Theoretical foundations of communication

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Communication is an essential feature of health care and one of the main roles you will undertake as a health professional. This textbook will help you to learn the practicalities and theoretical underpinnings of communication skills for engaging with children and their families. Children will be deemed persons under the age of 18 years unless otherwise specified. Alongside defining children according to their number of lived years, their developmental life-course as well as social, cultural, legal, and political contexts will be considered. Families take many forms: ‘in essence, the family is who it identifies itself to be, and therefore a family assessment should start by asking the family, who is in this family?’ (Hemphill and Dearmun 2006: 19). This chapter sets the scene for the chapters to follow by presenting some theoretical perspectives and principles of communication.

Learning outcomes

By the end of this chapter you should be able to:

1. Describe the core elements and interpersonal skills required to enact effective communication with children and their families
2. Identify and reflect on the personal and situational challenges encountered in engaging in dialogue with children and their families
3. Demonstrate knowledge of various theoretical lenses, or models, through which communication behaviours can be understood

Introduction

Child and family centred care is a central tenet and fundamental principle of providing quality health care to children and families. A core aspect of child and family centred care is that parents are extensively involved in caring for their child; the family is recognized as a constant in the child’s life whereas health professionals are involved intermittently (Shelton et al. 1987). Quality health care encompasses listening to and involving children in their own care and decision-making processes. Encouraging the active participation of both child and parent(s) in health care is dependent upon your ability to manage the dynamics of a
three-way dialogical relationship between yourself, the child, and the parent(s) in the context of a busy healthcare, and/or home, setting.

**Triadic interactions**

With increased third-party involvement, as in child–parent–health professional engagement, the dynamics of the interaction become increasingly more complex (Gabe *et al.* 2004; Pyorala 2004). In such circumstances, parents often assume an intermediary stance between you and the child. On the one hand, parents might hold a supportive role, acting as a communication buffer for the child, answering difficult questions for the child, empowering the child to take part, and enhancing the child’s understanding and memory (Gibson *et al.* 2010; vanStaa 2011). On the other hand, parents might hold an inhibitory role, filtering information before it reaches the child, blocking the child’s interaction by answering on the child’s behalf, or reprimanding the child for butting in (Young *et al.* 2003; vanStaa 2011). Triadic communication presents great challenges for health professionals because it is often considered to be nothing more than multi-party talk where children are often passive bystanders (vanStaa 2011). Parents can also reside on the sideline of nurse–child interactions (Callery and Milnes 2012). Callery and Milnes (2012: 8) highlight the need to recognize the influence of dyadic relationships within triadic interactions between child, parent, and health professional:

The dyads of nurse–parent, nurse–child and parent–child interact to form the triadic relationship that has features of a therapeutic alliance. There is potential for both cooperation and conflict in each of these dyadic relationships, with implications for the potential for alliances to be therapeutic.

Taking account of, and addressing, the needs of both child and parent(s) is central to the United Nations (1989) Convention on the Rights of the Child (UNCRC), which emphasizes the importance of listening to children and considering their views when planning services and making decisions, in addition to taking account of parents’ responsibility to act in children’s best interests.

**Activity**

During your clinical placement, observe an interaction between a parent, child, and another third party.

- How does each person behave (verbally and non-verbally) when interacting with another (i.e. third party with parent, parent with child, third party with child)!
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Communication messages

Verbal communications are messages imparted via language expressed as words. Words do not have the same meaning for everyone who hears them. Children often struggle to convey clearly what is important to them and you may not fully understand what they are trying to say. You may experience difficulty finding appropriate ways to discuss sensitive issues with children, leaving them unable to make sense of information presented (Lefevre 2010). Children less than 8 years of age interpret words concretely and frequently misinterpret medical terms (Mahan 1999). When communicating with families it is important to employ everyday, understandable language. Always check understanding of information exchanged with children and parents. It would be unhelpful to merely ask a child if they understand, since they are likely to answer ‘yes’ whether they understand or not. Some useful ways to validate understanding include:

- Ask the parent/child to repeat back to you what you have told them.
- Ask a series of open-ended questions to determine the parent/child's knowledge.
- Use creative participatory methods (e.g. picture, word activity board, game) to determine the child’s understanding.
- Observe the parent/child’s body language (e.g. movements, posture, eye contact, expressions).
- Involve the child’s parents/guardians in interpreting the child’s behaviour.
- Rephrase questions with words the parent/child uses.
- Paraphrase back to the parent/child what they said every so often to clarify meaning.
- Summarize the discussion at the end of long conversations.
- Ask the child what they would tell a friend if they had to explain it to them.

