# 1

# Basic communication skills

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## Introduction

This chapter introduces the veterinary student and practitioner to the skills necessary for effective communication with clients (owners), animals, colleagues and support workers they meet on a daily basis. The importance of communication for all professionals is explored, making particular reference to health professionals. The skills required for successful communication are specified, with key terms relating to communication skills defined and some theories examined. Some of the models used to describe the communication process are outlined and their relevance is considered. A circular model that may be useful in the context of the veterinary consultation is proposed. The verbal and non-verbal aspects of communications are explored, and it is hoped that the reader will recognize the interdependence of both elements in communicating effectively. The ability to be able to ask effective questions is recognized and some general guidelines are offered. Following this, the importance of listening as a core element of communication is considered. Finally, the influence of the environment and culture on the communication process is considered.

## BACKGROUND AND ORIGINS

The topic of communication and its importance in establishing and maintaining human contact can be traced back to the Bible. In the Old Testament story of the Tower of Babel, the builders of the Tower to the Heavens were punished and given different tongues. They were separated according to their language, with each group banished to a different land (Sundeen et al. 1998). Later in the New Testament, the story of Pentecost further illustrates the importance of communication: the disciples of Christ were given the 'gift' of tongues so

that they could be understood by people of all languages (Sundeen et al. 1998). Neverthe-less, in the field of health care, such as medicine, nursing and physiotherapy, communication skills training is a relatively recent addition to curricula. The notion that '*talking isn't working*' was identified in nursing in a number of papers published in the early 1980s (Melia 1982). In relation to medicine, there is a view that effective medical consultations are still difficult to achieve despite the vast amount of communication literature (Roberts et al. 2003).

## THE IMPORTANCE OF COMMUNICATION

'It is impossible not to communicate.' This idiom is often used by communication theorists (Laurent 2000). Communication helps us to learn about others and ourselves and is con-cerned with what is transmitted, how it is to be conveyed and what hinders or aids the process (Arnold & Underman-Boggs 2007). We are also reminded that interpersonal com-munication is vitally important to all caring professionals, and it is suggested that many of the problems associated with patient non-compliance could be avoided by improving the health professional's communication skills (Ley 1988). The lack of effective communication is a constant facet of complaints received by those dealing with complaints in health facili-ties (Roberts & Bucksey 2007). Hence, communication between health professionals and the client for whom they provide the care is important so that the client has a positive experience of the interaction (Roberts & Bucksey 2007).

In the field of medicine and nursing, communication has long been seen as a core com-petency for elucidating the patients' symptoms, problems and concerns and, according to recent research, an important clinical skill for ensuring health promotion, treatment and compliance (Ammentorp et al. 2007). Effective communication is largely considered to be a key factor in client satisfaction, compliance and recovery (Chant et al. 2002; Rider & Keefer 2006). The remark by Faulkner (1998), 'to be able to communicate effectively with others is at the heart of all patient care', is pertinent to any discussion on the importance of commu-nication. Studies have shown that when clients are involved in decision making they are more likely to adhere to the recommendations (Rainer et al. 2002). The statement written for nursing students and nurses is equally relevant to those in the veterinary profession. Inter-nationally, the teaching and assessing of interpersonal and communication skills are now accepted as an integral component of medical and related education programmes (Rider & Keefer 2006; Roberts et al. 2003).

Despite this increasing awareness of the importance of good communication in health care, a significant number of patients' complaints still relate to communication problems (Ammentorp et al. 2007). Misinformation, lack of information and lack of responsiveness are deemed to be at the forefront of such complaints in patients' satisfaction ratings (Ammentorp et al. 2007). The interface between communication skills and clinical skills is a common source of debate (Chant et al. 2002; Noble & Richardson 2006). In the medical literature, an example of the centrality of communication is illustrated in relation to cancer care in which the researchers predict that oncologists conduct between 150 000 and 200 000 consultations with patients and relatives during a 40-year clinical career (Noble & Richardson 2006).

It is imperative that health care providers develop an awareness of what exactly con-stitutes effective communication. Previous researchers and theorists have attempted to

enumerate the skills required for effective communication. According to MacLeod Clark (1983), the following may be included:

- Observing and listening
- Reinforcing and encouraging
- Questioning
- Responding
- Giving information

Thus, to communicate is more than just the utterance of words but also the exchange of ideas and information between two or more people. In developing the Calgary–Cambridge framework to the medical interview, its authors established the importance of guidelines for doctors and medical students (Kurtz et al. 2003; Silverman et al. 1998). The veterinary consultation model is a version adapted for veterinary practitioners and students (Chapter 2). As in human medicine, communication in the veterinary consultation is goal-directed, time-limited and focused (Arnold & Underman-Boggs 2007).

## DEFINITION OF KEY TERMS

Communication is the basic element of human interaction that allows people to establish, maintain and improve contact with others. It is the means by which a message is transmitted, how it is conveyed and what hinders or aids the process. There is inconsistency in the literature as to what constitutes a communication skill, if this skill is the same as an interpersonal skill and if it differs from a social skill (Chant et al. 2002). The literature would suggest that these terms are often used interchangeably (Chant et al. 2002; Hargie 2007). This poses difficulty in presenting an all-inclusive definition. This variant is particularly evident in the area of human resources. In the current era of competency requirements, many employers require candidates applying for a post to have high levels of social, interpersonal or communication skills.

Communication is the process of understanding and sharing meaning. Communication experts now appear to accept communication as a process with no beginning and no end (Hargie 2007; Wolvin & Coakley 1996). As such, it is continually occurring and constantly changing because no two interactions are the same (Wilson & Sabee 2003). This poses a difficulty if competence in the skill of communication is to be assessed (Hargie 2007). Some guidance in this area is provided in the work of Wilson and Sabee (2003), who suggested that competence is related to three qualities, namely knowledge, motivation and skill (Hargie 2007).

At a simple level, communication is the 'act of imparting of/or transmitting' and the word 'communicate' means 'to impart, to transmit, to be connected' (Simpson & Weiner 2005). For those in the helping professions, the latter 'to be connected' appears to be the most important. Communication skills are also associated with outcomes where the objective of the interaction is to achieve a particular outcome, as is generally the case in face-to-face interactions and professional consultations (McConnell 2004). Noticeably, some of the literature involving communication emphasizes the importance of the two-way function, the exchange of information between a sender and a receiver, while others stress the importance of understanding and feedback (Odell 1996).

