therapeutic process develops over time and

Table 3-2 Application of Peplau's Interpersonal Nursing Model to a Clinical Situation

Situation: The nurse is caring for a client who has a new colostomy.	
Without the Model	**With Interpersonal Model**
The client appears tense about caring for her colostomy. The nurse lightens the mood through distraction in an attempt to make the client feel more comfortable. The client smiles and appears more relaxed.	The nurse recognizes both her own anxieties related to colostomy care, and the client's anxieties, evidenced by the client's efforts to avoid caring for her colostomy.
Recognizing the client's discomfort, the nurse proceeds by taking care of the colostomy for the client.	The nurse uses therapeutic communication techniques to assist the client to explore her feelings about having and caring for the colostomy.
Result: The client's inadequate coping is reinforced.	The nurse openly prompts the client to talk about her concerns during care of the colostomy.
On subsequent days the nurse continues to "help" by taking care of the colostomy for the client, thereby promoting increased dependency.	The nurse encourages the client to look at, touch, and care for the colostomy. Gradually, the client assumes independent care of the colostomy.

Source: Adapted from Sparks, A. (2009). *Peplau Interpersonal Relations* (PowerPoint presentation). Available at www.slideshare.net

progresses through stages. There are various frameworks for viewing the stages of the nurse–client relationship. As presented in Chapter 1, Peplau identified four phases: orientation, identification, exploitation, and resolution, with specific outcomes associated with each phase. An alternative framework that identifies the four phases as preinteraction, orientation, working, and termination is presented next, along with the expected goals and tasks that are expected to occur during each stage of the relationship.

Preinteraction Phase

The preinteraction phase begins before the nurse and client meet. At this stage, the nurse prepares for the interaction by reviewing available data and considers personal feelings and thoughts that may relate to the client.

A review of available data may include a medical record, a verbal report, or other source of introductory information. The nurse uses this information to construct an initial plan for assessment and intervention. For example, the nurse who knows that a client who is being admitted has suicidal thoughts will plan for necessary safety measures, including adequate staffing should 1:1 supervision be indicated.

During this phase, the nurse examines any preconceived attitudes or beliefs that may interfere with providing therapeutic care to the particular client. If the client has negative feelings about people with addictions or a history of criminal behaviors, it is important for the nurse to acknowledge these feelings. This issue relates to the concept of countertransference, which is discussed later in the chapter.

Orientation Phase

The orientation phase is the getting acquainted or introductory phase, which begins when the nurse and client have their initial encounter. The tasks of this phase are to develop trust and to establish the nurse as a significant other to the client, establish a verbal contract or understanding of the nature and boundaries of the relationship, collect data as part of completing a nursing assessment, formulate a nursing diagnosis, establish mutually acceptable goals, and develop an initial plan of care.

The client's first impression of the nurse can be critical to the relationship. The client learns to trust the nurse only if the nurse is able to convey acceptance of the client (as a parent would of a child) and exhibit consistent behavior. The client identifies strengths as well as relevant concerns, and the nurse facilitates the process. During this phase, the nurse and client agree on a mutually acceptable contract that establishes the relationship's parameters. Although consistency and acceptance are desirable during all phases of the relationship, these behaviors are essential during the orientation phase.

Working Phase

The working phase, as indicated by the term, is the period during which much of the work is done. Therapeutic tasks during this phase may include acquiring knowledge, implementing problem-solving interventions, understanding the relationship of feelings to behaviors, and learning new behaviors and skills. The nurse collaborates with the client to promote insight and acceptance.

This phase is characterized by the highly individualized nature of the problems being addressed. During this phase the nurse is aware that the client may experience an increase in anxiety that can lead to resistance or reluctance to continue the work that is under way. Often without awareness of the underlying anxiety, the client may miss appointments or become angry during this stage of the relationship. The nurse helps the client understand this behavior and move past this anxiety. To accomplish this, it is necessary to maintain trust and rapport. Evaluation of progress towards the identified goals is made at intervals and adjustments are made, if indicated.

Termination Phase

Termination marks the ending of the nurse–client relationship. Tasks during this phase include evaluating outcomes, expressing feelings about ending the relationship, summarizing achievements, and transitioning to the next level of care, if applicable. The goal of this phase for both the client and nurse is to integrate helpful experiences so that what has been learned may be used in future relationships.

