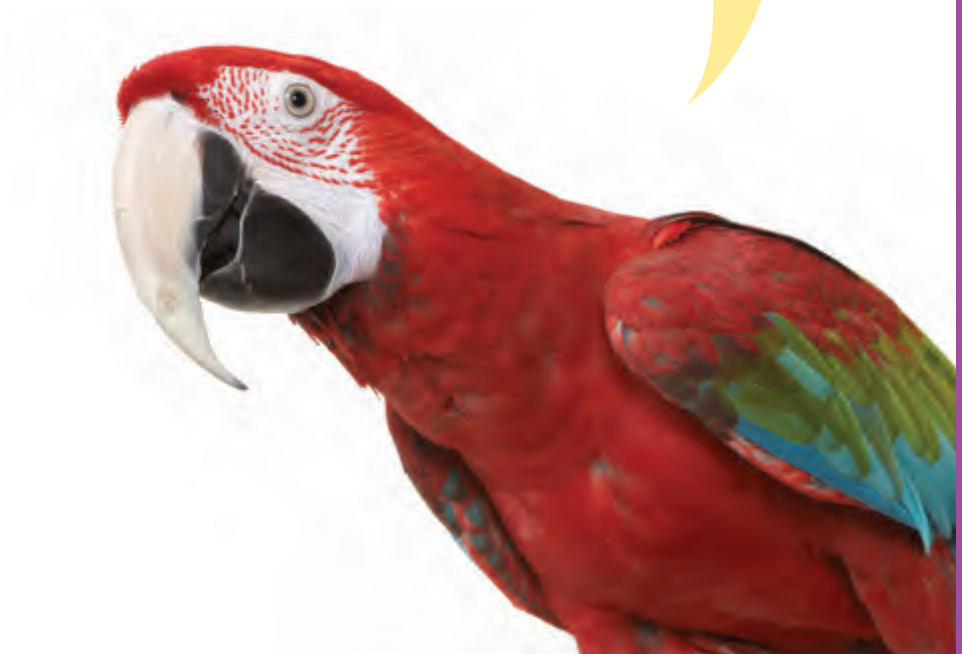
Star Wards

Encouraging the art of conversation on mental health wards

TALKWELL

"Here's the SECOND EDITION! With new information, new ideas, same old jokes."



Star Wards

If you're reading this (which you seem to be!), odds are you know more about Star Wards than I do. You're probably one of the thousands of heroic staff working on mental health wards, faced daily with extraordinary pressures and challenges – and enjoying satisfactions and achievements. (You certainly can't be in it for fabulous pay or convenient hours!)

I set up Star Wards to in some way reciprocate the amazing care I receive as a patient at St Ann's in Tottenham. Happily we now have about 600 wards in the country as cherished members and the ideas we collect, generate and share are making life on the wards considerably more fulfilling for patients and staff. A modern matron wrote to us that: "Star Wards has been a breath of fresh air and its success in our wards has been overwhelming. Everyone in mental health knows about Star Wards … [and] is so proud of the way we can make the changes irrespective of budgets and other demands on time. Star Wards has been the vehicle to say 'we can do this' and just get on with it."

TalkWell is a practical resource to support you in your fantastic work, by focusing on the continuous but complex and often fraught process of talking with patients. The skills required to communicate with us when we are at our most unwell and not always super-reasonable (!) tend to be under-rated. Yet they are the ones most valued by patients and which deserve a lot more attention, training and support.

This is the 2nd edition of TalkWell. That reminds me of an antiquarian book I saw in a library of Yiddish literature. The title, written in Yiddish, was *Shakespeare - translated and improved.* A great example of Jewish humour and chutzpah, which roughly translates as 'cheek'. We hope that you will find the changes and additions to this edition are indeed improvements, and that you'll forgive any chutzpah which is ethnically hardwired into me and erupts all over the place.

The changes have been inspired and informed by feedback from staff who have been using TalkWell, especially the wonderful Patrick Cullen in Birmingham and Jo Spencer in Highgate, north London. We are also very grateful to Len Bowers and colleagues at City University for the invaluable information and guidance in their publication Talking with Acutely Psychotic People. Details of this essential resource are on the inside back cover.

Many thanks to all of you for all your work with TalkWell and your feedback. I've been particularly struck by the following three pieces of advice:

1. Be yourself! That's what patients really appreciate
2. Find and connect with the patient behind the symptoms
3. Mentalising is an awkward name but an invaluable skill for improving conversational skills

Be yourself!

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

Buddy and me being ourselves.

Marion Janner

TalkWell

Contents

TalkWell

What is TalkWell?

TalkWell is a conversation training resource for mental health inpatient staff. 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 formalised training session. The exercises are 'addressed' to your staff directly rather than to you as the trainer, so that you can simply photocopy and use them. There are all sorts of resources to support TalkWell on the Star Wards website: www.starwards.org.uk And there are even more TalkWell treats on our YouTube channel: www.youtube.com/starwardschannel

Who we are

TalkWell is produced by Star Wards, 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 Star Wards, 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 inpatient 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. 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 intense, but the magical thing 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.

> Mentalising, or being 'mind-aware' 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, the 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-mentalising 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 mentalising 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 mentalising, 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 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!

> You don't need to have read any of the books about mentalising 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**).**

Caring Conversation

The main principle of TalkWell is that all conversations on 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.

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 minds. This should produce the necessary trust for the patient to care about what's going on in your mind and 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?***

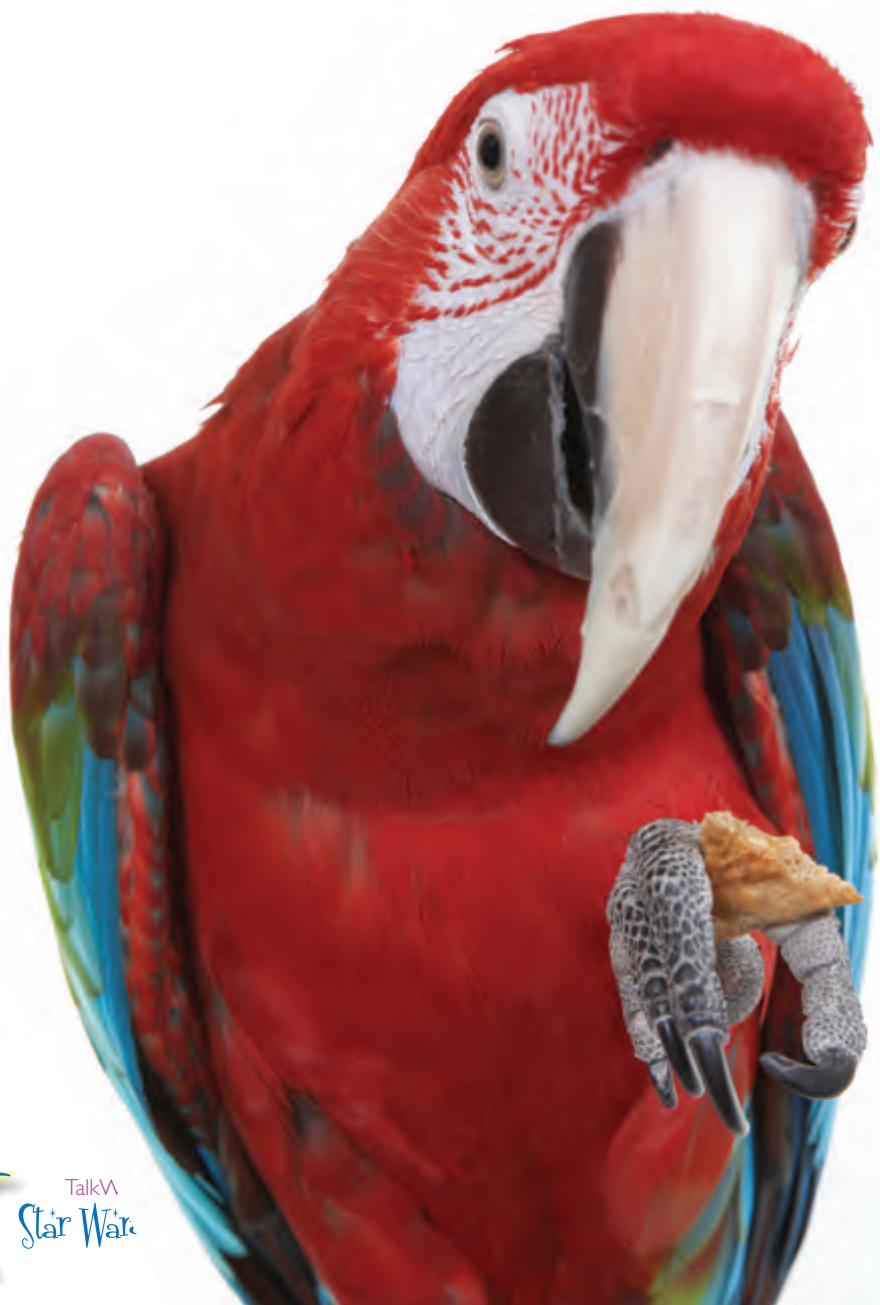
Examples:

