Easier relationships with emotionally vulnerable patients

INSIDE

★ Have richer relationships with patients in emotional crisis
★ Feel more confident about the enormous skills you already have in working with very distressed or confused patients
★ Learn a bit more about the main psychiatric illnesses
Marion’s support dog Buddy. So loved on mental health wards that the Maudsley Hospital have a new classroom named after her.

www.brief-encounters.org

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But please feel to share, copy, quote, blog, tweet and particularly to put up poster-size pictures of Buddy all over the ward. Incidentally, Brief Encounters is an adaptation of TalkWell, a conversation training resources for mental health ward staff.
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“Very often we are guided by our first impressions of a person or place and we've all felt that sense of trepidation and unease when met with the unfamiliar.

This wise and thoroughly thought through guide provides you with all the advice you are likely to need to ensure your first and possibly 'brief encounter' with an anxious individual, maybe in crisis, is a positive one.

Please use it!”

Jo Brand

To Jo,
maria
+ mi

Hero.
Love
Jo
1. What is Brief Encounters?

Being in hospital is always a difficult time for patients. However, for some it can also be very distressing and emotionally traumatic. When looking after these patients it can be hard to know what to say - what is the ‘correct thing’, how to behave, how to help relatives and also how to help yourself so you don’t go home and worry about your patients and the interventions you’ve made. We’ve called it Brief Encounters as this captures the intense and necessarily swift interactions ward staff have with patients continuously through a shift. Less romantic but more practical than the film. And with an s.

Issues that are particularly difficult for staff and patients include:

- Patients who have long term conditions eg stroke, diabetes and can’t see a way out
- Patients who are anxious, frightened and distressed because they’re in hospital
- Patients with a diagnosis of a mental health disorder who find it difficult to cope in a stressful, busy environment
- Patients who are frightened of dying
- Patients who are demanding and time consuming
- Patients who are in pain and don’t know how to cope with it
- Patients who feel powerless and no one listens to them, staff ignoring them
- Disagreeing with colleagues about the best way to treat a patient
- How to keep the relationships with patients professional
- How to keep yourself sane
Many general hospitals have a mental health liaison team who can advise and support staff and patients. Brief Encounters can provide additional ideas and information to help staff:

- have richer relationships with patients in emotional crisis
- feel more confident about the enormous skills you already have in working with very distressed or confused patients
- learn a bit more about the main psychiatric illnesses
- become more popular, charming and gorgeous and probably win the lottery.*

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

Brief Encounters recognises that the two people 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 be honest with staff about what’s going on for 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 physical and 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
- trying to do all the above at the same time as wash patients, give medication, ensure people are drinking enough, help relatives...

The patient’s needs include:

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

Staff and patients’ needs here can be very hard to reconcile. The ferocious demands on staff time and energy, including emotional energy, can make it feel impossible or even inappropriate to spend time chatting with patients. But a few minutes invested in a chat can save many hours or days of ‘fire-fighting’ when important issues are covered, and the relationship between the member of staff and patient is bolstered.
There’s some great advice about reconciling competing demands in the wonderful book ‘If Disney ran your hospital’. At Disney there are 4 areas to focus on – these have an order of priority and when faced with conflicting demands you can use these to help you decide what is your priority. If it works for Disney it can work for the NHS.

Disney’s priorities are:

- SAFETY
- COURTESY
- SHOW
- EFFICIENCY

(‘Show’ means how the hospital appears to people using it - is it clean, well maintained, fit for purpose? For example, do staff look like NHS professionals should look to inspire confidence and trust? How informative, welcoming and reassuring is signage?)

Throughout Brief Encounters these are your priorities - we create patient safety by having a relationship with them, however brief, by knowing and connecting with our patients. This covers every aspect of care from safe drug administration to listening to their fears, hopes and anxieties.

Brief Encounters looks at how relationships between staff and emotionally vulnerable patients are nurtured through ‘caring conversation’. It’s informed by the evidence of the recovery power of conversation to help people with mental illness or in extreme distress where there is no actual diagnosed 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 - even when stuck in a general hospital. This then helps them to have a greater understanding of themselves, their situation, their illness, its treatment and the recovery process.
The magical thing is that even a simple, sociable conversation can have a profound impact on someone who is in a bad emotional state. It can also increase ‘relational security’ - having someone to relate to emotionally increases feelings of safety, and therefore someone is more likely to stay on the ward and participate in their treatment.

Please don’t feel you need to use or read all of Brief Encounters. Just dip into the bits that interest you or where you feel most in need of some fresh ideas.
Mentalising

‘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. Profs Bateman and Fonagy created Mentalisation Based Treatment for a group of patients whose high level of emotional needs had till this century led to them being regarded as untreatable – people with Borderline Personality Disorder. But the approach is equally valuable working with patients with any or no psychiatric diagnosis. (And indeed when wrangling at home about whose turn it is to put out the rubbish.) 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. Similarly, being aware of your own thoughts and feelings is also crucial to being able to manage the situation calmly and effectively.
For example, your patient has pressing her call bell: ‘Nurse, you’re late again with my pain killers. I can see you all sitting at the nurses station chatting, it’s all hopeless on this ward’. Your immediate reaction is to want to respond defensively - you weren’t chatting, it was the nurses’ handover, there are 20 other patients on the ward, you can’t always get everything done on time..... However, using mentalising you think ‘She sounds very alone and worried, maybe she thinks the pain means she’s not getting any better. I’d be fed up if I was in this much pain and could hear others laughing.’

Anthony Bateman, co-creator of Mentalisation Based Treatment, said: “Brief Encounters enjoyably covers the many aspects of mentalising skills which ward staff successfully use throughout each shift. Working with patients in emotional crisis requires particular attention to what might be going on in their minds as well as your own. Although patients in emotional turmoil can be very demanding to care for, they are often also exceptionally appreciative of and responsive to gentle, non-judgemental support.”

Further info about mentalising in ‘Mentalizing in Clinical Practice’ by Allen, Fonagy and Bateman and at www.mentalising.com

Who we are

Brief Encounters is produced by Joy Bray, mental health specialist nurse at Cambridge University Hospitals Trust, and Marion Janner and Nic Higham from Star Wards, a project which works with mental health trusts to enhance inpatients’ daily experiences and treatment outcomes. For more information, please visit: www.starwards.org.uk.

Illustrations are by Matt Moore (part of Star Wards’ Service User Crew) www.matthewmoore.me.uk and Randy Glasbergen www.glasbergen.com
2. Emotionally vulnerable patients in general hospitals

Who are these emotionally vulnerable patients? How do we recognize them? Are they different to us?

Anyone, because they are in hospital, becomes emotionally vulnerable as soon as they walk through the door. Some people have great coping strategies, lovely families and millions of friends - on the surface they look fine but underneath they may be as vulnerable as the next person who only has a dog for company at home and has had to leave their precious pet to come into hospital. The only way we find out about patients’ vulnerabilities is by getting to know them, which is where Brief Encounters comes in. It can be emotionally draining for staff we’ll talk about this later.

So, this is all about patients who are:

- Frightened, confused, anxious
- Struggling with bad news
- In pain
- Complaining
- Depressed
- Not getting better
- Burdened with horrible life stories (where you feel you can’t help)
- Fearing breaking down or losing control
- Afraid of being stigmatized if they admit their fears and needs
- Vulnerable because they can’t communicate
- Reluctant to speak about vulnerabilities because they feel so many others are worse off than them
- Living with a diagnosis of mental illness.
Staff have an assortment of concerns about caring for people who are experiencing extreme emotions. Here are some of these with ideas we hope you find helpful

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

If we’re ever going to progress our care and skills we have to get rid of this idea - it is a large part of our work to talk to patients. That’s what makes them feel safe and that they’re treated as an individual. Remember the Disney priority of Safety - this is our priority. 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 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. It’s not about avoiding other duties – chatting with a patient IS a duty, as valid as any other.

**How safe am I with a patient who’s mentally ill?**

The answer is as safe as with any other patient. However, there will be some exceptions such as where a patient is very disturbed by psychosis, dementia or delirium - they’re not sure what is real and may become very frightened. The classic is the frail old lady who has the strength of Tarzan when you approach her to take her to X-ray because she thinks you’re burglars who want to beat her up. Reading the sections on these conditions will help. Also have basic safety awareness - make sure you are between the patient and the door so you have a quick exit strategy; know the emergency number for security back up; when approaching some patients you may want security back up but of course always spend enough time talking with the patient first to try and establish rapport.

