Skills

Therapeutic Communication Using Trauma-Informed Care - CE

Extended Text

ALERT

Avoid using language that is harsh, abrupt, or demeaning; this type of communication escalates dysfunctional patient behaviors, reduces cooperation, triggers treatment withdrawal, and retraumatizes a patient with a history of trauma and abuse.[10]

OVERVIEW

Childhood and adult trauma are significant risk factors for mental illness, stress, disability, and even death. A recent task force has suggested that all patients be screened for lifetime incidents of abuse and the emotional consequences of any trauma, including depression, suicidality, substance abuse, and chronic pain.[11]

There is a link between exposure to trauma and adverse mental health outcomes. Patients exposed to trauma are overrepresented among those who seek mental health, forensic health, and substance abuse services.[3] This evidence highlights the need to recognize the extensive impact that trauma has on a patient's perceptions and behaviors, identify the signs and symptoms that can be related to the experience of trauma, and the need to always approach the possible victim of trauma in a manner that will not result in retraumatization.[5] Therefore, coercion or actions that may be perceived as threatening should be avoided.[12]

Understanding how best to communicate therapeutically with a patient who has a mental health condition is critical. Therapeutic communication provides an avenue to achieve consistent, effective patient cooperation and participation in treatment. Knowing and understanding the psychiatric diagnosis is important in determining which communication techniques are the most helpful.

Many patients with mental health conditions have been treated condescendingly, ignored, or addressed in belittling, antagonistic ways, and many are sensitive to negativity. Unfortunately, these problems occur not only in a patient's daily life but also in professional medical settings. Patients who are perceived as being difficult may be avoided, ridiculed, blamed, or punished by health care team members.[3] Physical complaints may be minimized, dismissed, or attributed to psychiatric problems. These team member behaviors often result in increased patient anxiety and inappropriate behavioral responses.

Tolerating unacceptable behavior or negatively enabling patients does not promote therapeutic communication. Using rapport and alliance enables therapeutic communication by providing support, consistency, and reliability in patient care. Therapeutic communication reduces patient anxiety and allows for the delivery of the intended message to the patient. Communicating in a therapeutic manner encourages expression of emotion, reduces anxiety, and encourages a patient-centered care environment.[11] Communicating in a therapeutic manner by using nonbiased language and restating or reframing of patient responses exemplifies professional behavior.

SUPPLIES

Click here for a list of supplies.

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Provide family members with an opportunity to offer information, observations, and insight about the patient.
- Enlist family members' cooperation in achieving the plan of care.
- Educate family members about the use of therapeutic communication techniques.
- Encourage family members to recognize and avoid power struggles.

- Collaborate with family members in the early recognition of increasing anxiety.
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene before patient contact. Don appropriate personal protective equipment (PPE) based on the patient's need for isolation precautions or the risk of exposure to bodily fluids.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.[8]
5. Assess the patient's cognitive function, including the ability to provide information, answer questions, and orient to reality.
6. Assess the degree of exacerbation of psychiatric symptoms based on the patient's history (if available).
7. Assess the patient's mood and affect, noting any agitation or anxiety.
8. Assess the patient's ability to cooperate with requests from health care team members, including the ability to remain in control of behaviors.
9. Assess for any difficulty in expressing pain, discomfort, or anxiety.
10. Observe the patient's use of nonverbal communication when expressing needs.
11. Assess the patient's willingness to participate in treatment.
12. Question the patient about symptoms related to mental illness, especially hallucinations, thoughts of self-harm, and any history of trauma or abuse.
13. Ask the patient about physical comfort, including hunger, pain, and warmth.
14. Assess the patient's ability to interact appropriately with others.
15. Assess the patient's understanding of current medical and psychiatric diagnoses, including associated symptoms.
16. Observe the patient's reactions to interventions from health care team members.
17. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.

STRATEGIES

1. Evaluate communication with the patient to ensure that verbal and nonverbal communication is consistently therapeutic.
    a. Make eye contact; avoid turning away from the patient.
    b. Use a respectful tone of voice.
    c. Avoid dismissive nonverbal communications (e.g., eye-rolling).