- 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 (!!)
- Keeping 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."
- Keeping 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 tranparently 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'.***

suggest 5 open questions and 5 closed questions you could ask.

suggest how the patient might respond to each of these questions

use these possible responses to illustrate the effects of asking:

- ***open questions***
- ***closed questions***

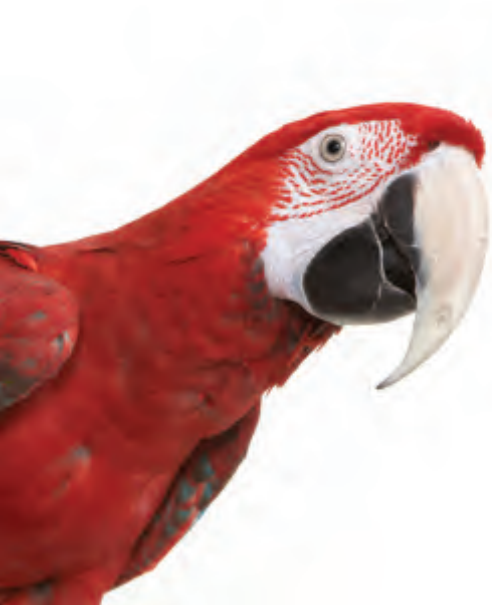
Here's an easy way to remember ways to ask 'open' questions. It's comes from Kipling. (The poet, not the cake maker):

'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:***

you're sitting in the lounge and a patient comes and sits next to you

you're sitting in the lounge and a patient comes and sits at the other side of the room to you

you go past a patient's bedroom and see that they are crying

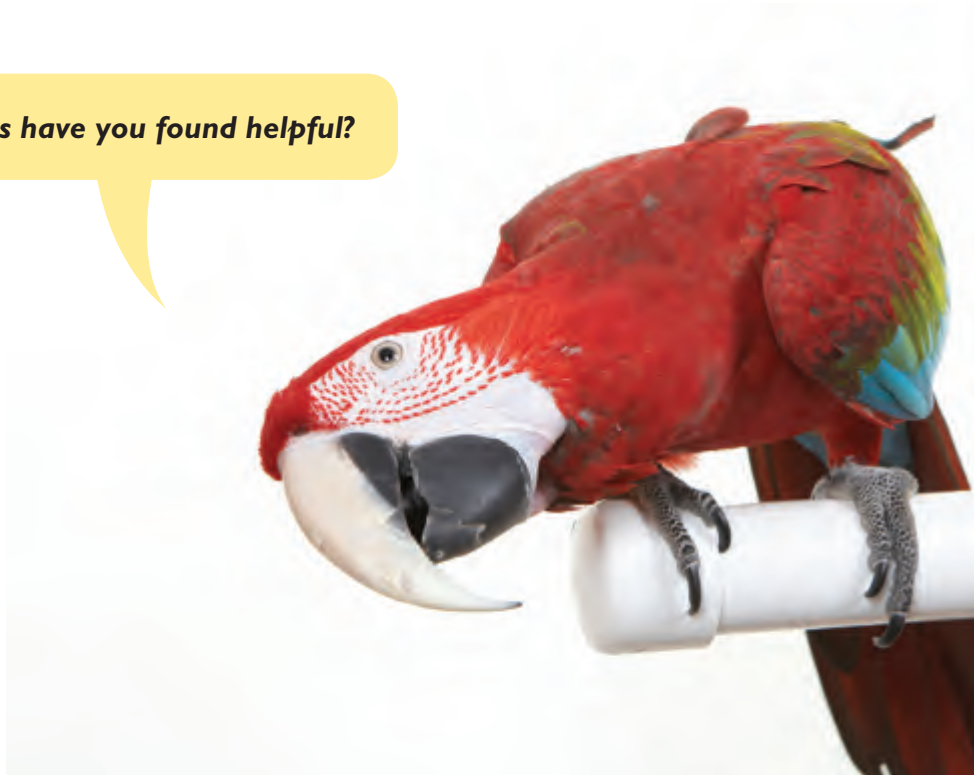
a patient is highly agitated, pacing up and down the corridor

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. Staff concerns

It would be easy to chat if there were activities going on in the ward which we could talk about. But there often 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. It's great if you can find a topic that the patient knows more about than you do. This could be stock-car-racing or managing intrusive voices but will help them to feel expert - and be interesting for you!

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. If none of the patients who are around want to have a chat, simply by being obviously available to listen gives out an important messages 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.14)

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. For example, you can only know only know what effect medication is really having on a patient by listening to what they say about this.

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.44.

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.

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.

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.

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:

1. to make sure you're really understanding what the patient is saying!
2. to check what the patient has understood about about what you're saying
3. because it demonstrates that someone is listening.

Checking you've understood correctly what the other person is saying is a core mentalising skill, as it recognises 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

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 mentalising helps! We can be mind-aware by understanding that what's comfortable is what we're familiar with.

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?'***

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 mentalising 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 mentalising 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

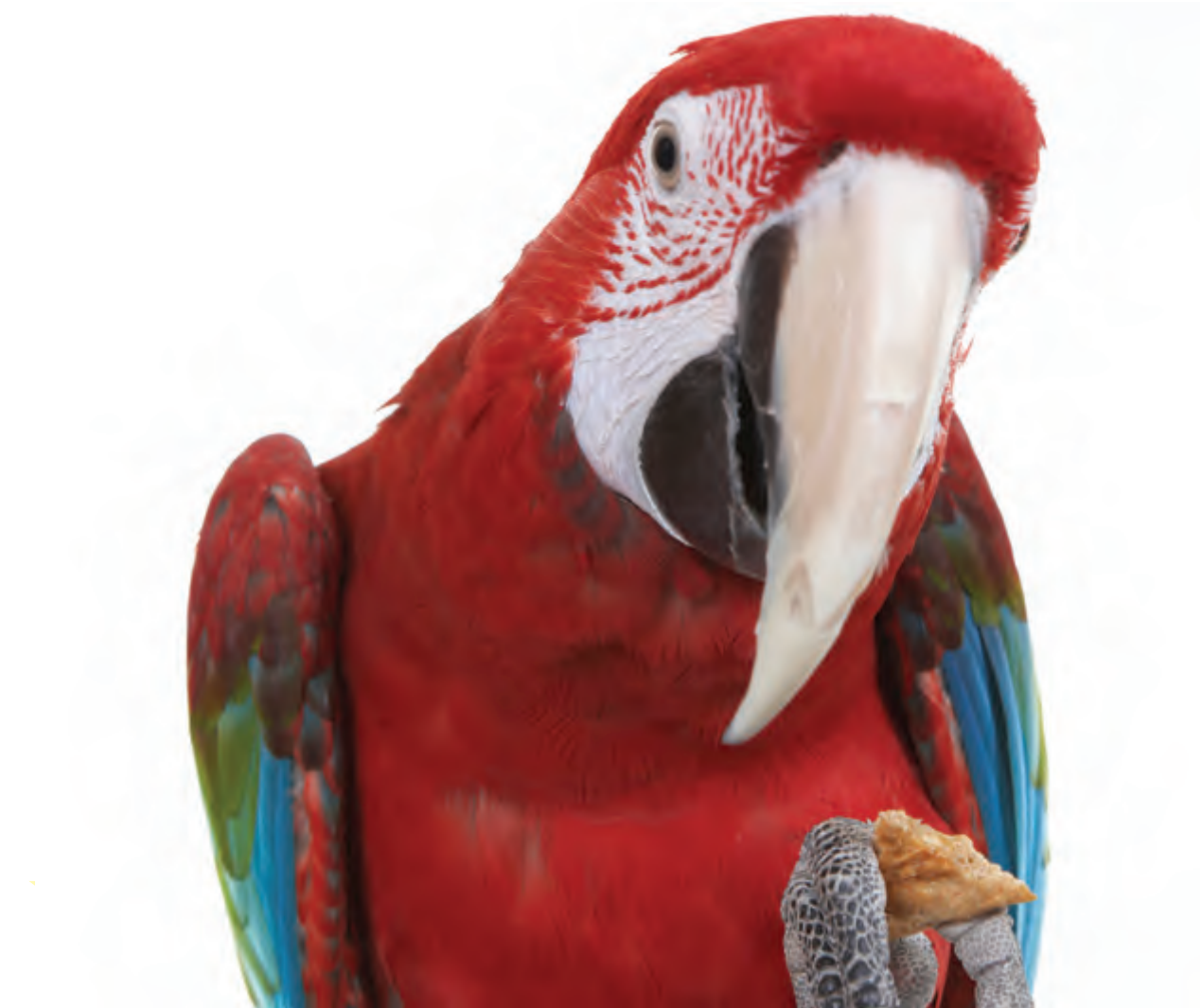
One of the reasons why the Samaritans take over 5 million phone calls a year is their reputation for listening rather than advising. (The Citizens Advice Bureau, on the other hand….)

