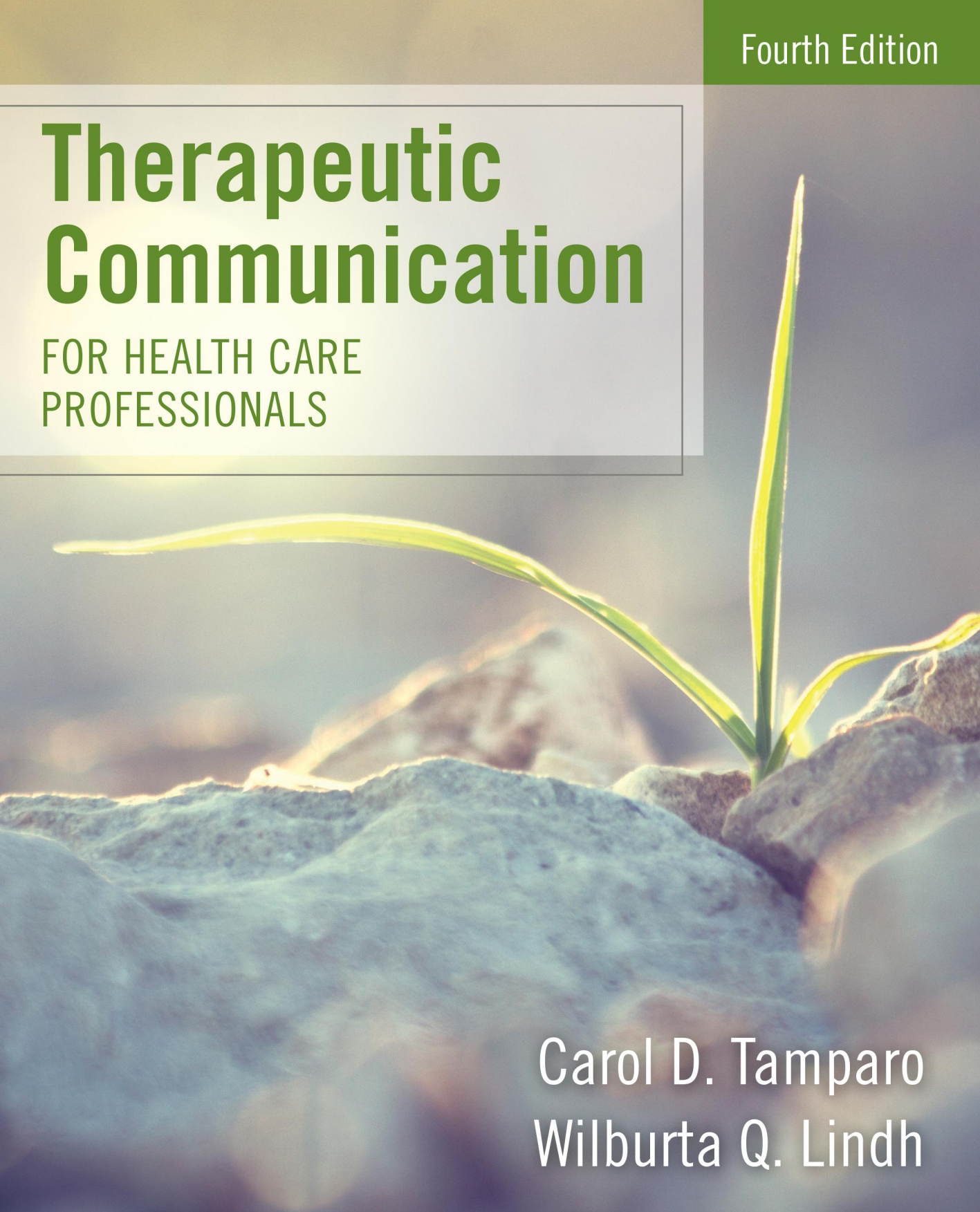
Fourth Edition

Therapeutic Communication

FOR HEALTH CARE PROFESSIONALS



Carol D. Tamparo
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Therapeutic Communication for Health Care Professionals, Fourth Edition

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Dedication

This book is dedicated to every instructor, professor, student, or health care professional who recognizes and practices the all-important component of comprehensive health care—therapeutic communication. It is also dedicated to supportive and helpful husbands—Tom Tamparo and DeVere Lindh—who added helpful suggestions, carried the laptops on vacations, and encouraged us just at the right time.

Contents

Preface

Therapeutic Communication for Health Care Professionals, Fourth Edition is a critical and key component of health care for any client. Today's climate of health care is both technical and clinical. Because interaction with clients and patients can often be rushed, the client may be left feeling devalued and with many unanswered questions. This text addresses the critical need in health care today for successful therapeutic communication between health care staff and clients. Effective communication with clients can decrease stress, increase client compliance, and result in a positive experience for all involved. Members of all health care professions will benefit from the information in this text, including students of allied health programs and nursing programs.

Instructors at all levels of health care indicate that teaching "soft skills" like effective communication is one of the most difficult tasks they face in the classroom. Students in all areas of health care can be taught the clinical and technical skills with the right amount of instructional oversight and practice; teaching students how to respond therapeutically in all situations is more difficult to teach in a classroom setting.

Organization of the Text

The key to learning the soft skills is exposure to and the ability to think critically in the moment. This text introduces the reader to the purpose and reality of therapeutic communication in all types of settings. The first five chapters introduce students in how to communicate with multicultural clients, with clients embracing complementary or alternative therapies, and with clients of varying ages and circumstances, as well as health care peers and professionals. In the last six chapters, the reader will learn how to respond therapeutically to clients who are stressed, anxious, fearful, angry, aggressive, abused or abusive, and depressed or suicidal. Special attention is given to clients with substance use disorders or life-altering illnesses, and to clients experiencing loss, grief, dying, or death.

Features

The Fourth Edition of *Therapeutic Communication for Health Care Professionals* is designed to make the learning process as intuitive as possible. Here is a brief description of each feature and its intended use.

Chapter Objectives: Provided at the start of each chapter, *Chapter Objectives* may be used to guide learning and test key facts presented in the chapter. Use these objectives, together with review and *For Further Consideration* questions and *Exercises*, to test student understanding of the chapter's content.

Opening Case Study: An Opening Case Study puts chapter content into a real-world context, to provide a framework for learning.

Key Terms: All key terms appear in bold at the first occurrence for easy identification. The glossary provides definitions for all key terms.

Case Studies: The "real-world" case studies provided within each chapter serve as a springboard for discussion, provide food for thought, and can be a means to emphasize key points in the chapter. Through these case studies students will come to understand some of the stimulating challenges faced by health care professionals and gain insight into how these challenges are overcome.

Stop and Consider: The *Stop and Consider* feature occurs throughout the learning process and provides an opportunity for critical thinking discussions.

The Therapeutic Response: Each chapter focuses in on the therapeutic response to health care client situations, applying techniques discussed to specific situations and special client needs in health care.