There are some great new guidelines ‘Meeting Needs and Reducing Distress’ with training scenarios by NHS Protect, 2014

What do I do about a patient who self-harms?

The key here is to always get to know your patient - chat to them find out basic things eg do they like music? What bands do they like? What star sign are they? Do they read Heat/OK magazines? What work do they do or did they used to do? Get to know them as a person; this is reassuring for the patient as well as for you.

In our experience, generally the more severe the self-harm the more traumatic the past life experiences of the person this may include bullying; cyberbullying; neglect; physical and sexual abuse. Many but not all people who self-harm have a diagnosis of Borderline Personality Disorder – see section 25.

You don’t have to know the person’s full history however. If the person has very bad scarring you could say ‘You must have had a very difficult time and felt very bad in the past’. This simple acknowledgement that you recognise how emotionally painful their life has been can help generate trust and understanding. Ask the person if they feel safe (i.e. not in immediate risk of self-harming); ask them if they have any strategies that they use when they have an urge to self-harm (eg listening to their music, having a relaxing bath) and implement these if at all possible. Take practical precautions eg don’t wear scissors; watch for anything that could be used as a ligature; remove sharps bins etc from the area; don’t leave the drug trolley unattended in their sight even for a moment - the urge maybe too strong to resist these opportunities. If the patient feels unsafe they may need close observation, having a nurse with them at all times.

As you get to know the patient there may be a mental health assessment which you can read to understand their past history and current problems. Individuals who self-harm severely can have a voice/voices telling them to self-harm. It’s important that we know this as we can try to help them resist the voice, possibly by using distraction eg by talking, reading a magazine together; giving medication if prescribed.

What do I say to a patient who is suicidal?

This is one of our greatest fears, that a patient will say: ‘There’s no point in living I want to end it all’. Because of this many staff can avoid talking in any depth with a person who we know is feeling down and desperate and may already have a diagnosis of clinical depression. We’re frightened of opening a ‘can of worms’ and that we won’t know how to respond.

There’s no magic answer except to remember that this person is in a very dark place and feels a profound hopelessness; any warm interaction with a member of staff who seems caring is going to help. The key here is warmth and hope - the person has lost hope and we help by giving them some hope back.

There is no harm in asking about suicidal feelings, by asking and not ignoring you are showing the patient you understand how awful they are feeling. You can respond: “You said you want to ‘end it all’ what do you mean by that?” said in a low, calm, warm tone of voice. If the patient responds ‘I want life to finish’ check by gently asking: “Do you mean you want to end your life?” If the patient responds yes say something like “You’re in a very dark,
hopeless place at the moment and you need help, we would like to help you. I can ask my colleagues working in mental health to come and see you. I'll carry on working with you - we don’t have to talk about this but I’ll be aware of how awful you feel and if you just want a chat I’m here.

As you can see this isn’t a great sophisticated intervention but it’s telling the patient that you’re here and you understand how hopeless they’re feeling. The next time you talk to the patient take your cue from them they may just want to chat about the TV or weather as a distraction - go along with that. If they want to talk about how they feel, get a chair, sit next to them and listen. You can’t change their life or resolve major life problems but as we know (Section 4) listening alone is a powerful, therapeutic tool.

As the patient has said they feel suicidal they need an immediate referral to liaison psychiatry; tell senior staff who will organise this. If the patient says ‘I’ve got something I really want to tell you because I trust you BUT you mustn’t tell anyone else’, you have to respond “I’m sorry but I work in a team and will have to discuss any care issues with them, to make sure you get the best care.” Confidentiality never applies to suicidality.

Always debrief with another member of staff after talking and listening to a suicidal patient – this situation can be very difficult but also very rewarding as you are genuinely making a difference.

Admitting mistakes and saying sorry.

If staff say or do something ‘wrong’, they can worry the patient could sue the hospital. For example if staff know that something’s gone wrong with a patient’s care it can feel impossible to admit it. Staff don’t know who has spoken to the patient, have they been told there’s a mistake been made? If staff admit liability can they be sacked? This is what the NHS Litigation Authority says: ‘Saying sorry when things go wrong is vital for the patient, their family and carers, .... Of those who have suffered harm as a result of their healthcare fifty percent wanted an apology and explanation’.

Who should say sorry?

If you lose a patient’s glasses or false teeth you say sorry and look for them. But what about the more complex cases? You or colleagues may be ‘...unclear about who should talk to patients when things go wrong and what they should say; there is the fear that they might upset the patient, say the wrong things, make the situation worse and admit liability’ (NHS Litigation Authority 2014). NHSLA say that all hospitals should have a local policy that states who is the most appropriate member of staff to give both verbal and written apologies to patients. The decision about who does so relates to seniority, relationship to the patient, experience and expertise. PALS services are available at all hospitals and you can advise patients that they can go there.

The point is made very clear that saying sorry is not an admission of legal liability; it is the right thing to do.
Remember Disney priorities - Safety is first. The NHS want to be an organization where all staff are motivated and encouraged to report safety incidents and staff should be supported to do this. Just like the airlines.

Nevertheless, 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 think as a professional we should always be ‘right’ or we lose our credibility
• We don’t want to look, or feel, ‘weak’ especially if we feel it’s important to be seen to be in a strong position of authority in relation to the other person
• We might worry that the other person will ‘take advantage’ of the situation

Q.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?

Q.2 How do you feel when someone apologises to you when they’ve made a mistake?

Q.3 What phrases do you use, or might you use in future to say sorry?
So often we feel we can’t help a patient. We know they look distressed in some way BUT this is where listening comes in. IT REALLY HELPS! Both the patient and our ability to be the classy, effective professional we strive to be. With so many high-tech features of acute hospital care, it can be easy to lose sight of just how therapeutic it is for patients to be fully listened to. They don’t necessarily need answers, action or problem-solving – the process of being heard is highly validating and trust-building and can often lead to patients working things out for themselves. (See Section 6.)

**Q1. Which people make you feel really well listened to? What is it about the way they listen that is so helpful?**

**What 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

**Q2. Think of a time when you’ve felt very vulnerable – like being at the dentist or a job interview or a bad time at work. What has another person said which has helped you feel more secure? Did they say anything that made you feel worse?**
5. Superstar Listening

It may not always feel like it, but you’re already a superstar listener. Ward staff are the Mozarts of really tuning into what patients are expressing and needing. The following are simply refresher tips. Even Mozart needed to get his piano tuned regularly.

Q.1 List 3 things you do to show you’re really listening to someone:

Examples:

• Showing it with your face – looking interested, concerned, etc. Even if we are not really interested, appropriately changing our body language can affect our feelings and how we appear to others. There’s a great Ted Talk on YouTube illustrating how simply changing our posture can have an immediate, dramatic effect on how confident we feel and how others regard us. [http://youtu.be/Ks-_Mh1QhMc](http://youtu.be/Ks-_Mh1QhMc)
• Showing it with your body – sometimes nodding your head, leaning towards the person, gently touching them on their arm
• Leaning against the wall or bed locker to show you’re not in a hurry
• Putting down the charts/medical/nursing notes you’re carrying to suggest you’re not rushing off
• Showing it with your voice – by making those small ‘yes, I’m following what you’re saying noises’ like “uh-huh”, “hmm”, etc..
• Showing 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....?” This one’s really important - when you’re super-busy it’s easy to get the wrong end of the stick. (More on this in Section 7.)
Q.2 What sorts of things make it hard to listen to people?

- Distractions in the room, e.g. other people, noise from TV or radio
- An uncomfortable place to sit and chat. Or worse, no place to sit
- Being in the middle of a busy ward with no privacy. In the absence of sound-proofed curtains it’s often worrying that the patient will say something they don’t want others to hear
- Concern that if you spend time listening to patients, other staff will be very critical of you and think you’re not working
- Worrying the patient will break down and you might not know how to handle that
- Distractions in your head, e.g. worrying about your kids, thinking about your next holiday, the cat smelling strange, or general daydreaming
- Assuming there’s a ‘right’ thing to say but you don’t know what it is
- Worrying about saying the wrong thing, especially if it might upset or anger the patient
- Knowing you can’t solve their problem so feeling it’s best to avoid it
- The 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 that the patient will ask you if they’ll get better - and you know they may not
- 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
6. Helping patients to express themselves

When people are acutely ill, factors such as pain, medication side-effects, not wanting to bother you or even the person’s levels of self-esteem can get in the way of them identifying and describing what’s going on for them. We’ve all been told about ‘open’ rather than ‘closed’ questions – here’s a quick recap. 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’. ‘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’, ‘in what way’ are open questions. These will generate more interesting, fuller answers.