Ideally, termination of the relationship occurs when the goals have been met. At other times, termination may be related to discharge from one level of care, with plans for continued treatment with another nurse or therapist in a different setting, or it could be related to a change in nurse assignment, such as vacation or the end of a student's rotation. In these situations, because the termination is anticipated, the nurse and client will have time to prepare for and carry out the tasks associated with termination. If, for

an unexpected reason, the relationship ends abruptly, attention must be given to assisting the nurse and client with feelings about the termination.

Termination can be difficult for both the nurse and the client. Paradoxically, the more successful the relationship, the more emotionally painful is the termination. As a result, both the nurse and client are tempted to deny the inevitable and pretend that their parting is only temporary. They may use phrases such as, "Keep in touch," "I'm sure we'll run into each other," and, "See you later." These strategies are comforting in the short term but do not help either in the long run. It is better to acknowledge the end of the relationship. In response to ambivalence about termination, the client may regress and exhibit behaviors that were part of the original treatment goal, or the client may verbalize uncertainty about readiness for discharge. These behaviors are understandable, and their occurrence provides an opportunity for the nurse to help the client explore these feelings, review the client's achievements and strengths, and identify other sources of support that will be available to the client.

Essential Characteristics of the Nurse in a Therapeutic Relationship

Several qualities are recognized as significant to the development of a helping relationship.

Respect

Psychologist Carl Rogers (1951) referred to respect as unconditional positive regard or the ability to accept another's beliefs even if they differ from one's own feelings and beliefs. This concept is the foundation for an accepting and nonjudgmental attitude. It communicates to clients that their personal beliefs and values are important. The nurse does not need to agree, but, at the same time, does not impose personal values on the client. Rather, the nurse attempts to understand the client's perspective. When the client feels understood, a rapport or affinity develops between the client and the nurse. An accepting and respectful attitude is likely to promote client comfort and facilitate the client's honest expression of symptoms, beliefs, thoughts, feelings, and concerns.

Ways to foster respect include asking clients how they prefer to be addressed, spending time with the client, being honest in all communications, providing for privacy, maintaining confidentiality, collaborating with clients on treatment planning, providing information, and answering questions.

Trust

Trust is the foundation of all interpersonal relationships and the first task in Erikson's developmental hierarchy. The client's ability to trust will be influenced by how well this developmental task was accomplished during early interactions with parents and caregivers. In describing trust, Erikson (1963) used the terms *consistent*, *familiar*, and *predictable*. The client needs to know that the nurse is reliable, honest, and dependable. Trust is particularly important, given the vulnerable position of clients with healthcare needs. Trust does not happen immediately but evolves or, more correctly, is earned over the course of the relationship. Every interaction with the nurse will either support or shake the development of trust on the part of the client.

Nurse actions that promote trust include following through on promises, showing kindness, treating the client fairly, and presenting a confident manner.

Genuineness

The nurse's ability to be oneself, or to be real, when interacting with clients is referred to as **genuineness**. By acting in a genuine way, the nurse helps the client to see the shared humanity between client and nurse. Genuineness implies congruence between what the nurse is feeling and the expression of that feeling. The nurse must learn appropriate use of self-disclosure. The nurse would not share all personal experiences, even if relevant, nor would the nurse express judgments that are critical of the client or the client's values. Still, there are many ways that the nurse can show his or her humanity when interacting with the client. The nurse may laugh at a funny joke told by the client or express understanding about a difficulty the client is having, or share that the nurse finds meditation to be a helpful form of relaxation. A novice nurse may try to disguise his or her inexperience from the client out of concern that the client will think less of the nurse. In fact, clients can easily detect a lack of genuineness and are more likely to respect the nurse for honestly acknowledging limitations. The quality of genuineness, or the authentic representation of the self, will greatly enrich the nurse–client experience.

Critical Thinking Question

How would you feel if, as a novice nurse, a client asked how long you had worked as a psychiatric nurse? What would you be thinking? How would you reply?

Empathy

Empathy is the ability to put oneself in another's place and see the world as the other person does. This objective understanding of the client's emotions allows the nurse to be sensitive to the client's feelings without experiencing the emotions. This is in contrast to sympathy, a subjective experience, in which there is an actual sharing of experienced emotions. Sympathy can interfere with the nurse–client relationship in a couple of ways: the nurse can become overwhelmed by the emotions and be unable to help the client; the nurse who shares an experience with the client as a way of saying "I know how you feel" risks shifting the focus of the interaction away from the client. The nurse's intention may be to support the client, but the action is not effective. Empathy promotes sensitivity to the client's feelings and needs. The nurse must communicate this understanding to the client in a way that the client can understand. This will contribute to the client's experience of being understood, thus building trust.

