



*Encouraging
the art of
conversation on
mental health
wards*



TALKWELL



Join Star Wards!

Star Wards helps mental health wards become more fulfilling and pleasurable places for patients, staff and visitors. Our wonderfully dynamic, creative, caring member wards are from the complete spectrum of inpatient wards, from acute admission to high security wards.

Over 500 wards are enjoying taking part:

It was fantastic to see it take off so naturally and easily

Such a breath of fresh air and so inspirational, and our ward is in need of exactly this. Thank you for your vision!

We have only been a Star Ward's ward now for a few weeks and already the ward is a very different place.

We are all really enjoying it.

We were doing a lot before Star Wards came along but it has really helped, not only to focus us but to implement other ideas

Why join?

Here are just a few reasons...

- Become a member of a dynamic community of mental health wards.
- Share your best practice and challenges with other members of the network.
- Learn from others' best practice and challenges.
- Members are eligible for exclusive schemes including: the Star Awards achievement initiative for healthcare assistants; the Full Monty Award for implementing all relevant 75 ideas; arts projects such as Book Sanctuary and taking part in the Star Wards Festival
- Receive (and contribute to!) the regular e-newsletter.
- It's money-free and strings-free to join!

Interested? For more information, visit www.starwards.org.uk.



Thanks to Christian Sinibaldi for letting us use his photo from The Guardian

TalkWell

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TalkWell

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What is TalkWell?

TalkWell is a conversation training resource for mental health workers. It's a lively and practical way to help your staff to:

- **become better listeners**
- **enjoy and feel able to manage conversations about anything from Coronation Street to coping with compulsions**
- **have a greater awareness of what's happening in patients' minds and their own**
- **have richer relationships with patients**
- **become popular, charming and gorgeous and probably win the lottery.***

How to use this resource

As with most training resources, this is written in the hope that trainers will start at page 1 and work their way systematically through the information and exercises till the very last full stop. But, since we're realists, we also know that some trainers won't have the time to do this! (For example, because you've got a few million other tasks in order to run your ward.) And you'll be very aware which of your staff need extra help in which aspects of effectively talking with patients so will no doubt choose features and exercises accordingly.

The exercises are marked by a speech bubble. Like this...

What conversation starters have you found helpful?

The exercises are intended to be useful whether staff are working on these by themselves, in pairs or small groups, or in a more formalized training session. The exercises are 'addressed' to your staff directly rather than to you as ward manager, so that you can simply photocopy them for use in training. To make life even easier for you, we've developed a PowerPoint presentation with all the exercise questions on it. This can be downloaded from the StarWards website: www.starwards.org.uk. You can either print the exercises out from there or glow with environmentally friendly smugness as you simply present them on a screen.

There is an accompanying practical pocket resource for staff which they can use as a daily reminder of TalkWell's main points.

Who we are

This resource is produced by StarWards, a project which works with mental health trusts to enhance inpatients' daily experiences and treatment outcomes. We discover, celebrate, share, publicise and inspire excellence in inpatient care – and there is plenty of that all round the country. Our members create resources and adopt or adapt resources we produce, to stimulate and structure therapeutic and enjoyable daily programmes for inpatients. The full range of wards are imaginatively and energetically introducing StarWards, including elderly, rehab, learning disability and secure wards.

For more information, visit www.starwards.org.uk

* Or not... May have got a bit carried away there.

Introduction

The importance of conversation on acute wards

Think of three of your closest friends. Or think about a boss you respected, a sales assistant who was particularly helpful, a health practitioner who really understood and responded to you. What qualities do these people have in common?

It's likely that you felt as though they were really listening to you, as though all their attention was focused on you.

Just listening to someone – really listening to them – is one of the best gifts you and your team can give patients and ward staff's skill at listening to patients can make a massive contribution to their recovery.

This training book introduces TalkWell – a communication system based on 'caring conversation', intended particularly for non-registered ward staff including healthcare assistants. It's informed by the evidence of the recovery power of conversation to help people with mental illness, especially those on inpatient wards. There is considerable research showing how expressing themselves and being heard in a particular way enables patients to access thoughts, feelings and experiences and to gain new perspectives on these. This then helps them to have a greater understanding of themselves, their situation, their illness, its treatment and the recovery process.

That makes TalkWell sound like hard work! Well, it can be, but the magical thing about it is that even a simple, sociable conversation can have a profound impact on someone who is in a bad emotional state.

Why is this? Everything about humans has been designed for social interaction. In evolutionary terms, what separates humans from our ape ancestors is our ability to use complex speech. (Well, that and opposable thumbs. And the ability to enjoy Strictly Come Dancing.)

Conversation is the primary currency of social contact. If someone is experiencing a period of acute mental illness, most of their life and daily patterns are temporarily up-ended. So caring conversations suddenly become exceptionally important as a way of continuing to feel connected with other people, never mind what

the subject of the conversation. And a very important factor in recovery from mental illness is gaining a sense of hope, which most conversations should be able to bolster.

In some ways, there's no big deal to conversing. Conversations are as easy as having an ice-cream. (And with less calories.) But just as there are those who can turn out a nice bowl of pasta, and then there's Gordon Ramsay, similarly there are enormous skills in being a good conversationalist. And in particular, a great listener.

What is TalkWell?

TalkWell recognises that the two partners in a caring conversation have very different current experiences and needs.

The member of staff's needs include:

- building up a relationship with the patient, so patients like and trust them, and are motivated to spend time talking with them
- getting to know the patient as an individual – what their life is normally like, what they enjoy, what they find difficult, etc.
- reducing the gulf created by the power difference between staff and patients
- understanding what that person's experience of mental illness is like and how they cope with it
- assessing their current emotional state, including what is helping or slowing their recovery and their level of risk

The patient's needs include:

- wanting someone to be interested in them as an individual, not just as a patient
- feeling able to trust a member of staff so they can rely on them for emotional support, information and company
- simply wanting to have a bit of a natter to relieve what can often feel like long and empty hours in hospital

Mentalising

TalkWell is under-pinned by an aspect of psychotherapy called 'mentalising', created by Prof. Anthony Bateman and Prof. Peter Fonagy. 'Mentalising' is a slightly odd name but don't let

that put you off! It refers to that essential life skill of being aware of what's happening or happened in our own minds and in other people's minds. Being 'mind-aware', as we're calling it here, is about being in touch both with what we're thinking and feeling and what other people are thinking and feeling. This is a simple and practical concept and one you and colleagues are already using hundreds of times a day.

At times of considerable stress, our ability to be aware of what is in the patient's mind is put under great pressure. It's hard to think straight, and even harder to tune into what other people are thinking and feeling. But it's at exactly these times that we need to be effectively mind-aware. Let's take a common and very tough example – when a patient is highly agitated and gentle attempts to reassure and calm them have failed, and there's a real risk they will hurt themselves, or someone else. A non-mind-aware response would be to focus only on the practicalities – noticing where the patient is, who's near them, what staff are available to help, etc. A mind-aware stance would not only take into account these important considerations, but also help you to identify what you're feeling (e.g., scared, angry, empathetic, calm...) and, crucially, what the patient is feeling. By being aware of what's in the patient's mind, you will be in a much better position to see things from their perspective, and work out how best to resolve the situation.

Laid-back social conversations are a happy part of ward life. It's possible to have a conversation without either person being mind-aware, but it might be a bit dull and unsatisfactory! It would be like one of them chatting about the programme on purple newts that they saw on TV last night while the other waxes lyrical about their child's eating habits. If they're mind-aware, they'll each be conscious of what the other person is making of their conversation and trying to connect up what they're both thinking about and feeling. Sticking with the newts and kids' example, this could become a

You don't need to have read any of the books about mind awareness to be able to put TalkWell into practice. (But if you want to, the most relevant one is ***Mentalizing in Clinical Practice*** by Allen, Fonagy & Bateman).

more mind-aware conversation if the two people started making links, e.g., talking about their kids' interest in reptiles, or purple newts' eating habits!

Caring Conversation

The main principle of TalkWell is that all conversations on inpatient wards have a therapeutic value. They don't need to be about treatment, or illness: even casual conversations about sport or the weather can be therapeutic, in the sense that they support the 'therapeutic alliance'. The therapeutic alliance is the essential relationship between a mental health professional and a patient, or service-user. This is an important concept for all your staff to feel confident (and enthusiastic!) about. It's been found that whatever therapeutic approach is used (e.g., psychoanalysis, cognitive behavioral therapy), one of the strongest factors in determining how well a patient responds is the strength of the therapeutic alliance. In other words, it's all about building a good, trusting, respectful relationship with each other.

Of course, 'caring conversation' really comes into its own when you're talking with a patient about emotional issues in their life, including their illness and recovery. Being aware of what you're thinking and feeling and what the patient is thinking and feeling, will enable the patient to talk to you in an open and safe way. And enable you to listen carefully and respond in a way that they find supportive.