For example, ‘Are you in pain?’ 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. If you want to find out how they’re experiencing the pain, all you need to do is turn it round into, for example, ‘Can you tell me more about the pain?’ 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. Which isn’t to rubbish closed questions; these can give you hard information which we also need sometimes.

Other examples of open questions you could try:

- 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?
- What are/were the best things about that? What are/were the worst things about that?
- And then what happened?
- Do you mean that....?
7. Checking you’ve understood

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

- to make sure you’re really understanding what the patient is saying!
- to check what the patient has understood about what you’re saying
- because it demonstrates that someone is listening interestedly
- the patient may have gone round the houses so it’s important to check that you’re taking away the most important bit

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:

- 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....
- So it seems that you’re feeling...
- Can I just check I’ve got it right 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...
- You sounded really distressed when you were talking about ....
- 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.

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.)

Q.1 What phrases do you use, or might you use in future to reflect back what the patient seems to be feeling?
8. Silence

We tend to avoid silence because it makes us uncomfortable (lots of excuses - the ward’s noisy, we’re busy, it’s not private etc etc). We’re the professionals, we should have the answers is often what’s in our heads. BUT the patient needs time to think, they also can be testing if you’ll stay with them so they’re silent for a while. Can they trust you to stay? Often people give a summary of what they want to say; if you stay and are encouragingly silent (yes it can be done - keep looking interested) it can help them to describe the situation in more detail which helps you understand better and telling their story in more detail helps them.

Sitting silently with a patient may sound like a luxury on a frenetic ward, unless it’s the ICU. But even a few seconds of comfortable, supportive silence can be very powerful and comforting for a patient.

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!

Q.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, or perhaps other staff will look at you and think you’re not competent you don’t know what to say
These concerns are understandable. But the benefits of silence during a conversation should outweigh the anxieties. Have some confidence, try it out, maybe firstly with a friend or partner, or boldly try it out with a patient then ask them if they noticed.

**Q.2 What are some of the benefits of 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
- 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
9. Appreciating difference

We need to recognise that differences in lifestyle, beliefs, etc. can make us feel uncomfortable or uncertain, to make sure that this discomfort doesn’t get in the way. You won’t be surprised that there’s a mentalising take on diversity! Because mentalising 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. There is the concept that we go against other people because it makes us feel better. A basic example, if you see someone being bullied you can have several reactions; firstly, “poor thing how awful”, secondly “thank god it’s not me”, thirdly “well it would happen to them, they’re not in the ‘in group’ (whatever that is) but I am.” And so you can sometimes feel better about yourself. This very human tendency obviously needs to be watched out for at work.
People who have English as an additional language

This is clearly a potentially major barrier to the effective communication that’s essential for patient care and treatment. Hospitals have policies and resources (including interpretation and translation services) to meet this need. A few quick ideas:

• 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. (See Section 12 on Humour.)

• 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.
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.

Giving advice and giving information – what’s the difference and which is best? Advice is suggesting what the person may do. Giving information means giving them the facts so they can decide for themselves what to do.

Q.1 In which of these situations might it be appropriate to offer advice or give information? When is it definitely not a good idea?

1. A patient wants to stop taking their medication
2. A patient with an open wound wants to self-discharge
3. 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
4. A patient asks you if they should forgive their wife for having an affair
5. A patient asks you what kind of pension they should invest in
6. A patient asks about how they can cope with ward rounds, which they find very intimidating
7. 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
8. A patient asks you what you think are the chances of a horse called Temazepam winning the 3.30 at Ascot.
9. 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.
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
11. Dealing with sensitive issues

When you need to talk to a patient about something which touches on sensitive or painful issues, such as diagnosis or bereavement, there are all sorts of things which can help.

Really difficult questions patients may ask you

You know the sort of thing:

- Am I going to die?
- Will I get better?
- When am I going home?
- I don’t want my husband to know I’ve got cancer. Do I have to tell him?

These always seem to be asked in the middle of the night when there’s no-one to refer the patient on to. It’s no surprise when you’re ill and awake during the night, this is the quiet time when you have no distractions and can become very frightened about your future and have to face your worse fears. There’s no easy way to answer this sort of question but it’s very important that you’re there as another human being who can respond in some way. This can be as simple as holding someone’s hand or talking to them. The fact that you are there is the critical thing.

These are definitely mentalising moments! Always look at the emotion behind the question - does the person look anxious, distressed, resigned? What thoughts and feelings is this stirring in you?

It’s best to sit down - this tells them you’re not going to run away and that you want to encourage them to talk although you probably don’t have the answers. Rather than panicking about what to say, consciously stay calm and thoughtful; you want to find out
what’s in their head so you can say things like “What’s made you ask that at the moment?” Often the patient will want to talk about how frightened they are and by sitting there and listening to their fears you are really helping. If they need or want information you will need to follow this up with their treating team.

**Q.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....
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

There are, of course, particular considerations for staff using humour with patients, including being sensitive to each individual’s experience of their illness. Among other variables of the appropriateness of humour with an individual, the specifics of their symptoms, self-esteem and the impact of their illness on their life are important to take into account.
Being aware of an individual patient’s humour preferences helps staff judge if, when, and how to use humour with that person. We’re not suggesting that a nurse should excuse herself in the middle of a conversation with a patient, and rush off to look at the patient’s notes before making a gentle quip about the weather. But where they have a substantial relationship with a patient or humour has emerged as an issue for the patient, it can help:

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

Often the patient will say ‘I like a good laugh, it helps me’, this gives you permission, but be sensitive to any change which indicates that the person wants to be taken seriously. The laughter can be a defence and it may be a positive sign that they are ready to be serious.
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 2,474 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

Q. 1 What are your humorous skills and gaps? What effect on conversations with patients could these have?

Q. 2 Give an example of when you’ve seen or used humour sensitively and effectively in a stressful situation.

Q. 3 Give an example of when you’ve seen or used humour damagingly in a stressful situation.
13. Body language

Like most other aspects of communication, body language mainly develops from observing and (sub-consciously) copying those around us. So it varies between countries, cultures, communities. The usual example given is eye contact. In the dominant (i.e. white, Christian) 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.

One thing to remember is that when frightened or angry the body releases adrenaline this has many effects including:

- Heart rate increases
- Respirations increase.
- Pupils dilate - eyes concentrate, stare
- Sweat
- Face goes red or pale
- Restless - may pace around
- Hands may shake
14. **Voice**

The voice is an invaluable instrument in looking after patients. And we don’t mean switching on the TV on a Saturday night for lashings of will.i.am and Tom Jones. The ward may be frantic and busy but you convey warmth, calm and intimacy with your voice. You are there for the patient, concerned about them.

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 we’ve yet to hear anyone who can make bowls sound thrilling.)

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

But looking at things more positively (!), 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.
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 wards by:

- Caring physically and therefore intimately touching patients
- 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 mental health 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 can be especially so for children, women and patients with dementia.
NMC guidelines are very clear that any touch which is sexually motivated is not allowed and is a disciplinary issue. It’s important to know what the NMC say: ‘Physical contact is an integral part of healing. Supportive physical gestures as part of a therapeutic caring relationship can be essential in helping a client or in providing reassurance. In advocating a policy of zero tolerance of abuse, the NMC continues to support appropriate physical contact as a therapeutic part of nursing and midwifery practice’ (Practitioner-client relationships and the prevention of abuse, 2002, by NMC)

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.

**Q. 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?
A major concern for many staff is getting the balance right between being warm, friendly, human, normal with patients – and crossing boundaries. What if the relationship gets too close? This can mean firstly the patients gets too close to you or you get too close to the patient. The problem here is what does ‘too close’ mean.

The nurse/professional carer role involves being physically and emotionally intimate with patients. This is an essential part of care and must be based on trust and respect - we know this. But we’re saying that we need to have relationships with patients, however brief, and these maybe difficult. We need to know where we are.

Here are some real life examples of going outside the acceptable boundaries of the relationship (a nurse was suspended for a year because of these):

• Giving a patient personal information about herself and her family including her home telephone number and a photograph of a relative
• Giving the patient her partner’s and relatives names then discussing her private life and relationships
• Going on holiday with her family and a patient
• Accepting several payments from a patient.

