# Barriers to Effective Communication

Communication is the process of sending and receiving messages between two or more people; this is something that we do all the time. It is important that nurses recognise that communication is the key to good holistic care, as patients need reassurance and information regarding their care.

Communication is so much more than just talking to one another. It is how people respond to each other in many different ways (Langs 1983).

Some examples of communication are talking, writing, signing, reading and body language, which is suggested, has several elements (Dimbleby and Burton 1992).

Communication can be very effective but first it needs to be established, and then maintained. Nurses can do this during an assessment when a patient/client comes into hospital.

However, it is argued that barriers to communication can prevent appropriate and effective care being given to patients. Communication can either facilitate the development of a therapeutic relationship or create barriers (Stuart and Sundeen 1995).

Because of their diverse nature, communication disorders are difficult to classify (Crystal, 1980).

You can discover problems simply by observing an individual. Observation can be used to establish which language is being used, if the client has any hearing difficulties or visual impairments, physical illness or disability, or if there are learning difficulties. Any of these issues could control how well a person is able to communicate with you.

Therefore, for the purpose of this piece of work, I have chosen to explore two barriers to communication, and illustrate key points.

The first barrier I have chosen is hearing impairment and then I am going to go on and explore speech problems as the two are linked together. Hearing loss can be broken down into many different categories. For example, there are two main types of hearing loss, these are pre lingual deafness and post lingual deafness. These can then be broken down into physical, psychosocial and spiritual aspects. For the purpose of this work, I am going to explore the physical aspects of deafness.

Many people just assume that the main problem with having a hearing impairment is that it is hard to understand speech and the consequent isolation from the rest of the noise-producing world. However, pre lingual deafness is defined as someone who has been completely deaf from birth so therefore gives rise to expressive problems in both speech and language (Syder 1992). A post lingual deaf person is someone who has lost there hearing suddenly or gradually and the loss can be partial or total (Syder 1992).

One fifth of the countries population suffers some sort of hearing loss (Martin and Grover 1986). This covers a wide range of problems from minor difficulties to complete loss.

Not recognising a hearing problem could result in patients/clients becoming withdrawn, isolated and excluded from people around them.

Chalfont suggests that deafness was the loneliest disability as it isolates them from the rest of the community (Chalfont 1986).

The most frustrating and depressing part about having a hearing problem is the fact that it is invisible. Most other disabilities are easy to recognise.

Yet a hearing difficulty can have a powerful impact on health, psycho, social, spiritual and physical dynamics of health.

However, it would appear that the barrier could be simply rectified by a hearing aid, either being inserted into the ear and used effectively. There are many good points to using a hearing aid. The potential advantages include solving isolation, boosting confidence and enable clients to talk and socially interact.

As well as advantages, there are also disadvantages, these I think are the fact that hearing aids do not always work, unfortunately, sometimes they can be perceived as ineffective, fiddly and look horrible, causing people not to wear them, and elderly people forgetting to turn the on or turn them up. This problem is also compounded by the lack of technical information expressed in the sort of language that makes it accessible to non-specialists.

Advances in technology have led to an explosion of devices; gadgets and other methods to help people with hearing loss listen and talk to others.

Older people are often reluctant about using a hearing aid; this could be b ecause of many reasons, either a fear of technology, or maybe that they don't want to accept the fact that they are ageing it could even be due to the stigma of deafness or the rough deal that people often get from society (lewycka 2001).

Deafness can make things very difficult when caring for a client in a ward situation, there is a lot of background noise, which can be very disrupting. In an ideal world it would be nice and more practical to care for them in a side room but this is not an option due to lack of side rooms.

Clients may only communicate by signing which will mean you will need to have a sign language interpreter available. Some people can only lip read this will mean that you will have to speak at a reasonable speed and clearly so that they can understand

you. Even the best lip readers will only be able to understand about fifty percent of what is being said, the rest is guessed from the context of the conversation (Syder 1992). If this is all discussed during a client's assessment when they first come into hospital, it can be implemented into their plan of care for each nurse to follow. Hearing loss can also have an effect on speech and voice particularly for those who are profoundly deaf creating a second problem in communicating.