Icons: Icons for *Self-Awareness, Culture, Legal,* and *Professionalism* information are interspersed throughout the chapters and highlight important topic reminders.


Self-Awareness

The Self-Awareness icon indicates how health care professionals become aware of their character, feelings, motives, and desires, and their reactions to circumstances around them.


Cultural

The Cultural icon refers to attitudes, customs, beliefs, races, etc. that distinguish one group from another group.


Legal

The Legal icon applies to any procedure, practice, circumstance, etc. that is based in law or has legal ramifications.


Professionalism

The Professionalism icon refers to how health care professionals demonstrate competence, accountability, participate in teamwork and shared responsibility, and how they place their "best foot forward" with clients.

Exercises: Exercises at the end of each chapter present interesting and interactive ways for learners to apply theory and skills presented in the chapter to specific environments and situations. These exercises are practical and help learners become confident in using knowledge and skills.

Review Questions: These questions test the learner's comprehension of the chapter with structured multiple-choice questions.

For Further Consideration: This feature provides opportunities for learners to think beyond the text. The understanding of chapter material, as well as personal insight and judgment, will be required to respond.

End-of-Chapter Case Studies: These case studies challenge learners to think through options for solving problems critically, using the skills and knowledge they just learned.

References and Resources: A list of references from the text and materials readers may wish to explore is provided at the end of each chapter.

New to This Edition

Always, in any new edition, each chapter has been reviewed and updated with current information pertinent to therapeutic communication for health care professionals. Updates to the Fourth Edition include the following:

- A new chapter, Therapeutic Communication in Complementary Medicine, provides examples of negative and positive components of both alternative and traditional therapies for medical care. Learners are guided to an understanding of "integrative medicine."
- An improved text design and four-color art program with more tables, graphics, updated cartoons, and photographs enhance the content by providing quick visual references.
- An increased number of case studies throughout the chapters provides students with more opportunities to see real-world applications of the content.
- Multicultural interaction is again emphasized in the text with new material and examples.
- Emphasis has been placed on therapeutic communication across the life span in varying situations, including growth and development, stress, depression, and suicide.
- Bullying is defined and its impacts are discussed.
- A discussion of appropriate therapeutic approaches for those left behind after a suicide is presented.

- Palliative and hospice care are discussed as they relate to life-altering and life-threatening illness. Recent legislation on assisted death is included in the discussion of death and dying.
- The new *Professionalism* icon (noted earlier) highlights key information on characteristics of professionalism, such as competence, accountability, teamwork, and responsibility.

Teaching Package for the Student

MindTap

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Therapeutic Communication for Health Care Professionals, 4e on MindTap is the first of its kind in an entirely new category: the Personal Learning Experience (PLE). This personalized program of digital products and services uses interactivity and customization to engage students, while offering instructors a wide range of choices in content, platforms, devices, and learning tools. MindTap is device agnostic, meaning that it will work with any platform or Learning Management System and will be accessible anytime, anywhere: on desktops, laptops, mobile phones, and other Internet-enabled devices.

This MindTap includes:

- An interactive eBook with highlighting, note-taking, and more
- Flashcards for practicing chapter terms
- Computer-graded activities and exercises
- Easy submission tools for instructor-graded exercises
- Video case studies and listening drills

Teaching Package for the Instructor

The following supplements are available to enhance the use of *Therapeutic Communication for Health Care Professionals* in the classroom:

Instructor Companion Website

(ISBN 978-1-305-57470-0)

Spend less time planning and more time teaching with Cengage Learning's Instructor Companion Website to accompany *Therapeutic Communication*

for Health Care Professionals, 4e. As an instructor, you will have access to all of your resources online, anywhere and at any time. All instructor resources can be accessed by going to www.cengage.com/login to create a unique user log-in. The password-protected instructor resources include the following:

- An electronic *Instructor's Manual* that is packed with everything an instructor needs to be effective and efficient in the classroom. The Instructor's Manual includes complete answer keys to textbook questions, as well as expert answers to the case studies in the book. It also includes complete lesson plans with suggested media and other visual aids, a complete presentation of topic-by-topic outline, and a discussion of how to use the textbook features and supplements to your advantage in the classroom.
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In the *Therapeutic Communication for Health Care Professionals, 4e* MindTap platform, instructors customize the learning path by selecting Cengage Learning resources and adding their own content via apps that integrate with the MindTap framework seamlessly with many learning management systems. The guided learning path demonstrates the relevance of basic principles of therapeutic communication, through interactive quizzing and exercises, video case studies, and listening drills, elevating the study by challenging students to apply concepts to practice. To learn more, visit www.cengage.com/mindtap.

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Carol D. Tamparo and Wilburta (Billie) Q. Lindh are coauthors of numerous health-related texts used by medical assistants and allied health care professionals throughout the United States. Both are Certified Medical Assistants, (AAMA) with more than 30 years of experience in the field and in higher education. The authors have combined education and experience at the community college, 4 year university, and graduate school levels. Their goal as educators was always to teach and model successful therapeutic communication in health care, and they continue to pursue this goal as authors.

Avenue for Feedback

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Chapter 1

Therapeutic Communication

CHAPTER OBJECTIVES

After completing this chapter, the learner should be able to:

- Define key terms identified in this chapter and presented in the glossary.
- Compare professional, therapeutic, and social communications.
- List the six steps to successful professional communication.
- Summarize the various forms of social media used in the health care setting and identify goals of its use.
- Discuss the meaning of a "helping profession."
- List six questions to ask before entering a helping profession.
- Diagram the five basic elements of the communication cycle.
- Critique a minimum of four communication channels.
- Analyze the five Cs of communication and describe their effectiveness.
- Contrast verbal and nonverbal communication by using examples.
- Demonstrate nonverbal communication behaviors.
- Create a drawing to illustrate general "personal space" parameters.
- Discuss HIPAA rules for both email and fax.
- Recall at least five important points for effective team communication.
- Describe and give an example of the four selves.

Opening Case Study

An elderly woman, Mrs. Nelson, was attacked by a German shepherd while walking her toy poodle. The German shepherd came out from its yard, attacking Mrs. Nelson and her poodle on the sidewalk. Serious injuries resulted.

Mrs. Nelson was pushed onto the pavement, falling backward and striking her head. A deep, 5-inch laceration was made in the back of the skull, and heavy bleeding resulted. There were two puncture wounds in her ring finger from the dog's bite. The finger was fractured in two places. In the emergency room, she learned she also had a fractured coccyx. The toy poodle, also seriously injured, later survived emergency surgery at a veterinary clinic.

Mrs. Nelson was treated with care and compassion in an overcrowded emergency room on a Sunday night. Many health care professionals were involved in her care. Several efforts failed to stop the bleeding from the head wound, and it was several hours before Mrs. Nelson was released to go home with her finger in a splint, her head wound sutured, and a very tight bandage around her head.

She was told to see her primary care provider the next morning for a blood test to determine if there were any problems with her platelet count or in coagulation time. She was advised to return in 3 days either to the emergency room or to her doctor to have the stitches removed.