Hargie (2007) proffers that communication emerges in childhood as a skilled performance and views interpersonal communication as a skill. He equates the acquisition of communication skills in the same way as gross or fine motor skills. Given that the basic elements of social skills are verbal and non-verbal behaviours, we begin to acquire a repertoire of social skills to a greater or lesser extent from infancy. In attempting to differentiate between social interactions and interpersonal communication, Hargie (2007) reviewed previous research and asserts that there are elements of commonality with social skills and other skills. He cites the six basic elements identified by previous studies (Michelson et al. 2007) as central to social skill acquisition:

1.  Are learnt
2.  Are composed of verbal and non-verbal behaviours
3.  Entail appropriate initiation and responses
4.  Maximize available rewards from other
5.  Require appropriate timing and control of specific behaviours
6.  Are influenced by prevailing contextual factors

Based on the assumption that these elements are central to the skill aspect, the following definition of social skills is presented (Hargie 2007):

> A process in which the individual implements a set of goal-directed, interrelated, situationally appropriate social behaviours which are learned and controlled.

In order to put this definition in context, the theoretical components of communication, which are believed to have a basis in three areas, are presented (Arnold & Underman-Boggs 2007):

1.  The knowledge that underpins practice – includes theory from psychology and management.
2.  The technical factors such as the skills used in practice, for example communication skills such as listening.
3.  The creative component, the personal contribution of self.

This belief is resonant with the principles suggested by the enhanced Calgary–Cambridge framework (Kurtz et al. 2003), which clearly emphasizes these three elements, if in a slightly different order. The creative component (from self) and the technical skills are needed in initiating the interview and building the relationship, and providing structure to the process. The knowledge element is used in gathering information during physical examination and in explaining and planning the follow-on care. The creative element of self is important in closing the session and ensuring that the client/owner has received and understood the message(s) transmitted.

## MODELS OF COMMUNICATION

Prior to examining models of communication, let us examine the elements involved in the communication process. These elements are the sender, the message and the receiver. The communication process is initiated by the sender who encodes the idea, feeling or thought to another person who receives the encoded message and begins the process of decoding the
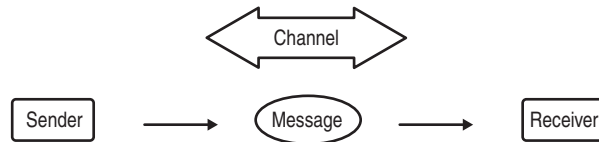
**Figure 1.1**    A basic linear model of communication.

content. Textbooks on communication illustrate this process as a model in an effort to high-light the core elements. A model can be described as 'a description or analogy used to help visualize something that cannot be directly observed' (Simpson & Weiner 2005). Figure 1.1 depicts this model as a linear process (Grover 2005). This shows a sender and a receiver and the channel through which the message is sent and received, such as the auditory channel.

A message is sent within a particular context; frequently, hidden messages are embedded in the verbal interaction (Ellis et al. 2006). A sender may intend to convey a particular thought or feeling; however, more than the exact message may be transmitted in the interaction. This is an important aspect of the communication process (Ellis et al. 2006). The receiver may grasp the message that was intended, in addition to other aspects. As the encounter continues, the sender and the receiver interact with each other, both modifying their responses in the light of the feedback from the other person (Ellis et al. 2006). The simple model outlined in Figure 1.1 fails to capture the important element of the two-way process of ongoing feedback. Attempts have been made to improve the model by adding a feedback loop (Figure 1.2). Adding the feedback loop recognizes the hidden messages conveyed in the non-verbal aspect of the process. A message is encoded by the sender and decoded by the receiver. Feedback is therefore an ongoing and two-way process. Therefore, the sender must transmit the message effectively for the receiver to interpret or decode the message (Grover 2005).

By using a circular model to illustrate, the communication process can be visualized as a cyclical process rather than a linear process. This conveys the idea of a process that is ongoing, changing and contingent on feedback. This is particularly useful when we examine possible barriers to communication later on. This circular model (Figure 1.3) depicts seven stages of the communication process and illustrates how some of the stages are subject to influences such as the appropriateness of the channel chosen.
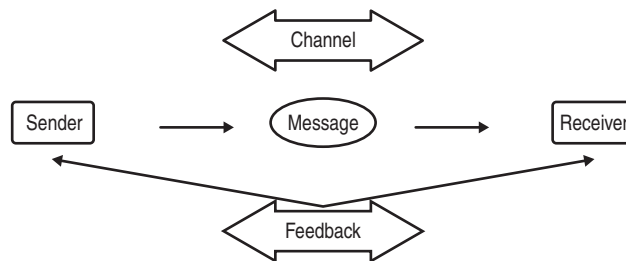


**Figure 1.2**    This model takes into account the feedback loop of the process. The message is encoded by the sender and decoded by the receiver. Feedback is, therefore, an ongoing and two-way process, as indicated by the arrows.
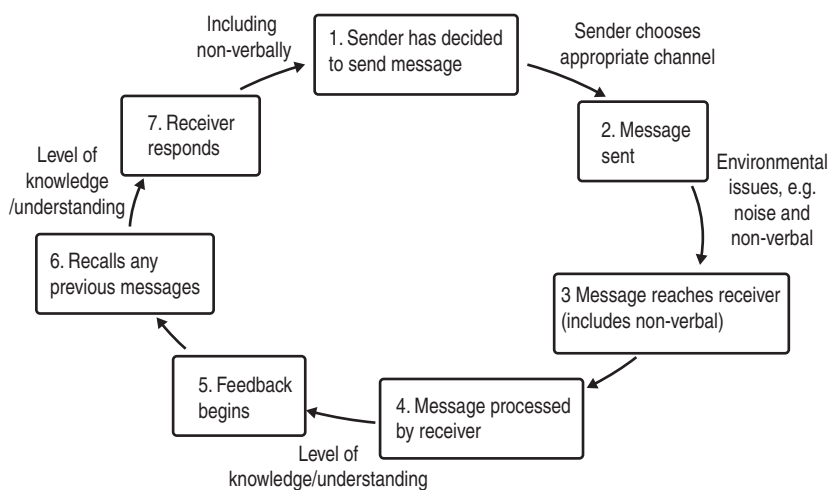
**Figure 1.3**   The circle represents the cyclical process of communication. The boxes represent the seven main stages in the communication process. Some of the stages are subject to influences such as the appropriateness of the channel chosen, environmental issues and the level of knowledge and understanding of the receiver.