> Rationale: Many patients are sensitive to perceived rejection or negativity. Not making eye contact, turning away from the patient, and eye-rolling can be interpreted in a negative manner by the patient. Monitoring voice tone is important; speaking in a loud, rapid, curt, or sarcastic manner may exacerbate the patient's negative response to the communication.[6]

> **Pay close attention to nonverbal communication; simply using the right words is not enough. Patients react more to nonverbal communication than to verbal communication.[9]**

2. If safety is a concern, ask the patient's thoughts concerning what would help maintain safety. If the patient is currently the victim of domestic abuse, be mindful of a return to a potentially dangerous environment.

> Rationale: Asking the patient directly, rather than assuming what would be helpful, increases the patient's involvement and investment in care.

Although patient input is important, use sound clinical judgment concerning safety and follow the organization's practice.

3. Assess the patient's level of cognitive organization and modify language appropriately.

Rationale: Abstract language should be avoided because the patient may not understand what is being said. The patient's level of cognitive organization may change throughout the inpatient stay.

a. Patients who are experiencing active psychosis or mania respond best to short, simple statements and requests.
b. Patients with symptoms of depression or anxiety may be easily overwhelmed or confused.

4. Interact with the patient on a regular basis and check back frequently.

Rationale: Regular interaction with the patient helps health care team members build rapport and establish trust, which reduces the patient's anxiety and negative behaviors.[6] In addition, it allows for monitoring of the patient for changes in status.

5. Monitor the patient's response to interactions with health care team members, noting any team member behaviors that trigger patient anxiety.

Rationale: Many patients are sensitive to perceived negativity and rejection. Predicting which behaviors trigger anxiety may be difficult; thus, any reactions should be noted.[5]

a. Knowing and understanding the patient's history of psychiatric illness or experience of trauma is important in understanding factors that may trigger anxiety.
b. This is especially important if the patient has a history of posttraumatic stress disorder or abuse.

6. Use supportive, nonjudgmental language.

Rationale: Patient cooperation and teaching are facilitated by respectful language and attitude.

7. Encourage the patient to approach health care team members with concerns in a straightforward, timely manner.

Rationale: When patients are encouraged to express concerns or complaints directly to health care team members, they are less likely to use indirect methods to meet their needs. This strategy also builds rapport and trust between a team member and the patient.[11] After a patient reveals a history of trauma, it is important to be empathic and supportive, and validate the patient's experiences.[12]

To maintain credibility, take the patient's concerns seriously.

8. Avoid statements that minimize the patient's feelings (e.g., "I know how you feel," "That's no worse than my problems").

Rationale: Health care team members should have credibility with patients. Statements that minimize or dismiss the patient's feelings tend to create distrust.[11]

Health care team members who are experiencing abuse themselves should be mindful of their counter-transference to patients who have experienced or are experiencing trauma.

9. Pay close attention to the patient's reactions.

Rationale: Knowing which statements may upset the patient can be challenging. The patient may display subtle cues (such as a change in affect) that indicate a statement was perceived negatively.

10. Do not engage in power struggles; avoid the need to be right.[4]

Rationale: Power struggles shift the focus from problem-solving to blaming. A "need to be right" attitude may give the impression that health care team members do not value the patient's opinions or beliefs. Team members who engage in power struggles lose credibility. Power struggles create an atmosphere of tension and lack of cooperation between team members and patients, undermining a therapeutic relationship and compromising effective limit setting.

11. Do not react to patient attempts to antagonize or provoke a reaction.

Rationale: Reacting emotionally to a patient's behaviors makes the task of maintaining a professional attitude difficult and can compromise the safety of the health care team member and patient.

Seek professional supervision when maintaining objectivity becomes difficult.

12. Avoid making statements or using coercive behavior that is likely to increase defensiveness.[6]
    a. Avoid words such as *never*, *always*, and *constantly*.
    b. Avoid statements that exaggerate the truth (e.g., "You have rung the call bell a thousand times today").
    c. Avoid issues that are irrelevant (e.g., "You didn't cooperate the last time you were admitted").

Rationale: Statements that are untrue, exaggerated, or irrelevant to the current situation are likely to result in an argument between the health care team member and the patient. Statements that increase defensiveness decrease the likelihood that the patient will openly listen; instead of listening, the patient is thinking of a defense, which will likely result in an argument.

13. Monitor the patient for changes in anxiety level. Keep the signs of escalation in mind: anxiety, agitation, and aggression.

