1. **Using Broad Opening Statements** The use of a broad opening statement allows the patient to set the direction of the conversation. Such questions as “Is there something you’d like to talk about?” give the patient an opportunity to begin expressing himself. In using a broad opening statement, the nurse focuses the conversation directly on the patient and communicates to him that she is interested in him and his problems. Upon sensing that the patient may have a need, the nurse can use a broad opening statement to initiate discussion, while at the same time allowing the patient to determine what will be discussed. When the patient opens the conversation, the nurse can then follow his lead to discover the meaning his opening remark had for him, encouraging him by question or comment to express himself further. Whether what he has said is of an obviously serious nature (“Am I dying?”), or less emotionally charged (“I’m going home tomorrow,”) the nurse should avoid making assumptions as to its meaning or the need he may be expressing.

2. **Using General Leads** During the conversation, general leads, such as “yes” or simply the “uh hum” will usually encourage the patient to continue. General leads, like broad opening statements, leave the direction of the conversation to the patient. They also convey to him that the nurse is listening and that she is interested in what he will say next. This can be accomplished verbally or non-verbally, but nodding or through facial expressions, which demonstrate attentiveness and concern. The major purposes of general leads is to encourage the patient to continue, and to speak spontaneously, so that the nurse can learn from him how he perceives his situation, and get some idea of what his need may be. By becoming aware of and resisting any tendency she may have to jump to conclusions regarding the nature of the patient’s problem, and instead of drawing him out, the nurse can begin to obtain the information she needs to be of continuing assistance to the patient. Some additional samples of general leads are: “I see.” “And then…”, “go on” and incomplete or open-minded sentences such as “You were saying that…”

3. **Reflecting** In reflecting, all or part of the patient’s statement is repeated to encourage him to go on. If he says, “Everyone here ignores me” the nurse might reply, “ignores you?” Letting him hear all of what he has said, or part of what he has said may lead him to more fully consider and expand upon his remark. Reflecting can be overused, and the patient is likely to become annoyed if his own words or statements are continually repeated to him. Selective reflecting can be used once the nurse has begun to understand what the patient is driving at. For example, if the patient says, “I feel so tired, I don’t like it here,” the nurse can either reflect, “tired?” or “You don’t like it here,” depending on which part of his statement she thinks is most important.

4. **Sharing Observations** Here, the nurse shares with the patient her observations regarding behavior. The patient who has a need is often unaware of the source of this distress, or reluctant to communicate it verbally. However, the tension or anxiety created by his need creates energy which is transformed into some kind of behavior, nail biting,
scratching, hand clenching, or general restlessness. By sharing her observations of this behavior with him, the nurse is inviting the patient to verify, correct or elaborate on her observations. In doing so, she is attempting to find out from him the meaning of his behavior rather than assuming she knows. In her efforts to ascertain the meaning of the observed behavior, the nurse may share with the patient what he has actually perceived through her senses (“You are trembling”), or she may share her interpretation of what she has perceived (“You seem upset”).

Generally, her perceptions tend to be correct; her interpretations of her perceptions, however, may often be incorrect. When sharing her observations of the patient’s behavior, the nurse should phrase her remarks tentatively, in such a manner that it is her observation, rather than the patient’s behavior which is being questioned. This observation can be accomplished by “afraid” or “angry” may evoke a response of denial from the emotional impact, e.g., “tense”, “upset”, or “restless.”

5. Acknowledging the patient’s Feelings  The nurse helps the patient to know that his feelings are understood and accepted and encouraged him to continue expressing them. If he were to say, “I hate it here. I wish I could go home”, the nurse might respond, “It must be difficult to stay in a place you hate.” When a patient talks about something that is upsetting to him or expresses a complaint or criticism, the nurse can convey acceptance by acknowledging the feelings he is expressing without agreeing or disagreeing with them. By sympathetically recognizing that it must be difficult or embarrassing or frightening or frustrating, etc. to feel as the patient does, she does not pass judgment on the thought or feeling itself. If communication is to be successful, it is essential that the nurse accept the thoughts and feelings her patient is expressing, irrespective of whether or not she, personally, thinks and feels the same way. For if the patient senses or is told that the nurse does not approve of or does not agree with what he is expressing, it is extremely unlikely that he will continue, or that a positive nurse-patient relationship will ensue.