Transference and Countertransference

Transference and countertransference are unconscious processes that can interfere with communication in the nurse–client relationship. It is important for the nurse to recognize behaviors that suggest transference or countertransference so it can be addressed with the client or in supervision.

Transference

Transference consists of realistic and unrealistic feelings that the client has toward the nurse.

Countertransference refers to the feelings the nurse has toward the client.

Transference is traditionally defined as a client's projection or displacement of unconscious feelings, desires, and actions from a person in his or her life onto the nurse or other therapist (APA, 2007). The concept of transference includes a realistic appreciation for the role that the therapeutic relationship plays in determining the client's response to treatment and attitude toward the nurse or healthcare worker. For example, a minority client who has been the victim of prejudice may be appropriately apprehensive about disclosing information to a nurse of the same ethnic background as his or her oppressors. The rationale for the client's feelings towards the nurse is outside of conscious awareness. In another example, the nurse may remind the client of a punitive parent and the client may then act towards the nurse with anger or with behaviors that challenge the nurse's authority.

Countertransference

The healthcare professional's feelings and reactions toward the client are known as **countertransference**. The nurse or healthcare worker displaces or projects unconscious feelings, desires, or actions from a person in his or her life onto the client (APA, 2007). The countertransference feelings can be based on positive or negative associations. In either case, they can interfere with the therapeutic relationship. For example, a nurse who cared for her grandmother during the final months of her illness may value the experience and remember the appreciation and love she received from her grandmother. The nurse may transfer feelings for her grandmother to a female client and attempt to take care of the woman, doing for her things that the woman can manage independently. This has the nontherapeutic effect of fostering dependence.

The following behaviors should alert the nurse to the possibility of countertransference: inappropriate or exaggerated emotional responses toward the client, feelings of exhaustion, stereotyped or fixed responses regardless of what the client is saying, impulses to treat the client in a special way, and extreme over- or underinvolvement with the client.

Education, supervision, and consultation with colleagues are essential for the nurse to use the countertransference productively. Appropriately analyzed, countertransference may offer important clues to a client's diagnosis or symptoms. For example, a nurse's feelings of extreme anger during an interview may identify the client's hidden rage.

Power Disparity

One important source of transference and countertransference is the power disparity between the nurse and the client. The nurse assumes the responsibility for moving the interaction forward to achieve a goal, while the client passively answers questions.

Clinical Example

Leo is a 15-year-old male admitted to a residential treatment center for the treatment of oppositional defiant disorder. Immediately upon his arrival to the unit, the admitting nurse sat down with Leo to complete a four-page nursing assessment form. When the rest of the residents lined up to go to the cafeteria for dinner, Leo promptly got up to join them. The nurse shouted at Leo to sit back down because the assessment was not yet complete and he had not asked for permission to join the group. Leo cursed at the nurse and stated that he was hungry. The nurse shouted back to Leo that she—and not Leo—was in charge of the unit, and that if he kept it up she would ban him from the cafeteria for the rest of the week. The supervisor arrived on the scene and quickly recognized that a power struggle had developed between the nurse and the new resident, who were demonstrating countertransference and transference, respectively. The supervisor asked another nurse to go over the rule book with Leo and to inform him that food would soon be brought to the unit for him, while the supervisor discussed the problematic transaction privately with the admitting nurse.

This situation often results in a transference, which for the client represents a repetition of feelings and reactions from past experiences with authority figures. Depending upon the client's history and current symptoms, the client may be overly compliant with the interviewer (e.g., tell the interviewer exactly what the interviewer wants to hear) or overly oppositional (e.g., assert that the professional has no right to ask such personal questions). For the nurse, the power disparity may cause feelings of omnipotence and fantasies of being able to save the client. The nurse may fail to involve the client in the treatment plan and may feel anger toward noncompliant clients as well.