Of course this doesn’t stop you having a laugh with a patient ‘My partner never puts the cap on the toothpaste’ hahaha ‘neither does mine’ etc etc

The other issue is the sexual one. The NMC has a zero-tolerance approach to sexual activity with patients, so will your hospital Trust. Disney says safety first and that means safety of staff as well. It’s usually clear when a patient approaches you sexually either verbally or physically. Do get advice and help from appropriate senior staff if this happens to you.
BUT what about when a health professional gets ‘too close’ – what is too close?

You need the self-awareness to recognize behaviour which may show you’re attracted to a patient and moving towards breaching professional boundaries, such as:

- Giving or accepting social invitations especially if it’s sexually motivated
- Visiting a patient’s home unannounced and without an appointment
- Seeing a person in your care outside normal practice
- Clinically unnecessary communication - includes texting and Facebook!!

So what are breaches of sexual boundaries? Examples include:

- Beginning a personal relationship during or after treatment
- Engaging in sexual activity
- Discussing sexual matters that are not relevant to treatment
- Using sexual humour or telling ‘dirty jokes’
- Repeatedly engaging in conversation about personal sexual matters unrelated to treatment.

In short disclosing personal information (this doesn’t include your name, but beware of Facebook); accepting gifts (this doesn’t include the box of chocolates given to the ward); going on holiday with patients and engaging in sexual activity with patients are ‘too close’.

Source:
Professional boundaries in the nurse-patient relationship, by Griffin R, 2013, British Journal of Nursing

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 you can stretch your 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 you time to think about how to respond, and also to consult a colleague.

**Q. 1 What phrases do you use, or might you use in future to respond to personal or uncomfortable questions?**

**Q. 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?
17. Wrapping up

One reason for being reluctant to start a conversation with a patient when there’s so much else to do is the concern about how to keep it contained and necessarily brief. But there are some simple techniques for ending conversations in a way that feels good for you and for the patient.

**Endings**

If it’s been quite an intense or emotional conversation for the patient, it’s really important to end it in a way that makes them feel OK. You know what’s coming next…. It’s very important to be mind-aware! What might the patient be thinking most about at this moment? What are they feeling? What’s going on for you? 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, you could say something like: ‘I’m sorry that you still feel upset/angry/frustrated.’

   If the patient feels better than before the conversation, something along the lines of: ‘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 later on/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:

- Sorry but 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

**Q. 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.

Q. 2 What are some of the nicest compliments you’ve been given at work or at other times? How did they make you feel?

Q. 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. Practicing out loud, even if by yourself, really helps you to say it out loud to someone you’re complimenting.

Q. 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....

Q. 5 What phrases do you use, or might you use in future to show you appreciate something about the other person?
Accepting thanks

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

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

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

Q.6 How does being thanked make you feel?

Q. 7 What phrases do you use, or might you use in future when a patient thanks you?

Q.8 What are the worst things we can say when someone thanks us? How could these make the other person feel?
18. Top tips

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.
- ‘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 Section 12).
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 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 and when they’d feel most comfortable chatting
- 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)
  - side-effects of medication
  - 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.
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
- Being careful about using analogies and metaphors which can be very confusing. Conversely, metaphors can sometimes help to convey things we can’t find words for – they can help get a message across.
- 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
- With people who have severe communication impairment, eg because of dementia, it can 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 include:
  - Signs and gestures
  - Physical props e.g. books, clothes, cash
  - Clip-art, cartoons, illustrations, photos (including by patients or staff)
  - Doodles, simple line drawings
  - 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
  - Ward photos, e.g. of special occasions.
  - YouTube
  - Specialist health organisations e.g. for mental health, healthy eating, quit smoking…
  - Specialist communication systems for people with learning disabilities – also useful for others e.g. www.widgit.com, www.photosymbols.com.
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.
- It’s 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. This is obviously very risky.
- 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 asking them 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

In addition to the points in Section 13, 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.

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
- The Brief Encounters’ website (www.brief-encounters.org) has recommended communication resources
- 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.intensiveinteraction.co.uk/
  - Communication and the Care of People with Dementia by Killick and Allan
- 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.
19. Distressed or depressed 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

- Staff don’t actually need to say anything. Patients find it comforting just to have someone sitting with them.
- People really appreciate being told they can take their time, however hard this feels for staff on a super-busy shift. It’s definitely better to say nothing than to ask a patient to stop crying!
- 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.
- 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.
- 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.

Q. 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.

Q. 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?
Patients who are or become depressed.

Being ill is a depressing experience, everyone knows this because we’ve mostly all been there. However, if you have a long term condition such as diabetes or a cerebral vascular accident (stroke) this is stressful and can lead to depression and anxiety. And of course people without chronic physical health conditions also develop depression.

A report published by the Academy of Medical Royal Colleges *No Health Without Mental Health* is quite clear ‘patients with any form of long term physical illness have an increased risk of depression.’ They add ‘Over half of all cases of depression in the general hospital setting go unrecognised by physicians and nursing staff’. This means that as frontline staff we are in a great position to recognise when someone may be becoming depressed or is depressed and we can ask for them to be referred to the liaison psychiatry service, and get them help.

Great, but is someone going to tell you they’re depressed? Not always. Men in particular (sorry to sound sexist but the evidence backs this up) find it difficult to say they are down or depressed, they can see it as a failure or an admission of weakness or they’ve never learnt the language to talk about their feelings - the same for some women.

**How do we recognise depression?**

You can’t give a blood test or an x-ray to see if someone’s depressed. The answer is simple: look and listen (anyone remember the Green Cross Code?) Often it can be the patient you’re finding it particularly difficult to establish a rapport with, they don’t smile, don’t chat with you and whenever you ask them to do something like get out of bed to mobilise they say ‘I can’t be bothered’. Instead of getting fed up and thinking the patient is being uncooperative, start looking for other signs of depression and also listening to what they’re saying.

**How they may look:**
- Sad depressed and anxious
- Slow in moving and thinking (the brain and body literally slow down)
- Speak in a flat, slow, monotonous way
- Look unkempt, untidy
- Aren’t interested in appearance and personal hygiene
- Crying

**What they may say**
- ‘I’ll never get better’
- ‘Life is always going to be like this’
- ‘My family would be better off without me’
- ‘My pain will never go away, this is my life now’
- ‘I’m worthless, no good to anyone’
- ‘I can’t go on like this’
- ‘I want my old life back, I can’t do this’
If you see changes in a person’s appearance and behaviour for no obvious reason, discuss your concerns with the team and think about a referral to liaison psychiatry. If a patient makes negative, hopeless statements as above, again discuss with the team and refer for a mental state assessment to liaison psychiatry.

Have patience with the person they do not want to be like this - they are really struggling.

Sometimes the person may seem depressed but actually it’s anxiety driving their behaviour, so it’s always worthwhile checking if they’re anxious about something - have a look at the next section on anxiety, ask the person if they’re having any of the physical signs of anxiety.

The second counter-intuitive thing is that someone can appear very agitated and restless, anxious but they’re actually depressed - it’s called an agitated depression. You’re not expected to diagnose this. Call in the experts - liaison psychiatry, but support the patient by listening and reassuring them that we can help them; they have a psychological condition that we can treat.

The Samaritans offer an exceptional service to people who are emotionally troubled, from mildly to actively suicidal. You might want to suggest to some patients that when they’re back home they can always contact Samaritans, 24/7, by phone (08457 909090), text, email or good old-fashioned letter.

Sources used:

- Mental Health First Aid England Handbook [www.mhfaengland.org](http://www.mhfaengland.org)
- Academy of Medical Royal Colleges (2009) *No Health Without Mental Health* London: Royal College of Psychiatrists
Feeling anxious is a normal state to be in when in hospital - just being in hospital whether as an in or out patient can make you feel anxious for lots of reasons such as ‘What’s going to happen to me?’; ‘Will staff be understanding. Can they help me?’; ‘All my embarrassing relatives will want to visit - what will the staff think, will they judge me?’; ‘I’m going to have to have an endoscopy. I hate them’; ‘I’ll miss my dog so much’. The list is endless. What people don’t always remember is how horrible anxiety is if it lasts (even for a short time it’s awful. Who can forget their driving test?). When we’re anxious the hormone adrenalin is released causing an amazing of physical and psychological effect.