10. Dealing with sensitive issues

When you need to ask something which touches on sensitive or painful issues for the patient, such as bereavement, there are all sorts of things which can help:

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

- 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….



11. Apologising

As Sir Elton so wisely said (and tunefully 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 sent 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,

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.

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' 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 or experienced 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 mentalising 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 nosey!)

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?

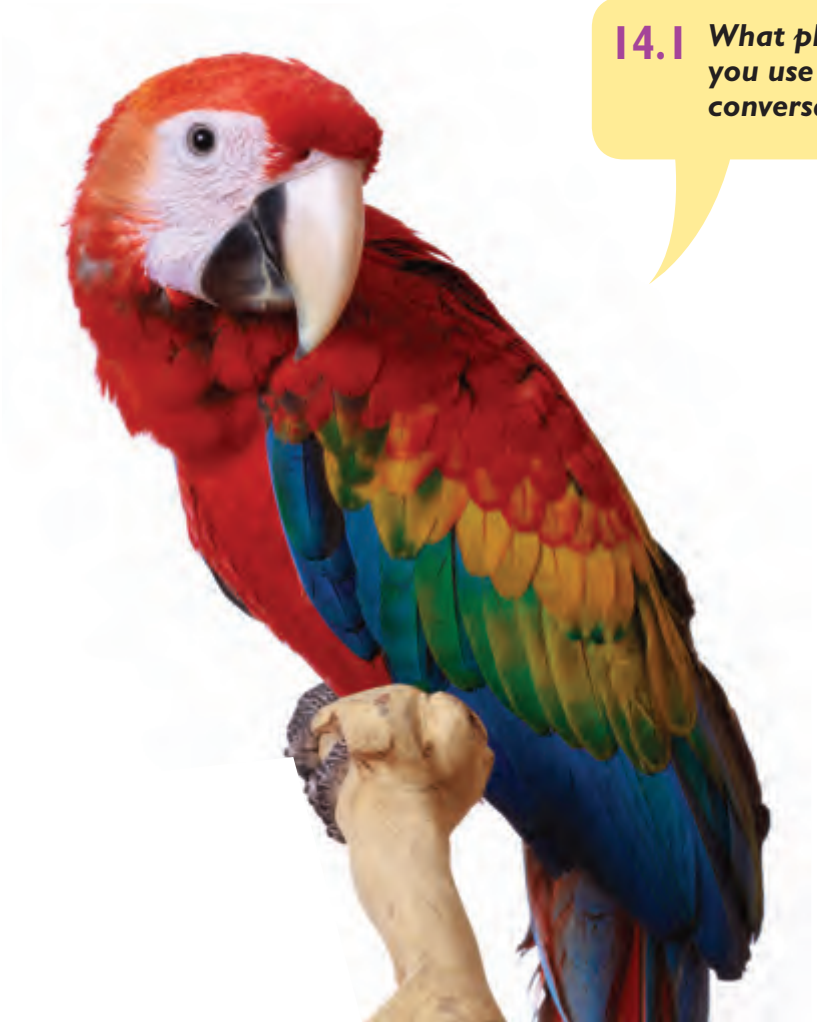
14. Keeping it going

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.
- Being patient (er, being patient with the patient), taking things at the patient's pace
- Coping with or even savouring some silence
- If a patient seems to be struggling to know what to say, try 'The Politician's Dream Conversation' – a monologue, or one-sided conversation. You chat away, about topics that you hope will interest the patient, or at least not stress them. They might eventually join in and could appreciate your attention and efforts to engage them.

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. 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, hand gestures or even sitting position!

It's particularly important for staff to be aware of body language when working with inpatients, as the patients may respond much more to non-verbal signs. This is especially the case for people with additional communication challenges (see creative conversing p.31) 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, how will you know how this seems 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 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 ***Questions about the photos***

- ***How would you describe their expression?***
- ***What are some other possible interpretations of their expression?***
- ***What is their body language saying?***
- ***What might they be thinking?***
- ***What might have happened just before this photo was taken?***
- ***Write some captions for the photos – bonus points for wit!***
- ***What would be the best and worst responses to each person in words and body language?***
- ***Do you ever feel like this at work or home? What helps?***

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***
- ***Yawnin***
- ***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. Voice

Our voices convey more than just information, opinions and quirky versions of our favourite songs. 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, voices can have a postive 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 (!), 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.

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

16.2 ***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

Speed

Tone (e.g. warm, sarcastic, friendly, patronising…)

Emphasis (stressing particular words)

Pitch (high, low, deep, squeaky…)

Accent

16.3 ***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			

16.4 ***Try saying these sentences in very different ways, e.g. compassionately, irritatedly, patronisingly, angrily:***

'Your mother phoned.'

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

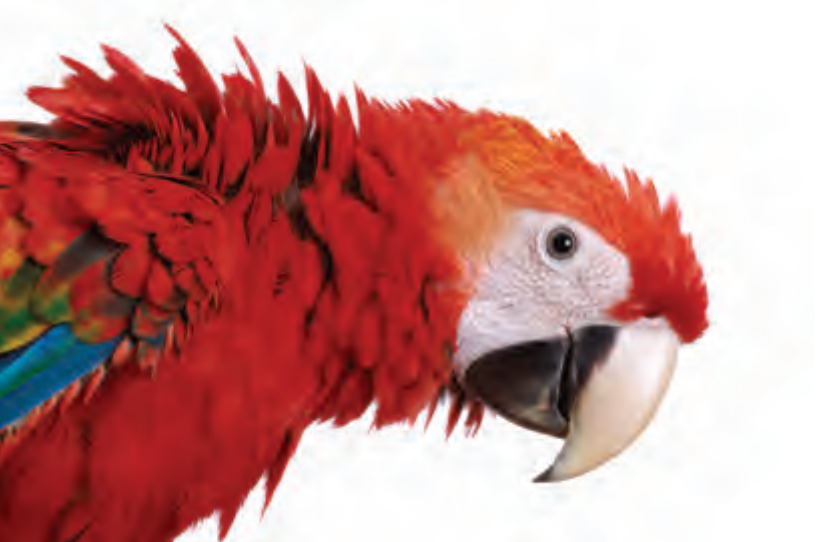
'Where did you get that t-shirt from?'

'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?

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

Kind	*Sarcastic*
Worried	*Trusting*
Very worried	*Genuine*
Hysterically worried	*Superior*
Irritated	*Lying*
Furious	*Confident*
Calm	*Arrogant*
Amused	*Professional*
Dismissive	*Respectful*
Powerful	



17. 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. This is especially the case for women and patients with dementia.

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.

17.1 ***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?***

18. Wrapping up

Ending a conversation can feel as daunting as starting one. But there are some simple techniques for ending conversations in a way that feels good for staff 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 sessions, bang on 50 minutes! (They're usually more flexible about other conversations!) 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 pressie, 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?***

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

19. Creative conversing

Staff are faced each day with having particularly complex conversations with patients, conversations which can be very emotionally and intellectually demanding. These conversations might be exacting because a patient is in a very fraught state or because they have additional communication disadvantages such as dementia or psychotic symptoms.

Confusion and misinterpretation are often major features of these interactions. If you're feeling confused, it's likely to be much more bewildering for the patient who has the double challenge of mental illness and an additional communication complication.