What is the impact of supplementing a verbal message with written information or reducing noise in the environment in which the communication is taking place? It is advisable to have well-written information leaflets available to supplement oral communication as this will improve the process, as will locating a quiet area to reduce unnecessary noise. Additionally, the amount and depth of knowledge conveyed, or if the receiver understands the information, will determine whether or not the encounter is successful. The element of understanding is the key element when communication is defined (Odell 1996). Avoiding the use of jargon and unnecessary medical/veterinary terminology is an important consideration, as is allowing time for questions and answers. The circular model presented in Figure 1.3 is applicable to both verbal and non-verbal aspects of the communication, especially in the context of any veterinary consultation, as several messages are sent and received by the professional and the client/owner.

The concepts outlined in both the original Calgary–Cambridge model and the 2003 enhanced model are congruent with the notion of communication being a cyclical process, as outlined in Figure 1.3 (Kurtz et al. 2003; Silverman et al. 1998). This circle will be traversed several times during any veterinary consultation. Barriers to communication, and particularly to understanding the message being transmitted, can occur at any point in the circle. Some of these are the choice of channel, the appropriateness of the non-verbal cue, an awareness of the environment and ascertaining the level of knowledge and understanding of the client/owner.

Within a veterinary consultation, stage 1 involves the professional preparing for and initiating the process. The channel chosen and the words and tone used will set the scene for the consultation. As rapport develops, the process moves to stage 2, which involves considering environmental factors such as noise, comfort and non-verbal aspects of the client/animal and the veterinary professional. As the encounter progresses into stage 3, information

gathering begins. The process of information gathering proceeds through stages 4 and 5, which will include the physical examination and past history of the animal being recalled (stage 6). It is important at this stage that there is mutual understanding so that explanations or treatment options are understood. As the relationship builds during the process, the consultation may come to a conclusion with a question-and-answer session to allow for clarification and the cycle starts again

# VERBAL AND NON-VERBAL COMMUNICATION

Human communication is distinguished from other forms of communication by the use of the spoken word. The main channels of communication are the visual (seeing), the auditory (hearing) and the kinaesthetic (feeling), although all five senses (including smelling and tasting) can be used. Human forms of communication involve, to a greater or lesser extent, the use of these three channels. Throughout our childhood, adolescence and adulthood, we learn and unlearn how to see, observe, hear, listen, feel and react to situations.

## Non-verbal communication

Communication refers not only to the content but also to the feelings and emotions conveyed in an interaction. Much of the meaning derived from communication comes from non-verbal cues. Non-verbal communication is defined as 'communication that involves all forms of communication other than the spoken word' (Ellis et al. 2006; Mirardi & Riley 1997; Roberts & Bucksey 2007). The old proverb that states 'actions speak louder than words' is very relevant to non-verbal aspects of an interaction between the veterinary professional and the client (Kurtz et al. 2003). There are many problems identified with the study of non-verbal communication such as the picking up of cues, which can be ambiguous, continuous, involve multiple channels and are culture-bound. The aspects of non-verbal communication discussed here cannot be considered in isolation from the other aspects of this chapter such as questioning skills, listening and the impact of culture on the communication process.

### Functions of non-verbal communication

Non-verbal behaviours have a number of functions; they convey interpersonal attitude and emotional states of the sender or receiver. They can support or contradict the verbal communication, give the receiver cues about what is being communicated (in this case it is necessary to be aware that the person may tell us what they think we want to hear) and adds meaning to the verbal communication. They also substitute for language when speech is not possible (Argyle 1988; Arnold & Underman-Boggs 2007; Caris-Verhallen et al. 1999; Kagan & Evans 2001). Consequently, non-verbal behaviours have a regulatory function by allowing people to take turns, give and receive feedback and demonstrate attentiveness to the other person (Kagan & Evans 2001). Non-verbal communication can have five times the effect of verbal communication on a person's understanding of a message, compared with words spoken (Argyle 1988).

## *Components of non-verbal communication*

Human communication, especially face-to-face communication, is largely non-verbal. Non-verbal communication is essential to convey acceptance, warmth, interest, love, respect and support and is essential to build rapport with other people. There is some variation in the communication literature concerning the number of components to be included when describing non-verbal communication. Variations of the list are common in many texts and include the following:

- Facial movements and expressions
- Gaze and eye contact
- Head movements
- Body movements and posture
- Proximity (interpersonal distance) and orientation
- Interpersonal touch
- Voice or paralinguistic features
- Personal appearance
- Environmental cues
- Time

Hargie (2007) uses just seven categories:

1. Kinesics
2. Paralanguage
3. Physical contact (touching)
4. Proxemics
5. The physical characteristics of people, such as colour or race
6. Artefacts and adornments, such as clothing and jewellery
7. The environment such as the setting where the communication takes place

There are ten aspects of non-verbal communication listed in the Calgary–Cambridge literature (Kurtz et al. 2003; Silverman et al. 1998), whilst the veterinary consultation model has shortened the list of examples to four key aspects: facial expression, eye contact, posture and position movement, and use of tone. By combining non-verbal behaviours, they can mean different things, and any movement can change the meaning. As these non-verbal components can replace, supplement or even contradict a verbal message, it is necessary to examine the main components with reference to their application in practice.

### Facial movements and expressions

Facial expressions (Figure 1.4) provide a rich source of non-verbal information, especially in conveying emotion. Our faces provide our identity and, according to research (Knapp 2000), the face reveals six primary emotions: surprise, fear, anger, disgust, happiness and sadness. Facial expressions are therefore cues that help evaluate emotions and determine if the message was received appropriately (Grover 2005).