6. Using Silence  In certain circumstances, an accepting, attentive silence may be preferable to a verbal response. This allows the nurse to temporarily slow the pace of the conversation and gives the patient an opportunity to reflect upon, then speak further about his feelings. Also, silence allows the nurse to observe the patient for non-verbal clues and to assemble her own thoughts. Due to the nature of conventional social conversation, in which pauses and lulls are generally avoided, the nurse may instinctively become uneasy when the patient falls silent for any length of time. However, periods of silence are often most beneficial to the communication process allowing the patient to collect his thoughts and to reflect upon the topic being discussed. Maintaining an attentive, expectant silence at this time lets him know that his silence, too, is accepted. Because silence can convey much – sadness, distress, anger, contemplation – the nurse can also attempt to assess the meaning of the silence within the context of the conversation and with attention to accompanying nonverbal behavior. It is important to practice silence as the nurse tends to exaggerate the period of time a silence lasts, due to her own anxiety. After several minutes of silence, the nurse can help the patient to resume verbal activity with statements such as, “You were saying that …” or “What were you thinking?”
7. **Giving Information**  
Studies have shown that a major cause of anxiety or discomfort in hospitalized patients is lack of information or misconceptions about their condition, treatment, or hospital routines. When the patient is in need of information to relieve anxiety, form realistic conclusions, or make decisions, this need will often be revealed during the interaction by statements he makes. By providing such information as she prudently can, admitting and finding out what she doesn’t know, or referring the patient to someone who can assist him, the nurse can do much to establish an atmosphere of helpfulness and trust in her relationship with the patient.

8. **Clarifying**  
If the nurse has not understood the meaning of what the patient has said, she clarifies immediately. She can use such phrases as “I’m not sure I follow…” or “Are you using this word to mean…” to request that the patient make his meaning clear to her. In seeking immediate clarification when she is in doubt as to the patient’s meaning, the nurse can prevent misunderstanding from hindering communication, also, because her efforts in clarifying will demonstrate her continued interest in what the patient is saying, the use of this technique can help motivate him to go on. Because meaningful communication depends greatly upon the extent to which the persons involved understand clearly what each has said, the nurse should not hesitate to interrupt the patient if there is any confusion in her mind about his meaning. She might say, “Before you go on, I want to understand what you meant by…” Also, the nurse should clarify identities, such as ambiguous “he” or “they”. In addition, to enable the patient to best understand her, the nurse should avoid the use of medical terminology or jargon whenever possible, and attempt to express herself in such manner appropriate to the patient’s apparent level of understanding.

9. **Verbalizing Implied Thoughts and Feelings**  
The nurse voices what the patient seems to have fairly obviously implied, rather than what he has actually said. For example, if a patient has said, “It’s a waste of time to do these exercises’ she might reply, “You fell they aren’t benefiting you?” Besides, enabling the nurse to verify her impressions, verbalizing implied thoughts and feelings, the nurse should be careful to verbalize only what the patient has fairly obviously suggested so that she does not get into the area of offending interpretations—of making conscious that which is unconscious.

10. **Exploring**  
Exploring or delving further into a subject or idea. “Tell me more about that”, “Would you describe it more fully?” and “What kind of work?” are examples exploring topics which the patient has brought up for discussion. The nurse should recognize when to delve further – she should refrain from probing or prying. If the patient chooses not to elaborate, the nurse should respect the patient’s wishes. Probing usually occurs when the nurse introduces a topic because she is anxious.