You know what's coming… mentalising. Trying to see things from the perspective of the patient and keeping track of what's going on with your own thoughts and feelings. Yes, very demanding on top of all the other pressures of your work, but also incredibly satisfying when unexpected breakthroughs happen. And the need for a creative, patient-centred approach means that there's tons of scope for interesting, fun, memorable experiences. A big reward for the respectful, tenacious interactions about issues that are important to the individual where you're effectively harnessing your own and the patient's motivation.

There's a fabulous approach to communication with people who have profound and multiple learning disabilities, called intensive interaction. Intensive interaction is about using everything that your 'communication partner' provides, and because it's designed for people who use little or no speech, body language and behaviour are carefully considered. A really valuable concept from intensive interaction is about taking the lead from the other person, building on the communication methods, style, pace etc they use, enjoy and can comfortably manage. The greater the person's communication challenges are, the more this approach helps. It's all about creative conversing – applying the full range of your personal qualities, imagination and artistic abilities.

1. The individual

- Like everyone else but even more so in this situation, and to state the obvious, patients with additional communication problems are very individual in what they find helpful
- It's crucial to encourage the person to communicate in the ways that work best for them and which build on their strengths, interests and motivation.
- People's health can aggravate or cause communication problems, especially issues of hearing, sight, medication, pain, fatigue or even ill-fitting dentures.
- Allowing a generous amount of time for the patient to understand and respond to you really helps
- It can unfortunately happen that given all the pressures on a shift, especially with many patients with multiple health and communication complications, staff can unintentionally say or do things which make the patient feel belittled. Substantial communication impairment doesn't mean the patient isn't very aware of people's attitudes to them. (see p.19 on apologising)
- 'Life factors' shared by a member of staff and a patient can help the patient feel more comfortable and confident about communicating eg age, gender, ethnicity

2. You

- You too will have your own attitudes, feelings and beliefs, and these will inevitably influence the way you see and interpret the person's needs, choices and interests.
- Success is highly motivating for staff and patients! Finding effective (especially breakthrough!) ways of communicating with individuals enables them to be more responsive and staff to appreciate them more. So it's worth investing time considering what is it about the person which makes you feel you want to respond and what's getting in the way.
- Staying calm not only supports your sanity but also reassures the patient and helps keep the emotional temperature low(er). Trying not to take things personally is a crucial skill here.
- When someone does or says something that seems weird or 'wrong', it's important to think of different possible interpretations for these. There's a great 50:50 principle from mentalisation based therapy. Assume there's a 50:50 likelihood that what's being said is accurate, or meaningful, or a muddledly expressed version of what did happen.
- The stronger your relationship with the patient, the easier and more satisfying the communication.
- Gentle humour can often help a situation where there's misunderstanding. But humour can also unintentionally add to the confusion and make the patient feel vulnerable or belittled. (see humour feature on p.20)

3. Preparation

- Lots of things can help prepare for conversations eg reading patients' notes, talking to colleagues and also, where appropriate, to patients' friends or relatives
- Sometimes it helps the patient be well-prepared for a particular conversation (and especially a meeting) by giving them advance notice, as long as this doesn't build up their anxiety. Some patients feel more comfortable and communicative if they have a friend or even an advocate with them
- Alternatively, it can work well to gently bring up a particular issue while you're doing an activity with a patient such as going for a walk, helping them with their self-care, or while making and sharing a cup of tea. (Preferably a cup each.)
- Speech and language therapists are endangered species in mental health inpatient care, but their fabulous skills are worth tracking down in other services, including the community. Psychologists are also specialists in communication especially in relation to people's behaviour and emotions.

4. Places

- Asking the patient where they'd feel most comfortable chatting, eg in the office, their bedroom, during a walk outside
- Ensuring privacy, both for that patient's sake and to protect other patients from what could become a distressing experience
- Making sure that where the conversation is happening is as comfortable as possible in relation to practicalities such as seating, heating, lighting, distractions (including any which exacerbate psychotic symptoms). For example:
  - smaller spaces are more private and quieter and can make it easier for both staff and the patient to focus.
  - there's a surprising amount of background (and often foreground!) noise on wards from talking, shouting, TV, radio, trolleys, outdoor traffic…
  - comfortable furniture and attractive homely decorations are good for self-esteem, motivation and concentration

5. Time

- Making sure you've got enough time, to build up to and have the conversation and if it distressed the patient, to support them afterwards
- Processing information and formulating a response can be strenuous for patients with additional communication impairments. Encouraging them to take their time reduces the sense of pressure and makes it easier for them to express themselves
- Working out, perhaps with the patient or someone who knows them well, what's the best time of day for them in terms of:
  - concentration and mental clarity
  - symptoms (mental and physical)
  - energy levels
  - planned activities (including visitors)

6. Building up

- Getting the patient's attention before starting the conversation; eye- contact is essential and touching their hand if that's appropriate
- Reassuring the patient by saying you're there to understand and to support them and asking them what they would find helpful
- Starting with gentler topics, checking how they're feeling, taking the conversation at a pace they're comfortable with and can follow, and being comfortable with silences.
- Going easy on introducing new information
- Being honest! Including if services or staff have let the person down. (Chapter 11 on apologising is likely to help with this!)

7. Language

- It's all a bit like being in a foreign country where you don't understand the language, so whatever you find, or would find, helpful in this situation is also likely to help the patient, for example:
  - using gestures or demonstrating what you mean as well as saying it can be very helpful.
  - speaking slowly, using simple words, short sentences, easy topics and repeating important points no fancy words, jargon, idioms, abbreviations or brain-tangling sentence structures
- Avoiding analogies and metaphors which can be very confusing. For a patient with communication difficulties, trying to understand some flowery language is like playing scrabble with only blank tiles. No one wins and we don't know the score. (Thanks to Nick McMaster for that memorable description!)
- A handy, slightly surprising tip is to make your language a little more formal than usual. You could try imagining you're speaking to an overseas' dignitary you particularly respect, or a member of the royal family if you're not a keen republican. This approach tends to result in clearer pronunciation, fewer idioms and of course the bonus of the patient feeling valued and respected.
- Simple yes/no questions can help get the conversation underway
- Using people's names rather than referring to them as 'he', 'she' etc. With people who have severe communication impairment, eg because of dementia, it can even help to refer to yourself and the patient by name instead of saying me, you etc.
- It can be clearer, as well as gentler, to give positive rather than negative instructions, for example saying "Please can you come to dinner?" rather than "Don't go into your room now."

8. Speech

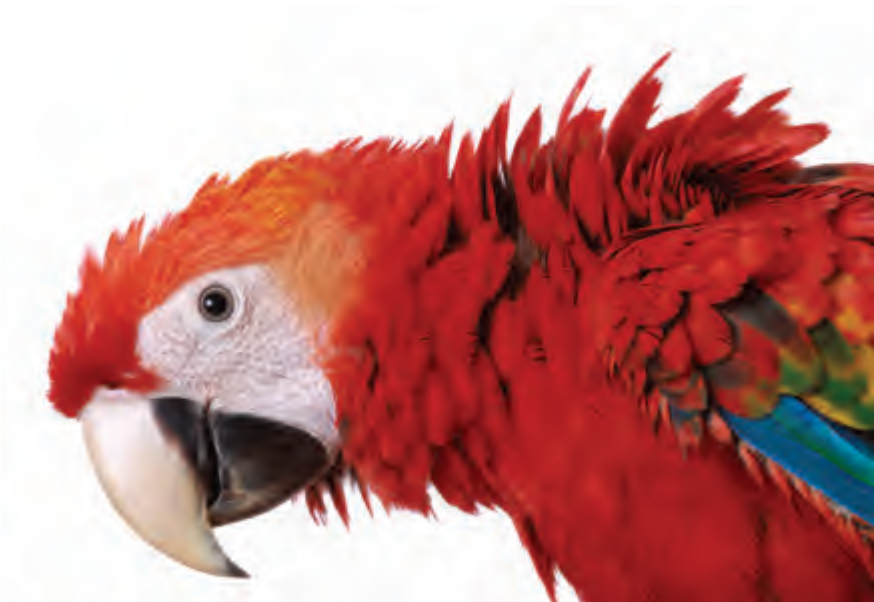
- The aim is speaking clearly and calmly – especially at times when you're under the most pressure and it's hardest to achieve this!
- Friends, relatives and staff who know the patient well will be familiar with the person's own vocabulary, which may have developed from local dialects, having English as a second language, memory loss and/or family traditions.
- Being aware of your accent and the patient's. Someone who has spent their life in Liverpool, Llanelli or Lagos may have difficulty understanding what the queen is saying – whereas she has lots of experience of understanding pronunciation differences from around the globe. (But she is unlikely to become a member of the ward team.)