The various regions of the face can add further non-verbal information. These include the eyebrows, nose, cheek, forehead, mouth, eye region and movements, mouth region and tongue. Information about the primary emotions is conveyed in facial expressions, for example 'raised eyebrows', 'pouted lip' or even the simple smile. Therefore, through a very
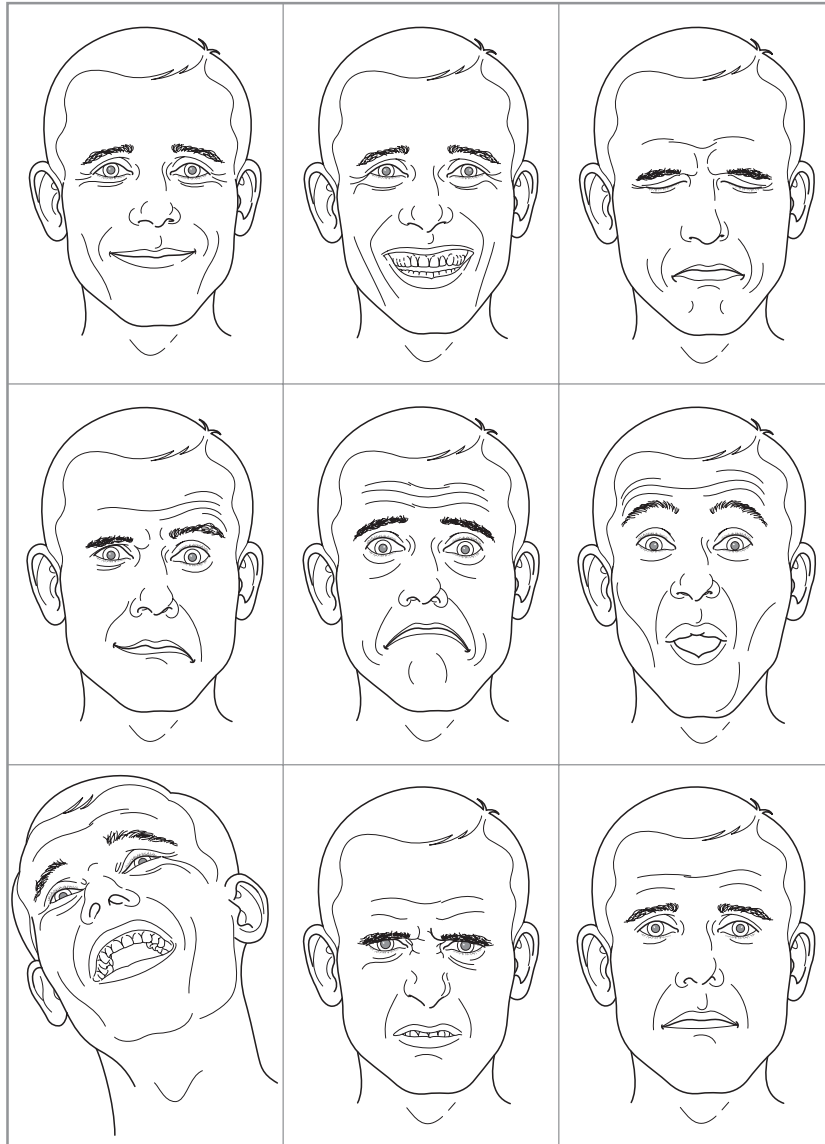
**Figure 1.4** Facial expressions.

subtle change in facial muscles, it is possible to convey a range of emotions (Redmond 2000).

Information gleaned from facial expressions will tell you if the listener is pleased, puzzled or even annoyed by observing particularly the eyes and mouth area (Ellis et al. 2006). It is therefore very important that the verbal message is congruent with the non-verbal facial expression. Previous research undertaken suggested that the power of facial expressions far outweighs the power of the actual words used (Arnold & Underman-Boggs 2007).

**Gaze and eye contact**

Making eye contact is one of a number of skills known as attending skills. Attending behaviours let the other person know that you are focused on understanding and ready to listen (Arnold & Underman-Boggs 2007).

The appropriate use of eye contact is one of the most powerful cues we have for opening and maintaining communication (Sheldrick Ross & Dewdney 1998). Looking at the person with whom you are communicating is an indication of your desire to convey interest, empathy and warmth. Therefore, eye contact both regulates and synchronizes conversation.

Making eye contact should not be confused with staring or with a fixed eye gaze, which may be unnerving or may make the listener uncomfortable. Eye gaze is not merely a way of sending signals but also of receiving signals. Therefore, eye contact needs to be at a comfortable level for both the sender and the receiver. It is important to note that what accounts for appropriate eye gaze is bound up with culture and varies from culture to culture (Sheldrick Ross & Dewdney 1998).

**Head movements**

Head movements include gestures such as nodding, shaking or tossing the head (Kagan & Evans 2001). These movements can be used in a positive or negative way. In Western cultures, nodding suggests agreement whilst shaking the head means either disagreement or even disbelief. Appropriate head nods in the listening process will increase the speech duration of the client, a signal that you are interested and can encourage a fuller disclosure (Wolvin & Coakley 1996).

Gestures can replace speech and head nods are considered as attending behaviours in listening and are a positive indication to the speaker that their story is being listened to. As such, head nods are deemed to be a sign of a desire to be helpful in the interaction (Wolvin & Coakley 1996). Furthermore, people who use appropriate head nodding are considered to be more empathic, open and warm, all desirable attributives of a caring professional.

**Body movements and posture**

The way you sit or stand (Figure 1.5) can signal your mood or attitude to the other person (Sheldrick Ross & Dewdney 1998). A slumped posture can indicate boredom; a relaxed posture may suggest a person is calm and unnerved. A shifting posture may indicate unease or discomfort. It is essential to realize that your body posture can give the client a powerful message (Arnold & Underman-Boggs 2007). Whether you are sitting or standing, your body should be relaxed and the upper part of your body inclined slightly towards the client (Arnold & Underman-Boggs 2007). Matching or mirroring a posture may be used to indicate congruence and establish empathic rapport. Certain non-verbal skills can be used to visibly tune in to the client. These skills provide a way of identifying and remembering the type of behaviour that encourages effective listening (Metcalf 1998). The acronym SOLER is useful when applying the behaviours in practice (Egan 2002):

S    Sit squarely in relation to the client/owner
O    Maintain an open position
L    Lean slightly forward
E    Maintain appropriate eye contact
R    Relax

**Figure 1.5**   Body language.

These behaviours, however, may require adapting when communicating with different cultures (Egan 2002).

**Proximity and orientation**

Body zones were identified as far back as the 1950s when Hall identified four zones marking the areas of social interaction, namely intimate, personal, social and public (Wolvin & Coakley 1996). We all have an area that we consider our personal space and feel uncomfortable if this space is breached. The term 'proxemics' refers to the use of space in interpersonal relationships.

The intimate space is generally up to 45 cm (18 in.) and is reserved for intimate thoughts and feelings. The personal distance ranges from 45 to 120 cm (from 18 in. to 4 ft) and is used for less intense interpersonal exchanges. Both the intimate space and the personal space are influenced by age, sex and culture (Ellis et al. 2006; Wolvin & Coakley 1996). Professionals such as doctors and nurses frequently, in their professional capacity, have permission to invade this space. The same applies to vets if, for example, they need to get the assistance of an owner during a physical examination of an animal. The social distance ranges from 1.2 to 3.6 m (from 4 to 12 ft) and is generally the distance used for formal exchanges. Most interactions during a consultation happen in this space.