11. **Presenting Reality**  
Examples of presenting reality are: “I see no one else in the room”, “That sound was a car backfiring,” and “Your mother is not here; I’m a nurse.” When it is obvious that the patient is misinterpreting reality, the nurse can indicate that which is real. She does this not by way of arguing with the patient or belittling his own experiences, but rather by calmly and quietly expressing her own perceptions or the facts
in the situation. The intent here is merely to indicate an alternate line of thought for the patient to consider, not to “Convince” the patient that he is in error. This technique is highly useful with patients who are confused and geriatric patients in nursing homes who show signs of confusion, psychiatric patients showing high anxiety and patients who are confused due to alcohol or drugs such as LSD.

12. **Voicing Doubt**  Statements like the following express uncertainty as to the reality of the patient’s perceptions: “Isn’t that Unusual?” “Really?” “That’s hard to believe.” Another means of responding to distortions of reality is to express doubt. Such expression permits the patient to become aware that others do not necessarily perceive events in the same way or draw the same conclusions that he does. This does not mean that he will alter this point of view, but, at least he will be encouraged to reconsider and re-evaluate what has occurred. And, the nurse has neither agreed nor disagreed, yet, at the same time, she has not let misinterpretations and distortions pass uncommented upon.

13. **Suggesting Collaboration** by offering to share, to strive, to work together with the patient for his benefit. “Perhaps you and I can discuss and discover what produces your anxiety (pain, frustration, etc.). The nurse seeks to offer the patient a relationship in which he can identify his problems in living with others, grow emotionally, and improve his ability to form satisfying relationships with others. She offers to do things not For him or to him, but with him.

14. **Validating**  When the nurse feels that the patient’s need has been met, she should validate her impression with him. If his reply to such a question as “Do you feel relaxed?” or “Are you feeling better now?” suggests his need has not been completely met, the nurse should renew her efforts to assist him. The nurse should not assume that she has been successful in meeting a patient’s need until this has been validated with him. Also, since the patient may have needs in addition to that which the nurse has attempted to meet, validating gives him an opportunity to make any such needs known. Also, the nurse observes his nonverbal behavior. A lessening of tension or a positive change in behavior would support an affirmative verbal response; if tension or behavior is not perceptibly altered, however, an affirmative reply would not be as meaningful.
1. **Using Reassuring Clichés** “Everything will be all right,” “You don’t need to worry,” “You’re doing fine” are reassuring clichés which are often given automatically, or may be used when a person has difficulty knowing what to say. Although the nurse may say, “Everything will be alright” out of a sincere desire to reduce the patient’s anxiety, such a response may also result from an unrecognized need to reduce her own anxiety to feel more comfortable herself. When a patient who has expressed apprehension is told, “Everything will be alright” he is likely to feel that the nurse is not interested in his problem and thus will refrain from discussing it further. Reassuring clichés tend to contradict the patient’s perception of his situation, thus implying that his point of view is incorrect or unimportant. When there are facts that are reassuring, the nurse can, give genuine reassurance by communicating them to the patient. A less direct, but basic reassurance is given as the nurse communicates to the patient understanding, acceptance, interest.

2. **Giving Advice** “What you should do is…” “Why don’t you…” By telling the patient what he should do, the nurse imposes her own opinions and solutions on him, rather than helping him to explore his ideas so that he can arrive at his own conclusions. Even when a patient clearly asks for advice, the nurse should be cautious in her response, and supply only pertinent information that may give him a better basis for decision-making. Giving the patient advice may imply to him that the nurse thinks she knows what is best for him, and that she feels his problem can be easily solved. If the patient does not accept these implications, he may resent the nurse for advising him, if he does accept them, it may reinforce his feelings of dependency. If, instead of giving advice, the nurse helps the patient to think through and attempt to resolve his problems for himself, she makes an important contribution to his feelings and self esteem. When a patient asks for advice, the nurse can assist him by asking such questions as “Tell me what your feelings are about…” She can provide pertinent information (facts, resource people, services, etc.) and help him examine all parts of the problem by encouraging him to express his own thoughts and feelings about the problem and helping him to identify possible solutions and the factors involved in possible outcomes. While it is obvious that some patients, by reason of age or extreme physical or emotional stress are incapable of this kind of activity, the nurse should foster decision-making to whatever extent is possible.