To re-cap, TalkWell:

- is informed by research on the importance of good communication and conversation
- is based on the importance of 'mentalising' or being mind-aware
- is about the value of 'caring conversation' on inpatient wards
- can be used in casual or emotionally-rich conversations
- relies on the skills your staff already have – their ability to make people feel listened to and understood, to hold an interesting conversation, and perhaps most importantly, their friendly and caring nature.



1. Why does being listened to feel so good?

1.1 Which people make you feel really well listened to?

What is it about the way they listen that is so good?

I did some on the hoof research and asked people, including mental health staff, what they enjoyed about conversations. Some of the things they said were:

“ *‘It’s like a gift. Something you can give someone, which will make them happy - or at least less sad!’*

‘Pleasure’

‘I usually learn something. It might be something about the other person, or something about myself. Sometimes it’s about something I knew nothing about before, like why dogs do so much sniffing!’

‘It makes me feel good that I can help a service-user work out for themselves what’s their next step in recovery, and all I need to do is listen carefully. I don’t even need to advise them!’

‘This person is interesting, has coped with exceptionally difficult things and knows things I don’t because I’m not her.’

‘I like to feel appreciated and being a good listener makes me popular!’

‘Patients can get to trust me if I listen carefully to them. This helps avoid the build up of tension and frustration which could otherwise lead to aggression. And if someone is behaving aggressively, it’s particularly important to listen very carefully to what they’re saying.’ ”

1.2 What do you think is the most enjoyable thing about a conversation?

If we’re being mind-aware, it is essential to listen carefully to a patient to know what’s going on in their mind. This should produce the necessary trust for the patient to care about what’s going on in your mind and in other people’s.

What do patients get from being listened to?

1. They feel understood
2. They feel cared about and accepted
3. It helps to make sense of things that are happening or have happened to them
4. It connects them with someone else when they’re probably feeling very isolated and perhaps abandoned because they’re in hospital
5. It helps patients trust staff so that they can:
 - a. tell you about what’s going on for them
 - b. learn from you
 - c. participate in care planning
6. It helps them release tension in a safe way

1.3 Think of a time when you’ve felt very vulnerable – like being at the dentist or a job interview. What has the other person said which has helped you feel more secure? Did they say anything that made you feel worse?

2. Listening skills

2.1 List 3 things you can do to show you're listening to someone:

Examples:

- Show it with your face – looking interested, concerned, etc..
- Show it with your body – sometimes nodding your head, leaning towards the person, gently touching them on their arm
- Show it with your voice – by making those small 'yes, I'm following what you're saying noises' like "uh-huh", "hmm", etc..
- Show it by checking you've understood them, e.g. by saying "Can I just check that I've completely got what you're saying. Do you mean....?"

2.2 List three little things you can say to show you're listening:

Examples:

- Yes
- Sure
- Absolutely
- I see
- Gosh
- Good grief
- I'm sorry
- Oh?
- Oh dear
- Really?
- Really!
- How interesting
- Good point
- I agree
- You're kidding?
- Amazing

2.3 What sorts of things make it hard to listen to people?

Examples:

- Distractions in the room, e.g. other people, noise from TV or radio, an uncomfortable place to sit and chat
- Distractions in your head, e.g. worrying about your kids, thinking about your next holiday, daydreaming, letting your mind wander
- Feeling pressure of work and time
- Making assumptions – especially negative ones – about what the patient is like, and not hearing what they say which conflicts with your assumptions
- Worrying about saying the wrong thing, especially if it might upset or anger the patient
- Rehearsing what you're going to say rather than listening to what the patient is saying
- Hearing the patient talk about things that you can't believe are really happening, e.g. that the TV is instructing them
- Having a strong personal response to what the patient is saying because of similar difficult or traumatic experiences you've had, e.g. a bereavement



2.4 And now list 3 things that show you're not listening properly to someone:

Examples:

- Yawning (!)
- Looking at your watch (!!)
- Keep glancing at the TV or newspaper
- Looking around the room rather than at the person
- Saying things like "You're not making any sense. Perhaps we should talk again when your medication is working."
- Keep interrupting the person, either by finishing their sentence (probably inaccurately!) or saying something else
- Talking about yourself or someone or something else, rather than responding to what the patient is saying



3. Structuring conversations

The Samaritans (surely the ultimate great listeners?) use a simple framework to help structure conversations –

- Story
- Feelings
- Options

This gives people firstly the chance just to get through the 'facts' – what has happened. They're then able to talk about how this has made them feel. And then, if there is an issue or dilemma they're struggling with, they can think about what their choices are. This last process is very important. Samaritans don't give advice. They help people work out for themselves what the possible solutions are.

3.1 The following sketch shows the three parts of the structure in action - story, feelings, options. You can either get two people to read it straight through and then ask people to spot the different parts, or at the points marked * you could pause the sketch and ask people for suggestions. What might the nurse say? How should she/he respond? What would get the conversation moving?

Nurse: How are things?

Patient: Not good. It's the whole jigsaw thing.

Nurse: The what?

Patient: The jigsaw thing. You know.

*

Nurse: Tell me about it.

Patient: I was doing a jigsaw with Brian. And then we got to the end and Brian had the last piece!

Nurse: Really.

Patient: You see?

Nurse: I'm not sure I've quite understood. What actually happened?

Patient: Brian had the last piece. He'd obviously hidden it, while we were doing the jigsaw, just so he could be the one to put it in.

*

Nurse: I see. So how do you feel about that?

Patient: How would anyone feel. Angry. Annoyed. Betrayed.

Nurse: And how does Brian feel?

Patient: I don't know. I wouldn't pretend to understand the mind of a sneaky jigsaw-piece stealer.

*

Nurse: OK. Did you tell Brian how you were feeling?

Patient: Of course. I made my disgust transparently clear. I threw the whole jigsaw onto the floor.

Nurse: Right. And you think he would have understood that?

Patient: (Pause) No. Probably not. It made me feel worse. Because he just carried on as though nothing had happened. And then I thought that maybe he didn't hide the piece after all, and now I don't know what to do.

*

Nurse: What do you think you could do to help feel better?

Patient: I don't know. I could ask him about it, I suppose.

Nurse: Sounds a good idea.

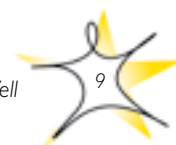
Patient: I could apologise about throwing it on the floor.

Nurse: That makes sense.

Patient: What about if I suggest we do another jigsaw together?

Nurse: That would be positive.

Patient: Then I could hide the last piece instead of him...



Another aspect to structuring conversations is helping the patient to fully express themselves. When people are acutely mentally ill, factors ranging from medication side-effects to the person's levels of self-esteem can get in the way of them identifying and describing what's going on for them. A core communication skill is asking 'open' rather than 'closed' questions. Open questions are ones which encourage the person to respond freely with their thoughts and feelings. A closed question classically produces a one word answer, whether 'yes' or 'no' or a fact – 'Blue'. 'Horse'.

- Questions starting with 'are' or 'do' tend to be closed questions because they generate just 'yes' or 'no' answers.
- Questions which start with 'what', 'where', 'which', 'who' and 'when' are open questions. These will generate more interesting, fuller answers.
- If you're looking to probe a little deeper, then you could try questions beginning with 'how', 'why' and 'in what way'.

For example, 'Are you feeling better today?' is a closed question. The patient doesn't have to answer anything more than 'yes' or 'no'. Or they might just deliver a grunt or a shrug of the shoulders. All you have to do is change the question slightly. Turn it into 'How are you feeling today?' and the patient has the opportunity to describe how they feel. Open questions, therefore, are much better at providing information. Open questions are an avenue leading somewhere; closed questions are a dead end.

3.2 Imagine you're having a conversation with a patient who is anxious about their next 'ward round'.

- 1. suggest 5 open questions and 5 closed questions you could ask.**
- 2. suggest how the patient might respond to each of these questions**
- 3. use these possible responses to illustrate the effects of asking:**
 - a. open questions**
 - b. closed questions**

Here's an easy way to remember ways to ask 'open' questions. It's comes from Kipling. (The poet, not the cake maker):

*'I keep six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.'*



4. Openers

4.1 Think up ways to start a conversation in each of these five different situations:

- 1. you're sitting in the lounge and a patient comes and sits next to you**
- 2. you're sitting in the lounge and a patient comes and sits at the other side of the room to you**
- 3. you go past a patient's bedroom and see that they are crying**
- 4. a patient is highly agitated, pacing up and down the corridor**
- 5. you need to give a patient some news which is likely to upset them**

Examples:

- Hello. (Er, yes, I know that's rather obvious, but actually often all patients need to get started is a 'hello' and a warm smile.)
- Hi. Do you mind if I join you?
- Good morning. How did you sleep last night?
- Good afternoon. How are you feeling?
- Hi. Did you see that programme about [whatever] last night?
- Gosh. It's getting cold! We haven't had much of a summer! (The weather is probably the most common, easiest, safest ways of starting a conversation.)
- Hello. Do you feel like having a bit of a chat? What would you like to talk about?
- Hello. I've been thinking about...