Non-verbal communications are messages imparted without resort to spoken language. Such communication encompasses body language (e.g. facial expressions, eye contact, body movements, and touch) and paralanguage (e.g. vocal tone, pitch, and pace). Non-verbal communication represents a large portion of any interaction, especially with children because children's communicative styles and skills are often less verbal and more demonstrative (Thomas 2001). Some children may struggle, or be unable, to convey their experiences and thoughts through words and may demonstrate these instead through gestures, facial expressions, and sounds (Lefevre 2010). It is important to approach children less than 2 years old slowly, using a calm, soothing voice to avoid startling them. Approach children aged 3–7 years at eye level to appear less threatening by de-emphasizing the child’s small size. With older children (i.e. 8–12 years), avoid a facial expression that might convey disappointment or anger (Mahan 1999).

Interpersonal skills

The effective exchange of messages depends upon core interpersonal skills used by those involved, such as, questioning, explaining, reassuring, and listening.
Questioning

There are many different forms of questions that shift the interaction in diverse directions and yield distinctive responses. Closed questions are a directive type of exploration and are health professional driven and focused. They have a specific fact-finding purpose and can be quickly answered with short, monosyllabic responses, such as ‘yes’, ‘no’, ‘not sure’, or with a short phrase. While asking children and parents closed questions is legitimate to establish what is wrong with them and to instigate appropriate interventions, closed questions do not explore the child’s and/or parent’s agenda because their answer and involvement in the communication process is restricted (Faulkner 1998). This type of exploration can disempower the child and family.

Reflection point

Think about the answers you might get to the following closed questions and how these answers might affect your ability to engage with a child:

- Are you sore?
- Do you want something for pain?
- Have you eaten anything?
- Do you feel like eating anything?
- Did you have your operation?

Open-ended questions usually begin with ‘what’, ‘why’, ‘could’ or ‘how’, and request an answer of perception, information or feelings. Such questions invite children and families into the conversation at a more participative level. Open-ended questions bestow upon children and families the opportunity to talk freely about their experiences; things of interest or importance to them, as opposed to things of interest or importance to your agenda. Gathering parents’ viewpoint is important because parents have knowledge and experience in detecting subtle changes in their child’s behaviour and can make a valuable contribution to their child’s care. Gathering children’s views is of equal importance because children may have different objectives, preferences and, in some cases, may be in the best position to assert their own perspectives.

Reflection point

Think about the answers you might get to the following open questions and how these answers might influence your ability to engage with a child:

- Tell me about your pain.
- How you are feeling?
- What have you been eating?
- What do you feel like eating?
- How have you been since your operation?
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Questioning also encompasses providing parents and children with an opportunity to ask questions. Children and their parents often have many questions about, for example, a forthcoming hospital admission, health clinic visit, operation or disease/condition (Fortier et al. 2009; Gordon et al. 2011). Sometimes children experience difficulties formulating questions and you might need to help them to do so (Beresford and Sloper 2003; Gibson et al. 2010).

Explaining

The provision of accurate and comprehensive information is an individual entitlement, and a prerequisite for children and parents increased participation in healthcare decisions that affect them directly (Mikkelsen and Frederiksen 2011). Although children and parents should have access to accurate and easily understandable information, the type and amount of information they want varies according to their different needs and individual desires for information (Lambert et al. 2008; Gordon et al. 2011).

Activity

Consider a boy or girl of middle to late childhood age you encountered during your clinical practice. Write a brief synopsis about how informed the child was of what was going on around them and/or their health condition and then answer the following questions:

- What, and how much, information was relayed to the child?
- Who relayed the information to the child?
- What format (e.g. verbal, written, drawings, creative methods) was used to relay information to the child?
- What words or tangible analogies (e.g. ligaments that move the knee joint are like an elastic band) were used to transmit the information?
- Where was the information relayed to the child?

Once you have written your brief synopsis consider whether things could have been done differently or better.