9. Creative

- If you or the patient have repeated what you're trying to convey once or even twice and the other still doesn't understand, it's time to try a different route.
- Happily, spoken words don't have the monopoly on communication and are often the least effective. Alternatives (see chapter 20) include:
  - signs and gestures
  - pictures, photos, clip-art
  - symbols (eg Widgit)
  - written words
  - objects – where possible, this is the least ambiguous way of showing what we're talking about
  - websites

10. Choices

- The more that a person has direct experience of the choices, the sounder the outcome. It's difficult for anyone to make choices in the abstract, but this is especially so if someone has an additional communication complication. For example, with housing options, the best is when someone can actually stay in a potential new home. Followed by being able to visit it or talk to people who live (or work) there. Minimally, seeing pictures (or a video) of it with additional information and being able to have their questions answered.
- Its easier to start with small choices before moving on to bigger ones, and to deal with just one choice at a time.



11. Understanding

- The starting point of course is finding out as much as possible about what the patient can understand, from specific vocabulary to length of sentences, as well as alternative methods of communication like pictures or symbols.
- It's very tempting, especially on hectic shifts, to pretend to understand what the patient is saying. There's a balance between avoiding frustrating the person by acknowledging that despite your best efforts you can't understand what they're communicating, and being honest and avoiding acting on an incorrect guess about what the person means or wants.
- Additional complications arise when someone seems to understand but doesn't. It could be a straight misunderstanding, or they could be agreeing to prevent causing difficulties. People may understand less language than they seem to because there are a surprising number of cues in a given situation, eg the time of day and routines, or your tone of voice and facial expressions. Even asking if someone understands what you're saying is no guarantee as it's tempting for people to avoid embarrassment or further confusion by simply saying they do understand.
- An invaluable safeguard is to check with the patient, for example to use their own words (or gestures or pictures) to express what they think you've said. And for particularly important matters, it's best to check with people who know the person well to see if your understanding of their views fits in with the person's usual preferences and needs.

12. Body language

There's that much-touted thing about 70% of communication being non-verbal. Body language is particularly important with people who have major problems in communicating clearly using words. So body posture, gestures, facial expressions, and eye movements aren't just a bit of a bonus, they're the essentials. A truly holistic approach is needed, using everything available. All your resourcefulness and creativity and acknowledging all the communication indications the patient gives you. For example, communication-impaired people's actions or behaviour (like the rest of us!) are usually very significant, not arbitrary. This is particularly important, but difficult, to remember if the person is behaving in a very challenging way.

In addition to the points in chapter 15, the following may help in communicating with patients who have additional communication challenges, especially if things are particularly fraught.

- If possible, sitting down next to the person so that you're on the same level, and generally avoiding them feeling threatened by you standing too close or seeming to tower over them.
- Helping the person feel they have your full attention and enough time for them by being as still and calm as possible.
- As well as your body language conveying how you feel, a lot can be picked up from the patient's body language eg their facial expressions, body position and movements etc.

13. Distressed patients

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.

For understandable reasons, staff can want to urge patients to stop crying, perhaps because it saddens the member of staff or they feel crying prolongs the patient's distress. 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. Two of the most difficult aspects of being with very distressed patients are coping with them crying and balancing being optimistic with not belittling the genuine, often overwhelming challenges they're facing.

The following can help.

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.
4. Anything you can do which helps the patient feel better about themselves, their coping skills and their problem-solving abilities will be really beneficial. For example, asking them if they've experienced something like this before, what have they found helpful? If they're very stuck, becoming one stage removed can free things up a bit, eg asking them what they might say to a friend in a similar situation.
5. Trying to avoid going off to get mountains of tissues or distracting the patient so they stop crying; going with the flow and being comfortable with the tears without feeling that you are responsible for making them stop. Sometimes staff may want the tears to stop because they feel uncomfortable or awkward. But if the patient is comfortable enough to cry in the company of someone else, this should be supported rather than suppressed.

19.1 ***What might a patient feel if you ask them to stop crying?***

Examples:

- ***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***

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

Examples:

- ***Take your time***
- ***I'm sorry this is so painful for you***
- ***You let it all out. It's best to have a good old cry***
- ***It's OK. Have a tissue.***
- ***It's not surprising that you find talking about this so distressing.***
- ***What would you find helpful right now?***

14. People with learning disabilities

The learning disabilities field has produced some of the most creative and effective communication approaches eg intensive interaction, total communication and symbol systems. (As well as kids' buggies, job coaches and Wolf Wolfensberger's searing analysis of the specifics of how stigmatised people are socially devalued.)

There aren't any crucial considerations or approaches for communicating effectively with people with learning disabilities beyond those outlined in the points above. So we'd like to mention a slightly tangential but very common issue, that of age-appropriateness. Because people with learning disabilities are, by definition, developmentally delayed, there is often a pull towards behaviours, activities or products associated with considerably younger people. While it's obviously not on to treat adults like kids, there is a frequent dilemma when the individual themselves has interests, abilities or pleasures which aren't 'appropriate', or at least conventional, for someone of their age.

Our view is that unless there are disproportionate penalties in terms of the person's emotional or skills' development, their self-identity and/or how others regard and respond to them, it's important to let them express themselves in this way. We all enjoy products or activities intended for younger people – that's often part of the pleasure. A handy principle is to support the most age-appropriate version of an activity, leisure product, item of clothing etc that they can manage and enjoy.

15. Talking with people who are experiencing psychosis

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. 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.

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 – is 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 experience of psychosis can be terrifying and distressing, especially if the voices or hallucinations are threatening or abusive. Patients appreciate staff acknowledging just how distressing the experiences are. A great concept is to use validation techniques which respond more to the person's feelings rather than focusing on the facts or accuracy of what they're saying. Rather than being diverted into a mutually frustrating 'debate' about whether an individual is a member of the royal family, the focus becomes what the patient feels about this identity and role.

19.3 *Talking with a patient experiencing psychosis*

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***

How might your body language and voice help the patient feel comfortable? Or make them feel uncomfortable?

16. Dementia

Progressive communication impairment is arguably the most complicated, puzzling, frustrating and distressing feature of dementia - for staff and even more so for the individuals themselves. (And their anguished loved ones.)

Mentalising skills are indispensable when talking with people with dementia because the more complex the situation in terms of feelings, thoughts and relationships, the more important it is to mentalise. As well as careful consideration of your own speech and what the patient is trying to say, it's equally important to be very tuned in to what they seem to be feeling.

Validation techniques described on p.38 above are again an excellent way of addressing what's underlying the apparently irrational or inaccurate things a patient is saying. The classic scenario is around time orientation, a particular area of confusion for people with dementia. Wrangles about, for example, which decade we're currently in tend to be futile and demoralising for staff and patients. Unless there are valid reasons for trying to convince the patient of the real date, using validation techniques produce the more fruitful consideration of what the patient might be feeling about the period of time they are locked into.

An even more fraught ethical and practical, and very common, dilemma for staff is when a patient believes that a loved one who has died is still alive. The pragmatic situation is that it is very unlikely that the patient can be persuaded they are wrong. None of us like the process of someone trying to persuade us we are wrong, and it's clear that when the disputed facts are about the death of a loved one, emotions are going to run very high. This is a classic situation where it's best to use validation techniques. It can also help to use approaches described on p.38 for responding to patients with psychosis who are talking about something which is an 'alternative reality'.