3. **Giving Approval** “That’s the right attitude” or “That’s the thing to do.” Although conceivably a useful response when the nurse wishes to motivate or encourage a patient, giving approval can sometimes create a block by shifting the focus of the discussion to the nurse’s values or feelings, and by implying standards of what is and what is not acceptable. The nurse’s approval of a patient’s statement such as “I know I shouldn’t let it get me down” makes it difficult for him to admit that it is getting him
down. Approval also implies that the nurse’s concepts of right and wrong will be used in judging the patient’s behavior. For it is possible that the nurse may approve behavior of which the patient himself disapproved—such as crying or expressing strong feelings. In such cases, the values and goals of the nurse would conflict with those of the patient. To the extent then that (1) a standard has been set that the patient may not at another time be able to achieve, (2) a value judgment has been given and the patient may be consciously or subconsciously aware that non-acceptance of at least some type of behavior has been implied, (3) that the patient may be motivated to repeat the behavior for the sake of approval, rather than because he himself values the results, (4) that the focus of the conversation is on the nurse’s values of goals rather than the patient’s and (5) that the patient may not value or may disapprove those actions or expressed feelings of which the nurse approved—this extent giving approval may function to block communication.

4. Requesting and Explanation “Why did you do that?” “Why are you here?” “Why are you upset?” are examples of questions which some patients find difficult and even intimidating because they call for the patient to immediately analyze and explain his feelings or actions. Patients who cannot answer “why” questions frequently invent answers. The nurse should avoid asking “why” questions except when asking simple, direct questions pertaining to patient care, e.g., “Why are you going to the bathroom?” In general, the nurse is of more assistance, however, if she assists the patient to describe his feelings. There are two types of questions the nurse can ask in order to get descriptive information; closed and open questions. A closed question is phrased so that a yes or no answer is indicated, e.g., “Did you sleep well last night?” or so that a specific choice of answers is given within the questions, e.g., “Do you want this injection in your right or left arms?” Although this type of question does not encourage the patient to express himself or give him the lead, it can be useful in eliciting specific information needed to assist the patient once his need has been identified. It is also useful in caring for the patient who has limited energy or who by reason of age or severe stress is mentally or emotionally incapacitated. Open questions, though still determined by the subject, let the patient provide his own answers. Words such as “who”, “what”, “when”, and “where” elicit factual information and will help the patient to begin learning to describe his experiences. “How” questions should usually be avoided also since they ask by what process or for what reasons; some patients will respond to “how do you feel?” with my fingers.

5. Agreeing with the Patient “I agree with you,” or “You must be right.” “When the nurse introduces her own opinions or values into the conversation, it can prevent the patient from expressing himself freely. Be agreeing with the patient she can make it difficult for him to later change or modify the opinion he has stated. Or, if he has expressed something other than what he actually believes to be true (sometimes to test the nurse to see if she’s interested in him) he may be prevented from saying what he really thinks at a later time. Rather than stating her own views, the nurse should accept the patient’s statements and encourage him to elaborate on them by using responses such as General leads or reflecting.
6. **Expressing Disapproval** “You should stop worrying like this” “You shouldn’t do that.” When the nurse indicates that she disapproves of the patient’s feelings or actions, she imposes her own values, rather than accepting the patient’s. Such negative value judgment may intimidate or anger the patient, and will often block communication by expressing disapproval; the nurse implies that she is entitled to make negative value judgments regarding his behavior, and that he is expected to conform to her standards. If the patient accepts this role, communication will probably be hindered as he modifies his behavior to avoid incurring further disapproval. Rather than making value judgments about a patient’s behavior, the nurse can encourage further examination of a remark with statements such as “You feel that…” or “You seem to be…”

7. **Belittling the Patient’s Feelings** “I know just how you feel,” “Everyone gets depressed at times.” Because the patient is usually primarily concerned with himself and his own problems, telling him that others have experienced or are experiencing the same feelings will seldom do much to comfort him. On the contrary, to do so devalues his feelings, implying that his discomfort is common place and insignificant. The nurse can communicate understanding, acceptance, and interest in him as an individual by simply acknowledging his feelings. “This must be very difficult (upsetting, exhausting, annoying, etc.) for you.”