4.2 What conversation starters have you found helpful?



5. Content

It can feel difficult to know what to talk about with patients. Here are some of the most common and understandable concerns, and their responses:

It would be easy to chat if there were activities going on in the ward which we could talk about. But there usually aren't!

It can certainly be easier to have a conversation if the ward is very active, as you can always ask people about what they've been or are planning on doing that day. But patients are usually keen to chat and often need little more encouragement than simply feeling listened to, and will then bring up the things they want to talk about.

Patients are too ill or too wrapped up in themselves to be able to have a conversation.

Very few patients are too ill to want to have a conversation, even if it's just a very short, friendly one that makes them feel cared about. And those patients who seem very wrapped up in themselves would probably benefit from being able to share whatever they're going over and over in their heads. In the unusual event that none of the patients who are around want to have a chat, simply by being obviously available to listen gives out an important message of patients being valued. (Patients are very aware of the difference between being 'observed' and staff being nearby and keen to talk with them. This is closely related to the issues about silence outlined on p.15.)

I might say the wrong thing and upset a patient.

If you're mainly listening rather than talking, you're not likely to say anything 'wrong'. And if you're listening carefully, you will have the sensitivity to say only helpful or neutral things. At times we all say things we regret! But if patients feel you listen to them, respect them and genuinely want to help them, they'll usually be very understanding if you feel you've put your foot in it.

It's not what I'm paid to do.

Many hospitals specifically include listening to patients as one of the most important roles of ward staff. There are very few tasks which can be done well without having listened to patients. You can only know what effect medication is really having on a patient by listening to what they say about this. Although some admin is simply (boring!) head-counting type stuff, most of it involves describing how a patient is. The better you know your patient, the more accurate your records are.

I'm OK starting up a conversation but I worry that I then won't know what to talk about and there will be awkward silences.

Again, patients usually have stored up lots of things they want to talk about given the chance. We also give some ideas about conversational topics in the section starting on p.38.

I'm told to 'observe' patients so surely this doesn't involve talking to them?

Good point! But what's wrong is the term 'observation'. It's very unhelpful because it does suggest simply watching patients. How is all that being watched likely to make patients feel? Many wards are now using the term 'engagement' rather than 'observation', including 'special engagement' for patients who need a member of staff with them all the time. Listening to patients is the most important element of engagement.

If I'm chatting with a patient, it will look like I'm not working.

On the contrary! It will look like you're really getting to know patients and that you are actively helping them not just cope with being in hospital, but progressing from whatever stage of their mental illness landed them there. Even if it's 'just' a simple social chat, this is a really valuable part of building up a relationship, and trust, with a patient. (You can't immediately plunge in with the heavy stuff if you haven't done the preliminaries of chatting about the weather or football results!)

If I'm chatting with a patient, I won't be on the look out for a difficult incident that might be about to blow up.

This can be one of the strongest dilemmas for ward staff. But:

- All the research shows that the best way of preventing difficult incidents, including avoiding patients going missing, is for staff to have good relationships with patients.
- If suddenly there is trouble on the ward, you can simply leap up and go to help. You can apologise later to the patient you were talking to, who will understand why you had to break off so abruptly.

5.1 Which of the following do you think patients may want to talk about:

- **Whether Britain should adopt the Euro**
- **Whether a character on EastEnders should adopt their brother's child**
- **Their mental health**
- **Whether a character on Eastenders should buy a donkey.**
- **How they're feeling right now**
- **Whether a character on Eastenders should adopt their brother's donkey**
- **Their physical health**
- **Their family**
- **Their leisure interests**
- **The effect of European monetary policy on the Croatian Steel industry**
- **Their medication**
- **How they're finding being in hospital**
- **The history of the Ottoman empire**
- **What activities they've been doing today, or which ones they're going to be doing later on**

6. Checking you've understood

There are three main reasons why it's so important to check that you're really understanding what the patient is saying:

- to make sure you're really understanding what the patient is saying!
- because it's very affirming to all of us to have someone reflecting back to us what we've said, or at least what they think we've said.
- because it demonstrates that someone is listening.

Checking you've understood correctly what the other person is saying is a core mind-awareness skill, as it recognizes that we often (or usually!) make assumptions about what the other person means, and we're often wrong.

Useful questions for checking understanding include:

- Could you just go over that once more so that I've definitely understood you?
- Please could you say a bit more about that so that I've understood you properly?
- I think what you're saying is...
- When you said... did you mean that...?
- If I've understood you correctly....
- If I've got it right, you're saying...
- Let me check that I've followed that properly. You're saying that....
- That's really interesting. Can I just go over what you said to make sure I've understood what you mean. You're saying that...
- So it seems that you're feeling... about...
- Sorry. I don't know about... Please could you tell me more about that?
- Sorry. What do you mean by...
- I'm sorry, but I was distracted by the shouting over there. Please could you repeat that?
- Please could you just explain a bit more about...

A more specific way of checking and validating what the patient is saying is to reflect back what you think they are feeling. One of the most powerful benefits patients can gain from conversations is the sense that their feelings have been recognised. The sorts of things you can say are:

- It sounds like you feel...
- I can see how upset/angry/anxious that makes you
- You seem particularly upset/angry/anxious about that
- Although you say it wasn't a big deal, you sounded really upset when you talked about it.

6.2 What phrases do you use, or might you use in future to reflect back what the patient seems to be feeling?

It can also be helpful to repeat the last few words they've said, turning them into a question. (Rather than turning yourself into a parrot.) For example, if a patient says: 'And then a rabbi scampered into the bushes', you could repeat but with a questioning tone: 'A rabbi scampered into the bushes?' The patient will then clarify that it was a rabbit not a rabbi. (Mind you, if it was a rabbi, it would probably be an even more interesting conversation.)

6.1 What phrases do you use, or might you use in future to check understanding?

7. Silence

What do the following have in common?

- Relaxing in a hot bath
- Going for a walk by yourself
- Sitting watching your child sleep
- Staring at a sunset
- Reading a book
- Looking at a painting

They can all be enjoyed in complete silence. Silence doesn't = nothing happening. On the contrary, some of the most important thinking and emotional progress can be made during pauses in conversation.

But first we have to get past the anxieties that silence can stir up in us!

7.1 Why can silence feel scary?

Staff can be worried that:

- they'll be seen as disinterested in the patient or not listening properly
- the patient will think they're boring
- the patient will feel under pressure to come up with something to say
- it could look like they're not working

These concerns are understandable. But the benefits of silence during a conversation should outweigh the anxieties.

7.2 What do you think are some of the benefits of silence?

Silence:

- gives time for you and the patient to reflect on what has been said and what you both feel about this
- allows the chance for some mind-awareness – for both of you to consider what's going on in your own and the other person's mind, including what feelings may have been stirred up for each of you
- is a lovely breather. Just like having a rest during a walk
- shows you're not in a rush as a listener. This really helps patients feel valued and able to take their time in getting to the issues which matter to them and which might be very difficult to say at first

7.3 In terms of mind-awareness, what are the benefits of silence during conversations?

Examples:

- Provides time to give more thought to what thoughts and feelings are going on in the patient's mind and in your own
- It gives the patient time to absorb the implications of what they've said and you've said and potentially to give more thought to these

8. Appreciating difference.

One of the most enriching, but also challenging, aspects of inpatient care is the very different life experiences of patients.

8.1 **Make a quick list of some of the ways that patients may have different lifestyles to each other and to staff**

Examples:

- Jobs
- Marriage, relationships, sexuality
- Kids
- Religion
- Ethnicity
- Country of origin
- First language

Everyone is unique and special. It's vital that we don't feel that how we live or what we believe is the only or best way. Most other ways are simply different – not the only or best way, but what is right for that person. (Some behaviours are wrong and not to be condoned, eg dipping sardines into the chocolate fountain at a Bar Mitzvah party.)

We need to recognise that differences in lifestyle, beliefs, etc. can make us feel uncomfortable or uncertain, in order that we can make sure that this discomfort doesn't get in the way. It's another case of where being mind-aware helps! We can be mind-aware by understanding that what's comfortable is what we're familiar with. So differences in, for example, lifestyle, dress, religious beliefs, even diet can feel difficult or even threatening. By being aware of this, we can move past it and bring in other values of enjoying and appreciating difference.