Her family called and took her to her doctor the next morning, with her emergency room records in hand.

Stop and Consider 1.1

1. Identify positive aspects of Mrs. Nelson's treatment in the emergency room.
2. You are the clinic receptionist for Mrs. Nelson's provider. What will you say to Mrs. Nelson when she arrives? What will you do for Mrs. Nelson?

The receptionist told Mrs. Nelson that she would have to wait because the doctor would not see anyone without an appointment. Mrs. Nelson explained that the emergency room provider said it was important the test be run in the morning. After more than an hour, she was finally seen and the blood test was performed.

Mrs. Nelson's provider hurriedly checked the head wound and the finger, and asked the assistant to redress the wound. Mrs. Nelson's hair was badly matted with dried blood and the assistant was uneasy about touching it. However, she did replace the bandage and sent her on her way with no instructions to return. The bandage was so loose that it fell off in the afternoon.

(*continues*)

Opening Case Study (*Continued*)

Stop and Consider 1.2

1. What might Mrs. Nelson's feelings be right now?
2. Identify the positive actions in this case study.
3. Identify the negative actions in this case study.

Mrs. Nelson had hoped that her personal provider would be able to discuss her fears and anxieties, answer her questions, and give her some assurances about recovery. Mrs. Nelson's emotional needs right now were greater than her need for technical medical care. (See Maslow's Hierarchy of Needs, found in Appendix A.) When it was time to have the stitches removed, she returned to the hospital, where she felt treated with care and concern.

She was embarrassed about the dried blood in her hair, still present due to the instructions not to get the wound wet, so the nurse who helped remove the stitches used a warm washcloth and peroxide to gently remove most of the dried blood. The doctor told her the head and finger wounds were healing nicely, but that the coccyx fracture would cause her discomfort for quite some time. Mrs. Nelson left the hospital a little less traumatized, knowing it would be several weeks before she would feel like herself again.

Three months later, Mrs. Nelson needed a primary care provider's summary of her recovery process and any expected complications for insurance purposes. She returned to her primary care provider, who said, "There is nothing I can do for you now. Your head wound has healed nicely. You saw the orthopedic surgeon about your finger. I have no idea how long you will have pain from the coccyx fracture, and neither would any other provider."

Still uncomfortable about this response, she sought another provider. In her interview with the new provider, the verbal exchange turned to the accident. The provider leaned forward, seeking out the cause of Mrs. Nelson's concern, and said, "Gosh, tell me what happened." In less than 5 minutes, she poured out her story.

Recognizing Mrs. Nelson's needs, the provider asked, "How is your dog?" He also commented, "It certainly seems to me that you should be able to safely walk your dog on a public sidewalk." He then proceeded to examine her.

Technically, this final provider could do no more for the woman than either her primary care provider or the emergency room provider. What this final

provider did do, however, is listen to her, acknowledge her trauma, verify that she was not at fault, and assure her that any medical needs would be cared for to the best of his ability.

Stop and Consider 1.3

1. Contrast the communication style of the two providers giving Mrs. Nelson care.
2. Has the first provider lost a client? Explain your response.

INTRODUCTION

This case study describes an actual ordeal, and illustrates both positive and negative communication skills. In this chapter, you are introduced to basic communication and listening skills to help you respond therapeutically to the needs of your clients. You will also become more aware of how your personal perceptions influence your personal communication style. Throughout this text you are given many examples of both therapeutic and nontherapeutic communications, reminded of the clients' right to privacy and confidentiality in the communication process, and taught how to assess your ability to be therapeutic.

THERAPEUTIC COMMUNICATION DEFINED

Professionalism

Therapeutic communication is defined as the interaction taking place between the provider and the client that is important to enhance both the physical and emotional needs of the client. It is one aspect of professionalism, which is defined as demonstrating competency and skill expected of a professional. Therapeutic communication requires clear communication of technical information in a manner that is empathetic to the client's emotional state. It requires adherence to accepted social behavior and political correctness. Therapeutic communication uses specific strategies to encourage clients to express their feelings and ideas. These expressions are then accepted by the health care professional with respect and understanding.

It includes both verbal and nonverbal communications, the language used, and how you communicate and whether you are aware of the effect you have on others. Therapeutic communication involves both professional and technical skills.

Professional Skills


Professionalism

Professional skills in the health care setting include communication, presentation, empathy, attitude, competency, integrity, and attention to detail. See Table 1-1.

TABLE 1-1 **Characteristics of Health Care Professionals**

Characteristics	Manifestation	Client Benefit
Communication (verbal and nonverbal)	Written communication is clear and concise and reflects clinic image Nonverbal communication reflects acceptance, values client, and expresses willingness to help	Needs are met, trust is fostered, and client is open to express health concerns
Presentation	Appears dressed and groomed appropriately Demeanor or outward behavior and conduct is respectful Expresses kindness, caring, and respect	Confident in health care choice Comfortable in setting Feels valued and respected
Empathy	Identifies with client, feels what client is feeling	Dispels fear and anxiety Comfortable
Attitude	Cultivates a positive outlook, supportive	Compliant Cooperative
Competency	Knowledgeable, skilled, competent in performing skills, dependable, demonstrates initiative, desires to continue to learn	Safe, confident, assured of confidentiality
Integrity	Honest, follows moral and ethical principles, is accountable	Builds trust, confidence, assured of confidentiality
Attention to detail	Completes correct documentation, follows all protocols of the clinic, completes all tasks	Improved health care Insurance benefits assured

You will be required to demonstrate professional skills in your interactions with clients.

Professional interaction will require you to:

1. Focus your observation.
2. Fully engage in listening.
3. Become skilled in asking open-ended questions.
4. Be intentional about affirming clients' feelings.
5. Avoid placing blame.
6. Help clients ask questions and/or express their concerns.

Becoming skilled in the six steps identified above requires another component on your part, called the "caring" component. Health care is a caring and helping profession that requires health care professionals to value and support clients.

Verbally or nonverbally, professional skills are employed every day—from the date of birth to the time of death. This communication may be a mother's soothing and loving words to a child or a simple "well done" to a colleague. Therapeutic communication focuses on enhancing the well-being of another person, and for the purposes of this text, your clients.

Technical Skills

Technical skills represent those specialized tasks that are required to deliver and support medical care. It includes skills used to explain difficult ideas and concepts, and skills to deal with difficult individuals. The opening scenario illustrates several technical skills demonstrated by the staff in the emergency room, the lab and x-ray staff support, and the assistant who bandaged the wounds. Those who assessed the injuries and followed appropriate medical-care guidelines exhibited technical skills. In comparing the responses from the two providers, one provider showed competency in technical communications but less competency in professional communication and the other was competent in *both* technical and professional communications.

PROFESSIONAL APPLICATION

As mentioned earlier, you are entering into a "helping profession." Caring must be an essential emotion for you. Are you the type of person most suited for a career in the health care profession? Some members of helping

professions give so much of themselves to their clients and their work that they quickly become disillusioned and suffer burnout. Others remain so aloof and detached from their work and their clients' needs that they can become rude and disinterested. Neither situation is appropriate, successful, nor therapeutic.