Conditions That Influence the Nurse–Client Relationship

Client Factors

Religion and Culture

Styles of communication vary across cultures and religions. It is helpful for the nurse to be familiar with the beliefs, values, customs, and preferences of the groups most often served in the community. Even with knowledge of general beliefs and practices, the nurse should not assume that the client fits that expectation. Therefore, the nurse should clarify personal preferences with each client. Consideration should be given to the proper pronunciation of the client's name, the need for an interpreter, the role of the family, and preferences or religious requirements regarding interaction with persons of the opposite gender. Cultural variances may include the use of eye contact, the acceptable distance between persons while communicating, posture, and other nonverbal communication. The nurse needs to be sensitive to these differences and respectful to the client.

Age or Developmental Level

The nurse must have knowledge of the client's developmental level and be aware of the client's ability to communicate. This understanding will shape the way the nurse relates to the client. Communication must be appropriate to the client's level of comprehension. The nurse will need to be aware of the client's nonverbal communication and open to alternative ways of communicating, such as play. Children can express feelings, fears, and concerns through play.

Nurse Factors

Self-Awareness

Even with knowledge of general customs and practices, the nurse should not assume that the client fits that expectation. Therefore, the nurse should clarify personal preferences with each client.

Self-awareness literally means understanding the self. The nurse has a responsibility to examine personal feelings, thoughts, behaviors, attitudes, and intentions. This ongoing monitoring requires openness and an ability to be self-critical. The nurse's emotional responses and actions have a significant impact on the client. The nurse must be sensitive to this effect. Self-awareness allows the nurse to separate personal feelings from the client's responses. This ability to control and manage personal emotions and respond appropriately to others is called emotional competency or **emotional intelligence**. The personal growth that comes through self-awareness will enrich the therapeutic relationship.

Boundaries

Boundaries are limits that help establish and maintain the nurse and client roles in the relationship. To be truly helpful to clients, nurses need to understand the difference between professional and social relationships. Social relationships are interactions in which the needs of both persons are of equal importance. In contrast, professional relationships are those in which the needs of the client are paramount. This principle guides the nurse's decisions on handling difficult situations with clients.

Self-Disclosure. One area of boundaries involves self-disclosure. **Self-disclosure** refers to revealing personal information about oneself, with the goal of benefiting the client and the therapeutic process. It is not always easy to know if the information will help the client. Self-disclosure can reverse the nurse–client dynamic and sever the client from the role of information giver. The focus of the nurse–client relationship is always the client. With experience, the nurse is better able to determine what information may be shared without compromising the relationship. In the following example, the nurse balances genuineness with maintaining a professional relationship.

Self-disclosure is a controversial intervention that should only be used to benefit the client and the therapeutic process, never for selfish reasons.

Example:

Client: "I think I have to place my mother in a nursing facility. She is becoming very forgetful and needs help with her personal care. What do you think I should do?"

Nurse: "That is something you will have to decide. I have an elderly parent, and I can imagine how difficult this is for you."

The nurse should never reveal intimate information or answer questions that raise feelings of discomfort.

Example:

Client: "May I have your phone number so I can stay in touch after I leave the hospital?"

Nurse: "I cannot give my phone number. Are you concerned about who to call if you have questions or concerns after you are discharged?"

In this example, the nurse appropriately refuses to give personal information and counters the client's possible feelings of rejection by showing concern and a willingness to help.

Because decisions about what information is appropriate to share with the client are difficult, the nurse should seek guidance from an experienced nurse or colleague.

One piece of information important to disclose to the client to protect the client's rights is the nurse's name, title, and position. As mentioned earlier, students and beginning practitioners may be reluctant to divulge their novice status. Clients, however, may pick up on an interviewer's newness. Thus, denying that you are new in the field may cause a lack of trust. Clients who seem distressed by the nurse's lack of experience should be encouraged to discuss this with the nurse and may be referred to the nurse's supervisor for reassurance if necessary. Psychiatric clients who have had previous experience with new nurses and students often come to expect this as the norm; certain clients actually take pride in "training" new nurses.

Touch. The use of touch is another area that is influenced by the importance of maintaining appropriate boundaries. Touch is commonly used to convey caring, provide comfort, or offer support. Touch is essential to carry out physical care or treatments. However, touch can be interpreted differently by clients, and at times may be misinterpreted. Touch may not be welcomed based on cultural or religious preferences. Clients who are experiencing paranoia or psychoses may be threatened by touch, and clients with sexual preoccupation may misinterpret the nurse's touch as sexual. Inpatient settings often have a general rule of no touching as a way of reducing incidents related to such misinterpretations. This rule is helpful to students and novice practitioners, since it often takes experience to recognize when touch can present serious risks. In the absence of a rule,

Clinical Example

A client is going through a bad breakup of a relationship. The nurse may feel tempted to tell the client of a similar experience (e.g., "I know how you feel. My boyfriend and I just split up."). The nurse may feel good revealing this; however, a client in acute distress may feel that the nurse is not understanding his or her unique feelings and circumstances.

the nurse should use touch cautiously and inform clients before touching them for physical care, such as taking a blood pressure.