Some parents/children may actively seek out information, thus insufficient or a lack of information can lead to uncertainty and worry about what will happen. Other parents/children might resist information for fear of its potentially negative impact. The resistance of information might be considered a coping strategy, and excessive or inappropriate information could have negative consequences in increasing anxiety and insecurity. Sometimes, children and parents alike become overwhelmed with information received, especially on hearing bad news, at a time of illness diagnosis and/or poor prognosis (Hummelinck and Pollock 2006; Soanes et al. 2009). Children’s and parents’ worries and anxieties may impede their ability to absorb and/or remember information (Lowe et al. 2008). Thus, the provision of information needs to be sensitively individualized to parents’ and children’s
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needs, by addressing their information requirements but not increasing their anxiety or insecurity by relaying excessive information to them, or involving them in decision-making processes beyond their desire. It is important to assess individual child and family information preferences, present information in small pieces frequently, repeat as needed, and continue to build on and scaffold information for families.

Parents have an important role as information provider for their child, often acting as an intermediary between their child and health professional, transmitting and translating information. You must not assume that parents are always confident and/or competent undertaking this information provider role (Tourigny et al. 2005; Gordon et al. 2011). Parents need to be adequately supported, prepared, and informed so that they can accurately answer their child’s questions and meet their child’s informational needs.

Reassuring

Health professionals frequently tell children and parents that what they are doing will make them or their children better. While children and parents value such reassurance, you need to be aware of the difference between optimistic/reflexive and false/premature reassurance. While optimistic/reflexive reassurance focuses on protecting the patient, false reassurance centres on protecting the health professional (Teasdale 1989; Morse et al. 1992; Fareed 1996). False or premature reassurance can result in the marginalization of children and families by failing to address issues of concern to them. This dismisses, belittles, and minimizes any worries/feelings families may have. There is the risk that if children come to believe that expressing and sharing their views and concerns are not permissible, they will carry this conception forward into their adult life (Petrie 2011). By offering parents and children an opportunity to express their views and feelings, it is possible to demonstrate to them that those views and feelings are legitimate. Not offering children an opportunity to voice their concerns and worries means children and families often feel not listened to.

Activity

Consider the following short interaction between a nurse and John aged 10 and answer the questions that follow.

**Nurse:** How are you? Are you okay?

**Child:** I might have to get my appendix out [holding tummy].

**Nurse:** Oh, you look like a strong boy.

- What do you think about the nurse’s approach in this interaction?
- Was John offered an opportunity to voice his concerns?
- Is there anything you think John might have been worried about?
- How would you have responded to John?
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Did your analysis match the following?

The nurse neglected to explore John’s concerns, worries or feeling about having his impending operation. John is extremely anxious and scared about what will happen. He now conceals his worries and feelings about his impending surgery because he wants to be brave and strong. The nurse could have picked up on John’s ‘cue’ to open a conversation with him about having to have an operation; for instance, ‘You might have to have your appendix taken out, how do you feel about that?’

Listening

Children have a right to be heard and have their views taken into account in decisions that affect them, and parents have responsibilities, rights, and duties to provide appropriate direction and guidance and act in the best interests of their children (Lundy 2007). Yet there is evidence within healthcare provision that children’s right to be listened to is not always embraced (Kilkelly and Donnelly 2006). One of the most important elements of listening to children and including them in decisions is respect. To ensure children are engaged in dialogue, Thomas (2001) recommends that you should:

- accept that all children have the right to be included;
- look actively for children’s competence rather than assume incompetence;
- use methods of communication that children find helpful/enjoyable;
- give children time to express their views in their own way; and
- treat children, and their views, with respect.

If you don’t have sufficient time to listen to a child you should, explain this to them and suggest an alternative time when you will be able to offer them your undivided attention. When children are allowed time to express their views, are listened to, and offered realistic choices, their felt need to protest is minimized (Mahan 1999). To actively listen to children, value silences to allow them time to think about what they want to say, avoid interrupting them by waiting for natural pauses in conversation to intervene, do not interrupt to hurry them along or attempt to finish their sentences for them, and observe their body language, movements, gestures, and facial expressions.