### Interpersonal touch

Touch is a personal form of non-verbal communication. Touch is the very first way of communicating caring, i.e. touches between the mother and the baby (Fredriksson 1999). How we use touch will give information about the nature of the relationship and the degree of friendliness between the two people (Ellis et al. 2006). The use of appropriate touch is considered one of the non-verbal signals of a friendly and caring attitude (Argyle 1988; Fredriksson 1999). Messages such as affection, emotional support, encouragement and personal attention are conveyed through touch. Appropriate touch helps in creating and maintaining connection with the client (Fredriksson 1999). However, it is important to bear in mind that touch is governed by social norms and is also influenced by the cultural context.

### Voice or paralinguistic features

'Paralinguistics' is the term used to describe the tone, volume, pitch, timbre and intonation, emphasis and fluency which accompanies speech (Sheldrick Ross & Dewdney 1998; Sully & Dallas 2006). Paralinguistic features accompany words to make up the true meaning. These features help in the interpretation of the message by giving the receiver clues about the sender's state of mind (Ellis et al. 2006). The tone of a speaker's voice can have a dramatic impact on the meaning of the message. A person's emotional state can directly influence the tone of voice. Sometimes this effect is unconscious and the words send one message while the tone sends the opposite message. Therefore, voice tone can be a cue to a person's emotional state. Fear, anger and grief are emotions conveyed through intonation and pitch of the voice. The paralinguistic aspects of an interaction are of particular importance when the other person is not visible, such as in telephone consultations. Hence, a warm voice can convey empathy and loud tones may be anxiety provoking and therefore act as a barrier to the communication process (Sully & Dallas 2006).

### Personal appearance

Appearance plays a significant role in determining how a message sent or received is interpreted or understood. Hence, how one dresses and looks is a component of non-verbal communication. The dress code for an acceptable appearance can vary according to the immediate task and the culture. People form an impression of one another in anything from 20 seconds to a few minutes. The phrase 'a glance across a crowded room', usually used in relation to eye contact that occurs in romantic human relationships, is equally apt to describe this aspect of non-verbal communication.

The use of artefacts such as cosmetics, hair, accessories and possessions, such as make of car, provide prompts to the person's physical well-being, personality, social status, religion, culture and self-concept.

### Environmental cues

The physical environment of the consultation influences the ability of both parties to communicate, and therefore to set up a successful communication one must attend to the environment (Arnold & Underman-Boggs 2007). The environmental context consists of those factors outside the people involved in the communication. It includes the physical factors such as location, the furnishings and their arrangement, as well as size of treatment room and waiting room, if relevant. One can arrange furniture to enhance or restrict the communication process. Also included are comforts such as heating, lighting and ventilation. Noise

is an important facet when considering the environment (Redmond 2000). Radios, stereos and background noise from traffic are all relevant. Another aspect of this is the time of day that the consultation takes place. The environment may be either at the client's home or farm or in the consulting room. In either instance, the environment needs to be considered during the consultation. Including a relative or friend whom the client trusts can greatly increase the comfort of the client if the ensuing conversation is likely to produce anxiety (Arnold & Underman-Boggs 2007).

**Time**

Timing is fundamental to the success of the interaction. The professional may need to take account of the client's emotional readiness to accept a particular diagnosis or course of action. Remember that the client may be anxious or even angry at the event leading up to the consultation. Hence, planning the communication when the client is more receptive and able to participate is both time efficient and respectful of the client's needs (Arnold & Underman-Boggs 2007).

In summary, non-verbal communication is intrinsic to all messages sent and received during the communication process. A number of functions are identified including adding meaning to verbal communication, aiding feedback and sometimes substituting for verbal communication. Various taxonomies relating to aspects of non-verbal communication are available in the literature, and each aspect can influence the interaction positively and negatively for both parties in the interaction.

## Verbal communication

### Questioning skills

In our daily lives we all ask and answer many questions. Asking questions is a fundamental skill for all health professionals (Balzer-Riley 2000). This section examines some skills and practices that may make the process more effective. In Chapter 2, the structure of the veterinary consultation is dealt with in detail. The purpose here is to examine the skills required in a general way. The more effective you are at asking questions, the more time you will save (Balzer-Riley 2000).

It is possible to improve questioning skills by becoming aware of the different types of questions that can be asked. In addition, using a variety of questioning styles to elicit different types of information will improve the communication encounter. The main reason for asking questions is to obtain essential data that will assist in providing quality care for the client (Balzer-Riley 2000). One way of achieving quality care is to provide an equal opportunity to the client to ask, as well as answer, questions. This will allow the professional to clarify issues as well as explore and prescribe treatment options (Geist-Martin et al. 2003). It is important to consider that professional relationships can have an imbalance of power and asking questions can mark status differential between the professional and the client (Hargie 2007).

### Functions of questions

A question is defined as 'any statement or non-verbal act that invites an answer' (Hargie 2007). The essential function of a question is to elicit a verbal (or, if not possible, a

non-verbal) response from the other person. Questions can be used to open a conversation or to initiate social interaction (Kagan & Evans 2001). Other functions of questions include conveying interest, obtaining information, identification of problems, seeking clarification and ascertaining the extent of knowledge and understanding of the client (Hargie 2007; Kagan & Evans 2001). The type of question asked will influence the extent to which the various functions are fulfilled (Hargie 2007; Kagan & Evans 2001). Questions are also part of the listening process (detailed later in this chapter) when the question is used to encourage the client to continue or elaborate on the topic (Kagan & Evans 2001).

### Types of questions

There are a number of different ways to classify types of questions. The main categories are either open or closed questions and the remainder are subgroups of these. This list represents some of the common classifications:

- Closed questions
- Open questions
- Reflective questions
- Probing questions
- Focused questions
- Leading questions

A closed question is used when there is only one answer such as 'yes' or 'no'. This type of question limits the explanation but can elicit important and concise information. Hence, this method is useful in eliciting facts (Kagan & Evans 2001). Closed questions make it easier for the interviewer (questioner) to control the talk, but conversely, may make the client feel threatened due to the limitations and restrictions imposed (Hargie 2007). Most closed questions will start with words such as 'do', 'is', 'did' and 'will'.