Some of the most prevalent communication difficulties for people with dementia arise from severe memory limitations, especially short-term, such as:

- limited attention span
- mpaired ability to be logical
- confusion about fact and fantasy
- confusion and about past and present, including muddling generations
- impossibility of focusing on more than one thought at a time
- losing their train of thought
- repeating thoughts or words over and over
- given all the above, an unsurprising inability to maintain a conversational topic

More specifically, the following are often characteristics of the speech of people with dementia:

- saying very little and finding it particularly hard to initiate a conversation
- using 'empty phrases' (a rather loaded term for vague descriptions like "that thing" or "you know".)
- Using generalised descriptions of an object whose name they can't remember, or an apparently arbitrary substitute word or, impressively, creating a new word for it

Attitude/approach

- The over-riding priority is to help the patient to feel good about themselves, motivated to express themselves and confident about your desire to support them.
- Play to the patient's strengths – their memory of the past; words, concepts, and topics that they often use
- Simple acts of physical contact such as holding or the person's hand or putting your arm around them, can be very reassuring and contribute as much as a complex conversation with someone who isn't this intellectually impaired.
- Appreciating the individual's qualities and their history will be reflected in how you care for and regard (in both senses of the word!) the patient, and greatly help avoiding unintentionally being or sounding patronising.
- People with dementia do have some behaviours and needs which overlap with those of children. But of course they're the very opposite of kids in terms of having decades of experiences, skills, relationships, achievements….
- When a patient is very withdrawn and unresponsive, and when you are having yet another incredibly pressurised shift, it's easy to fall into the trap of speaking about them as if they weren't there. Managing to make the extra time and effort to avoid this prevents the patient feeling excluded and/or more bewildered, and both reassures and sets a positive example to others including their loved ones and their other visitors.

Language

- Just like best cocktail party etiquette, it really helps to begin a conversation by identifying yourself by name and perhaps role and by calling the patient by their name.
- Using words that the patient is familiar and confident with, especially those that they use with the words' conventional meanings.
- If the patient doesn't have English as a first language, it's a real bonus to learn and use some words and phrases from their (evocatively termed) 'mother-tongue' or 'heart-tongue'.
- Interrupting someone who has dementia when they're trying to communicate an idea is likely to result in them losing their train of thought.
- But… talking with people with dementia creates an exception to the usual good practice of not jumping in quite quickly to provide a word the individual is struggling to find. Depending on the person and situation, helping out with a word or phrase can spare considerable frustration and distress, provided that its accuracy is checked with them.
- Open ended questions can be very daunting for people with dementia. For example, it's easier for them to be given the option of saying yes or no to a choice of two, let's say food, options.

Speech

- Making sure you face the person when speaking to them rather than being slightly (or very!) out of their line of sight – which might itself be limited by visual impairment.
- People with dementia usually remain highly sensitised to people's tone of voice so it's very very important to keep this as warm, calm and respectful as possible. The GP journalist Dr Ann Robinson helpfully describes this as being the way we expect to be talked to by staff at John Lewis.

- Older people tend to lose hearing more in the higher ranges, so it's important to speak slowly, at a normal level (not too loud), using a low-pitched voice rather than a 'talking to kids' higher pitch that it's easy to fall into using. It's not just a matter of avoiding sounding (and feeling and being!) patronising, but also of the patient actually being able to hear what you're saying. (And avoiding sounding like a Disney character.)

17. People who have English as an additional language

- An early exercise is to check if the person knows essential phrases like "I don't understand," "Slowly, please," and "Please repeat." And if they don't, to try to teach these.
- Humour can be particularly helpful but also risky as there are considerable national differences in what's considered funny and what's experienced as offensive. (We're of course not referring to the running gag in the UK about Germans on holiday getting up at 4AM to towel-nab the best spots on the beach.)
- Similarly, while making eye contact is an important element of 'traditional' British communication, in many cultures it is regarded as intrusive or over-familiar. This is a tricky one, because a patient from a minority culture may be avoiding eye-contact because of custom, but it may (also) be an indication of them feeling particularly withdrawn. As ever, the better the knowledge of the individual and their background, and the stronger the relationship with them, the more accurate and helpful the interpretation is likely to be.

18. Resources

- Definitely top of the list: family, friends, advocates and others who know the person well.
- So very closely followed by the ever-fab speech therapists and psychologists
- Without the slightest bias, we're of course highly recommending the next chapter, on using images.
- *Talking with Acutely Psychotic People* – superbly magnificent information and practical advice courtesy of Len Bowers, Geoff Brennan and pals - www.citypsych.com
- People with dementia:
  - Intensive Interaction - http://www.bild.org.uk/pdfs/05faqs/ii.pdf
  - *Communication and the Care of People with Dementia* by Killick and Allan
  - Talking mats - http://www.jrf.org.uk/sites/files/jrf/2159.pdf
- Phrase books, dictionaries in the minority languages most used by patients
- *Point It Traveller's Language Kit* by Dieter Graf or the similar *Wordless Travel Book* by Jonathan Meader, costing about a fiver they're a bargain, or as we say in Yiddish, a metsiyah

20. Talking with images

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*

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 images' (photos, drawings and actual objects - 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 images can you get, from where, to support conversation?*

Some examples:

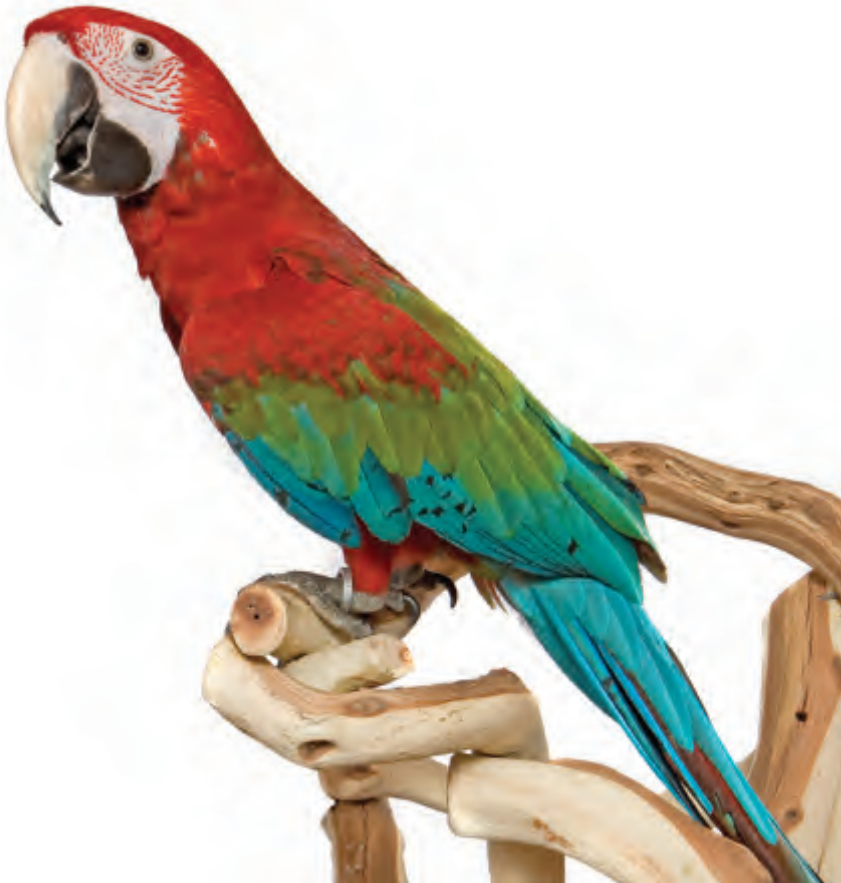
- Physical props e.g. books, clothes, cash
- TV and radio programmes
- YouTube
- Clip-art
- Cartoons
- Illustrations
- Photos
- Doodles
- Simple line drawings
- Patients' own photos, drawings or paintings
- Photos taken by staff
- Staff drawing pictures – forget Van Gogh, think Picasso! If he could get away with wonky pictures, so can you
- 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.

You can get these resources from:

- Websites about the issues being discussed
- Google images
- Websites, e.g.
  - www.clip-art.com
  - www.istockphoto.com
  - http://careimages.com
- Ward photos, e.g. of special occasions
- Specialist heath 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 needsy. We'd recommend avoiding the excessively used Change Picturebank and the equally frumpy Valuing People Clipart Collection.)

20.3 ***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 during the week?
- Do you enjoy your work/studying/being a parent?
- 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?
- What do you like doing in the evenings?
- 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 creatively conversing with patients who have additional communication difficulties?

Answers

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

Answers might include:

- They feel understood, cared about and accepted
- It helps to make sense of things that are happening or have happened to them
- 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

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

Answers might include:

- 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:

- Patients may respond much more to non-verbal signs.
- Body language can be easier to understand for patients with additional communication challenges

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 creates barriers between us

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
- It may be the wrong advice!