> Rationale: Early identification of worsening anxiety or agitation increases the effectiveness of management techniques. Therapeutic communication strategies are more effective when the patient's anxiety level has been appropriately managed. Managing anxiety is an important feature of trauma-informed care. Anxiety, agitation, and aggression are a common sequence of escalation. Unrecognized and untreated anxiety or agitation often leads to aggression.[2]

14. Use appropriate humor.

> Rationale: Humor is helpful with mild-to-moderate anxiety and is useful in establishing rapport.

> **Avoid sarcastic humor that is directed at issues about which the patient may be sensitive.**

15. Provide options when possible by using verbal and nonverbal techniques, especially if the patient appears resistant, overwhelmed, or anxious.

> Rationale: Providing options using verbal and nonverbal techniques gives the patient a sense of control and autonomy and reduces anxiety.[6]

> **Do not use ultimatums or threats as options, such as, "You can cooperate now, or you can be discharged." The use of ultimatums or threats can have a negative impact on the therapeutic rapport with the patient.**

16. Involve the patient in problem-solving.
    a. Use questions, such as "What has worked for you in the past?" or "What would be most helpful for you right now?"
    b. If the patient suggests solutions that are not allowed or acceptable (e.g., smoking), provide redirection; be prepared to offer alternatives (e.g., a nicotine patch).

> Rationale: Helping the patient to identify solutions reduces anger, increases investment in treatment, and gives the patient a sense of control over options and environment.[6] Questions engage the patient in developing solutions.

17. Give the patient an opportunity to express difficult or uncomfortable feelings or reveal any recent or previous abuse.

> Rationale: Allowing the patient to express difficult feelings without interruption may be a therapeutic intervention. In many cases, it decreases anxiety and frustration. Revealing any recent or past abuse is potentially therapeutic.

18. Refrain from suggesting that the patient's feelings are inappropriate or unacceptable (e.g., statements such as, "I don't know why you are so angry" or "I think you are overreacting").

Rationale: Statements that suggest the patient's feelings are inappropriate or unacceptable are likely to cause the patient's negative behavior to escalate.

19. Note positive changes in the patient's behavior and well-being.

Rationale: Communicating that the patient's efforts have been noticed and appreciated reinforces positive behaviors, enhances patient cooperation, and builds rapport.

20. Note negative changes in the patient's behavior in a nonconfrontational, nonjudgmental way (e.g., by saying, "This seems to be really difficult for you. What can I do to help you?").
21. Reassure the patient that the health care team is available to provide support and assistance. Explain to the patient that, although the team members are available, some circumstances may prevent them from being immediately available.

Rationale: Reassuring the patient of support from health care team members reduces anxiety and enhances a cooperative alliance between the patient and team members.

22. Demonstrate active listening as often as possible to communicate respect and gain the patient's trust.[11]
    a. Reflect what the patient said.
    b. Identify the patient's real concern.
    c. Avoid directive statements.

Rationale: Allowing the patient to speak without interruption or distraction demonstrates active listening behaviors that show respect and encourage trust. Patients who believe they are listened to are more likely to be cooperative and invested in treatment.[7]

23. Avoid negative, dismissive, defensive, or coercive communication (e.g., disrespectful tone of voice, dismissive or rejecting body language, sarcasm).
    a. Do not try to make the patient feel guilty.
    b. Do not ignore the patient.

Rationale: Negative, dismissive, or defensive communication gives a message that the patient and the patient's feelings are not important. Coercion often results in patients feeling controlled and not respected, which disturbs the therapeutic relationship.[6]

Many patients who are anxious, overwhelmed, angry, or uncomfortable use negative, dismissive, or defensive communication themselves. To avoid power struggles, do not respond in the same way, even if feeling provoked.

24. Apologize for miscommunication. Avoid blaming the patient directly or indirectly for miscommunication.

> Rationale: Miscommunication and misunderstanding can happen quite easily on a busy unit. Apologizing defuses the situation, making problem-solving with the patient easier. Blaming often increases defensiveness and makes collaborating with the patient more difficult. Statements such as “I’m sorry that this happened” help build rapport and trust with health care team members.

25. Review unit rules with the patient on admission and periodically thereafter. Set limits when necessary, using nonjudgmental language.