> Example: 'Did the tablets work OK?'
> Answer: 'Yes'

Open questions, in contrast, aim to get the client to tell a story. They invite the client to elaborate in a direction of their choosing (Balzer-Riley 2000). The idea of opening an interaction with an open question is recommended by many researchers and experts, and some suggest gradually reducing the level of openness by a process called *funnel sequence* (Hargie 2007). This approach provides clients with an opportunity to discuss the issues high on their agenda at the outset in a manner that comes naturally to them (Hargie 2007). It is important for the professional not to ask more than one question at a time, or move on to another topic, until the current topic is explored in adequate depth. In any interaction it is important to watch out for non-verbal as well as verbal responses. Open questions allow the client to describe their experiences, feelings and understanding of the issue under discussion (Sully & Dallas 2006). This approach can lead to pertinent, yet unexpected, information (Bradley & Edinberg 1986). Open questions usually start with words and phrases such as 'tell me . . .', 'how would you . . .', 'what seems to be . . .' and 'which . . .'

> Example: 'What seems to be the problem with Toby?'
> Answer: 'We were in the park and he . . .'

This gives the listener an opportunity to follow up for more detail.

Reflective questions can be considered as a subdivision of either open or closed questions. This type of question is useful if it is necessary to soften the questioning process and also demonstrates to the client (speaker) that you are really listening to their story. Generally, reflection involves summarizing what the person said and therefore is similar to paraphrasing. In this instance, the client gets feedback and is aware that they have been listened to. It is important that this is done correctly as, if the message is changed, the communication may become ineffective.

Probing questions are used as a follow-up to the initial question to elicit the scope of information required (Hargie 2007). This allows in-depth exploration of a specific area. The ability to probe effectively is therefore at the core of effective questioning. A probe can follow on from either an open or closed question. It can take a great deal of sensitivity to determine how far to go in this line of questioning (Bradley & Edinberg 1986). Non-verbal cues are important – note that the client may tense up if uncomfortable with the line of questioning. There are different ways to approach probing depending on the purpose of the information that is being sought. For example, one may wish to seek clarification on a particular aspect or require the client to expand on a particular element. Accuracy probes can be used to check the correctness of what has been said. Probes can also take a non-verbal form such as raising the eyebrows (Hargie 2007).

A focused question is neither open nor closed but includes characteristics of both. The function of a focused question is to limit the area to which a client can respond but encourages more than a yes or no answer (Bradley & Edinberg 2007).

Leading questions, as the term suggests, lead to a predicted answer (Kagan & Evans 2001). Hence, the phrase 'putting words in your mouth' is used in this context. Leading questions can be subtle and encourage the acceptance of ideas, but may limit the possible replies (Kagan & Evans 2001). Using this format may imply that the person should respond in a particular way and so may limit the information that is transmitted.

In summary, it is important to remember that the same question can be used in different ways and in each circumstance a different response may be elicited. Knowing how and when to use different types of questions is useful in order to obtain essential data that will assist you in providing quality care for your client. Open questions encourage the client to open up and expand on the information. Closed questions are useful to close down an overly wordy or rambling response or encourage a more concise answer. Probing questions are useful for added detail. Reflective questions are useful to get the other person back on track. Leading questions have limited use in health and related professions. Critical to the success of questioning strategies is the use of attentive and active listening skills (O'Gara & Fairhurst 2004).

## LISTENING

Any discussion on communication usually refers to the act of listening. To 'be listened to' is considered a core attribute in organizations, businesses and services and is a critical component of the communication process and the most effective communication technique (Hargie 2007; Sundeen et al. 1998; Wolvin & Coakley 1996). Expertise in the art of listening is essential when interacting with clients and colleagues (Metcalf 1998). Conversely, poor listening skills are cited in a large percentage of medical negligence cases and one of the main reasons why individuals take legal action against health care professionals (Rainer et al. 2002).

Listening and attending are cited as the two most important elements of therapeutic communication, with 'overtalking' the least productive (Burnard 1992). Listening and attending require hearing and understanding of both verbal and non-verbal cues such as eye contact and paralinguistic aspects of the message alluded to earlier in this chapter. Perception is closely related to listening as surrounding stimuli are taken into account when a message is being conveyed (Redmond 2000). Together, the art of listening and perceiving involves decoding or interpreting the message and gives information about whether the listener understands the information transmitted.

## Defining listening

There are many definitions of listening, such as 'the selection and retention of aurally received data' (Weaver 2007), or 'the process by which spoken language is converted to meaning in the mind' (Hargie 2007). Some theorists regard listening as a purely auditory activity, a process that takes place 'when the human organism receives data aurally' (Hargie 2007; O'Gara & Fairhurst 2004). In making a distinction between hearing and listening, hearing is regarded as a physical activity while listening is a mental process. A more comprehensive definition by Wolvin and Coakley (1996) describes listening as 'the process of receiving, attending to, and assigning meaning to aural and visual stimuli'. This definition captures the complexity of listening and includes the three core elements of listening – receiving, attending and assigning meaning – as described in most communication texts.

Some literature describes the concept of listening with the addition of one of three prefixes: active, reflective and therapeutic (Fredriksson 1999). Additionally, these prefixes are used interchangeably, but the term 'therapeutic' is generally associated with helping relationships such as the relationship between a client and a health care professional.

In terms of interpersonal interaction, the emphasis is on the process by which spoken language is converted to meaning. Just as we see with our eyes but read with our brains, so we hear with our ears but listen with our brains. We do not need to learn how to hear, but we have to learn how to listen (Wolvin & Coakley 1996). In this sense, listening is not something that happens physically in the ears, but rather happens mentally between the ears and is a deliberate and active behaviour (Fredriksson 1999). Aural definitions of listening ignore the non-verbal cues emitted by the speaker during social interaction. Yet, such clues can have an important effect on the meaning of the communication to be conveyed during social interactions. As a result, listening is often conceived as encompassing both verbal and non-verbal messages.

## Functions of listening

The goal of listening is to understand as fully as possible what the other person is trying to communicate. The functions of listening, in a health care context, can be summarized as follows (Metcalf 1998):

- To focus specifically upon the messages being communicated by another person
- To gain a full and accurate understanding of the other person's problems/issues
- To convey interest, concern and attention for the other person
- To encourage full, open and honest expression
- To develop a client-centred approach during the interaction

Successful communication is dependent on effective listening. This is crucial to satisfy the other person's goals and needs, as well as our own. Effective listening is a specific interpersonal skill that can be developed and practised in professional interactions. Earlier research on listening was conducted in academic institutions and the assumption was that college students learnt by reading textbooks and listening to lectures (Hargie 2007). More recent educational research, which focuses on student-centred education, emphasizes how listening and other communication skills are only part of the learning process. Contemporaneous research concludes that listening is more than just hearing and therefore is an active rather than a passive process (Stickley & Freshwater 2006).