Critical Thinking Question

What personal information might you share with a client? How and in what context would you disclose this information? What personal information would you not disclose to a client?

Communication Techniques

Active Listening

Active listening is an interactive process between the nurse and the client with the goal of understanding and being understood, involving hearing the message, understanding the message, and giving feedback about what was heard (Sheldon, 2009). Active listening requires vast energy, self-control, patience, genuine interest, and concentration (Antai-Otong, 2007). Active listening fosters trust and establishes a dialogue for the expression of the client's feelings. **Table 3-3** lists actions that promote active listening.

Table 3-3 Actions to Promote Active Listening

Sit upright facing the client
Lean slightly forward toward the client
Maintain an open posture (arms and legs not crossed)
Make eye contact; keep gaze comfortable; do not stare
Relax
Be attentive; block out distractions
Nod or make encouraging overtures, e.g., "Go on."
Avoid interruptions

Source: Adapted from Sheldon, L. K. (2009). *Communication for nurses, talking with patients* (2nd ed.). Sudbury, MA: Jones and Bartlett Publishers; and Antai-Otong, D. A. (2007). *Nurse-client communication, a life span approach*. Sudbury, MA: Jones and Bartlett Publishers.

Nonverbal Techniques

Facial Expression

Facial expression can communicate a variety of emotions. Tears communicate sadness, while a smile can communicate warmth or happiness. While the nurse may interpret the client's feeling or mood based on the facial expression, it is important to validate the interpretation with the client. It is significant to note if the client's facial expression is incongruent with the stated feeling. Incongruence or an absence of facial expression can be related to certain physical or mental disorders.

Eye Contact

Eye contact varies greatly across cultures. In the American culture, direct eye contact communicates interest, openness, and trustworthiness. In other cultures, this may be considered disrespectful or even hostile. An averted gaze may be interpreted as shyness, disinterest, or avoidance. However, in some cultures, it is a sign of respect. Eye contact is a form of communication, but the meaning must be validated with each individual.

Active listening requires vast energy, self-control, patience, genuine interest, and concentration.

Posture

A person's body posture communicates how the person feels about him or herself, and, if engaged in an interaction, posture also communicates feelings towards the other person. Standing tall communicates confidence and self esteem. Hands on the hips or clasped behind the head conveys superiority. The person with slumped shoulders, staring at the floor, suggests low self esteem. Tapping fingers or feet indicate nervousness or impatience. A closed posture, that is crossed arms and legs, indicates the person is closed to communication. In contrast, an open posture, with hands on lap, legs uncrossed, signals an openness or receptivity to communication. The nurse must validate the meaning of the client's posture. Knowing that posture is a way of communicating, the nurse must be aware and sensitive to the messages sent by his or her own posture.

Verbal Techniques

Therapeutic Techniques

To be effective, the nurse depends on skillful communication. In addition to the qualities of self-awareness, empathy, genuineness, and a positive self-image, the nurse needs to apply constructive strategies for obtaining and conveying information. The nurse selects specific strategies based on the goal of the interaction or the type of response being elicited. **Table 3-4** matches common goals of the nurse's communication with techniques best suited to soliciting the desired response.