> Rationale: Setting limits that are therapeutic, clear, reasonable, and consistent is an essential component of therapeutic communication.[1]

26. Use language that is less likely to trigger anger.

> Rationale: Statements with words that are more neutrally perceived, such as *frustrated, confused,* and *worried,* are less likely to trigger a defensive, angry response from the patient. Statements that can be perceived as blaming often trigger anger.

> **When using "I feel" statements, avoid giving an opinion or blaming the patient (e.g., by saying, "I feel that you are not trying very hard").**

27. Provide the patient with linkages to safe housing, police, legal representation, if necessary, and outpatient therapy.
28. Remove PPE and perform hand hygiene.
29. Document the strategies in the patient's record.

REASSESSMENT

1. Reassess the patient's level of anxiety and agitation after interventions.
2. Reassess the patient's symptoms related to medical and psychiatric illnesses.
3. Frequently reassess the patient's level of cognitive organization.
4. Reassess the patient's willingness to cooperate with treatment.
5. Assess, treat, and reassess pain.

EXPECTED OUTCOMES

- Psychiatric symptoms are well managed, and the patient remains in control of behaviors.
- The patient cooperates with treatment and engages as an active participant.
- The patient engages in problem-solving with health care team members.
- The patient expresses feelings and concerns in a safe, effective way.
- The patient feels supported by health care team members in efforts to manage medical and psychiatric illnesses.
- The patient remains safe during the inpatient stay and communicates any safety concerns to health care team members.

UNEXPECTED OUTCOMES

- The patient causes harm to others.
- The patient leaves the acute care setting against medical advice.
- The patient engages in self-harm behaviors.
- The patient's behavior escalates and becomes out of control.

- The patient refuses to participate in treatment.
- The patient requires restraints to maintain safety.

DOCUMENTATION

- Changes to the plan of care
- Communication with family members
- Conflicts, concerns, problems, and resolutions, including assessment of abuse
- Education
- Medication given for anxiety or agitation and its effectiveness
- Patient's mood, affect, and behaviors
- Review of the unit rules and expectations
- Safety concerns, including threats to health care team members or others including domestic abuse situations
- Health care team member interventions and the patient's responses
- Unexpected outcomes and related interventions

ADOLESCENT CONSIDERATIONS

- The adolescent patient's desire to maintain privacy should be respected, unless contraindicated by safety concerns.
- A rapport with the adolescent patient should be established. It is important to take time to talk with the patient about interests, hobbies, and peers.
- A rapport should be established with parents. Therapeutic communication techniques should be demonstrated to family members.
- Barraging adolescents with personal questions or lecturing them should be avoided. Educational interactions should be kept short and simple, unless the adolescent requests additional information. Adolescent patients often have fears of being embarrassed.
- Adolescent patients should be encouraged to ask questions and to express concerns or frustrations, but they should not be forced to do so.[1]
- It is important to not take sides between parents and adolescent patients, especially over minor conflicts.
- The unit rules should be explained on admission; the adolescent patient should be assessed for any major concerns (e.g., mobile phone issues).

OLDER ADULT CONSIDERATIONS

- Older adults should be encouraged to talk about new symptoms of depression.
- The older adult's need for independence should be respected.
- The older adult should be treated with respect and dignity, avoiding patronizing language.
- A rapport with older adults can be established by engaging them in conversation about their families, accomplishments, and leisure activities.
- If confusion is present, simple, clear language should be used.
- The healthcare team member should be mindful of signs and symptoms of abuse and neglect.
- The older adult should be assisted with identifying concerns or issues during the inpatient stay.

SPECIAL CONSIDERATIONS

- Certain patient populations, such as those with traumatic brain injury, may not respond to attempts to establish a rapport and are more likely to be reactive to health care team member interventions perceived as negative; in these situations, therapeutic communication should be more directive.

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Elsevier Skills Levels of Evidence

- **Level I -** Systematic review of all relevant randomized controlled trials
- **Level II -** At least one well-designed randomized controlled trial
- **Level III -** Well-designed controlled trials without randomization
- **Level IV -** Well-designed case-controlled or cohort studies
- **Level V -** Descriptive or qualitative studies
- **Level VI -** Single descriptive or qualitative study
- **Level VII -** Authority opinion or expert committee reports