## Listening as a communication skill

Most communication textbooks consider listening a core communication skill, which would imply that it can be learnt and practised (Fredriksson 1999; Redmond 2000). It is important not to confuse the skill of conversation with the skill of listening as great talkers do not always make good listeners (Stickley & Freshwater 2006). Listening at the beginning of the consultation is fundamental to the success of the interaction. In medical practice, listening to the patients' story contributes to almost 85% of diagnosis without further examination or tests (Cocksedge & May 1999). Listening is integral to models of consultation (Kurtz et al. 2003; Silverman et al. 1998) as the professional gathers data on which to base diagnosis and treatment (Cocksedge & May 1999). The merit of picking up both verbal and non-verbal cues early in the consultation and the option to engage in 'the listening loop' (Cocksedge & May 1999) can contribute positively to the outcome for the client.

As already established, for communication to occur between individuals there must be both sending and receiving of signals from one person to the other. In order to respond appropriately to others, it is necessary to pay attention to the messages which they are sending and relate future responses to these messages, specifically to engage in active listening. This is clearly evident if we refer to the circular model of communication described in Figure 1.3.

## Types of listening

Wolvin and Coakley (1996) have identified a number of different types of listening. They describe these as a hierarchy using a tree and its branches to illustrate how each type fits a particular purpose:

1. Discriminative listening is at the root of the tree where the listener attempts to distinguish auditory and visual stimuli. At this level, the listener is making a rapid assessment of the problem and it may be as simple as reading facial expressions.
2. Comprehensive listening is at the next level but located within the tree trunk. It occurs as one attempts to understand the message in order to recall a previous message or retain it for use later in the interaction. Some examples of comprehensive listening include attending lectures, listening to radio or watching news and current affairs on television. The emphasis is on listening for central facts, main ideas and critical themes in order to fully comprehend the messages being received. It is suggested that discriminative listening at the root of the tree and comprehensive listening as the trunk are the two

elements that support the other types, which form the branches of the tree and shape listening behaviours.

3. Therapeutic listening is one of the three branches when we listen to provide support, help and empathy to someone who has a need to talk and be understood by another person. In the context of this text, this is representative of the client/owner who presents for the veterinary consultation. Here, the listener demonstrates a willingness to attend to and attempt to understand the thoughts, beliefs and feelings of the client.

4. Critical listening is the second branch described, where the intention is to evaluate the purpose of the message. This is described as similar to meeting with sales people or listening to advertisements on the radio or TV. The speaker is trying to persuade the other person by attempting to influence attitudes, beliefs or actions. In this context, it is considered important to use the three other types described to make a critical judgement. Additionally, taking account of non-verbal as well as verbal messages is vital to the process.

5. Appreciative listening is the final branch. This form of listening requires that the listener distinguishes auditory and visual cues in the message, comprehends the message, processes the message and appreciates the content, so as to respond. Listening to music is an example of appreciative listening.

These types of listening can be linked to methods or used as the reasons to listen appropriately in a particular interaction, with each method having appropriate and inappropriate uses (Redmond 2000). Listening methods include listening objectively to gain information and achieve understanding (Redmond 2000). This compares with comprehensive listening described above (Wolvin & Coakley 1996). Redmond (2000) lists listening critically as a method and describes it as analysing and evaluating messages. This requires the listener to evaluate all information received by stepping back from the emotion and to use critical thinking before responding. Listening appreciatively, conversely, advises you to suspend objectivity and be open-minded and open to emotional reactions. Finally, listening personally is presented as a method of engaging the client; this is likened to the type of therapeutic listening described above (Redmond 2000).

## Passive and active listening

Communication literature pertaining to health care generally considers listening to be either an active or a passive process. Many people share their ideas, concerns and feelings if sufficient encouragement is received. All this requires is a verbal or non-verbal cue 'mm', 'ah' or 'really', a smile, a nod of the head, a lean forward or a 'tell me more'. This is known as passive listening or minimal listening (Kagan & Evans 2001). Passive listening occurs when minimum acknowledgement to the other person is provided, but it is sufficient for that person to feel comfortable about talking.

Active listening is similar to therapeutic listening as described by Kagan and Evans (2001). Active listening occurs when an individual displays certain behaviours, which indicate that he or she is overtly paying attention to another person. In using this skill one is actively involved. It is sometimes called reflective listening as one reflects back the 'music of the message' received from the other person. Active listening requires the professional not only to hear but also to interpret the meaning and to give feedback (Arnold & Underman-Boggs

2007). Active listening requires the listener to ask questions, guide the flow of communication and seek clarification (Redmond 2000). An active listener shares responsibility with the speaker in order to reach understanding. Consequently, active listening is considered a dynamic, interactive process in which the listener suspends judgement (Arnold & Underman-Boggs 2007). Active listening involves giving time, attending to and observing behaviours, recognizing and responding to verbal and non-verbal cues and being aware of words and gestures including one's own. Additionally, in some incidences all that is required is to be comfortable with silence.

## Metacommunication and listening

All messages include non-verbal instruction from the speaker. This is described as metacommunication or 'the third level' of communication (Sundeen et al. 1998). It is more than hearing someone speak. It involves being with the other person so that we give them time, attend to their non-verbal signals and listen to what they are saying. It includes telling the sender both verbally and non-verbally that you are interested (Arnold & Underman-Boggs 2007). The professional non-verbally communicates acceptance, interest and respect for the client/owner through eye contact, body posture and head nodding, and even by smiling. Listening is a basic principle to ensure that communication is congruent by endeavouring that all three levels of communication – verbal, non-verbal and metacommunication – are giving the same message (Sundeen et al. 1998).

## Guidelines to improve listening

In order to consider how to improve listening skills, it is useful to reflect on the aspects of listening. There are four main aspects which need to be considered in relation to the process of listening. These are the characteristics associated with the listener, the speaker, the message and the environment. Communication moves in a circular manner, alternating between the speaker and the listener over the course of the interaction.

### *Characteristics associated with the speaker and the listener*

The non-verbal aspects already discussed all impinge on the listening process. A number of positive correlations have been found between the characteristics of the listener and the ability to listen effectively. These include:

- *Linguistic aptitude*: Those with a wider vocabulary are better listeners.
- *Motivation*: If the listener is highly motivated, he or she will remember more of the information.
- *Organizational ability*: The ability to organize incoming information into appropriate categories facilitates listening. Good listeners can identify the key elements of the messages received.
- *Physical condition*: Listening ability deteriorates as fatigue increases, an important consideration for busy professionals and clients.