Self-Awareness

Health care professionals will want to ask themselves the following simple questions:

1. *Do you genuinely enjoy helping people in a therapeutic manner?* This implies that you have the technical skills and knowledge to help people solve their problems, and that you do so without the need to create more power for yourself.
2. *Can you feel comfortable assuming a "servant" role for those in need?* "Servant" does not imply "slave," but you must genuinely enjoy serving the needs of others.
3. *Will you be able to treat any person as a "guest" no matter what their special circumstances may be?* Remember, your employment is dependent upon a satisfied customer.
4. *Can you be open to people and accept their differences?* Even though your personal lifestyle might be quite the opposite, can you be accepting and unflappable? Are you tolerant? Can you keep your opinions to yourself and be aware of your body language?
5. *Can you be firm, yet gentle?* Procedures you perform may cause discomfort and/or pain, but your verbal and nonverbal communication must convey both firmness and gentleness.
6. *Can you keep yourself out of a codependent relationship with those you help?* People in helping professions may adopt a hostile attitude toward their clients after so many years of rescuing and giving so much. Many health care professionals are harried and overcommitted, and so locked into a caretaker role that they feel dismayed and rejected when they cannot "save" someone.

Prior to considering the numerous aspects of communications more closely, read the following scenario, and ask yourself how you might respond as a health care professional. What does your response reveal about you?

Case Study: Elaine's Pregnancy Dilemma

When a young woman discovers she is pregnant, the news can be either joyous or devastating. For one young woman named Elaine, it was not good news. She was unemployed, had no money, and was very much alone. Her desperation took her to the welfare office. Elaine realized that she needed proper care for herself and the baby.

As time passed, Elaine realized that she did not have what she wanted for her baby—a place to live, two loving parents, proper medical attention, and a mother who was emotionally mature and financially secure. Elaine chose adoption as the best solution. She finally selected an adoption agency after investigating several.

After several weeks and no opportunity to identify for the agency the kind of parents Elaine would like for her baby, and little or no prenatal care assistance, she left the agency and decided to work through a private attorney for the adoption.

After only two conversations with the attorney, who explained his services for birth mothers and adoptive parents, Elaine's self-esteem improved. She completed a detailed questionnaire describing herself and her family. She completed an equally detailed summary of the kind of qualities she was looking for in parents for her baby. The attorney insisted Elaine receive prenatal care and provided her with the proper resources. Soon he matched her with a set of prospective parents.

Even though the decision had been made prior to the baby's birth about whom the adoptive parents would be, Elaine knew the final separation would be very difficult. Elaine's obstetrician and his clinic staff knew of her decision. They described for her the procedure at the hospital, and even arranged for her not to be in the maternity suite. But at no time did they discourage her from seeing her baby or deny her the rights of any other expectant mother.

At the time of the baby's delivery, the reckoning came. The comments and the nonverbal actions of the hospital staff would make the difference. Elaine was given the same treatment any other expectant mother would receive, and her best friend and birthing coach were ushered into the delivery room with her. When the baby was born, the delivery room nurse asked Elaine if she wanted to hold the baby. When Elaine said no, the nurse held her hand, smiled, and told her that was fine. She could see the baby, hold the baby, and even feed the baby at any time, if she wanted.

Stop and Consider 1.4

1. What do you think of Elaine's decision and her attitude?
2. Was the hospital staff therapeutic? Justify your response.

(*continues*)

Case Study (*Continued*)

Later that day, Elaine would appear at the nursery room window, asking to see her baby. During the next 24 hours, while the attorney and adoptive parents were being notified, Elaine would hold, feed, and change this baby girl she was about to release. The adoptive parents had flown over 1,500 miles to receive the baby, so they were still a few hours away when it was time for Elaine to be discharged from the hospital.

Elaine and the adoptive parents had agreed that the baby should not go to a foster home for even a few moments, so the nurses made arrangements for Elaine to remain in the hospital, without additional charge, until the adoptive parents arrived.

The tearful exchange took place later, and Elaine gave over her daughter to be loved and cared for by the adoptive parents. One nurse assisted the ecstatic adoptive mother, while another walked the birth mother through the hospital dismissal. Elaine was deeply saddened by her loss, but she was not broken or ashamed.

Twenty-one years later, Elaine would be reunited with the daughter she allowed to be adopted. A day was spent together. They discussed similarities, including blond hair and blue eyes, their likes and dislikes—all this taking place also in the presence of the adoptive mother. At the close of the day, Elaine's daughter said, "Thanks for picking such great parents for me. I know you made a choice you thought was best for me. I love you for that and love the fact that I have two moms."

This story is repeated every day around the country. How different might it be if the comments and actions of the health care professional were critical and judgmental? Can you cite examples of both social and therapeutic communications? A closer look at how communication takes place will help assess therapeutic communications.

THE COMMUNICATION CYCLE

Communication is the sending and receiving of messages. Sometimes we are aware or conscious of the messages being sent or received and sometimes we are not. We are, however, always sending and receiving them.

Communication is a complex action in which two or more people participate. As shown in Figure 1-1, there are five basic elements involved in the communication cycle:

1. the sender,
2. the message,
3. the transmission or mode of communication,

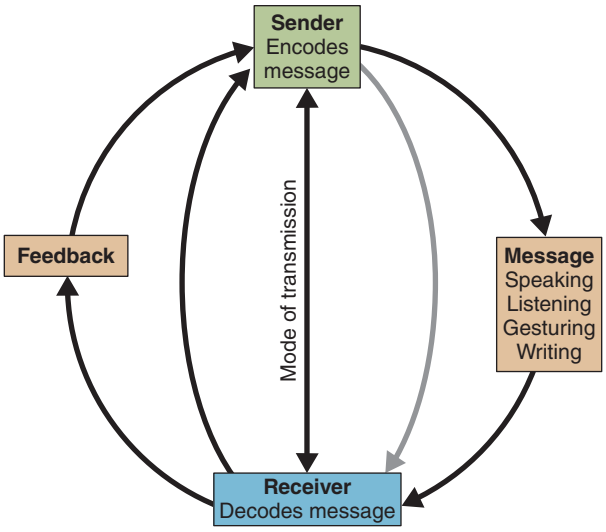

FIGURE 1-1 The communication cycle and channels of communication.

4. the receiver, and
5. feedback.

The Sender

The sender begins the communication cycle by creating or encoding the message. The sender must formulate a clear thought to send. There is great value in choosing words carefully in order to send a clear message to the receiver. Knowledge of the audience or the receiver of the particular message is important, otherwise messages can be misunderstood.

The Message

The message is the content to be communicated. The sender chooses the words and medium to best match the message to be sent. The message is most likely either spoken or in written word, but can also be categorized into verbal and nonverbal communication. The message is affected by the communication styles displayed in the sender's tone, how the message is presented, the information the message contains, and even what has been omitted.