8.2 **We've invented the 'staff comments' in the list below. Mark with a J which of the following are judgmental comments (i.e. ones where they're saying that they disagree with the person) and mark with an N ones which you think are non-judgmental (i.e. they regard the person's views or behaviour in a neutral way.)**

- **'I see. Could you help me out by explaining a bit more about why you did that?'**
- **'That's interesting.'**
- **'That's weird.'**
- **'I haven't met anyone before who indulges in that sort of thing.'**
- **'I haven't met anyone before who has had that experience.'**
- **'You seem very upset by what happened.'**
- **'No-one in their right mind would be upset by that!'**
- **'I totally disagree.'**
- **'Don't take this personally, but you'll probably go to hell.'**
- **'Do you have a religious belief about the choice you made?'**
- **'Does your imam/rabbi/vicar/priest suggest anything that you find helpful?'**
- **'No wonder she walked out on you.'**
- **'How did you feel when she walked out on you?'**
- **'I can't believe you just said that.'**

Native Americans have an old saying: 'Don't judge anyone til you've walked a mile in their moccasins.' This is a great principle. Unless we've had an identical experience to someone else (and that's impossible!), we can't truly know what it's like for them. So we should never assume we know, or know best, what it's like for the other person or just what they should do. However different people's experiences are, we can usually find something in their lives, values or personalities that are similar. What tends to work well is to find common ground. It can be affirming and reassuring if the other person knows you're trying genuinely to relate to their experience, for example by saying something like: 'I can't possibly know what it's like for you to have been brought up in a very religious family. But I can relate to you having parents with strong views.'

8.3 Finding common ground

This is one of the few exercises in this book which, ideally, should be done in a structured training session, as it can raise powerful feelings.

Ask people to get into pairs and to find a slightly controversial topic which neither of them has strong views on. (It's just an exercise and we don't want to provoke a major staff incident!) Something like whether it's better to buy organic strawberries flown in from Spain or non-organic strawberries grown locally. Or who should have won X Factor/Pop Idol/Big Brother. (Football may be too contentious!)

Anyway.... What then happens is:

- ***the pairs then decide on two opposing views – e.g. “Gavin should have won because...” “No he shouldn't, because...”. They don't need to believe what they're putting forward – just to be able to think of enough reasons to back up their position. (Bear with us on this exercise! It's actually very powerful and constructive!)***
- ***they agree who will take which position to advocate***
- ***each person spends up to 3 minutes making the case to their pair and then they swap round***
- ***This is the important part! They then spend up to 10 minutes finding common ground between their two positions – i.e. points they can both agree on.***
- ***The whole group then discuss how it felt doing the exercise and perhaps give some examples of how they've found common ground in the past with people putting forward views very different to or even conflicting with their own.***

You won't be surprised that there's a mind-awareness take on diversity! Because it stresses the need to really focus on each individual and what they're experiencing, it keeps reminding us that we mustn't make assumptions but must find out directly from the other person. This is a particularly useful skill with people who have very different life experiences to our own, as the courteous curiosity that mind-awareness encourages is invaluable in asking open, non-judgmental questions. And in being genuinely interested in the answers.

9. Giving advice

Staff can often feel like the most helpful thing they can do is to give a patient advice, especially if the person seems very stuck in their situation and/or it seems obvious what the patient should do. But it's usually more complicated than that! And what's a mind-awareness angle on advice? That it's somewhere between unhelpful and irrelevant because, as you hardly need us to remind you, it's all about what's going on in each other's minds. It's not about working out what we think the other person should do, but like most therapeutic approaches, is to support people to work out their own solutions.

9.1 In which of these situations might it be appropriate to offer advice?

- **A patient wants to stop taking their medication**
- **A detained patient asks you not to tell anyone else, but they are planning to slip out of the ward tomorrow and go home to see their dog**
- **A patient asks you if they should forgive their wife for having an affair**
- **A patient asks you what kind of pension they should invest in**
- **A patient asks about how they can cope with being at a ward review, which they find very intimidating**
- **A patient says that they find working makes them too tired to be a good parent. They ask what you'd do in their situation**
- **A patient asks you what you think are the chances of a horse called Temazepam winning the 3.30 at Ascot.**
- **A patient says they feel uncomfortable about claiming Disability Living Allowance even though they are entitled to it. They ask for your advice about what to do.**

In some of these scenarios it's far from clear whether it's reasonable to advise someone. In others, it might be patronising or just unnecessarily unhelpful to withhold advice, eg if the issue is a simple one or one that you're expert in. But if advice is given, it should be followed up with an enquiring, open question – i.e. not one which prompts just a “yes/no” answer (see p.10).

The following are the sorts of factors staff need to consider before doing what comes naturally, advising someone who is either asking for your opinion or who you feel you can really help by suggesting to them what to do:

- People don't necessarily want to be told by someone else what to do. It can make them feel less able to sort things out for themselves
- The process of trying to work out what to do can be as valuable as the solution, or options, they come up with
- It's very unusual to have enough information about the person and situation to be able to give advice that is as useful as the ideas the patient themselves can generate
- It may be the wrong advice!
- Usually it's possible to guide the person through the options, so that they can make the decision themselves without being influenced by what you think is best

One of the reasons why the Samaritans take over 5 million phone calls a year is their reputation for listening rather than advising. (The Citizens Advice Bureau, on the other hand...)

10. Asking sensitive questions

When you need to ask something which touches on sensitive or painful issues for the patient, there are a few phrases which can help both you and them:

- I hope you don't mind me asking but...
- If it doesn't make you feel uncomfortable, please could you just tell me a bit more about....
- If this doesn't feel too personal, please could you explain....
- Please feel free not to answer this, but I was wondering whether....
- It would help me understand better, but you might not want to tell me about....

10.1 What phrases do you use, or might you use in future to ask about sensitive issues?



11. Apologising

There will of course be times when you or your staff put your foot, both feet or all 4 limbs in it. As, by now, you are ultra-mind-aware, you usually won't need a patient to burst into tears to realise that they feel upset by something you've said or done. And no surprises with these suggestions for what you can say:

- Sorry!
- I'm sorry.
- I'm so sorry
- I apologise for that
- Please forgive me for saying that.
- I'm really sorry. That came out all wrong
- I'm sorry. That was an inappropriate thing to say.
- I'm sorry that what I said made you feel bad.
- I'm sorry. We seem to be misunderstanding each other. Let's try that bit of the conversation again.
- I'm sorry. I put that badly. What I should have said is...
- Oops. That was a stupid thing to say! I'm sorry about that.
- Gosh. Did I really say that? That was daft. I'm sorry. No wonder you're annoyed.
- I'm sorry. I put that so badly that you're probably feeling...
- I'm sorry. That was a clumsy thing to say. How has it made you feel?
- Aarrgghhh! I'd be really annoyed if someone said something like that to me. I'm sorry.
- I was wrong to say.... I'm sorry and hope that I didn't make you feel too bad.

As Sir Elton so wisely said (and tunelessly sang...) 'Sorry seems to be the hardest word.' It can be ridiculously difficult to apologise. Some of the reasons why everyone can sometimes find it impossible to squeeze out that word that rhymes with lorry include:

- We don't want to admit we were wrong. This usually underlies whatever else may be preventing us from releasing that simple word which might instantly make the situation much better
- We don't want to look, or feel, 'weak' especially if we feel it's important to be seen to be in a strong position of authority in relation to the other person
- We might worry that the other person will 'take advantage' of the situation,

11.1 Thinking about a time, at work or home, when you probably should have said sorry but couldn't manage to:

- **Why do you think this was?**
- **How might things have turned out differently if you had said sorry?**
- **Do you think you were being mind-aware, in particular about what the other person was thinking and feeling?**

11.2 How do you feel when someone apologises to you when they've made a mistake?

11.3 What phrases do you use, or might you use in future to say sorry?

12. Humour

You and your colleagues will be very aware that using humour with patients can be wonderfully helpful or woefully hurtful. The starting point is certainly tricky – there is so much intense suffering on wards, and not just because of gruelling ward rounds. But humour can also be created by the extent of the distress and can dissolve the pain of the moment. There's lots of research showing that humour is beneficial for many reasons.

Laughter can:

- reduce physical pain
- strengthen the immune system
- stimulate the cardiovascular system
- sharpen thinking
- provide different perspectives
- counteract stress
- be very bonding between people
- and show that we're sophisticated enough to appreciate obscure comedies.

Using humour on mental health wards

There are, of course, particular considerations for staff using humour with patients, including being sensitive to each individual's experience of their illness. Among other variables of the appropriateness of humour with an individual, the specifics of their symptoms, self-esteem and the impact of their illness on their life are important to take into account.