- *Disposition*: Introverts are usually better listeners than extroverts, as they are generally content to sit back and let the other person be the centre of attention.
- *Anxiety*: This reduces the ability to listen. If worried about self, animal or others, we do not listen carefully (Hargie & Dickson 2004).
- *Feedback*: When given appropriately, it assists with the art of listening.

### Characteristics associated with the message

This refers to the ability to use clear, unambiguous language, avoiding unnecessary jargon and medical terminology. Each sentence used to convey a message must be structured to get one significant point across to the listener. Non-verbal behaviours are carried in all messages.

## Silence

Silence used deliberately and carefully is a powerful listening response (Arnold & Underman-Boggs 2007). Sometimes, all that is required is to sit quietly with another person, using touch if appropriate. Silence, coupled with a relaxed approach, gives the client time to think. Some people are uncomfortable with silence and rush in very quickly with words or interrupt with words; however, the overuse of words has the effect of covering up feelings and may stop ideas emerging. Sometimes, to pay attention to what is not being said is as important as attending to the words spoken. Another use of silence is to emphasize important points that you want the client to reflect on.

Some listeners are uncomfortable with silence during their interaction and attempt to interrupt their silence by talking. Silence, as with many aspects of communication, is culture-bound and in some cultures it is viewed in a negative way (Ellis et al. 2006). Listeners can make use of silence in order to promote communication instead of being intimidated by it (Davidhizar & Newman Giger 1994).

## Summary of listening

Listening is a core element of communication. Important components that are included in the definition of listening include receiving, attending to and assigning meaning to messages received aurally. The functions of listening relate nicely to the definition. The central aim is to understand, as fully as possible, what the other person is trying to communicate, and successful communication is dependent on effective listening. Listening is deemed a skill that can be learnt and practised and is integral to the veterinary consultation as this is the time that the professional gathers data on which to base diagnosis and treatment, as well as to build rapport with the client. Different taxonomies are used to classify listening; these aim to give guidance on the best approach to use in response to the circumstances of the consultation. Active or therapeutic listening requires the professional not only to hear but also to interpret the meaning and to give feedback. Metacommunication is linked to listening and includes verbal and non-verbal communication in addition to overtly making the speaker aware of the importance of their story. In order to improve the art of listening, it is necessary to take account of the characteristics of the listener, the speaker, the message and the environment in which the interaction is taking place. In some instances, it is appropriate to listen in silence and to allow appropriate time for the emotional aspects of the message.

# THE CULTURAL CONTEXT OF COMMUNICATION

As the world is getting smaller and travel becoming easier, people from many different cultures interact in their daily lives. Veterinary practitioners and clients/owners are more likely to have cross-cultural professional interactions as individuals from other cultures settle and become part of the population. Culture has been defined as 'a learned set of shared interpretations about beliefs, values and norms that affect a relatively large group of people' (Redmond 2000). It is important, therefore, to consider the impact of culture on communication. References to culture have already been made in relation to several aspects of non-verbal communication. More recent research focuses on non-verbal cues within different cultures (Arasarathnam & Doerfel 2005). Non-verbal communication such as tone of voice, eye gaze, hand gestures, self-disclosure and use of touch are cited as areas that influence the interaction by the culture of the persons involved (Argyle 1988). This is a complex area; it requires time and understanding on the part of the veterinary professional and client (Ellis et al. 2006). An example of this may be gestures used in greeting such as embracing and kissing, whilst normal in some cultures, these are reserved for close family and special friends in an Irish or British context (Ellis et al. 2006). In some cultures, respect for other people is conveyed by avoiding eye contact, yet in other cultures this would show lack of interest. Emotional expression varies between cultures, and this may particularly impact on how the veterinary practitioner prioritizes telephone calls.

How individuals relate to each other is influenced by cultural heritage and values and beliefs (Sully & Dallas 2006). All cultures are composed of individuals of differing socioeconomic groups, educational background and ethnic and racial heritage (Sundeen et al. 1998). It is vital that individuals are not stereotyped according to their culture as differences within a culture can be as great as differences between cultures. A number of definitions of intercultural communication are provided in the literature, i.e. 'people of two different ethnic groups or cultures trying to communicate', or intercultural communication occurs when 'a message produced in one culture must be processed in another culture' (Arasarathnam & Doerfel 2005). Hence, cultural differences are more than national boundaries and include values and beliefs.

Rogers (2003) suggested that three principles – genuineness, warmth and empathy – alongside demonstrating unconditional positive regard are the cornerstones of effective interpersonal relations. Such an approach will give guidance in maintaining a person-centred approach, as advocated (Arasarathnam & Doerfel 2005; Rogers 2003). When communicating with individuals from other cultures, these principles offer a road map for the veterinary professional in facilitating intercultural dialogue and relations.

Clearly, no discussion on intercultural communication would be complete without reference to the use of different languages. Words have power because we respond to them (Redmond 2000). Therefore, it is necessary to choose words carefully when communicating with a person whose first language differs. Initially, pronouncing a client's name correctly will set the scene for the interaction. Some word meanings change with cultural groups and this can lead to misunderstanding of the message being communicated (Sundeen et al. 1998). Consequently, the professional needs to check understanding during any interaction.

Professionals are required to develop an awareness of the cultural context and adopt a flexible attitude when engaging with individuals from different cultures (Redmond 2000). It is important to establish the cultural norms when communicating with a client who

appears to be anxious or stressed. Culture will predetermine behaviours that are outside the norm.

## SUMMARY

References to the topic of communication date back to biblical times. The importance of communication in the heath care arena is firmly established; despite this, problems that relate to lack of communication and miscommunication still abound and remain the subject of much client dissatisfaction. This chapter attempts to present an all-encompassing definition of the skill of communication. There is agreement that communication is a process, which is ongoing. The definition of a social skill as presented by Hargie (2007) is a valuable and practical method of considering the communication skills required by professionals such as veterinary practitioners. The use of a model is a way of considering the central elements embedded in the communication process, the sender, the receiver, the message and the channel. The circular model attempts to depict the cyclical nature of the communication process and fits well with the veterinary model of consultation. Interpersonal communication encompasses both verbal and non-verbal aspects. Professionals need to attend to both aspects as non-verbal components can replace, supplement or even contradict a verbal message. Questioning skills and the selection of the most suitable type of question are central to good practice and the best use of valuable time. Listening is a core communication skill and central to the art and science of the caring practitioner. Finally, culture and the awareness of how a cultural heritage impacts on a consultation is a worthwhile attribute for the skilled veterinary professional.

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