The Transmission

How the message is actually sent is known as the transmission. This can be done through face-to-face encounters, telephone, email, texting, letters, facsimile (fax), reports, videoconferencing, and social media routes. Whatever

the route, it is important to transmit the message clearly, at an appropriate time, and with the appropriate mode of transmission if the message is to be perceived correctly by the receiver. How we send and how we perceive messages, to a large extent, are based on the influences discussed earlier. Regardless of these influences, the message sent must be adapted to fit the situation and the receiver.

Each of these channels of communication has its appropriateness. In some instances, a written message may be the most effective means of communication; in other cases, spoken communication may be best. Email and videoconferencing is growing in popularity in the health care environment, and videoconferencing can be most helpful in communications involving a number of individuals or medical specialists in different areas of the country. Cell phone texting is also increasingly used in today's environment.

The Receiver

A receiver is the recipient of the sender's message. The receiver must decode the message by evaluating the communication. The primary sensory skill used in verbal communication is listening. The spoken words, as well as the tone and pitch of voice, carry meaning. Even written communications carry a "tone" that is perceived by the receiver. It may be entirely neutral, only factual, but it may also indicate care and concern by the words used and the expressions identified. Any emphasis made by the sender must be fully understood by the receiver for the message to have meaning. The receiver, however, must also remember that his or her experiences, emotions, ideas, and beliefs will enter into the sense of the message.

Feedback

Feedback occurs when the receiver and sender both verify their perception of the message. Feedback may be either verbal or nonverbal. It reveals to the sender whether the message was interpreted accurately, and enhances understanding by verifying and/or clarifying any misunderstanding. Feedback should be succinct, timely, and relevant to the situation.

VERBAL COMMUNICATION

Verbal communication refers to the sharing of information via the spoken word. Mere words, however, carry no message unless they have meaning. If you overhear a conversation in a language foreign to you, you are a witness to verbal communication, but you may not understand the message.

For communication to have any meaning, it must be understood by all parties to the communication. The book *Legal Nurse Consulting Principles* (Peterson & Kopishke, 2010) identifies the five Cs of communication. These five Cs apply equally well to therapeutic communications as well as spoken and written communication. They are (1) complete, (2) clear, (3) concise, (4) cohesive, and (5) courteous.

The message must be *complete*, with all the necessary information given. It appears that the adoption agency first told Elaine that she would be able to choose her baby's parents. What she discovered much later in the process was that she would not be able to do so until she had signed papers releasing the baby. The message was incomplete, even misleading, in its detail.

The information given in the message must also be *clear*. It must be presented in terms understandable to both parties. It is best to enunciate carefully, with good diction, to keep objects out of and away from your mouth, and to keep background noises at a minimum.

A *concise* message is one that does not include unnecessary information. Imagine how different the message would have been had the delivery room nurse said to Elaine, "Well, you really should hold this baby. She is yours. I'd certainly hold her if she were mine."

A *cohesive* message is logical and in order. It does not jump abruptly from one subject to another. You would not say to a client, "Please remove all your clothes. No, we better weigh you first. Or do you want to give us a urine sample now?" You have confused the receiver and lost his or her attention.

A message must always be *courteous* if it is to be therapeutic. Any time communication is not considerate, there is a risk that the message will be unclear, even not received, because of the defenses likely to be present in either the sender or the receiver.

NONVERBAL COMMUNICATION

Nonverbal communication is information shared without spoken words. Communicating nonverbally uses gestures and mannerisms. It is the language we learn first. It is learned seemingly automatically, as infants learn to smile in response to a smile or loving touch on the cheek long before they respond verbally.

Taber's Cyclopedic Dictionary defines body language as the unconscious use of postures, gestures, or other forms of nonverbal expression in communication. **Kinesics** is the term often used to define the systematic study

of the body and the use of its static and dynamic position as a means of communication.

Much of our body language is a learned behavior and is greatly influenced by the culture in which we are raised. For example, eye contact may send different nonverbal messages depending on the culture of the client. These variations make it important to assess clients' cultural identity to ensure proper nonverbal communication.

Feelings are communicated quite well nonverbally. Since nonverbal communication is much less subject to conscious control, emotional dimensions are often expressed nonverbally. The body naturally expresses our true, repressed feelings. Most of the negative messages we express nonverbally are unintended. But whether they are intentional or not, the message is relayed. Experts tell us that 70% of communication is nonverbal. The tone of voice communicates 23% of the message, and only 7% of the message is actually communicated in what is said.

Two Key Points to Successful Nonverbal Communication

There are two key points to remember in any successful communication.

- First, there must be congruency between the verbal and the nonverbal expressed message. This means the two messages must be in agreement or be consistent with each other. If I verbally tell you I am not angry, but speak in angry tones and have my fists clenched and my face contorted, I am sending a mixed message. Chances are you will believe my nonverbal message rather than the verbal.
- Second, remember that nonverbal cues appear in groups. The grouping of gestures, facial expressions, and postures into nonverbal statements is known as **clustering**. In the previous example, the tone of voice, the gesture of clenched fists, and the facial expression form a nonverbal statement or cluster of cues to true feelings and emotions.

TYPES OF NONVERBAL COMMUNICATION

Facial Expression

Eye contact is another form of facial expression, and is often viewed as a sign of interest in the individual. It provides cues to indicate that what others say is important. A long stare may be interpreted as an invasion of privacy, which creates an uncomfortable, uneasy feeling. A lack of eye contact in

Western culture is usually interpreted to mean a lack of involvement, or avoidance.

Perhaps the most important nonverbal communicator is facial expression. It has been said that the eyes mirror the soul. Certain movements of the eyebrow seem to indicate questioning, while others may disclose feelings of amusement, surprise, puzzlement, or worry. The manner in which the forehead is wrinkled also sends similar messages. The eyes can communicate several kinds of messages. Have you ever seen laughter and joy, grief, or pain reflected in another's eyes?

Touch

Touch is one of the most sensitive means of communication. Touch is often used to express deep feelings that are impossible to express verbally, and can be a very powerful means of communication.

For all health care professionals, many tasks involve touching the client. Most clients will understand and accept the touching behavior, as it is related to the medical setting. Some clients, however, are not comfortable being touched, so sensitivity is essential. It is helpful to tell clients when, where, and how they are to be touched during an examination. Explaining all assessments and treatments tends to put individuals at ease. This technique is essential when a client is autistic. An individual with autism has heightened sensory abilities and may attempt to escape sensory overload or a sudden invasion of their personal space. They tend to want to get away from strange people, voices, and equipment. If you find yourself in a helping situation or profession and feel uncomfortable touching, self-assessment or self-awareness may be necessary.

Touch is often synonymous with reassurance, understanding, and caring. It is important to assess our level of comfort, and that of the client, in relation to the use of touch. When we are comfortable using touch and when we are sensitive to a client's level of acceptance to touch, touch can be used in a therapeutic manner.

Personal Space

Personal space is the distance at which individuals are comfortable with others. It may be determined by social and cultural influences. Personal space can be thought of as the invisible fence no one can see. However, the *way* in which we define boundaries *is* evident to others.