Being aware of an individual patient's humour preferences helps staff judge if, when, and how to use humour with that person. We're not suggesting that a nurse should excuse herself in the middle of a conversation with a patient, and rush off to look at the patient's notes before making a gentle quip about the weather. But where they have a substantial relationship with a patient or humour has emerged as an issue for the patient, it can help:

- to know that the more an individual uses positive humour, the more they're likely to appreciate a member of staff sometimes being humorous with them.
- to understand the role humour plays in the patient's life, for example by finding out what comedy films, programmes, people etc they enjoy.
- to know about the person's ability to laugh at their situation
- to see how the person reacts to other people's humour

Healthful not hurtful humour

Homer Simpson says to the medic: 'My little girl's stomach hurts. Do you have anything to stop her complaining?'

If Hippocrates were alive today he'd be 2,379 years old. And not too pleased that people think he says one thing and does the opposite. But at least he'd be consoled that 'First do no harm', his mantra for doctors, is still going strong. This principle is highly relevant to using humour with acutely distressed patients. Stuff that's funny can also be deeply wounding either inherently (e.g. teasing, insulting, humiliating) or stylistically (e.g. sarcasm used as a put-down). And, just as patients often rely on humour to help distance them from painful thoughts, staff use humour to help them cope with patients' pain and complexity. But this creates potentially harmful distance between the staff and patients.

Happily, some rather serious and studious people have gone to the trouble of providing some good tips, which we're reproducing rather than working it out for ourselves:

- wait until you have a good rapport with the patient before using humour; so that the patient trusts you and your intentions
- humour aimed at ourselves is more likely to be healthful
- humour aimed at others is more likely to be harmful
- don't make light of or joke about the patient's experiences – unless they do so first, and even then be cautious
- don't make light of or joke about one patient's experiences to another patient. Ever.
- try waiting until the patient says something that makes her laugh and respond and build on this
- be very careful with your body language and tone of voice when using humour; so that the patient is clear that you're not mocking but supporting
- steer clear of the classic Christmas or Passover family meal conflict-igniters: sex, ethnicity and politics

Practical ideas for funnier conversations

Like all aspects of conversation, whether on a ward or in an ice-cream factory, the more activities going on, the more there is to laugh about. And the easier it is to find safe things to laugh about, during and after the activities.

Those that are particularly fun, and also appealing to visitors, include:

- a funny noticeboard with cartoons, jokes, flyers for local comedy events, etc.
- starting ward meetings with a good joke or funny anecdote or hilarious TV clip
- funny board and other games, e.g. Pictionary, Twister (single-sex playing!)
- books – joke books, humorous books, comics, novels,
- comedy films, TV and radio programmes, poetry, music, drama. . . .
- religious festivals tend to be rather serious, if not gloomy, but there are some which are particularly good fun, such as the Jewish festival of Purim
- comedy outings, e.g. films, plays and, of course, comedy clubs
- pets – dogs in particular can be very funny, (as can meerkats and aye-ayes but these are even less likely to slip under Infection Control's penetrating radar)

12.1 *What are your humorous skills and gaps? What effect on conversations with patients could these have?*

12.2 *Give an example of when you've seen or used humour sensitively and effectively in a stressful situation.*

12.3 *Give an example of when you've seen or used humour damagingly in a stressful situation.*

13. Responding to personal or sexualised questions and comments

Being asked personal questions, or other questions that you don't feel comfortable answering, is yet another occasion when mind-awareness is very handy! It can be very difficult in this situation to think beyond: 'Blimey! That's much too personal! Can't possibly answer that.' And this could be accompanied by feeling anxious or even angry. But if staff can stretch their mind-awareness to include considering what the patient may be thinking and feeling, this should help. For example, the patient themselves may be very anxious, and realise that it's an inappropriately personal question but feel so desperate to know about someone else's experience that they'll risk asking. (Or, sometimes patients are just chancing their arm or being nose-y!)

The most important thing about responding to this sort of question, is, perhaps, not the words staff use, but the tone of their voice and the expression on their face. If they smile and say something gently, or humorously, most patients will understand and accept that the member of staff can't answer the question.

It's sometimes possible to politely ignore the question and carry on the conversation. But better to say this sort of thing:

- I can see why you're asking this, but we're here to talk about you not me. (The classic therapists' answer.)
- I'm afraid I can't really talk about that
- Thanks for being interested, but I don't think that knowing about my experience will be any help to you.
- I'm sorry, but that's a bit too personal for me to talk about.
- Is there a particular reason why you've asked that?

An invaluable ploy in situations where staff are asked a difficult question is to buy some time. A patient will appreciate that staff are taking their question seriously and courteously if something like this is said: 'Hmm. I'll need to think about how best to answer that. Can I get back to you on that one?' This will genuinely give the member of staff time to think about how to respond, and also to consult you or another colleague.

Staff should be alert to the possibility of a patient's care plan identifying as a problem their asking of personalised or sexualised questions. In this case, it's particularly important for everyone to follow what was agreed as the most appropriate approach or response.

13.1 What phrases do you use, or might you use in future to respond to personal or uncomfortable questions?

13.2 How do you think mind-awareness helps when a patient asks you a very personal question?

Examples:

- Being aware of your own thoughts and feelings, especially if they're so strong that they get in the way of being properly in tune with the patient
- Working out what might be going on in the patient's mind e.g.:
 - What do you know about the patient's past experiences (e.g. having been abused or bereaved) that might explain more about the purpose of the question?
 - Is there a more hidden, important, underlying reason why they're asking that question?
 - What is their body language saying about how they're feeling at this moment? Is it aggressive? Withdrawn? Distressed?

14. Keeping it going

OK. The conversation is underway. The member of staff wants to help the patient feel able to say what's really on their mind. The following should help.

- Providing brief, noncommittal acknowledging responses, e.g., "Uh-huh," "I see."
- Giving nonverbal acknowledgements, e.g., head nodding, facial expressions similar to the patient's, open and relaxed body expression, good eye contact.

Saying things like:

- Please could you tell me more about how you felt about this?
- That's really interesting. Would you like to tell me a bit more about that?
- Just let me think about that for a moment.
- What are/were the best things about that? What are/were the worst things about that?
- And then what happened?
- So then...?
- Do you mean that...?
- That's fascinating/intriguing/interesting.

14.1 What phrases do you use, or might you use in future to encourage the conversation along?



15. Body language

We're usually pretty aware of what we've just said, or generally what our speech is like and what people might make of what we're saying. But it's incredibly difficult to be aware of our body language, and our tone of voice. However, it's impossible to over-emphasise how important these are to patients, and how easy it is for staff to unintentionally upset, offend or anger patients by giving a strong message through facial expression, tone of voice or even sitting position!

It's particularly important for staff to be aware of body language and tone of voice when working with acute inpatients, as the patients may respond much more to non-verbal signs. Patients' ability to follow what someone is saying can be impaired if, for example:

- they're very distressed or angry
- they're very out of touch with reality
- English isn't their first language

15.1 ***Spend a few minutes imagining you're having different sorts of conversations with a patient, e.g.:***

- ***Enjoying a hilarious conversation comparing cooking disasters you've both had***
- ***Having a practical conversation about the patient's programme for the week***
- ***Struggling to keep your temper when a patient is saying rude and aggressive things – and their body language and tone of voice is similarly hostile***

But hang on a second! As this is an exercise about body language and tone of voice, how will you know how these seem to others? One useful way of checking out your body language is to practice looking at a mirror. (Once the bathroom door is locked, your embarrassment should soon evaporate... if you keep your voice down!) But the best way of checking out both body language and tone of voice is to get direct feedback, from another person. Colleagues (including your manager) are probably the best people to do this, but partners and friends can be surprisingly helpful!

Examples of body language

Like most other aspects of communication, body language mainly develops from observing and copying those around us. So it varies between countries, cultures, communities. The usual example given is eye contact. In the dominant (i.e. white) culture in the UK, it's polite to look at people when we talk to them. Not making eye contact can be regarded as a sign of shyness – or of lack of interest, insincerity or even deviousness! But in other countries, making direct eye contact can be interpreted as being over-familiar or even aggressive.

The sub-conscious body-language signal we're perhaps most familiar with is arms crossed against the chest. This usually can be 'interpreted' as the person putting up a barrier between themselves and others, maybe to give themselves a sense of protection from the other person, or a bit like hugging themselves.

15.2 Look at these four pictures. Judging by the body language, how is the man feeling?



15.3 How would you interpret these body expressions? You might come up with more than one possible explanation for some, even options that are opposite to each other.

- Shrugging shoulders
- Raising eye-brows
- Cracking knuckles
- Clenched fists
- Pointing
- Yawning
- Frowning
- Slouching
- Standing with legs apart, hands on hips
- Hands open, palms upwards
- Pointing finger at someone
- Pointing finger at someone's face
- Hand covering mouth when speaking
- Hand placed on heart

16. Touch

This is a touchy issue. Beyond touchy-feely, it touches on matters from the everyday (the sort of distance from others we feel comfortable with), to the traumatic (eg people's experience of abuse). It is also one where there are huge differences between cultures and communities including age and social groups.