Table 3-4 Therapeutic Versus Nontherapeutic Communication Techniques

Goals	Therapeutic Techniques and Examples	Nontherapeutic Techniques and Examples
To engage the client in treatment	Offering self: "I will stay here with you for a while." Suggested collaboration: "Let's work together to see if we can identify when your problems began."	Giving false reassurance: "Don't worry; everything will be fine." Using platitudes: "Keep your chin up; tomorrow is another day."
To get the client to open up and share information, thoughts, and feelings	Judiciously using silence. Using broad, open-ended questions such as, "Tell me about your family." Actively listening by nodding and leaning toward the client. Using encouraging verbalizations such as "yes" and "I understand." Offering general leads such as "please continue" or "I am interested in hearing more about that."	Asking questions that yield only "yes" or "no" answers. Asking incessant closed-ended questions, so that the conversation seems like an interrogation.
To convey to the client that you understand	Summarizing the content. Restating content: *Client:* "I am so depressed that I cannot even eat." *Nurse*: "So your depression has caused you to lose your appetite." Reflecting on process: "You seem anxious." or "It seems difficult for you to talk about this."	Using premature interpretations that deny the client's feelings: "You're not really angry with your mother; you're just looking for attention." Inappropriately using self-disclosure: "I know just how you feel, because my boyfriend just broke up with me, too."
To get the client more actively involved in treatment	Reflecting the client's questions back to him or her: *Client*: "What should I tell people at work about my hospitalization?" *Nurse:* "What are you thinking about telling them?" Encouraging comparison: "What have you done in the past when faced with such a difficult situation?" Encouraging decision making: "What will you do the next time that you find yourself in a similar situation?"	Overtly agreeing or disagreeing with the client: "What you did was definitely the right (or wrong) thing to do." Giving advice: "I think that you should . . ."
To explore a topic in more detail	Exploring: "Could you tell me more about that issue?" Focusing: "Let's go back and discuss that topic further."	Bombarding the client with multiple closed-ended questions on a topic.
To diffuse a client's nonpsychotic anger	Agreeing with the grain of truth in the client's complaint: *Client:* "I hate this hospital. It's like a jail." *Nurse:* "I can see how you would feel that way, with all of the rules and the locked door. Let's talk about how you can be more comfortable here."	Denying the client's reality: *Client:* "I hate this hospital. It's like a jail." *Nurse:* "You know that this is not a jail."

Table 3-4 **Therapeutic Versus Nontherapeutic Communication Techniques *(Continued)***

Goals	Therapeutic Techniques and Examples	Nontherapeutic Techniques and Examples
To help the client control aggressive behavior	Limit-setting: "I will not be able to continue to talk with you if you continue to act in a threatening manner." Giving positive reinforcement for calm behavior. Decreasing stimuli: Placing the client in a quiet area until he or she is calmer.	Punishing the client: "You are going to have to stay in your room for 1 hour because you cursed at me" (choosing an arbitrary time period, unrelated to the client's behavior).
To clarify information	Asking for clarification: "Could you explain that to me again?" "Let's see if I have this straight." Placing events in sequence: "Did you start to drink alcohol before or after becoming depressed?"	Jumping to conclusions about the meaning of a client's statement, instead of seeking clarification.
To determine causes of problems or behaviors	Nonjudgmentally exploring: "What is it that gets in the way of your getting up to make it to work on time?"	Asking confrontational "why" questions: "Why are you unable to get to work on time?"
To effectively address delusional content	Focusing on the feeling content of delusions: *Client:* "People are trying to kill me!" *Nurse:* "You must be very frightened."	Directly challenging a client's belief system: *Client:* "Laser beams are irradiating me!" *Nurse:* "There is no way that laser beams are being sent through you—that's impossible."
To move to another topic of discussion	Transitioning gently: "What you are saying is very important, and I want to give it proper attention when we have more time. Right now, however, we need to move on."	Rejecting a client's topic or abruptly changing the subject: "It's not necessary to go into that right now. Let's talk about your hallucinations instead."

Nontherapeutic Techniques

Table 3-4 also provides examples of nontherapeutic communication techniques, or strategies that are likely to impede successful communication. Students often express a fear of saying the wrong thing to a client. More important than the words used, is the intention to help and a caring, respectful manner. If the nurse notes an unexpected or unfavorable response from the client, it is important to clarify what the client heard and restate the nurse's message and intent. The nurse will only become skilled in the art of communication through practice and review. The effort will be worth the rewards.

Assertive Communication

Assertive communication is a style that effectively expresses the person's thoughts and feelings in a way that respects the needs and rights of others. Assertive communication promotes the use of *I* statements, which allow the client to own the feeling. In assertive communication, the client is encouraged to make clear what he or she wants from the other person. This clarity, and a respectful manner, maximizes the chances that the person's needs will be recognized and met in a satisfactory way. By avoiding anger, assertiveness helps to preserve relationships. Assertive communication avoids the use of *you* statements, which can sound angry or accusatory and put people on the defensive. This style of communication would be called aggressive. Assertive communication is also in contrast with the passive style, which is apologetic and in which the client subjugates his or her own needs in deference to the feelings or needs of another person. A comparison of these styles is presented in **Table 3-5**.