**Physical effects**
Physical effects of anxiety can include: palpitations, chest pain, rapid heartbeat, flushing, hyperventilation, shortness of breath, dizziness, headache, sweating, tingling and numbness, choking, dry mouth, nausea, vomiting, diarrhoea, muscle aches and pains - especially neck, shoulders and back, restlessness, tremor and shaking.

**Psychological effects**
Mind racing or going blank, decreased concentration and memory, difficulty making decisions, irritability, impatience, anger, confusion, restlessness or feeling on edge, tiredness, sleep disturbances, vivid dreams, excessive fear and worry.

*Source: Handbook - Mental Health First Aid England.*

You can see how anxiety can not only effect your body but your thinking as well, so we need to have an understanding of this and frequently check that the patient has understood us, give them space to make decisions, encourage them to use relaxation techniques. Many people find music soothing, there are many smartphone apps (e.g. Headspace – first 6 sessions free to try, just Google ‘relaxation’). Generally be aware that being anxious makes you feel awful. So we don’t assume that people can ‘snap out of it’, it’s not a choice they’re making, no one would choose to be anxious. You’re never going to solve all their problems but listening to them can make a huge difference - just let them tell their story. Sometimes simply explaining to the patient the effects of adrenaline on the body and how awful it makes us feel can help them understand why they feel so unlike themselves and helps them understand struggle less, becomes slightly less anxious.

If you see a patient showing these signs it is easy to misinterpret anxiety for aggression. Obviously if the person’s saying ‘Get out of my way or I’ll thump you’ it’s most likely they’re feeling angry and aggressive but if restless with staring eyes and shaking hands it may be anxiety. Often it is raw anxiety, or terror, that is fuelling the anger.
21. Patients who are experiencing psychosis

What do we mean by psychosis?

Psychosis is an umbrella term which includes the diagnosis of schizophrenia. The experience of psychosis, when a person’s reality is not shared by people around them can be terrifying; confusing; highly distressing or at times magical and uplifting for the individual experiencing it. Nowadays psychosis is the term used to refer to the experience of hallucinations (especially voices) or delusions (unusual beliefs) or odd behaviour as a result of these.

Schizophrenia has blurred borders not only with ‘normality’ (people without a diagnosable mental illness also have unusual beliefs) but especially with depression and bipolar disorder which can also result in experiences of psychosis. This overlap is why patients can be given different diagnoses by different clinicians. With psychosis you’re thinking of four areas of symptoms

1. Psychotic symptoms - hallucinations and delusions
2. Poorly regulated mood - depression, mania and anxiety
3. Negative symptoms - lack of motivation and social withdrawal
4. Cognitive difficulties - difficulties with memory, retaining information and such like.

There is a real stigma attached to a diagnosis of psychosis - thank goodness for Frank Bruno (the people’s hero) as he has helped many people to understand this disorder. As Sir Robin Murray has said: ‘Imagine suddenly developing an illness in which you are bombarded with voices which you cannot see, and stripped of your ability to understand what is real and what is not. You discover that you cannot trust your senses; your mind plays tricks on you, and your family or friends seem part of a conspiracy to harm you. Unless properly treated, these psychotic experiences may destroy your hopes and ambitions, make other people recoil from you, and ultimately cut your life short. Some 220,000 people in England have such psychotic experiences-we probably all know a family member who is affected but the stigma is such that they may be keeping it a secret’. (The Abandoned Illness Report, by the Schizophrenia Commission, 2012).
What causes psychosis?

We can’t point to any one cause which fits all but there are a number of risk factors and the more of these you stack up the more at risk you are. Stressful life experiences are risk factors:

- Childhood adversity and trauma, sexual abuse and bullying
- Abuse of non prescription drugs amphetamines, cannabis, ‘legal highs’ etc
- Migration and discrimination
- Bereavement or separation in families
- Dysfunctional parenting
- Rape or physical assault as an adult
- Poverty, urban living
- War trauma
- Physical illness

In psychosis there is an imbalance of neurotransmitters in the brain, in particularly dopamine but this biochemical imbalance is not the whole story and so the answer is never only medication. Currently there is no genetic ‘cause’ identified but risk factors can run in families.

Why do I need to know this?

We need to understand a patient and their life story, not just give medication and think this is all we need to do. Get to know the patient, listen to them and be your usual kind self. This is the most important thing we can do as health workers. Never avoid these patients because you’re frightened of them - this is the stigma - get to know them and you’ll find the real personality beyond the symptoms. If they are frightened and feel unsafe ask them what would make them feel safe and if doable, do it.

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.

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.

Source: ‘Beyond Belief’ by Tamasin Knight, 2009
How do I answer???

We want to know what to say when a patient experiencing delusions says something like: “M15 are outside the hospital, they’re out to get me, I’m really frightened. You do believe me don’t you?”

Your dilemma is - if I say ‘yes’ the patient will think it’s true, if I say no the patient will try and convince me because they’re frightened and think they’ll be harmed. This could turn into a real confrontation. The best response to this I’ve ever heard was by a professor of psychiatric nursing who said in response to the question ‘Do you believe me?’…. ‘I have no reason not to’.

What should you do if you can’t understand what the patient is 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.

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.

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.

At some point when they’re feeling less frightened the patient themselves may begin to question their beliefs.
Sources:

Psychological Perspectives on Distress and Unusual, by Coles S and Houghton P, 2012

The abandoned illness: a report from the Schizophrenia Commission, by The Schizophrenia Commission, 2012 www.rethink.org

22. Delirium

How do I know if a patient has delirium?

Listen to what they’re saying, this is where you get the clues - what they’re saying can sound bizarre ‘get me out of here, you want to experiment on me, I’m not an animal-let me go’.

Delirium is a problem for elderly patients in hospital - it affects up to a third. They can be confused with poor attention and they may be very frightened thinking that they’re being chased, tortured, wanted by the police etc. The onset is sudden and may be caused by an infection, medication and/or pain. Here we need to keep reassuring the patient that they’re in hospital, they are ill and we are treating them, they are safe here - you may have to repeat this time and time again. Each trust will have a Delirium Protocol which will suggest medication that is helpful, often Haloperidol, while the patient is very frightened they may need this. As soon as they are calmer it can be stopped.

A patient can have an acute episode of delirium when they already have a diagnosis of dementia. There is some helpful guidance on this here:

Other useful resources:

Guidance on cognitive assessment

Scottish Intercollegiate Guidelines Network 86 – Management of patients with dementia: a national clinical guideline. www.sign.ac.uk

For further guidance by the Department of Health and the Alzheimer’s Society on the assessment of cognitive function, please visit: www.dementia.dh.gov.uk

Delirium assessment tool

The confusion assessment method (CAM) (Inouye et al 1990) differentiates delirium from other causes of cognitive impairment.

ITU

Patients in intensive care units also get delirium (also called ITU Psychosis as the patient can have hallucinations and delusions) again caused by medication e.g steroids, benzodiazepines and others, infection/physical condition, many painful interventions, sleeplessness, noise-all of these contribute.

Practical things such as turning off lights at night and ensuring quiet, ensuring adequate pain control, and playing music can help too. Also ITU psychosis can go unnoticed as the patient may be too frightened to tell staff or may be intubated. We need to listen to what the patient’s saying during and after - the clues are usually there. If they say that they’re frightened and the nurses are dealing in illegal drugs it’s clear they’re have delirium. Reassurance is critical. Explain that the medication and the conditions in ICU can give strange thoughts. Use relaxation techniques, breathing exercises alongside a calm, reassuring approach.

Further reading:

Important study at UCH 2014, Dr D Wade and Dr D Howell on Improving patients’ wellbeing after a traumatic stay in intensive care.
https://www.uclh.nhs.uk/News/Pages/traumaticstayinintensivecare.aspx
23. Patients with Bipolar Disorder

We are not so concerned about the diagnosis rather with what the person is experiencing and how we can help. However, there are times when it is helpful to understand more about bipolar, for example a patient may appear calm and lovely pre-operatively but post-operatively miss their medication for a while, then become irritable and won’t listen to you and refuse care saying this hospital isn’t good enough for them. When you know that the patient has a diagnosis of bi-polar it helps you to understand their behaviour and know what to do (stay calm, don’t argue, be polite and helpful and provide their bi-polar medication as soon as possible).