All this is further complicated on mental health wards by:

- Patients' states of mind
- The use of physical interventions to control very disturbed patients
- The power imbalance between patients and staff
- Staff fears about touch being misinterpreted by patients or others, sometimes with even an anxiety about legal action
- The high percentage of patients, especially women, who have a history of physical and/or sexual abuse
- Mixed sex staff and patient groups

On the one hand, in most cultures safe touch is a very acceptable, welcome part of social contact between people of the same gender and, to a lesser extent, between men and women. And for most UK communities, a gentle hand on hand or arm around the shoulder is more consoling than gentle words can be.

But even this very conventional physical contact stops being 'ordinary' when located on a mental health ward and staff have to be aware of the risks to patients as well as themselves of even the most casual, spontaneous and unintrusive touching. Wanting to make a physical connection with a patient is usually motivated by warm, human, caring feelings. But people vary greatly in how they interpret, feel about and respond to others touching them, especially in a hospital situation where they're probably feeling vulnerable, anxious, frustrated, uncertain and other unsettling emotions.

There isn't the room in this training resource to properly cover this complex issue. But asking staff to consider the following questions should help them further develop their awareness and skills in relation to touch.

16.1 *How do you feel about physical contact with patients during conversations?*

- ***Are you a person who tends to include physical touch when talking with others?***
- ***Can you think of a time when you had a strong response to someone in a position of trust touching you during a conversation? What did you feel?***
- ***Can you think of a time when you were surprised by how someone responded to you touching them during a conversation? Describe why they might have responded in this way.***
- ***What sorts of factors can help you know how an individual patient might respond to being touched during a conversation?***

17. Voice

Our voices convey more than just mere facts, figures and information. If we sound excited, for example, the person listening to us will be more interested in listening to us. Famous sports commentators are able to convey the excitement of events, even when, if they're honest, things are a little more routine. (Although I've yet to hear anyone who can make bowls sound thrilling.)

On a ward, this can have a positive or negative effect. A member of staff may be trying to convey concern and warmth, but if they're speaking in a monotone with a detectibly sarcastic note in it, the patient will pick up the negative message more strongly than the intended one. (And of course this will be reinforced if there's contradictory body language.)

But looking at things more positively (!), their voices can be a huge help in making patients feel better. Even hearing a really painful message can be softened if the member of staff is careful to use a gentle, caring tone of voice. In fact, there are a surprising number of elements making up what one's voice sounds like which is why it's so important for staff to be aware of how they sound to others.

17.1 Watch a TV programme with the sound off, identifying what emotions or messages the people seem to be expressing through their body language.

17.2 Ask the group to identify the different elements of the voice, in other words what they can do with their voice to make it sound different or to express different feelings?

Volume

Tone (e.g. warm, sarcastic, friendly, patronizing...)

Pitch (high, low, deep, squeaky...)

Speed

Emphasis (stressing particular words)

Accent

17.3 How loudly or quietly staff speak also makes a strong impact. Which do you think is the most helpful volume in these situations?

| | Quiet | Normal | Loud |
|---|-------|--------|------|
| Welcoming a new patient | | | |
| Talking about the TV when there's lots of noise in the room and it's hard to hear | | | |
| Responding to a very distressed patient | | | |
| Calming a very angry patient | | | |
| Getting everyone's attention in a group of 16 patients when everyone seems to be talking (or shouting!) at once | | | |
| Breaking bad news to a patient | | | |

17.4 Try saying these sentences in very different ways, e.g. compassionately, irritatedly, patronizingly, angrily:

'Your mother phoned.'

'The doctor has said you can't have s17 leave.'

'Where did you get that t-shirt from?'

'Why do you think you'd be a good teacher?'

Then say the same sentence, smiling while you say it. What difference does it make when people smile while talking?

17.5 Practice consciously using a tone of voice which shows these different feelings (one after the other, not all at once!):

Kind

Worried

Very worried

Hysterically worried

Irritated

Furious

Calm

Amused

Dismissive

Powerful

Sarcastic

Trusting

Genuine

Superior

Lying

Confident

Arrogant

Professional

Respectful



18. Wrapping up

Ending a conversation can feel as daunting as starting one. But don't be put off! There are some simple techniques for ending conversations in a way that feels good for you and for the patient.

Endings

If it's been quite an intense or emotional conversation for the patient, it's really important to end it in a way that makes them feel OK. You know what's coming next... It's very important to be mind-aware! What might the patient be thinking most about at this moment? What are they feeling? These three steps always help.

1. Checking how the patient feels

'How are you feeling now?'

2. Acknowledging how the patient feels:

If the patient says they still feel upset/angry/frustrated:

'I'm sorry that you still feel upset/angry/frustrated.'

If the patient feels better than before the conversation:

'Well that's good. I'm really pleased that you feel a bit better'

3. Letting the patient know that there will be more opportunities to talk:

'Let's catch up again tomorrow/later this week'

Psychotherapists are very experienced at ending conversations or sessions, bang on 50 minutes! Staff can borrow these phrases:

- We need to finish now
- I'm afraid we've run out of time
- I'm sorry but that's all the time we've got today

This 'finishing up' phrase can be followed with something like:

- Thank you for being so frank with me
- Thanks for chatting with me
- Thanks. I've enjoyed this conversation
- Thanks for letting me get to know you better. I really admire [and then something like]:
 - the way you have coped with such a tough situation
 - how strong you've been through all this
 - your sense of humour despite how sad you're feeling
 - the way you've continued looking after your kids so well when you've been going through such a terrible time

18.1 What phrases do you use, or might you use in future to wrap up a conversation?

Praise and compliments

Perhaps the biggest conversational gift you can give is to pay someone a compliment. It's such a simple thing to do but makes the other person feel great.

18.2 What are some of the nicest compliments you've been given at work or at other times? How did they make you feel?

18.3 When you've made a real effort with something, at work or home, but no-one actually compliments you, how does that make you feel?

It can take a bit of practice (perhaps with family!) to notice things to compliment and to feel comfortable about saying this. Practising out loud, even if by yourself, really helps you to say it out loud to someone you're complimenting.

18.4 Finish the sentence with an example of what you could say

- I noticed that...
- I've noticed that other people really like the way you're so good at....
- I admire you for...
- I really like the way you...
- I'm impressed with the way you....
- I appreciate the fact that you're willing to...
- Your partner/family/friend must appreciate the way you....
- Congratulations. That must have been very hard for you.
- That was brave/honest/kind/smart/generous to...
- You're so...
- I'm pleased that you....

18.5 What phrases do you use, or might you use in future to show you appreciate something about the other person?

Accepting thanks

Funnily enough, being thanked often makes us feel very awkward. We can react as if someone has insulted us rather than made the effort, and channelled their generosity to say that they appreciate us.

Graciously accepting thanks has been compared to receiving a gift. If someone gives us a present, we don't usually squirm, mumble, etc., but smile and say thanks! Similarly, when we're being thanked we are being given a gift of appreciation, and a few simple words back are all that's needed, eg:

- It's a pleasure
- I'm glad I've been able to help
- Thank you for saying that
- Thanks. I appreciate that
- That's nice of you to say so
- I'm so pleased that you feel that way

18.6 How does being thanked make you feel?

18.7 What are the worst things we can say when someone thanks us? How could these make the other person feel?

17.8 What phrases do you use, or might you use in future when a patient thanks you?



19. Difficult conversations

Staff are faced each day with having difficult conversations with patients, conversations which can be very emotionally and intellectually demanding. They have to keep track of the 'facts' as well as paying attention to the feelings. Added to this, they're trying to notice what isn't being said. And on top of all this, they're trying to manage their own feelings! These kinds of pressures are why good support for staff is so important. But being very aware of the thoughts and feelings going on in the patient's mind and in their own is a mind-awareness bonanza!

What helps you to manage difficult conversations?

- Try to identify with, or imagine what it's like for the patient
- Recognise that each conversation is a development opportunity – for you. Your listening skills are the most valuable professional tool you have
- Remember what a powerful difference you are making to the patient by listening carefully to them
- If you're really stuck, think about how you could describe what the patient is saying, and how they're saying it, to your ward manager
- Gain a bit of extra thinking time by saying things like, 'can we just think about that for a minute?'

Talking with people who are experiencing psychosis

Perhaps the most important thing to remember is that people who have some thoughts which are highly unusual – or very disturbing – will also continue to have 'normal' thoughts, and certainly normal feelings. And when part of your life is feeling very out of control, it is stabilising and comforting to have an ordinary conversation with someone else. So don't avoid talking to people who are having psychotic symptoms!