Reflection point

Reflect for five minutes on why it is important to listen to children.
A child-centred approach to communication

When communicating with children and families, you must ensure your approach is appropriate to each child's age and developmental needs. Give attention to the vocabulary you use. Use short, clear sentences and everyday language as opposed to long, complex medical descriptions, which can be confusing to children. Take care when communicating with young people to ensure your approach is not too baby-like. Young people often find this patronizing, as if you are speaking down to them. Some children, especially when they are older, are more confident, articulate, and speak more freely than others, who are shyer, less articulate, and tend to respond with shorter and less in-depth answers. Sometimes children might appear reluctant to talk, answer monosyllabically or with 'I don’t know'. Although there are many reasons why children become non-communicative (e.g. unfamiliarity with health professional, lack of interest in the topic of discussion), one factor is the unequal power divide that exists between children and adults. The relative powerlessness of children makes them suspicious of adult questions and susceptible to saying what they think adults want to hear (Thomas 2001). Non-communication, withholding of information, and sidestepping adults' agendas are strategies children use to enhance their power base (McLeod 2008).

Activity

Select a procedure (e.g. recording of vital signs, lumbar puncture, wound dressing). Devise a plan about how you are going to prepare a 7-year-old child for this procedure. For instance, think of the words you might use to inform a 7-year-old about your selected procedure. Besides verbal communication, consider practical ways to demonstrate the procedure to the child, including ways to actively involve the child in this demonstration.

Creative participatory tools offer valuable additions to any engagements with children (Beddoes et al. 2010; Winter 2011). This might involve the incorporation of visual aids, play, arts and crafts, drawings, and/or various technologies. Engaging with children through such participatory media is a valuable means of getting to know them, building rapport and trust. Children are naturally cautious of strangers and will be reluctant to disclose information when they are suspicious of, afraid of or do not know adults. Rapport is a two-way process. From the beginning, ensure the child knows who you are, what your job is, and the purpose of your visit to them (Winter 2011). Children appreciate it when health professionals make an effort to learn about them as people and not just as patients (Gibson et al. 2010). Building rapport is a crucial part of forming trusting relationships with children (McLeod 2008), and means creating a connection that facilitates confidence and cooperation between parties engaged in verbal and non-verbal communication (Winter 2011).
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Table 1.1 LEARN mnemonic

- **Listen** with sympathy and understanding to the family’s perception of the problem
- **Explain** appropriate information about the care strategy to the family
- **Acknowledge** family explanations and discuss similarities with and differences to health professionals’ explanations
- **Recommend through negotiation** a treatment plan that takes account of both patient and health professional explanations

*Source: Adapted from Ahmann (1994)*

Activity

- Why is it important to build rapport with children?
- How might you earn a child’s respect and build trust?
- What barriers might you encounter in developing rapport with children?
- How might you overcome some of these barriers?

Models of communication for use in child health contexts

Two models adapted by Ahmann (1994) for use within the context of family centred care to assist with building collaborative communication with parents are LEARN (Table 1.1) and the Nursing Mutual Participation Model of Care (Table 1.2).

Activity

During your current or next clinical placement, follow Steps 1–4 of the Nursing Mutual Participation Model of Care to communicate with a parent about their child’s care. Record brief notes on the parent’s response and note your thoughts and ideas to discuss with your clinical preceptor/mentor/supervisor.

Table 1.2 Nursing Mutual Participation Model of Care

**Step 1:** Use open-ended questions to establish a caring atmosphere
- How is it going for you?

**Step 2:** Use direct questions to ascertain parental goals and expectations
- How did you hope I could help you [parent/your child] today?

**Step 3:** Assess parent’s perception of child’s illness through questions
- How does your child look to you today?
- How do you think your child is doing?

**Step 4:** Elicit parent’s suggestions/preferences and invite participation in care
- Do you have any suggestions concerning your child’s care?
- Is there anything you personally wish to do for or with your child?

*Source: Adapted from Ahmann (1994)*
Table 1.3 Nursing Approaches: Involvement in Care

- **Communicating/nurse-centred – permission**: nurses are authoritative and controlling – they assess parents’ wishes but only allow parent involvement on their terms
- **Non-communicating/nurse-centred – exclusion**: nurses exclude parents
- **Non-communicating/person-centred – assumption**: nurses make subjective assumptions of family needs with no record of systematic assessment
- **Communicating/person-centred – negotiation**: nurses communicate and share expertise/knowledge and listen to families

Source: Adapted from Casey (1995)

Casey’s (1995) Nursing Approaches model illustrates the effect that communication and nursing style can have on parents’ involvement in their child’s care (Table 1.3).

**Reflection point**

Think about Casey’s nursing approaches. It might be helpful to read Casey’s paper to help with your reflection. Identify examples from your clinical placements to support or refute Casey’s four levels of parental involvement.