Stephen Fry (who everyone now knows has a diagnosis of bi-polar disorder) has done a fabulous job in de-stigmatising this disorder, but in spite of being hugely successful as well as a great person he has let it be known that at times he struggles with it.

The main symptoms are being high or low and clinically depressed (if you in the main have high episodes you are Bipolar 1, if mainly depressive episodes Bipolar 2). Being high sounds great and can be at first. A good friend of mine described an experience she had on becoming high: ‘It was autumn I was walking along the street and the trees were an unbelievably intense colour and were dripping gold onto the pavement’. Sounds fabulous, but then she couldn’t sleep, was overactive and was driven to keep going not for hours but days with no sleep.

The Royal College of Psychiatrists provides a list of typical symptoms of manic phases:

**Emotional**

- very happy and excited
- irritated with other people who don’t share your optimistic outlook
- feeling more important than usual.

**Thinking**

- full of new and exciting ideas
- moving quickly from one idea to another
- hearing voices that other people can’t hear.

**Physical**

- full of energy
- unable or unwilling to sleep
- more interested in sex.
**Behaviour**

- making plans that are grandiose and unrealistic
- very active, moving around very quickly
- behaving unusually
- talking very quickly - other people may find it hard to understand what you are talking about
- making odd decisions on the spur of the moment, sometimes with disastrous consequences
- recklessly spending your money
- over-familiar or recklessly critical with other people
- less inhibited in general.

These perhaps don’t sound too life disrupting however they have consequences. For example you have a high flying job but start to become ill at work and don’t recognise it, you become irritable with one of your best clients. The client complains to your boss and you, thinking you are so good your boss won’t want to lose you, tell him he’s a rubbish leader and should resign right now and let you do the job. He then dismisses you.

You start to become ill and tell your very caring parents that it’s all their fault that you have this diagnosis, why weren’t they better parents, yet you actually care deeply for your parents. This was just an impulsive thought that you voiced - and then couldn’t take back. Your sexual urges are really high, you’re away at a conference and forgot your medication. You think ‘My partner won’t know that I’ve cheated, and I’ve always really fancied my colleague’. Unfortunately you don’t think of the consequences and have unprotected sex and acquire a sexually transmitted illness. If in the depressive phase you can become actively suicidal and at real risk to yourself.

As far as is known, which isn’t particularly far, Bipolar Disorder is caused by:

- genetics – it tends to run in families
- problems with the areas of the brain which control mood
- times of high stress or physical illness can trigger episodes.
- causes of psychosis can be relevant e.g neglect, abuse.

**How to help**

The correct medication for that patient can be very critical. It can be trial and error getting the right combination, which can understandably be very frustrating and demoralising for the patient. But once the patient feels things are right we need to ensure that medication is correctly given and importantly not missed out.
Once the person starts to get high the only thing that will stop this escalating into hypomania (the beginnings of mania) is medication. The patient is often great fun at this stage and very amusing to be with. Don’t respond by getting a bit high and giggly yourself, stay cool and go with the flow of what the patient’s saying, don’t argue or correct them. We need to try and persuade the patient that it is important and worthwhile to take their medication. There are a few things that can help here:

- Friends and family who can remind the patient how well they have been on their medication (obviously only if this is true).
- The patient may have completed a WRAP (Wellness Recovery Action Plan - try Googling it or speak to the mental health liaison nurse if your hospital has one.) This document is developed with the person when they are well and includes what the person is like when they’re well and also describes the signs that they’re becoming unwell. You can show the person this and it may help them recognise that they need help. The WRAP also says who the person wants informed when they are becoming ill and which medication they would choose to take.
- Routine is very helpful, including eating regularly and getting enough sleep. Many people keep a daily mood chart which helps them track their mood so they can anticipate problems and start helpful practices early. Self-help and mood monitoring are very important aspects of treatment.
- As much as is possible provide a low stimulus environment, this means low soothing music not rave, if the patient asks you to tell jokes with them gently refuse and suggest they read (obviously not the Hannibal Lector novels) or do something else non stimulating - this can be difficult as they may become very irritable but remind yourself how important this low-key care is for their recovery.

A person may be admitted for a routine problem and have a diagnosis of bipolar which we don’t need to address as they are currently well. It’s very stigmatising to be treated as the person with bipolar first not considering their physical problem which is usually paramount for them while in an acute hospital.
24. Patients with 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 in Section 21 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 other approaches described in Section 21 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
- impaired ability to be logical
- 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

As practitioners we’re often confused about how to respond to questions such as ‘Where is my dad?’, ‘I’ll be late for work!!’ (from a 91 year old), ‘Why are you keeping me here I must look after my children!!’

A helpful approach and an aid to memory for staff when working with patients diagnosed with dementia is VERA (must be associated with Vera Lynn and the 1940’s) – this stands for:

V= Validate, accepting that the behaviour exhibited has a value to the person and isn’t just a symptom of dementia
E= Emotion, paying attention to the emotional content of what the person’s saying
R= Reassure, can be as simple as saying ‘it’ll be okay’ and smiling, holding their hand
A= Activity, people with dementia need to feel occupied, active, see if you can engage them in some related activity

**Example of VERA**

Mr Joseph is trying to leave the ward, he’s up from his chair and very unsteady. He’s 91. He says ‘I’ll be late for work again, I’m going to be fired, I don’t know what to do. How do I get out?’

V…..‘You’re really worried Joseph, tell me about your work’
Here you accept his perception of the problem, you don’t question, and you encourage him to say more
E…..’I’d feel worried if I thought I might lose my job’.
This shows Joseph that you understand why he’d be worried.
R…..’You’re safe here Mr Joseph’ said with a smile
This states that no harm will come to him whether real or imagined
A….. ‘We’ve got some work to do here, can you help me tidy these chairs?’ . (An activity that fits in with Mr Joseph’s preoccupation with work and incorporates his behaviour rather than invalidates 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.
• Smile as much as possible so the person sees you as friendly and helpful.
• 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 ‘hear 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.

Sources:

VERA framework communicating with people who have dementia:


Patients with Borderline Personality Disorder

Three words which can produce almost as much anxiety in staff as in the patients with the diagnosis. Borderline Personality Disorder is a tough one. Joy and I have co-written Brief Encounters but it seems relevant to specify here that it’s me, Marion, writing this as BPD is the very unwelcome mental illness I’ve wrestled with for the last 10 years. Indeed it’s because my BPD produces rather outlandish behaviour, that was met with nothing but patience and kindness by the staff at St Ann’s Hospital, Tottenham, that I set up Star Wards.

So what is this illness and how does it impact on patients and staff? BPD is fundamentally a condition making it very, very hard (often impossible!) to regulate our feelings, and those feelings are frequently intolerably painful. There’s a website called “Anything to stop the pain” and that’s a pretty accurate ‘strapline’ for living with BPD. The present moment can be so agonising that anything is preferable – which is one reason why self-harming is such a powerful, addictive coping mechanism for many of us. Most people with BPD have a history of trauma or abuse (not everyone – I don’t) and the more that staff can bear this in mind when working with patients who have BPD, the more effective the response from both staff and patient.

For me, the relevant features for hospital staff to be aware of are:

• Seemingly trivial things can trigger a sense of catastrophe. I recently failed to catch a dog gone AWOL and was convinced he would die, it was all my fault and that I’d never be able to cope with the guilt.
• That sense of catastrophe is closely followed by a self-destructive response. Self-harming (cutting or overdosing for me) is a way many of us with BPD cope with overwhelming emotions. It gives us a sense of self-agency – the outside world may be unmanageable but we create a little micro-world/experience around the self-harming which is divertingly absorbing, externalises the internal pain (eg blood being released) and allows for us to self-soothe by tending the wounds. I have a sort of ‘hierarchy’ of self-destructive responses. The lowest-key is cutting, but when life is overwhelming and feels completely out of control, I take an overdose. I completely, totally appreciate that this can appear childish, selfish, attention-seeking etc and is time-consuming and expensive for a grossly overstretched NHS. But for me it’s the only way I have at that stage for regaining my equilibrium and continuing the slog of being alive. By bringing
myself to the point of death and then through my own actions (going to poor old A&E) getting that reversed, my emotional thermostat is sufficiently reset. Joy has a slightly different, arguably more ‘realistic’ take on supporting patients who self-harm, in Section 3.