8. **Disagreeing with the Patient** “You’re wrong”, “That’s not true,” “No, it isn’t.” By contradicting the patient, the nurse indicates to him that what he has said has not been accepted. Because the nurse’s judgment may cause him to feel threatened he may refrain from expressing himself further on the subject, or he may become defensive or angry. When the patient makes a statement with which the nurse disagrees, she can acknowledge his feelings and opinions without agreeing with them, e.g., “Then you feel…” or “I hear what you are saying.”

9. **Defending** “Your doctor is quite capable.” “She’s a very good nurse.” In defending herself, others, or the hospital in response to criticism from a patient, the nurse not only communicates a non-accepting attitude to him, but also, in becoming defensive, may lead to believe that his criticism is justified. Thus, this response may reinforce rather than change the patient’s point of view. By acknowledging the patient’s feelings, without agreeing or disagreeing—for example, “It must be difficult for you to feel this way” – the nurse avoids putting herself in opposition to the patient.

10. **Making Stereotyped Comments** “How are you feeling?” “Isn’t it a beautiful day?” “It’s for your own good,” “You’ll be home in no time.” By using social clichés or trite phrases, the nurse may lead the patient to reply in a like manner, thus keeping the conversation at a superficial level. While comments such as “How are you feeling?” may be used purposefully to elicit information, they are often made automatically, or out of a subconscious desire to avoid uncomfortable topics. In addition to social clichés she already uses, the nurse in her daily work may develop or adopt “stock” replies which she used in her interactions with patients. Because they are easy to use, they are a convenient substitute for a more thought out and individualized response. They may also be used when the nurse is unsure of an answer to a patient’s question, and she is reluctant to
admit that she does not have the answer. When the nurse has nothing meaningful to say, she should remain silent. Social cliches and stock replies function to keep distance between nurse and the patient. Behind stereotyped responses, there may be stereotyped attitudes on the part of the nurse.

11. Changing the Subject Patient “I’d like to die” Nurse: “Don’t you have visitors this weekend?” or “by the way…” or “That reminds me…” Generally, the nurse changes the subject to avoid discussing a topic which makes her uncomfortable (consciously or unconsciously) or to initiate discussion of a topic which she is more interested. In either case, by taking the lead in the conversation away from the patient, she can block any attempt he may be making to express his needs to her. Even when he is discussing a matter which seems to be of relatively little significance, the nurse may be able to pick up clues that will help identify his needs, or the patient may be proceeding in a round-about way toward making his needs known.

12. Giving Literal Response Patient: “They’re looking in my head with a TV”. Nurse: “What channel?” or Patient: “That doctor is a pain in the neck.” Nurse: “Would you like your pain medication?” Patients who are confused or highly anxious may have difficulty describing their experiences. They may use words in a very personal sense which has meaning to them, but can be misinterpreted by the nurse. If the nurse responds to his comment as if it were a statement of fact, she tells the patient she cannot understand when anxiety-producing feelings are being described. Instead, she could respond with, “Tell me what means to you.” or “I’d like to understand that better; tell me more.”

13. Challenging “If you’re dead, why is your heart beating?” “Your sister couldn’t be coming, she’s dead.” Often the nurse feels that if she can challenge the patient to prove his unrealistic ideas; he will realize he has no proof. She forgets that the patient’s ideas and perceptions serve a purpose for him, that they conceal feelings and meet needs that are real. When challenged, the patient tends only to strengthen and expand his misinterpretations as he seeks support for his point of view. Rather than challenging the patient’s views, the nurse might restate, or ask him to “say more about that” so she can understand the patient’s viewpoint more clearly.