- Permission
- Exclusion
- Assumption
- Negotiation

Based on your examples, reflect on the advantages and disadvantages of adapting each of Casey’s nursing approaches when communicating with parents.

The Parent–Staff Model of Paediatric Care, developed by Alsop-Shields (2002), is a way of viewing the family and interacting with them rather than a way of delivering any specific type of care. There are two main components to the model – parents’ presence and communication between staff and parents. The core element of the model is the view of the parent and child as a single, unified entity. They are in hospital [the environment] surrounded by hospital staff – a separate entity/unit. Communication is the linking factor between these two entities – that is, parent–child entity and staff unit. Health (or depletion of it) is inherent within the model. Within this model, the action is the communication between parents and staff.

In an attempt to improve partnerships with children and families, Figueroa-Altman et al. (2005) devised the mnemonic KIDSCARE to represent actions nurses could take to promote relationships with children and their families (Table 1.4).
Table 1.4 KIDSCARE mnemonic

- Knock before entering a family’s temporary personal territory
- Introduce yourself by name, role, length of shift
- Determine how patient/family like to be addressed
- Safety – demonstrate strict adherence to safety standards and explain reasons for them
- Clean hands in front of patient/family
- Advocate for family concerns, use open questions to elicit family preferences
- Respond – let families know your availability and accessibility
- Explain what you are going to do, allow time for questions, involve family

Source: Adapted from Figueroa-Altman et al. (2005)

Activity

During your current or next clinical placement, follow Figueroa-Altman and colleagues’ mnemonic KIDSCARE to initiate an encounter with a child and their family. Write a brief synopsis of your experience to discuss with your clinical preceptor/mentor/supervisor.

While many models focus on collaborative interactions with parents, following conversations with several children (aged 4–17 years) about communicating with healthcare professionals, Sydnor-Greenberg and Dokken (2001) proposed the CLEAR model of communication, which illustrates what children would prefer in their interactions with health professionals (Table 1.5).

Activity

Consider the first concept of Sydnor-Greenberg and Dokken’s CLEAR model – Context. How might you develop your ability to engage with a child about their life? What would you discuss socially with the child?

To help answer these questions, use various resources (e.g. TV guides, bookstores, toy stores, websites, etc.) to identify what is current in the child’s world (e.g. toys, characters, TV programmes, children’s books, technologies, games, sports). Don’t just identify what’s in vogue, experience it! Read a children’s book. Watch a children’s programme. Play a child’s electronic game. Follow up on this activity by having a conversation with a child.

- Was your search accurate?
- Did you find out what it was that attracted the child to his or her interests?
- Did knowing something about the child’s world help you in engaging socially with them?
Table 1.5 CLEAR model

- **Context** – regard the child as a whole person by asking questions about their life (i.e. school, friends, and activities) outside the illness they are experiencing
- **Listening** – listen to and include children
- **Empowerment** – communicate directly with children and provide them with information to prepare them for what is to happen, what you are going to do, and what they themselves will be able to do
- **Advice and Reassurance** – offer health promotion advice and reassure children about their health

*Source: Adapted from Sydnor-Greenberg and Dokken (2001)*

Investigating 6- to 16-year-olds’ experiences of communicating with health professionals in hospital, Lambert *et al.* (2011) devised the Child Transitional Communication (CTC) model, which is underpinned by two components: (1) a visible-ness construct and (2) five theoretical bodies of knowledge (Figure 1.1).

1. **Visible-ness** represents the extent of children’s inclusion or exclusion in the communication process, in addition to the degree to which children’s
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Communication needs are met (Lambert et al. 2008). Children can occupy one of two positions in the communication process:

- a background overshadowed position in which children are marginal to the communication process as passive bystanders; or
- a forefront position in which children are active participants in the communication process.

2. In an attempt to explain why children might occupy either a passive bystander or an active participant position in the communication process, Lambert et al. (2011) identified conflicting dichotomies within five theoretical bodies of knowledge:

- **Family centred care**: child as family member vs. child as unique entity.
- **Shifting power relations**: child as powerless vs. empowered child.
- **Universal progression versus guided participation**: child as immature, incompetent, and dependent vs. child as mature, competent, and independent.
- **Rights negotiation – protection versus participation**: child as having a right to protection vs. child as having a right to liberation.
- **Child as being and/or becoming**: child as becoming vs. child as being.