• Then there’s the suicidality! (It really isn’t an easy illness!) The emotional pain, guilt about being so ‘high maintenance’ and anxiety-provoking for friends and family and my restricted functioning make being alive unattractive. I am now pretty much programmed to look for ways out.

• I have attachment issues! One of the main factors resulting in BPD is attachment failure in infancy. This results in relationship difficulties for most of us such as a giant fear of abandonment.

• It took me years to really recognise how much of my severe depression is fuelled by anxiety. Anxiety sounds/feels rather a mild concept and can be submerged under all the considerations of distress, risk etc. But it’s a major factor in this mental illness, as indeed it often is with all mental illnesses.

What helps when in hospital

• Safety. The reality is that I’ve probably arrived at hospital equipped to self-harm, but even if unarmed, I’ll be searching (often successfully) for something to cut with. Mental health wards are very experienced at and geared up for minimising the availability of (potentially) sharp objects but it’s almost impossible on general wards. My view is firmly that it is usually better for someone to cut and that episode be over, rather than energetic, often fraught attempts by staff to prevent this, resulting in a ratcheting up of the compulsion to cut which can lead to much more serious injury. (Again, Joy expresses a rather more nuanced view in Section 3.) It’s impossible to remove ligature points and other potentially fatal elements of hospital design so a very suicidal patient may well need someone with them 24/7.

• Staff being understanding and non-judgmental. This can be very hard! The combination of extreme emotions producing what appears to be greatly unreasonable behaviour and all the risk from self-harming and suicidality can be overwhelming for staff. Yet again, mentalising is crucial – I completely stop mentalising when I’m in meltdown as the pain and confusion are so intense, and must rely on others to reintroduce perspective and calm. I suppose my main plea is that it’s not my fault! I didn’t go out and decide to acquire a mental illness and then choose BPD because it looks a good laugh. It’s hell to live with and I’m painfully aware how my behaviour can seem to others and the stress it creates.

• Trauma and abuse. For example, patients with BPD may need particular sensitivity to how intimate examinations are carried out.

• Attachment. Patients with BPD can feel an unusually strong dependence on hospital staff and small things can really help, like my named nurse coming to say goodbye before the end of their shift.

With all these complicated issues, ward staff will get invaluable help from the mental health liaison nurse and other specialist mental health colleagues.
26. **People with learning disabilities**

People with learning disabilities have increased needs, both health and social, which inevitably require more time, patience and imagination from staff caring for them. Often this additional input is willingly provided by the patient’s carers and staff can actively support this through warm, appreciative communication with relatives – and cups of tea and a listening ear are always welcome!

Additional or distinctive needs that learning disabled patients may have include:

- Exceptional closeness to and reliance on family.
- Higher rates of mental and physical illnesses (eg heart conditions, epilepsy) and of sensory impairment
- Impaired understanding and communication – and ‘inconsistency’ or unevenness – eg someone may have language and social skills which suggest the person understands much more/less than they do
- Limited or no literacy, including an inability to tell the time or use a diary.
- Poor coping mechanisms. Cognitive deficits might make it more difficult for people to plan ahead or consider the consequences of their actions.
- Frequent experience of loss and change and a lack of control/autonomy
- Sense of being different, inferior
- Lack of life experience combined with suggestibility and limited skills makes people very vulnerable and many have experience of harassment and abuse
- Problems with manual dexterity
- Difficulties with eating and swallowing.
There are some excellent resources (available on www.brief-encounters.org) with examples and techniques to help hospital staff support people with learning disabilities and their families. Things like:

- Right up at the top – it’s impossible to overstate the importance of supporting carers who are the best placed people to help their loved one receive and cope with the medical treatment they need. Relatives of people with learning disabilities usually have a devotion to their cherished loved one and a determination for them to be protected and have the best possible care. Carers will know their loved one’s preferences with communication, keeping calm, daily routines, self-care etc. The Triangle of Care is full of practical ideas for involving and supporting carers.
- Close involvement of the hospital Learning Disability Liaison Nurse, and/or the local Community Learning Disability Team.
- Learning disabled patients may have a Hospital Passport or equivalent, containing invaluable information about the individual’s needs and preferences.
- It’s a hard, often unrealistic ask, but wherever possible consistency of staffing means a smaller group of staff get to know the person well, and the patient builds up trust
- Reassurance and lots of flexibility
- Medication – careful explanations, repeated as often as necessary. A choice of drinks or ways in which medication is delivered (eg syrup rather than pill).

Given the problems with literacy and spoken communication that people with learning disabilities experience, the following (in addition to the other communication tips in Brief Encounters) really help:

- Speed – or rather slowness. It takes people with learning disabilities longer to process what’s being said, so it’s crucial to take a bit (sometimes a lot!) longer with explanations, repeating important parts, and checking back with the patient (and/or their carer) to see if they’ve understood. Patients might have a limited attention span so several conversations may work better than cramming it all into one.
- Using short sentences with just one main point. (For example, “Hello Fred. Would you like your bath now and how is your leg feeling?” is better separated into two sentences, with the patient answering each in turn.)
- Obviously medical jargon is unlikely to be helpful! Even commonly understood terms, including body parts, might be a mystery to the patient so showing a picture or pointing to the area you’re talking about can make things clearer. Objects can be shown (eg a stethoscope) and even touched by the patient if that helps reduce anxiety.
- Similarly, abstract language can be very difficult to grasp – even concepts like the future or the past won’t be understood by people with a severe learning disability. If you can’t easily draw it or point to it, the ‘it’ is likely to be abstract!
Finally, a quick note on caring for autistic patients. In addition to the additional needs (highly!) summarised above, people with autism can have particular difficulties with:

- Interacting with people, from avoiding eye contact to avoiding all contact.
- Sensory stimulation, resulting in sensory and emotional overload
- Change, even apparently tiny changes in routine.
- Taking things very literally – a bird in the hand becoming not a proverb but a scary prospect
- Special interests – a fascination with one thing, whether it’s a cherished toy or train-spotting.
- Mentalising. The under-pinning theme of Brief Encounters is an area of extreme challenge for people on the autistic spectrum, making it very difficult for individuals to understand that let alone what another person is independently thinking.

**Sources:**


Your next patient has a learning disability: [http://www.keele.ac.uk/nursingandmidwifery/mnphald/toolkitcontents/ynphald.pdf](http://www.keele.ac.uk/nursingandmidwifery/mnphald/toolkitcontents/ynphald.pdf)

27. Leadership

The only way that staff teams can effectively and sanely fulfil exceptionally demanding, distressing and exhausting work is if they are well supported. Leadership is obviously a core responsibility of senior managers but each member of staff can take a leadership role, applying the principles of being openly appreciative and supportive of colleagues, being a role-model, problem-solving, innovating, inspiring and motivating.

Of course senior managers have a particular responsibility for leadership. By far the best way to get a strong grasp on what it’s like to be a patient, member of staff or visitor on the ward, is to be on the ward. In addition to the much deeper understanding that comes from spending time on the wards, it can be a huge boost for staff to have senior managers show this level of interest in their work. And the more explicitly appreciative senior managers can be about staff’s skills and dedication, the huger the boost.

As Fred Lee puts it in *If Disney Ran Your Hospital*:

“In my experience with attempts to improve the interpersonal skills of the staff at hospitals, those who demonstrate outstanding performances day in and day out, rarely get praised for it. We like to single out those who did something “above and beyond” to please a guest, but we often take for granted the consistent repetition of desired behaviours by dependable performers. Like great actors they make it look easy every day of the week.”
Our favourite management guru is Henry Stewart of Happy – a company which consistently wins awards for being a great place to work. The Happy Manifesto very helpfully sets out 10 Steps to a Great Workplace:

1. **Trust Your People**  
   Step out of approval. Instead pre-approve and focus on supporting your people.

2. **Make Your People Feel Good**  
   Make this the focus of management

3. **Give Freedom within Clear Guidelines**  
   People want to know what is expected of them. But they want freedom to find the best way to achieve their goals.

4. **Be Open and Transparent**  
   More information means people can take responsibility and ownership.

5. **Recruit for Attitude, Train for Skill**  
   Instead of qualifications and experience, recruit on attitude and potential ability.

6. **Celebrate Mistakes**  
   Create a truly no-blame culture, to enable people to innovate without fear.

7. **Community: Create Mutual Benefit**  
   Have a positive impact on the world and build your organisation too.

8. **Love Work, Get a Life**  
   The world, and your job, needs you well rested, well nourished and well supported.