Assertive communication is a skill that clients can learn and apply to a range of situations, such as expressing feelings, asking for help, and saying no to requests that cause stress or discomfort. Most impor-

Table 3-5 Assertive Versus Passive and Aggressive Communication

Assertive	Effectively communicates personal needs, thoughts, and feelings while respecting the rights of others; uses *I* statements.	"I lose my train of thought when you come into class late. I expect all students to be here when class starts."
Passive	Personal needs are secondary to others; style is apologetic or complaining.	"I hate to bring this up, but could you try to come to class on time?"
Aggressive	Expresses needs but in a way that is disrespectful to others; manner is hostile, angry, accusatory; uses *you* statements.	"You are always late. Your behavior is unacceptable and will not be tolerated."

tantly, the nurse should model effective communication by the practice of assertive communication.

Critical Thinking Question

A colleague asks you to switch weekends and you don't want to make the change. Using principles of assertive communication, how would you refuse this request?

Summary

The nurse–client relationship is the hallmark of psychiatric nursing and the context in which all nursing is practiced. The nurse–client relationship is focused on meeting the needs of the client, is collaborative in nature, and has identified goals. There are four phases to the nurse–client relationship—the preinteraction phase, the orientation phase, the working phase, and the termination phase, each with expected tasks and goals. Essential characteristics of the nurse in a helping relationship include respect, trust, genuineness, and empathy. The unconscious processes of transference and countertransference can interfere with the nurse–client relationship and must be addressed. The client's beliefs and values, which are associated with religion and culture, as well as his or her developmental level, affect communication. The nurse must validate interpretations of behavior with each individual. Self-awareness allows the nurse to separate personal feelings from the client's responses. The use of therapeutic communication techniques and the avoidance of nontherapeutic techniques can help the nurse to guide the nurse–client interaction. Assertive communication skills are important for both the nurse and client as an aid to effective communication of needs.

Annotated References

American Psychological Association (APA). (2007). *APA dictionary of psychology*. Washington, DC: Author.
The dictionary provides definitions of psychology terms and encompasses all areas of research and application, concepts, processes, and therapies.

Antai-Otong, D. A. (2007). *Nurse–client communication, a life span approach*. Sudbury, MA: Jones and Bartlett Publishers.
This book presents an overview of effective communication and its influence on therapeutic relationships across the life span.

Erikson, E. (1963). *Childhood and society* (2nd ed.). New York, NY: W. W. Norton & Company.
This pioneering work regarding the evolution of personality over one's lifetime is easy to understand and apply to practice. Development is put into historical and sociological perspective, and the role of the child in society is also explored.

Peplau, H. (1952). *Interpersonal relations in nursing*. New York, NY: G. P. Putnam.
This classic psychiatric nursing textbook provides the basic concepts to guide professional nurses in establishing mature therapeutic relationships with clients (patients) with all types of conditions and in all settings.

Rogers, C. (1951). *Client-centered therapy*. Boston, MA: Houghton Mifflin Company.
A classic book defining the Rogerian approach to psychotherapy.

Sheldon, L. K. (2009). *Communication for nurses, talking with patients* (2nd ed.). Sudbury, MA: Jones and Bartlett Publishers.
This book presents communication techniques to enhance the nurse-client relationship with different client groups and across a variety of situations.

Additional Resources

Hays, J. S., & Larson, K. H. (1963). *Interacting with patients*. New York, NY: Macmillan.

Travelbee, J. (1969). *Intervention in psychiatric nursing: Process in the one-to-one relationship.* Philadelphia, PA: F. A. Davis Company.
This classic primer by one of the pioneers of psychiatric nursing is rich in clear explanations and clinical examples of the practice of psychiatric nursing.

Williams, C. L. (2008). *Therapeutic interaction in nursing* (2nd ed.). Sudbury, MA: Jones and Bartlett Publishers.
This book addresses communication issues relevant to a variety of nurse–client interactions and provides many clinical examples as well as exercises for the learner.

Internet Resources

For a full suite of assignments and additional learning activities, use the access code located in the front of your book to visit this exclusive website: http://go.jblearning.com/mentalhealth. If you do not have an access code, you can obtain one at the site.