The pre lingual deaf person has no knowledge of sound. Although the vocal cords can function properly, they have no idea how to use them or what the end result is supposed to be. It is much easier for them to reproduce a sound by imitating it then it is for them to use other means such as diagrams or written descriptions. Therefore, when we describe someone as being deaf and dumb we do not mean dumb in the true sense of the word (Syder 1992). The speech of a deaf person is determined from being very intelligible to unintelligible depending on the degree of hearing impairment. Most people with relatively minor loss can be reassured that their speech will remain normal (Martin and Grover 1986). The problems that a deaf person has is that they cannot differentiate between vowels, omission and distortion of consonants, they have an incorrect stress pattern, strained and breathy voice quality, they usually have a pitch which is too high or too low and volume which is mismatched with the context of the conversation. Teenage boys often need help with the pitch of their voice to allow it to drop at the right time (Syder 1992).

The post lingual deaf person's speech will eventually deteriorate. This is due to lack of feedback, which interferes with speech production. This could be reduced with training, which will inform them of other ways to monitor their speech. Volume is often a problem, as most post lingual deaf people will raise their voice to compensate for the fact that they cannot hear themselves. A hearing aid should alleviate this

problem, which is another advantage for using one. Pitch range, breathing control, speech rate and rhythm could also deteriorate. Consonants are simplified and vowels become distorted. Therapy could help to control this be allowing the person to be able to monitor their own speech (Syder 1992).

Communication is a very important tool in nursing and if there are any barriers, then nurses need to assess the degree of severity and then encourage communication. They can do this in many different ways depending on what the barrier is. For example: if there is a hearing impairment then you can speak clearly, listen carefully, and respond to what is said to you. You can remove any distractions and other noises. Make sure any aids to hearing are working. Use written communication where appropriate and understood, and use properly trained interpreter if high level of skill is required.

If there is a physical disability, you should ensure that surroundings are appropriate and accessible, allow for difficulties with voice production if necessary. Do not patronise the client/patient, and remember that some body language may not be appropriate.

The essential part of any interpersonal relationship is communication, not at least of all in the professional relationship between the nurse, the patient, and the patient's family and friends. A huge part of that relationship involves face-to-face contact and interaction, and professionals are expected to have appropriate knowledge of and expertise in, communication skills. Hargie (1986) refers to these as social skills, which are a set of goal orientated, inter-related, situationally appropriate social behaviours which can be learnt and which are under control of the individual.

For the relationship between the nurse and the patient to be a quality helping relationship, it needs to contain elements such as empathy, warmth and understanding and unconditional positive regard. These qualities will be portrayed through attending,

listening and responding. Burnard (1991) refers to this as staying awake and to be fully present in the moment that is being lived.

Nurses must also remember that there is a great deal of diversity between different cultures and that this is also important when communicating. For example in a number of oriental cultures the appropriateness of interaction distance is determined by status. Because of the cultural teachings of humility, modesty, and the subordination, too close proximity would indicate insubordination. Similarly, people from Asian cultures indicate respect by allowing more space, keeping their heads low and adverting their eyes.

It is not possible to establish communication with everybody, no matter how hard you try, and in some cases, it is inappropriate to try to develop an interpersonal relationship (Ellis and Gates et al 1995). There are many nursing situations when it is not necessarily appropriate to develop a more sustained relationship with your client. Instances might include pre-operative care, accident and emergency, crisis situations or outpatient settings (Wilson and kneisl 1992) However, the provision of empathetic understanding, warmth and genuineness and unconditional positive regard towards an individual can be learnt through becoming aware of all the channels through which these can be portrayed.

It is important that nurses are aware about the barriers to communication and can assess their impact on patients and create meaningful and effective care packages. There are many consequences of not communicating properly. For example, one of these consequences could be neglect, due to not listening or not being able to understand the patient and their needs, the end result of incorrect or insufficient communication could have dire effects. From doing this piece of work I feel that I have discovered that there are many aspects to communication, and many barriers to

communication. Some of them I had not even considered as barriers, for example, there are not just physical barriers to communication, there are psychological factors as well like beliefs, denial and regression. All of these I have realised are just as important to overcome as physical barriers are.

For future practice, I am not going to just go on first impressions of a patient/client. I am going to assess the patient/client and look that little deeper to make sure that it is not just the physical barriers that I am alerted to, but that I am also aware of the associated psychological barriers that a patient/client might have.

As nurses we should all improve our knowledge based core skills as well as are practical core skills and be aware of difficulties and barriers that a patient might have. By being aware of these barriers it will enable us to assess the patient in a way that will benefit their care and also enable us as nurses to plan a suitable care package taking into consideration their barriers and difficulties.

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