Cultural

We feel threatened when others invade our personal space without our consent. Many individuals have well-defined personal space boundaries.

Examples of personal space in Western culture are listed below for your consideration.

Intimate	—	touching to 1½ feet
Personal	—	1½–4 feet
Social	—	4–12 feet (most often observed)
Public	—	12–15 feet

Many cultures uphold these four categories of spatial relationships; however, the distances may vary from one culture to another.

Many medically related tasks involve invading another's personal space. It is beneficial to explain procedures that intrude on another's space before beginning the procedure. This gives the client some control and a sense of dignity and worth.

Position

When speaking with a client, it is helpful to maintain a close but comfortable position. Standing over a client denotes superiority, while too much distance may be interpreted as being exclusive or avoiding. Movement toward a client usually indicates warmth, liking, interest, acceptance, and trust. Moving away may suggest dislike, disinterest, boredom, indifference, suspicion, or impatience (see Figure 1-2).

FIGURE 1-2 Positive posture and position encourage therapeutic communication.

Posture

Like distance, posture is important to the health care professional. Individuals in threatening situations usually tense, but tend to relax in a nonthreatening environment. Posture can be used as a barometer for feelings. For example, sitting with the limbs crossed over one's chest can send a message of closure and avoidance; leaning back in a chair with the arms up and hands clasped behind the head can indicate openness to suggestions.

Slumped shoulders may signal depression, discouragement, or in some cases even pain. It is important to validate the messages before continuing a procedure. For example, you may ask the client, "Are you comfortable?" or "Is this position too painful?" Technicians must be careful to be in tune with the client's physical comfort.

Gestures/Mannerisms

Most everyone uses gestures or "talks" with their hands to some degree. Gestures are useful in emphasizing ideas, in creating and holding others' attention, and in relieving stress. Some common gestures and their perceived meanings might be:

Finger-tapping	—	impatience, nervousness, rudeness
Shrugged shoulders	—	indifference, discouragement
Rubbing the nose	—	puzzlement
Whitened knuckles and clenched fists	—	anger
Fidgeting	—	nervousness, anxiety

It is important to recognize that nonverbal communication helps understanding, and frequently is more powerful than verbal communication. It is also more enduring and has more persuasive power than verbal communication. The nonverbal message is more quickly believed than the verbal message.

WORD OF CAUTION

It must be remembered, however, that nonverbal communication can easily be misinterpreted. The folded arms may mean the person is cold, not closed to communication. The wrinkled brow may indicate the person has a headache, not a questioning or doubting attitude. Look for congruency between verbal and nonverbal communication for a clear message. Do not make assumptions.

In the earlier scenario, when the delivery room nurse asked Elaine if she would like to hold the baby, the verbal and nonverbal messages were congruent. When Elaine said no, the nurse held her hand, smiled, and told her that was fine. Together, the cluster of mannerisms used by the delivery room nurse said, "I understand, I care, and your response is appropriate."

LISTENING SKILLS

Listening is often identified as the passive aspect of communication. However, if done well, listening is very active. Good listeners have their eyes upon the speaker, are attentive, and are aware of the nonverbal messages as well as the verbal information coming from the sender. Effective listening requires concentration.

Therapeutic listening includes listening with a "third ear": that is, being aware of what the client is *not* saying or picking up on hints as to the real message. In the scenario of Mrs. Nelson at the beginning of this chapter, her primary care provider (PCP) was either unaware of the nonverbal cues and hints being made or chose to see them as unimportant.

The health care professional should have three listening goals: (1) to improve listening skills sufficiently so that clients are heard accurately; (2) to listen for what is not being said or for information transmitted only by hints; and (3) to determine how accurately the message has been received.

A technique used by many and suggested by professionals is the ability to paraphrase the client's message or statement. This technique allows the receiver of the message to return the message to the sender, perhaps worded differently, allowing the sender to acknowledge the accuracy of the message.

Sender: "Will I be able to use my medical coupons for prenatal care in your clinic?"

Receiver: "You're concerned about whether our doctor accepts medical coupons for payment."

Sender: "That's correct. I have no money. My baby will be adopted, but I know we both need proper medical care."

Receiver: "Our clinic does take medical coupons, and we make no distinction in our care whether you pay privately or use your coupon. Would you like to make an appointment?"

This example shows both active listening and therapeutic communication skills. The clinic assistant heard both concerns—the monetary concern and the concern for quality and proper care.

Health care professionals must be prudent in how they use active listening techniques, however. It is not appropriate to paraphrase everything the client says; otherwise, the client begins to feel stupid, or believes the professional has a hearing problem.

One of the greatest barriers to listening occurs when receivers find themselves thinking about something else while trying to listen. It is difficult to try to concentrate on what is being said when the mind is wandering. When this happens, pull concentration back to the sender, apologize if necessary, and continue with the communication.

There is a time in communication, in listening, when silence is appropriate. So many times health care professionals try to "fix" everything with a recommendation, a prescription, or even advice. Sometimes none of those things are necessary. The client simply needs someone to listen, to acknowledge the difficulty, and to remember that the client is not helpless in finding a solution to the problem.

Skill in communication takes years of practice and frequent review. It will never become perfect; the goal is to become *better* at it with each passing day. Communication is and always will be the very basis for any therapeutic relationship.

INFLUENCE OF TECHNOLOGY ON COMMUNICATION

There will always be face-to-face communication, telephone conversations between two individuals, and paper communication in the health care setting, but email, fax, text messaging, and video and teleconferencing are increasingly common in health care. Personal electronic devices such as smartphones, tablets, and laptop computers can be linked to a network for Internet access or communication with satellite facilities from almost anywhere in the world. In this environment, however, the content of the message is most likely to be examined for credibility without any of the nonverbal cues such as eye contact, facial expression, or posture. Communication interactions when using this technology require careful consideration.

The use of *email* is popular in the health care setting, both in communication with clients and in communication with colleagues. It may be read at the convenience of the receiver. Clients are particularly interested in the

use of email for such things as prescription refills, appointment scheduling, information updates, or simple requests that normally would not require a visit and are more convenient than placing a telephone call, leaving a message, and waiting for a response.

Email communication is used only for clients who have been examined within the last 6 months. No information can be provided through email without the clients' release of information to do so. Only clients can determine what, if any, personal health information (PHI) can be shared.


Legal

The **Health Insurance Portability and Accountability Act (HIPAA)** is very specific in its guidelines for electronic transmission of client information. It is not the purpose of this text to detail HIPAA guidelines, but the Web site for the Department of Health and Human Services is helpful (www.hhs.gov).

General guidelines for all email etiquette include the following:

- Be concise and to the point.
- Respond in a timely fashion and answer all questions.
- Use proper spelling and grammar.
- Do not attach unnecessary files.
- Do not write in CAPITALS.
- Add disclaimers to the email.
- Read any email carefully before pressing "Send."
- Any clinical email regarding a client should be copied and placed in the medical record.