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

Answers might include:

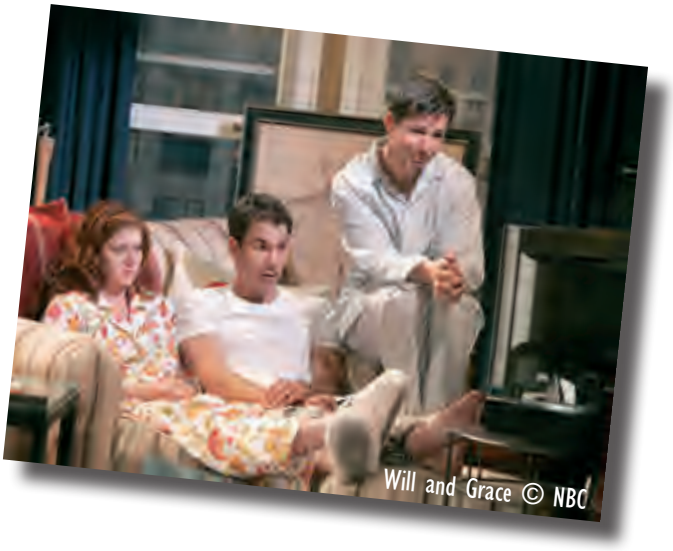
- Ask why they have asked that question.
- Use a 'diverting' answer, such as 'I'm afraid I can't really talk about that'
- Play for time by promising to think about it and get back to them.

10. What are some ways of creatively conversing with patients who have additional communication difficulties?

- Building on the communication methods, style, pace etc each patient can best manage.
- Applying the full range of your personal qualities, imagination and artistic abilities.
- Allowing enough time, finding the best place, giving patients the benefit of the doubt
- Speaking slowly, simply, clearly and calmly
- Using alternatives to speech eg signs, gestures, images, objects

23. Using TV for TalkWell training

TV programmes (and films and radio progs…) are great for refreshing communication skills because they are fun, clear, accessible, unthreatening and motivating. The approach and exercises can be used with any programme which is conversationally rich and emotionally fulfilling. And the Star Wards' websites have an extended version of this section based on using an episode of the fabulous *Everybody Loves Raymond* sitcom: www.starwards.org.uk and www.youtube.com/starwardschannel



Options for structuring staff learning

You can make learning more or less formal/structured with options such as:

- Free and easy, unstructured group discussion
- Structured group discussion, based on your questions and discussion prompts perhaps sprinkled with some from these notes
- Questions and discussion, using any of the questions and ideas below which grab your interest

Preparation

Trainers

- Choose a programme, film or short clip which shows some of the conversational issues you want to concentrate on. (Or use the *Everybody Loves Raymond* ready-made training resource!)
- Watch the whole episode/clip without taking notes or over-analysing. Just for the pleasure! (And as preparation for the work task ahead.)
- Watch it again, taking your own notes about anything that strikes you about the conversations, characters, context etc.

Trainees

- Staff members identify what (eg maximum 3) skills they'd like to focus on
- Watch whole episode/clip once to get feel for characters and to enjoy so that don't get distracted by plot etc when do the exercise
- Watch a second time, focusing on the skills they want to develop.

Finding examples of TalkWell topics on TV

Here's a list of topics and some notes about how they can feature in TV programmes.

Advice

"I'm not so good with the advice... Can I interest you in a sarcastic comment?" *Friends*

Advice is a great source of tension, comedy – and also resentment, anger and the advice turning out to be misjudged and harmful.

Anger

"I've got a good mind to join a club and beat you over the head with it." *Duck Soup*

Watching it on TV allows for emotional distance, reflection and regular trips to the kitchen for cups of tea

Apologising

"The only person I've ever apologised to was my mother, and that was court-ordered." *Will and Grace*

I'm sorry but I've got to state the obvious. There's plenty of apologising on TV, and we can learn from how other people deal with making and receiving apologies.

Appreciating difference

"WHAT?! Grace in Cambodia?! She thinks the Khmer Rouge is make-up!" *Will and Grace*

Human differences and the pleasures and prejudices around these are at the heart of most TV programmes.

Asking sensitive questions

"Fat people are so insensitive." *Will and Grace*

From the skillfulness of Paul, the therapist in In Treatment to the squalidness of Jerry Springer, questions which stir up strong feelings in others are handled with varying sensitivity on TV programmes.

Body language

Minister: "You think I shouldn't have asked Olly?"
Secretary: "No, no, I didn't say that."
Minister: "You sort of did with your face." *The Thick of It*

From the exquisite subtle observations of the Royle Family to the full-on performances on reality programmes, especially of the locked-up genre.

Clarification

"You're fired!" *The Apprentice*

Misunderstanding is a primary dynamic of comedy. In TV programmes, the audience know what each character is trying to express and what they intend, but the other person doesn't.

Content

"Not only is there no God, but try getting a plumber on weekends." *Woody Allen*

TV programmes provide as well as portray conversational content.

Distress

"It's not something you can just run away from like a hotel bill or a crying baby." *Will and Grace*

No shortage of distress on TV and when watching TV.

Insults

"How very dare you" *Catherine Tate*

Nobody does it better than *In the Thick of It's* Malcolm Tucker eg commenting on a colleague's disastrous *Newsnight* appearance: "All these hands all over the place! You were like a sweaty octopus trying to unhook a bra."

Keeping it going

"I've started so I'll finish." *Mastermind*

Chat shows in particular are a gift to those of us brushing up our conversational skills. Almost by definition.

Listening

"Yeah I called her up, she gave me a bunch of crap about me not listening to her, or something, I don't know, I wasn't really paying attention." *Dumb and Dumber*

The issue of listening arises in several ways when watching TV eg:

- We're witnessing people listening to each other (or flamboyantly not listening to each other, eg politicians and participants in the Jerry Springer show.)
- We're often identifying with characters and get some vicarious satisfaction from our on-screen 'presence' being listened to
- We often talk about the programme with others afterwards, and careful listening commonly results in modifying our previous opinions. (Within Jewish families, we talk throughout the programme, usually over each other, and with sounds muffled by the cheesecake we're fressing - Yiddish for noshing. Which is Yiddish for snacking but with a strong emphasis on high cholesterol choices.

Mentalising

"Let's be honest. Sometimes there is nothing harder in life than being happy for somebody else." *Sex & the City*

Everyone from scriptwriters to camerapeople use intense mentalising skills to work out what might be going on in the minds of the characters and audience and write/film/produce accordingly.

Openers

"Nice to see you, to see you nice." *Bruce Forsyth*

Certainly worth trying at work, but "How's it going?" usually also does the trick.

Over-personal comments

"You dirty old man." *Steptoe & Son*

Can be fun to watch on TV, requiring considerable dexterity to respond to at work.

Praise and compliments

"Ooh you are awful, but I like you." *The Dick Emery Show*

Not so much Songs of Praise, more Absolutely Fabulous. Or The Flintstones' "Yabba-Dabba-Doo".

Silence

"Do not speak unless you can improve the silence." *Chinese Proverb*

There's a notable absence of long silences on TV. Silence tends to be much better to experience rather than watch. But well-timed pauses and silences are central to comedy, drama and other genres.

Special considerations

"He's a smarty pants, Will... he uses big words like 'particularly' and 'delicatessen." *Will and Grace*

Best to circumvent any discombobulation by keeping language simple when talking with people with additional communications' difficulties.

Structuring conversations

"Houston, we have a problem" *Apollo 13*

The Samaritans' Story, Feelings, Options

Structure is pretty much the main elements of every soap episode, including posh, period soaps like *Cranfield*.

Talking with pictures

"Show me the money." *Jerry Maguire*

Er, that's what TV is largely about. And thanks to youtube, BBC iplayer, vuze.com etc we can borrow these pictures to support conversations on the wards.

Thanks

"I feel a very unusual sensation - if it is not indigestion, I think it must be gratitude."
Benjamin Disraeli More of an American President than a movie or TV prog but someone must have played him saying this some time.

TV programmes portray effusive, powerful, moving, insincere, skillful and clumsy thanking occasions. The stuff around the words is worth studying - the body language and in particular tone of voice.

Touch

"Oh, I love hugging. I wish I was an octopus, so I could hug 10 people at a time!" *Drew Barrymore*

We can (safely) watch the full spectrum from floor-tackling by rugby players and the FBI to raunchy sex scenes. Best to stick with the, boundary-respecting hand on shoulder, comforting hug, jubilant high-5.

Voice

"Phone home." *ET*

Lenny Henry, George Clooney, Sandi Toksvig. Zillions of choices of funny and/or fabulous voices.