One of the main difficulties a patient may be experiencing is the effects of their medication. This can make concentrating, or even thinking clearly, very difficult. You can work out how complex a conversation they can manage by starting with simple, everyday things, such as asking them how

they're feeling, or if they've had visitors. If they have been involved in a particular activity in the last day or two, you could ask how that went. Or instead of asking them something, you could kick off with something about you – a programme you saw on TV last night, or what your weekend plans are.

You may be unsure how to respond when they talk about things which don't seem 'real' or seem very peculiar. What should you do if you can't understand what they're talking about? As with everyone else, it's usually best to say 'I'm sorry. I didn't quite understand that. Could you say it again please?' If, when they repeat it, you still don't understand what they mean, you could reflect back to them what they've said, for example: 'I think you're saying that you can hear someone talking to you from the television, even though the television is switched off.' You don't have to believe this is really happening; but it's very important to accept that it's certainly very real for that patient. You could ask them how they feel about this.

Patients' comments or ideas that might appear to be very random, meaningless, or completely out of touch with reality, are actually very significant. As with dreams, there is often a strong reason why their minds or sub-conscious come up with particular images or scenarios. However, this is very sensitive territory and unless you have a very strong relationship with the patient, it's definitely best not to get into Freudian, interpretive mode! We don't need to understand what a particular image or voice means to the patient, we need to recognise that it does have meaning, respect its importance, and respond in an appropriate way.

Another way of thinking about these experiences – experiences a patient is having which are impossible for us to really understand – are that they are like complex poetry. Each has its own rhythms, meaning and validity and can be understood and responded to on different levels. (The only response which is a complete non-starter is a rubbishing dismissal of what the person is saying.)

19.1 Talking with a psychotic patient.

You ask a patient how they are. Instead of replying, they look at you suspiciously and say: 'I have to leave at once. I have to save the world. I'm the only one who can. The angels have told me.'

What do you respond:

RESPONSE A: 'Oh pull yourself together. There are no angels and if there were they'd hardly be likely to talk to you.'

RESPONSE B: 'Really? What makes you think that?'

RESPONSE C: 'You mean they talk to you as well? Which one's your favourite angel? Mine's the one with the big yellow wings.'

Which of these responses is most likely to make the patient feel:

- **listened to and cared about**
- **frustrated and patronised**
- **that you are experiencing the same hallucinations**

Talking with people who are very distressed

When they are with someone sympathetic and supportive, crying can be one of the most healing experiences for patients. The act of crying releases tension and dilutes painful feelings and thoughts. This effect can be made even more beneficial if they're with someone who is accepting of them and the state they are in.

It's certainly true that when someone is crying a lot it's hard to have a conversation. But if the essence of conversing is about communicating rather than specifically talking, then it's clear just what powerful communication is going on. The patient is conveying unambiguously how much emotional pain they are in. And the staff member who sits alongside them, gently and supportively, is conveying that they recognise this and care about them.

19.2 List some of the effects it has on you when you are talking with a patient who is very distressed and perhaps crying a lot.

19.3 Think of a time, at work or home, when you have talked to someone when you've been very distressed. List some of the things the person you were with did which helped.



We asked some patients what they've found helpful in being supported by staff when they're crying. They said:

“ ‘Just being there, sitting next to me.’

‘Not rushing me.’

‘The nurse saying understanding things like “I’m really sorry you’re so upset. It’s not surprising given everything you’ve been through.”’

‘I always feel better when a nurse puts her arm around me. It’s amazing what a difference this small act makes to how I feel.’

‘I divide staff into two sorts. Those who ask me to stop crying, which always makes me feel worse, and those who don’t ask me to stop crying!’

‘Giving me the time to feel calmer and to stop crying.’

‘This is hard to describe, but it’s something about the way that the helpful nurses look when I’m crying. They look sympathetic and understanding, without looking patronising!’

‘I remember one nurse in particular who was amazing with me when I was in a really bad state, crying and stuff. She would put her hand on my arm, and say nothing til I’d finished crying. Then she’d ask if I wanted to talk about what had upset me. I always did want to!’

‘The best thing anyone can say to me when I’m crying is ‘Take your time.’ It makes me feel that I’m not wasting their time and that they’re not desperate to rush back to the paperwork.’

‘Staff who don’t look panic-stricken when I cry!’

”

To recap:

1. Staff don't actually need to say anything. Patients find it comforting just to have someone sitting with them.
2. It's definitely better to say nothing than to ask a patient to stop crying!
3. Patients really appreciate being given time to stop crying, at their own pace. Some may then want to talk about what's going on for them. Others may feel it's been helpful enough just to have 'got it out their system' and not want to talk at that stage.

19.4 For each of these common responses to someone who is very upset, give a reason why a patient might not find them helpful:

- ‘Please don’t cry.’
- ‘If you stop crying, we can talk about what’s upsetting you.’
- ‘There’s no need to cry.’
- ‘Things aren’t as bad as all that.’
- ‘It’s not like you to cry.’
- ‘You don’t want other patients to see you like this.’
- ‘It’s not like a man to cry about this sort of thing.’

All of these statements are meant to be kind and comforting. But for the patient they can feel like:

- it's wrong, inappropriate or 'weak' to cry
- you don't recognise how serious the causes of their distress are
- you feel embarrassed or awkward with someone who is crying
- you've got old-fashioned views about "what men are like"!
- you don't accept them as an individual, complete with vulnerabilities as well as strengths

19.5 What phrases do you use, or might you use in future when a patient is crying?

Talking with people who are very angry

This is a whole book in itself! (Indeed, a whole bookshelf in a bookshop.) Talking with people who are very angry isn't exactly a normal 'conversation', but it's still about two, or more, people communicating with each other. You'll probably already have good strategies to use in these situations, but the intense pressure people are feeling means that it's particularly important to listen very carefully.

Starting with the predictable non-starters!

- Shouting (!) let alone swearing
- Threatening. It's particularly unethical to threaten the use of rapid tranquilisation, seclusion and other 'coercive' responses
- Personal insults (!)
- Standing too close to the person, especially if your face is then very close to theirs

19.6 What do you find aggravates very tense situations?

Of all the situations described in the book, angry, confrontative conversations are the most important times for staff to consciously be mind-aware – i.e. both to think very specifically what the patient is thinking and feeling and to recognise what the member of staff is thinking and feeling. Our advice is:

- Give the person space – physical space by not standing too close to them, emotional space and the sense that they're not being rushed or pressurised
- Listen super-carefully – to what the patient is saying, what they're not saying and what they are feeling
- However hard it is, try to use a calm and non-shouting voice
- Acknowledge their feelings
- Apologise if it's thought this will help
- Give reasons for whatever is being said or suggested
- Seek common ground. Ask the patient what would help resolve the conflict, and immediately try to find all the points, however small, where there is agreement (see the exercise on p.17). Compromise. Find a solution that's agreeable to the patient unless it's one that is genuinely unacceptable.
- Enable the patient to save face or 'climb down gracefully'. Ideally this should be because a resolution is found which is acceptable to both people.

19.7 What do you find diffuses very tense situations?



20. Talking with pictures

Talking without speech – how cool is that? There are lots of patients who for all sorts of reasons aren't able to understand or join in a conversation in English.

20.1 What reasons might someone have for not joining in a conversation in English?

Some examples:

The person is:

- from a different country and they don't have much English, especially when they're very ill
- learning disabled
- deaf
- highly agitated or withdrawn

In all these situations, it might be clearer to use pictures, perhaps in addition to rather than instead of words. (Ideally wards have important printed information translated into the relevant local community languages and quick access to interpreters.)

Trainers, or at least good trainers, use pictures not just to pretty things up, but also to help students understand and remember the information. So there's no need to limit using pictures to people with particular communication obstacles – they're great for explaining things in most situations. (Even brain surgeons and rocket scientists use pictures to learn.)

As well as using 'physical' pictures (photos, drawings – things you can hold), mental images can also be very powerful. In fact, because visualisation can have such an impact, it needs to be used with caution. But asking a patient to close their eyes and imagine a situation (like the classic calm, warm beach scene in relaxation exercises) can be very helpful. And it's a valuable coping technique for patients to use when back home.

20.2 What sorts of pictures can you get, from where, to support conversation?

Some examples:

- Clip-art
- Cartoons
- Illustrations
- Photos
- Doodles
- Simple line drawings

You can get these things from:

- Google images
- Websites, e.g.
 - www.clip-art.com
 - www.istockphoto.com
 - <http://careimages.com>
- Ward photos, e.g. of special occasions
- Specialist health organisations e.g. for mental health, healthy eating, quit smoking...
- Specialist communication systems for people with learning disabilities – also useful for others e.g. www.widgit.com, www.photosymbols.com, (BUT.... There are a few specialist clip-art collections designed for people with learning disabilities which are really awful! Squirmingly 1980s, community care, special needs. We'd recommend avoiding the excessively used Change Picturebank and the equally frumpy Valuing People Clipart Collection.)
- Patients' own photos or drawings
- Photos taken by staff
- Staff drawing pictures – forget Van Gogh, think Picasso! If he could get away with wonky pictures, so can they.
- Commissioning a local artist (preferably a volunteer such as an art student) to make pictures of some of the most common issues, words or situations patients need to understand.