Fax messaging uses telephone lines to transmit data from one fax machine to another. It is often used for referrals, insurance approvals, and informal correspondence. The same standards of confidentiality for any client information identified in an email exist for fax communication. HIPAA requirements dictate that fax machines are not to be placed in a centralized area where unauthorized individuals may see documents being sent by fax. A cover sheet should be included that stipulates the information is for the intended recipient only. Fax messaging saves the time and effort of copying and mailing a document, allowing the sender to keep the original while providing the recipient with an exact duplicate.

Satellite *video* and *teleconferencing* are used to share information, receive education and training in a particular field of health care, or conduct a meeting to make certain decisions. A video conference will allow participants to see one another and interact almost as if the individuals were together in

one room. A teleconference consists of a group of individuals connected by only a telephone. Both video and teleconferences can become difficult to manage if more than 10 participants are included. A telephone conference should be limited to 30 minutes or less, since it is difficult for participants to concentrate while looking into space for any longer period of time.

Effective video and teleconferencing, as well as telephone conference calls, include some basic rules of conduct:

- One person is the facilitator and is responsible for keeping the meeting on track.
- Come prepared with necessary documents or information that is to be shared.
- Before speaking, remember that everyone may not recognize your voice or know who you are; always begin with "This is _____."
- Silence is not bad. Facial expressions may not be evident, and someone may be formulating a question prior to speaking. Also, do not assume silence means consent.
- Stay focused on the meeting. The conscious mind cannot perform some other task and give full attention to the meeting at the same time.

SOCIAL MEDIA IN HEALTH CARE

In today's society, many individuals communicate via **social media**. Social media can be used for education, obtaining information, networking, goal setting, receiving support (i.e., losing weight or lowering blood sugar levels), and tracking personal progress. Health care providers increasingly turn toward online social media to connect with clients and share information about particular issues in health care or share the latest news of the clinic. Facebook, Twitter, and YouTube are most commonly used. For example, a PCP might send a message to remind everyone to get a flu shot. A pediatrician might use a **blog** to share information with clients who have diabetes and who then can connect with others with similar needs. A quick Internet search reveals many different social media sites for almost any health condition and group of people. For instance, breastcancer.org provides an online community for those diagnosed with breast cancer, including informational pages and newsletters, blogs, discussion boards, and podcasts.

Client-centered care is one of the primary goals of social media used within the health care environment. Increasingly, clients prefer social media for setting appointments and receiving reminders, getting test results,

refilling prescriptions, and getting answers to general questions. Twitter is often used to connect with other professionals about specific topics of interest to providers. The National Institutes of Health reports that PCPs use social media to read news articles, explore the latest drug research, and communicate with other providers regarding health care issues.

TEAM COMMUNICATION

Effective communication is essential to effective team interactions in the workplace. It is helpful if health care professionals receive specialized training in the facility's protocol for the use and dissemination of all forms of communications. Not only is there emphasis upon communication with clients and customers, the same attention is to be paid to communication among employees and providers. A sensitive employee can easily determine if another employee or one of the providers is having a "not so good" day. A warm greeting, the offer of a cup of coffee, a friendly gesture—all these go a long way in turning that day into something better for everyone in terms of productivity and accomplishments. All the guidelines and recommendations in this chapter are to be employed in team communication to help make the facility run more smoothly. Remember, your clients are smart. They will immediately pick up the vibes of discontent from employees when it exists.

Effective communicators in the health care team will strive to do the following:

- Listen carefully to others.
- Explain their ideas clearly.
- Clarify others' ideas as necessary.
- Express feelings in a nonthreatening manner.
- Check for feelings based on nonverbal cues.
- Initiate conversations with others if there appears to be tension.
- Encourage others to be effective communicators.

There also must be guidelines or policies on what can be communicated via email and any social media used within the facility and among coworkers. Some simple rules to consider follow:

- Do not use email if a walk into an adjacent office for a face-to-face communication is possible.
- Reserve two to four times daily to check email; notify others of your decision. Otherwise, you can become a "slave" to the technology.

- Answer email within a 24-hour time period.
- Create a response message when you are out of the facility for any period of time.
- Remember that email is not private.
- Be careful what you forward and seek permission when you do so.
- Do not use the facility's computer for personal email or any form of social media.
- Use "flags" and "Important" sparingly.
- Never send libelous, defamatory, offensive, racist, or obscene remarks.

In order to communicate effectively as a team member, take time to develop skills that will ensure trust, and to build into the team a sense of worth and importance.

Successful team communication requires collaboration. That means that health care professionals assume complementary roles and work together in a cooperative manner. Responsibilities are shared because there is an awareness of each other's knowledge, skills, education, and training. There is also a shared goal of carrying out plans for clients' care and working together for a common goal or common aim. Such an interdisciplinary approach pools the specialized services of each team member into an individualized care program for each client. Clients will find it more comfortable to communicate with a cohesive team rather than with individuals who do not know what others are doing in the client's care.

Stop and Consider 1.5

You are in a conversation with a professional regarding data usage on your cell phone. It appears that you are losing data that you actually have not used. After much checking by the professional and your responses to questions asked, the professional admits that a supervisor needs to be involved. You are transferred to a supervisor who can hopefully solve the problem. When the supervisor comes on the line, you have to explain the situation all over again because this individual knows nothing about your issue.

1. How do you feel about the cell phone service?
2. What is missing in this team's communication?
3. What might have occurred to make this professional and technical communication cohesive and therapeutic?

LIFE FACTORS THAT INFLUENCE COMMUNICATIONS

How you feel about yourself can and will directly affect how therapeutic you will be in both social and professional communications. There are a number of factors that influence your personal communication skills. They are neither good nor bad; they simply are a part of your heritage, culture, and lifestyle. These factors greatly impact our lives and dominate how we feel about ourselves and how we feel others perceive us. A few of these factors are listed here.

Genetic Factors

Inherited traits, such as height, body structure, and skin color, are defined and established by the genes passed on during fertilization. Even our gender influences perception. Nurses in hospital nurseries will tell you that every infant born has a unique personality. This is because even our personalities have a genetic component. Personality traits are **polygenic**, meaning multiple genes are involved in determining a trait that is then manipulated by life experiences.

Cultural Factors


Cultural

Every culture has its own customs and traditions that directly influence the person we are and how we are perceived. For example, in Western medical tradition, we look directly at someone when speaking and often address individuals using first names. In many cultures, however, it is disrespectful to look directly at another person (especially one in authority), or to use first names when addressing them. This topic is discussed more fully in Chapter 2, "Multicultural Therapeutic Communication."

Economic Factors

A person's financial status often relates directly to the type of education and life experiences they possess. If you were born and raised in poverty, your perception of life and others is likely to be much different than if you were born and raised in affluence. The amount and type of education and job training experience is a direct influence on perception.

Life Experiences

Life experiences are great teachers. Those who have experienced grief and loss generally respond with a deeper sensitivity to others than do those who have not experienced grief and loss. Whether life's trials have been fairly easy or very harsh will influence one's lifestyle.