Reflection point

In considering the child as *becoming* vs. *being*, reflect on the following:

- What is your stance on children in society today?
- How do you think children are portrayed in society?
- What are your thoughts on communicating with children?
- Is there any overlap between how you think children are portrayed in society and your thoughts about communicating with children?

Uprichard (2008) questions the dichotomy of child as becoming vs. child as being and argues that the conflicting discourses of child as being vs. child as becoming should be considered together, each complementing the other. Uprichard (2008: 303) argues that ‘understanding the “child” as both “being and becoming” increases the agency that child has in the world’.

Read Uprichard’s paper and reflect on the following:

- How might you integrate the two perspectives of child as being and child as becoming when communicating with children and their families?
- How can understanding the child as both being and becoming increase the agency that children might have in the communication process?
- Why is it important to build and value children’s agency?
Lambert et al. (2011) argue that these conflicting dichotomies are reflective of an overarching tension between the two discourses protection and participation. For instance, viewing children as being and/or becoming reflects tensions between the need to protect and safeguard (i.e. becoming), while simultaneously respecting the child’s right to participate (i.e. being). This presents an extreme challenge because in developing partnerships with children and families, you must not only acknowledge the participatory rights of children but also work to protect children from distress/upset and recognize the responsibility and rights of parents as children’s principal guardians. This is important because children frequently move between being – or wanting to be – a passive bystander or an active participant in the communication process depending on the situation they find themselves in (Lambert et al. 2008).

Applied within the context of educational decision-making, Lundy’s (2007) model provides an effective way for conceptualizing Article 12 of the UNCRC by considering other relevant provisions [i.e. Article 2 (non-discrimination), Article 13 (right to information), Article 3 (best interests), Article 5 (right to guidance) and Article 19 (right to be safe)] alongside four key factors: space, voice, audience, and influence.

- **Space**: Children must be given the opportunity to express a view.
- **Voice**: Children must be facilitated to express their views.
- **Audience**: The view must be listened to.
- **Influence**: The view must be acted upon, as appropriate.

Gibson et al. (2010) presented a supplementary model to highlight the evolution of communication roles in children’s and young people’s cancer care.

- Young children (age 4–5 years) rely on parents to communicate with health professionals.
- Older children (age 6–12 years) wish to communicate directly with health professionals, yet parents often assume the lead role.
- Young people (age 13–19 years) take the lead role in communicating with health professionals over their parents.

Gibson et al. contended that children remain in the background until they become young people and begin to gain independence, responsibility, and autonomy. As young people mature, they want a more visible foreground role and take on many communicative roles themselves (Figure 1.2).

Gibson and colleagues’ (2010: 1405) age groupings are ‘not fixed as it is recognised not all children are the same. Progression may therefore occur earlier or later than the ages specified’. This is important because age does not always reflect the extent to which children want to be included in the communication process (Lambert et al. 2008). The optimal role for children to assume is transitory, contextual, and based on each child’s individual preferences and needs at any given time (Lambert et al. 2011). You will need to be flexible in your interactions with children and establish each child’s individual preferences by continually engaging in a reciprocal process of assessment and reassessment. This will assist with capturing
the extent the child wishes to be involved – or not – in the communication process and their ongoing needs. Assessment will assist with interpreting Article 12 in conjunction with Article 5 of the UNCRC – ensuring that children are provided with appropriate adult direction and guidance consistent with their evolving capacities (Lundy 2007).
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Activity

Think about how, what, and when you would assess children's communication needs and their individual preferences for involvement and information. What would you document about your assessment, where and how?

Did you consider verbal interactions and questioning, creative participatory methods, non-verbal cues, parent involvement, and/or how the child normally communicates?

Conclusion

Effective communication is crucial for the delivery of quality nursing care and the establishment of child–parent–health professional partnerships. This chapter has highlighted some of the core elements of communication and interpersonal skills, alongside key theoretical perspectives and models of communication, to consider when engaging with children and their families.

Key messages

- Children's right to consultation and participation needs to be recognized in conjunction with children's right to protection and parents' rights and responsibility as principal guardians.
- Attention must be given to children’s developmental, cognitive, and linguistic abilities and the various mediums of communication available to facilitate interaction according to each child’s preferred mode of communication.
- Individual children and family preferences need to be assessed continuously to identify changing communication needs at different points in time.

References

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