9. **Select Managers Who are Good at Managing**  
   Make sure your people are supported by somebody who is good at doing that, and find other routes for those whose strengths are elsewhere. Even better, allow people to choose their managers.

10. **Play to Your Strengths**  
    Make sure your people spend most of their time doing what they are best at.

Find out more: Download The Happy Manifesto for free at [www.happy.co.uk/about/free-publications](http://www.happy.co.uk/about/free-publications)
28. Putting it together

A brief quiz to help recap what you’ve encountered along the way! (Some suggested answers are provided at the end.)

1. List three needs that patients have in caring conversations.

2. When faced with conflicting demands it’s helpful to feel clear about your priorities. List four priorities in ascending order – the top one being your number one.

3. What is mentalising?
   
   a) A physical illness or other condition caused or intensified by a mental issue.
   b) The skill of being aware of what’s happening in our own minds and in other people’s minds.
   c) The avoidance of difficult thoughts and feelings, believing that this would be helpful for patients with physical problems.

4. What are some typical characteristics of emotionally vulnerable patients?

5. How would you describe ‘closed questions’?

6. Can you think of two useful questions for checking understanding?

7. What are three benefits of using humour with patients?

8. Which of the following examples of staff behaviour go beyond the acceptable boundaries of the caring relationship?
   
   a) Giving the patient her partner’s and relatives names then discussing her private life and relationships
   b) Disclosing that they have had successful treatment for a similar condition.
   c) Seeing a person in their care outside normal practice
   d) Visiting a patient’s home unannounced and without an appointment
9. How might you sensitively end a conversation with a patient?

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

11. Can you think of two symptoms of psychosis?

12. A helpful approach and an aid to memory for staff when working with patients diagnosed with dementia is VERA: The ‘V’ stands for Validate and the ‘E’ for Emotion. What does the ‘R’ and ‘A’ stand for?

13. What are some of the things that help patients with a personality disorder to feel safe and supported?

14. Which of the following can managers do to help create a great workplace?
   
   a) Be open and transparent  
   b) Create a truly no-blame culture  
   c) Make sure staff spend most of their time doing what they are best at  
   d) Discourage responsibility and ownership

~

Some suggested answers

1. List three patient’s needs in caring conversations.
   
   • Someone to be interested in them as an individual, not just as a patient.
   • To feel able to trust a member of staff so they can rely on them for emotional support, information and human contact.
   • To have a bit of a natter to relieve what can often feel like long and empty hours in hospital.

2. When faced with conflicting demands it's helpful to feel clear about your priorities. List four priorities in ascending order – the top one being your number one.
   
   • Safety  
   • Empathy  
   • Clinical tasks  
   • Paperwork
3. **What is mentalising?**

B. The skill of being aware of what’s happening in our own minds and in other people’s minds.

4. **What are some typical characteristics of emotionally vulnerable patients?**
   - Frightened, confused, anxious
   - In pain
   - Depressed
   - Fearing breaking down or losing control
   - Afraid of being stigmatized if they admit their fears and needs
   - Vulnerable because they can’t communicate
   - Living with a diagnosis of mental illness.

5. **How would you describe ‘closed questions’?**

A closed question classically produces a one word answer. They might start with ‘are’ or ‘do’ and result in ‘yes’ or ‘no’ answers.

6. **Can you think of two useful questions for checking understanding?**
   - Please could you say a bit more about that so that I’ve understood you properly?
   - When you said... did you mean that...?

7. **What are three benefits of using humour with patients?**
   - It can counteract stress
   - It can be very bonding between people
   - It stimulates the cardiovascular system

8. **Which of the following examples go beyond the acceptable boundaries of the caring relationship?**
   - Giving the patient her partner’s and relatives names then discussing her private life and relationships
   - Seeing a person in your care outside normal practice
   - Visiting a patient’s home unannounced and without an appointment
   - With answer B, a member of staff disclosing that they have had successful treatment for a similar condition is usually very helpful and encouraging for patients but, as with most things, it depends on the circumstances.
9. How might you sensitively end a conversation with a patient?

- By letting them know that there will be more opportunities to talk.
- Being mind-aware - acknowledging how the patient feels.

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

- Taking the lead from the other person
- Using signs and gestures
- Physical props e.g. books, clothes, cash
- Doodles, simple line drawings

11. Can you think of two symptoms of psychosis?

1. Hallucinations and delusions
2. Lack of motivation and social withdrawal

12. A helpful approach and an aid to memory for staff when working with patients diagnosed with dementia is VERA: The ‘V’ stands for Validate and the ‘E’ for Emotion. What does the ‘R’ and ‘A’ stand for?

- R= Reassure, can be as simple as saying ‘it’ll be okay’ and smiling, holding their hand
- A= Activity, people with dementia need to feel occupied, active, see if you can engage them in some related activity

13. What are some of the things that help patients with a personality disorder to feel safe and supported?

- Building a trusting relationship with the patient
- Being understanding and non-judgmental
- Being mindful of possible past traumas
- Help to alleviate their anxiety

14. Which of the following can managers do to help create a great workplace?

- Be open and transparent
- Create a truly no-blame culture
- Make sure staff spend most of their time doing what they are best at
29. **References and resources**

Lots of helpful resources available from the website:  
www.brief-encounters.org

**Mentalising**
- Handbook of Mentalization Based Treatment ed Jon Allen, Peter Fonagy  
  www.mentalising.com

**Staff concerns**
- NHS Litigation authority Saying sorry, 2014  
- The Mid Staffordshire NHS Foundation Trust Public Inquiry -  
  http://www.midstaffspublicinquiry.com

**Boundaries**
- Practitioner-client relationships and the prevention of abuse, by NMC, 2002  
- Professional boundaries in the nurse-patient relationship, by Griffin R, 2013, British Journal of Nursing

**Top tips**
- Talking with Acutely Psychotic People – www.citypsych.com  
- Intensive Interaction – www.intensiveinteraction.co.uk  
- Communication and the Care of People with Dementia, by Killick and Allan  
- Talking mats - http://www.jrf.org.uk/sites  
- 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

**Distressed or Depressed Patients**

**Anxiety**
- Handbook - Mental Health First Aid England
Psychosis

- Psychological Perspectives on Distress and Unusual Experiences, by Coles S and Houghton P, 2012
- The abandoned illness: a report from the Schizophrenia Commission, 2012 www.rethink.org
- Beyond Belief, by Tamasin Knight, 2009

Dementia

- VERA framework communicating with people who have dementia, by Blackhall A et al, Nursing Standard 26, 10, 35-39

Borderline Personality Disorder

- Handbook of Mentalization Based Treatment ed Jon Allen, Peter Fonagy www.mentalising.com

People with learning disabilities

- Your next patient has a learning disability http://www.keele.ac.uk/nursingandmidwifery/mnphald/toolkitcontents/ynphald.pdf

Leadership

- Download The Happy Manifesto for free at www.happy.co.uk/about/free-publications
- Fred Lee – If Disney Ran Your Hospital

Star Wards stuff (available from http://www.starwards.org.uk)

- Star Wards 1 - The original
- Star Wards 2 - The Sequel
- Talkwell - Encouraging the Art of Conversation on Mental Health Wards
- Ward Buddy - Your Recovery Companion
- Wardipedia web site - A World of Ward Knowledge: http://www.wardipedia.org/
- Ward Stars – Applauding HCAs – the heart of care: http://wardstars.org

Other great resources

- Keeping everyone as safe as possible is a basic goal for any community. Keeping everyone as safe as possible also takes thought and effort: http://www.safewards.net/
Feedback

We very much hope that you enjoy Brief Encounters and find it helpful. It would be incredibly helpful for us if you could let us have some feedback, via the Brief Encounters website http://www.brief-encounters.org/tell-us-what-you-think/

These are the sorts of questions we’re wondering about, but any feedback would be very grateful received. Thanks!

1. What parts of Brief Encounters have you read?
2. What was particularly useful?
3. What was irrelevant or unhelpful?
4. How do you plan to use it in your work?
5. Are there any other issues you think should be covered?
6. Any suggestions for changing contents or presentation?
Credit, kudos and huge thanks to everyone who made Brief Encounters possible. In particular:

- You for reading and, we hope, applying ideas from Brief Encounters
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Everyone has been exceptionally generous and patient. Absolutely no need for this sort of unconventional comment:

https://twitter.com/DoctorJeph/status/287275069279981569