Wrapping up

"It's goodnight from me and it's goodnight from him..." *Two Ronnies*

So much sweeter than "You are the weakest link, goodbye"

Recovery techniques and issues

Acknowledgment, acceptance, appreciation, warmth, trust, integrity, respect, empathy, compassion, authenticity, transparency, honesty

- Anchors - continuity, familiarity and predictability, including places, people, rituals.
- Autonomy, self-determination, freedom.
- Balance and harmony, order, peace, ease, beauty
- Choice and balance between too much and too little
- Belonging, community, commonality and disparity
- Conflict prevention and resolution
- Developing our range of options
- Diversity
- Fun, humour, play, creativity, inspiration, pleasure, stimulation, serendipity, joy, celebration, festivity
- Hope, optimism, energy, resilience
- Independence and interdependence. Relationships, love, sex
- Justice, fairness, equity, logic, consistency.
- Learning, self-development, competence
- Motivation and reward
- Mourning
- Perspective and different perspectives
- Popularity and influence
- Problem-solving
- Purpose, contribution, giving to others, manageable responsibilities, socially and self-valued role. Nurturing – people, animals, plants
- Security, stability, protection, support
- Self-esteem, identity, confidence
- Self-expression
- Space and escape
- Spirituality and belief
- Stress prevention and diffusion
- Understanding – being understood and understanding the situation. Information and explanations. Clarity

Cognitive Behavioural Therapy Themes

- Black and white thinking
- Catastrophising
- Compare & despair
- Core beliefs
- Critical self
- Disqualifying the positive
- Emotional Reasoning
- Judgements
- Jumping to conclusions
- Labelling

- Memories
- Mental Filter
- Mindfulness
- Mind-Reading
- Mountains and molehills
- Overgeneralising
- Personalising
- Prediction
- Shoulds and musts
- Visualisation

For explanations and information on these CBT concepts see:

http://www.cognitivebehaviourtherapy.org.uk/guides/depression/negative_thinking

Mentalising

All of this is hard-core mentalising, but here are some over-arching mentalising issues that can be considered while watching a clip:

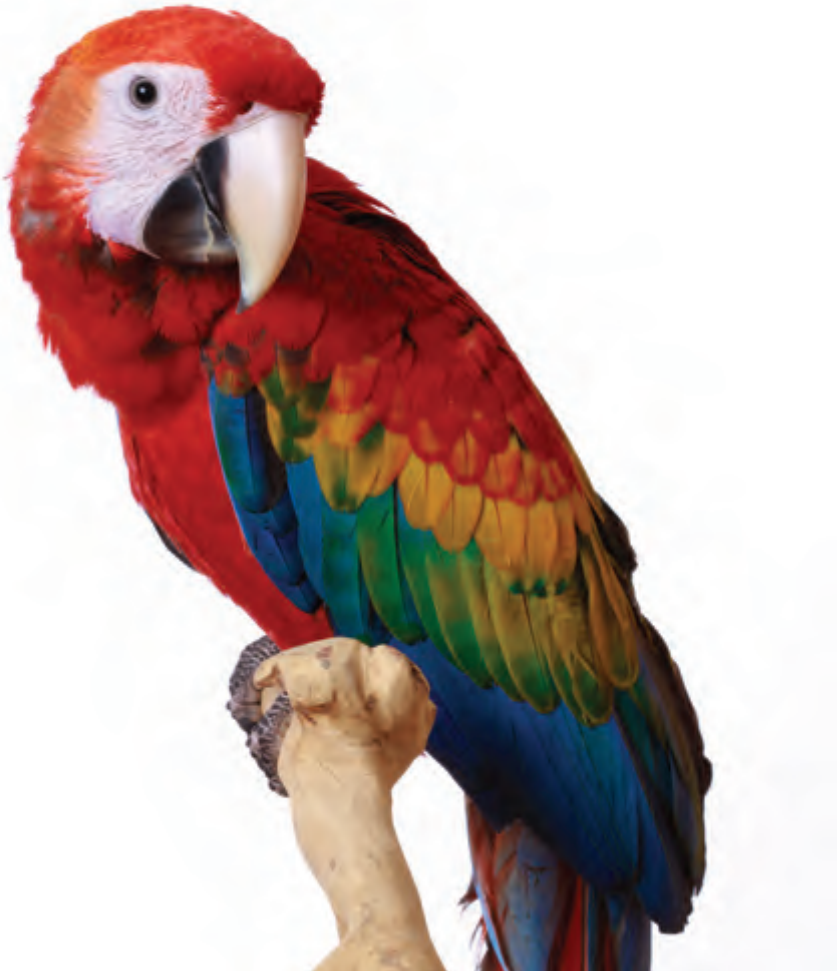
- What thoughts and feelings are going on in our own minds, as viewers?
- What's going on in characters' minds – thoughts and feelings, including what they thinks others are thinking and feeling
- What might that expression/comment/body language etc make the other person feel?

What helps particularly sensitive conversations?

It's worth using TV programmes to study what helps (eg some soap storylines) and what makes things worse (most sitcoms) in managing sensitive conversations. Questions worth considering are:

1. Where do they take place and does the location affect how the conversation goes?
2. How do timing issues impact on the conversation?
3. What are some of the differences in sensitive conversations between people of different:
   - Age
   - Gender
   - Ethnicity
   - Educational attainments
   - Cultural/spiritual/political genres
4. Are characters who are having sensitive conversations:
   - Trying not to take things personally
   - Acknowledging and empathising with another person's distress
   - Managing to stay calm, non-judgemental and open-minded about the others' perspective. (The contrast between the ostentatiously angry person and their impossibly mellow or indifferent partner is a favourite comedic ploy.)
   - Using clear, unambiguous language and gestures or other supporting communication
   - Using the other person's name more than they usually would

Notes and Ideas



Notes and Ideas

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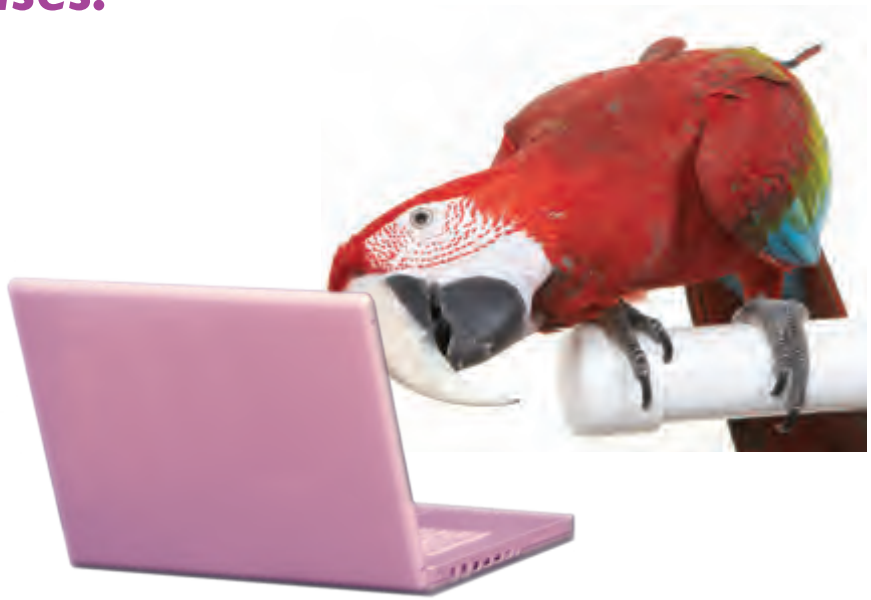
Star Wards is aware of the value of feedback as part of an extensive and expensive European-accredited quality assurance fabrication. For example, we always welcome positive feedback, preferably accompanied by either money or chocolate. Or chocolate money if you must.

You've got this far… so here are your bonuses!



There's a range of fun and practical TalkWell resources on our website www.starwards.org.uk

These include:

- **PowerPoint presentation**
- **Longer and even lovelier version of using TV for TalkWell training**

And even more fun and not necessarily all practical videos on our… ta-da… broadcast channel!!

www.youtube.com/starwardschannel

We hope you'll be super-keen to find out more about mentalising and strongly recommend the website (yup, another Bright creation and another not totally independent recommendation):

www.mentalising.com

The genius resource from City University, *Talking with Acutely Psychotic People* is downloadable from:

http://citypsych.com/docs/Talking.pdf

TalkWell Index

Star Wards

Another Bright idea

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