20.3 *In what situations might visualization be helpful to patients?*

20.4 *How might patients imagine and describe themselves in these imagined situations? (Use descriptions of what the calming room or environment looks like, what they patient looks like, what sounds are there and, in particular, how they feel.)*

- *Recovered, stable, happy.*
- *Having given up smoking*
- *Having lost weight*
- *With a new job*
- *Apologising to someone they've hurt*
- *Having fun with their kids*



21. Ideas for conversational questions

Every day, staff have conversations with patients which are more informal and unstructured than one-to-one, key-working or CPA conversations. Usually, these conversations will just flow, and it might be more a matter of how to end the conversation in a way that is comfortable for both people. But in case anyone in your team ever feels stuck, here are some questions they can keep tucked up their conversational sleeve.

For a conversation to feel relaxed, it's best to start with a comment before asking a question, so that the other person doesn't feel they're being interviewed – or assessed! We give examples of opening comments before each suggested question, but as mentioned above, staff will be able to skillfully insert a question or two into the conversation so it won't look anything like as contrived as it does here in one long list!

Themselves

- We've only just met and I'd really like to know more about you. So please can you tell me some more about yourself?
- I can imagine that you've got lots of skills. What are you best at doing?
- Most patients spend quite a lot of time thinking about the past. What's your most treasured memory?
- It's nice we've got the chance to get to know each other a bit better. What word do you think best describes you?

People and pets

- It's important to know whether or not the patient has kids before asking them about their relationship with children. 'One strange thing about being on a ward is that there aren't kids around. Do you miss seeing your kids?' (Or if they haven't got kids, you could ask them whether there are kids they are close to, like nephews or nieces.)
- It's really tough coping with a mental illness. Who do you feel supported by?
- I'm pleased to have the chance for a chat with you. Who do you enjoy chatting with? Why is that? What are your friends like?

- I'm afraid I don't know much about your home situation. Who relies on you? How does that feel?
- I sometimes imagine meeting a real hero of mine. If you could spend the day with anyone in the world, who would it be? Where would you go? What would you do?
- It's a pity we can't have a pet on the ward. (Or – it's lovely that we can have a pet on the ward.) Do you have any pets at home? Are you missing them?

Where they live

- I know you live in [location]. What's it like living there?
- Tell me about the street where you live.

What they do during weekdays

- What do you do for a living?
- What do you like doing in the evenings?
- Do you enjoy your work?
- What's the best bit about your job? And what's the worst part?
- I've always wanted to be a lion-tamer. Is there a job you've always wanted to do?

What they enjoy

- The food here is pretty good/unappealing. What's your favourite food?
- It's tough being in hospital. What would your perfect day be like?
- It's quite cold/hot today. What's your favourite sort of weather? What's your favourite season?
- We're all put together with people we don't know on the ward. Which person can you imagine you would most like to meet? I don't mean in hospital!
- The hospital is nice and near your home! But are there places or countries you'd particularly like to visit or go back to?

Hobbies and leisure interests

- It's good that we've got Internet in the ward/hospital. (Or – it's a pity we don't have Internet in the ward/hospital.) Do you use the Internet at all when you're not in hospital?
- I know the radio is often on in the ward and we might end up listening to whatever station has been chosen by someone else. What music do you like listening to?
- You do/don't seem to watch the TV when it's on in the ward. What's your favourite TV programme?
- I love looking at celebrity magazines! Do you? Who is your favourite celebrity?
- I know that you've been going to the art sessions here. When you're not in hospital what do you do for fun or relaxation?
- There are some interesting books in the ward library. What sort of books do you like?
- It's hard to find the energy to exercise when in hospital. What do you normally do to keep fit?

Hopes for and dreams about the future

- What would you do if you won the lottery?
- If you could choose any holiday, where would you like to go and what would you like to do?
- What would be your idea of a perfect evening's entertainment?

Other!

- There was an interesting thing on the news about x. What do you think about this?
- The hospital is/isn't very environmentally friendly, doing lots/little recycling and other stuff. Are there issues like the environment that you feel strongly about?

Golden questions

Here are some 'Golden' questions – real 24-carat conversation aids which can be used in a variety of situations.

- How are you?
- How did that make you feel?
- What was that meeting/activity/visit like for you?
- Can I just check that I've understood what you've told me?
- Could you tell me why that is?
- Please could you tell me some more about that?
- What do you think about that?
- Please could you give me an example of that so I really understand?
- Can you see how great you are at x?
- What was the purpose of. ... (This is a much gentler way of asking 'Why did you do that' or 'What was the point of doing that?')
- If you feel OK about telling me, how did...

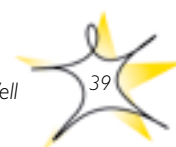
And 'open questions' – ones which let the patient give a full answer rather than one word such as 'yes' or 'no'.

Leaden statements

And here are a few statements that will sink any conversation like a very heavy thing that's been made especially heavy for 'National Really Weighty Objects Week'. Try to avoid these!

- Please don't cry.
- That doesn't make any sense.
- I understand exactly how you feel.
- Can we make this quick?
- Pull yourself together.

And 'closed questions' – ones which mean the patient gives a tiny answer such as 'yes' or 'no'.



22. PUTTING IT TOGETHER

A quick quiz to see if you've been listening!

- 1. List three things that patients get from being listened to.***
- 2. How would you show that you are listening to someone?***
- 3. What, according to the Samaritans, is a useful framework to help structure conversations?***
- 4. Why is it important to check that you are correctly understanding what the patient is saying?***
- 5. Can you list some benefits of silence during a conversation?***
- 6. Why is it important for staff to be aware of body language?***
- 7. Why is it important not to be judgmental in a conversation?***
- 8. Why should you be careful about giving advice?***
- 9. How might you respond to an over-personalised or sexualised question from a patient?***
- 10. What are some ways of dealing with difficult conversations?***

Answers

1. List three things that patients get from being listened to.

Answers might include:

- They feel understood
- They feel cared about and accepted
- It helps to make sense of things that are happening or have happened to them
- It connects them with someone else when they might be feeling isolated or even abandoned
- It builds trust in staff
- It helps release tension

2. How would you show that you are listening to someone?

Answers might include:

- By your facial expression
- By your body language
- By the tone of your voice
- By checking you have understood them

3. What, according to the Samaritans, is a useful framework to help structure conversations?

Answer: The Samaritans framework:

- Story
- Feelings
- Options

4. Why is it important to check that you are correctly understanding what the patient is saying?

Answers might include:

- to make sure you really understand what the patient is saying!
- because it's affirming to have someone reflecting back to them what they've said, or at least what they think they've said
- it demonstrates that someone is listening

5. Can you list some benefits of silence during a conversation?

Answers might include:

- It gives time for you and the patient to reflect on what has been said and how you feel
- It allows both of you to consider what's going on in your own and the other person's mind, including what feelings may have been stirred up for each of you
- It's a bit of a breather
- It shows you're not in a rush as a listener.
- It provides time to think

6. Why is it important for staff to be aware of body language?

Answers might include:

- Because patients may respond much more to non-verbal signs.
- They may be distressed or angry
- They may be out of touch with reality
- English may not be their first language

7. Why is it important not to be judgmental in a conversation?

Answers might include:

- Unless we've had an identical experience to someone else, we can't truly know what it's like for them
- It is more affirming to find common ground.
- It creates barriers between us
- It reminds us that everyone is a unique individual

8. Why should we be careful about giving advice?

Answers might include:

- People don't necessarily want to be told by someone else what to do
- The process of trying to work out what to do can be valuable
- We may not have enough information about the person and situation to be able to give useful advice
- It may be the wrong advice!
- It's better to help someone come to their own decision

Continued over...

9. How might you respond to a personalised or sexualised question from a patient?

Answers might include:

- Ask why they have asked that question.
- Use a 'diverting' answer, such as 'I'm afraid I can't really talk about that'
- Play for time by promising to think about it and get back to them.

10. What are some ways of dealing with difficult conversations?

Answers might include:

- Gain extra thinking time by saying things like: 'hang on a minute' or 'can we just think about that for a minute?'
- Try to imagine what it's like for the patient
- Recognise that each conversation can be regarded as a professional development opportunity
- Remember what a difference you are making to the patient by listening carefully to them.
- Think about how you could describe what the patient is saying to your ward manager
- Make sure you attend to the practical things, like being in a quiet place



Notes and Ideas

Notes and Ideas

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