Spiritual and Moral Values

Spiritual beliefs influence perception. A spiritual belief in one's life can influence an individual's attitude when caring for others' needs. Spirituality generally encourages a reach beyond the self to guide and care for others. Values or morals, the rules we live by or habits of conduct, are important in relation to self and others. This fact can make it difficult to relate to someone with entirely different rules of conduct or habits that you follow.

Role Models

Role models are found in national leaders, parents, teachers, spiritual guides, and public figures. They can be either positive or negative, but are likely to have a powerful influence over a long period of time. Positive role models can help cultivate sensitivity, confidence, and social skills. Negative role models can either channel one's desires toward creating more positive actions or more deeply reinforce the negative actions.

SELF-AWARENESS AND THE THERAPEUTIC PROCESS


Self-Awareness

To begin the therapeutic process, we must learn to recognize and evaluate our own actions and responses in given situations. It is important to know how we feel, understand, and like ourselves before we can begin to understand and like others.

What Is Self-Awareness?

Self-awareness is being aware of oneself as an individual. It includes all the beliefs a person has with respect to behavior. It is the mental image of the self, and may be realistic or unrealistic. Self-awareness begins to form at a very early age and is well established by the age of 6. It is also changeable, however, and is affected by all the influences mentioned earlier and many more.

Before going further, take time now to complete the "I am" statements in Exercise 1 in this chapter. This exercise will stimulate your thinking about yourself and assist you in making some assessments about yourself as well. Do you accept yourself as you are now, or would you like to make some changes? Would you add any "I am" statements?

While we cannot do much to change many of the things that influence our lives, we *can* recognize their presence, evaluate their effect, and begin to initiate changes as necessary. One way to do this is through self-assessment.

The Value of Self-Assessment

The value of *self-assessment* is that it helps us determine who we are, as seen by the self and by others. It is a tool to illustrate both positive and negative characteristics so that changes may be implemented. These changes encourage growth and keep us from becoming stagnant. Self-assessment gives us the power to accept or alter these changes.

Each of us has at least three selves: the *ideal self*, the *public self*, and the *real self*. The *ideal self* is the person we think we should be and the person we would like to become. The *public self* is how we want others to see us. We may have many public selves, depending upon the circle of people with whom we have contact. The public self is our reputation. The *real self* is the inner, natural self, authentic, and spontaneous. When you are most true to yourself and transparent to others, you are being your real self.

Some psychologists identify a fourth self called the *critic self*. This is the inner "shaming" voice. Shame, or the feeling we do not meet others' expectations of us, may start in childhood and be passed from generation to generation. Shame occurs in families where secrets are kept about addiction, infidelity, or anything that is kept quiet in order to keep up appearances. Teachers may shame students who do not perform well in their studies. Others may shame you for expressing anger or sadness. Shame can camouflage the *real self*, allowing the *critic self* to suppress the *real self*.

In order to have positive self-acceptance, there must be a congruency between the three selves and the critic self must be well understood and not allowed to undermine the real self. There should be balance and a good feeling about each dimension.

Complete Exercise 2, which is related to the four selves, to assist you in determining how you personally feel about these dimensions of yourself. What did you learn about yourself? Can you make any changes in your life to facilitate growth?

SUMMARY

Understanding self and the basic components of communication is vital to establishing a therapeutic relationship with clients, who likely come to the "helping relationship" with a number of barriers that impede communication. Clients may be anxious, experiencing pain, or be very ill. Communication that understands these barriers, keeps in mind the communication cycle, and comes from health care professionals who know and understand themselves will help empower clients to be full participants in the client–professional relationship. Remember, too, that effective communication

skills require special attention when interacting with others when nonverbal cues cannot be assessed, such as in email or social media. Recall the statement made earlier regarding confidentiality and not entering into any media form of communication without specific agreements with clients. With that step in place, most of the media sites are able to support HIPAA-compliant one-on-one messages and discussion forums. As with any other communication, recall the five Cs of communication when engaged in social media communications. In all communications, either within the clinic environment or with clients, strive for a pattern of openness, trust, support, and respect.

EXERCISES

Exercise 1

Read the following statements and select the 10 statements you think best describe you. Then select 10 statements you think *least* describe you. Ask a friend to indicate the statements they think describe you the best, and the least.

"I AM" STATEMENTS

I am a perfectionist.	I am afraid of failure.
I am dependable.	I am hard to get along with.
I am reserved.	I am competitive.
I am realistic.	I am ambitious.
I am a happy person.	I am courageous.
I am well liked.	I am an understanding person.
I am easily hurt.	I am often depressed.
I am impulsive.	I am easygoing.
I am self-conscious.	I am socially adept.
I am secure.	I am often lonely.
I am sympathetic.	I am in control.
I am able to express emotions.	I am socially inept.
I am unpredictable.	I am disorganized.
I am often opinionated.	I am well groomed.
I am creative.	I am attractive.
I am self-reliant.	I am selfish.
I am naive.	I am a decision maker.
I am sometimes incompetent.	I am unattractive.

I am self-sacrificing.
I am generous.
I am able to live by rules.
I am a worrier.
I am shy.
I am intelligent.
I have a good self-image.
I am a people person.
I am assertive.
I am fickle.
I am argumentative.
I am fun-loving.
I am often suspicious of others.
I am confident.
I am precise.
I am realistic.
I am overprotective.
I am energetic.
I am tolerant.
I am responsible for myself.
I am content.
I am often insecure.
I am generally trusting.
I am usually able to make decisions.
I am oversensitive.
I am poised.

Exercise 2

Using the columns provided, list adjectives that describe how you might perceive yourself.

Ideal Self	Public Self	Real Self	Critic Self
Ask the question, "What kind of person do I wish to become?"	You may wish to ask someone who knows you to describe you.	What do you really feel inside?	Do I feel shame? If so, when, how?

Exercise 3

Write a paragraph discussing a recent incident, preferably personal, in which a communicator failed to communicate what was intended. Analyze why this happened and how it could have been avoided.

REVIEW QUESTIONS

Multiple Choice

1. How are technical skills best described?
   a. Specific and specialized tasks are required.
   b. They are only necessary in the health care setting.
   c. They are interpersonal skills both in professional and personal relationships.
   d. They are not exhibited through nonverbal communication.

2. Which of the following is true about therapeutic communication?
   a. Specific and well-defined professional skills are required.
   b. There is no influence by personal feelings of self.
   c. It takes place only in verbal communication.
   d. It does not change with culture.

3. Can you list the four selves?
   a. Social self, real self, hidden self, and critic self
   b. Ideal self, critic self, hidden self, and public self
   c. Critic self, social self, ideal self, and real self
   d. Ideal self, public self, real self, and critic self

4. What is essential in the feedback element of the communication cycle?
   a. The message is encoded and verified.
   b. The message will always be verbal in format.
   c. The receiver gets the message, decodes it, and verifies it with the sender.
   d. Speaking, listening, gesturing, and writing form the elements of feedback.