

Section on Personal Identity, Experience and Meaning in Health

Emotions, narratives and empathy in clinical communication

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Introduction

Patients sometimes report that doctors consider them a set of symptoms rather than a person. A recent article by a patient in a major Norwegian newspaper had the title 'I am not a knee cap'. The author had suffered a knee injury, but felt that he was treated by doctors merely as a knee cap rather than as a human being. This feeling is hardly unique. In a focus group study a few years ago patients with rheumatic diseases reported similar experiences and emphasized the importance of being seen as an individual rather than a disease entity [1]. Moreover, in an empirical test of the Four Habits communication skills training model Krupat et al. found that skills in taking the patient perspective were among those performed most poorly in a sample of primary care physicians [2].

An alternative approach to the focus on symptoms is to communicate with patients on a personal level, with an emphasis on eliciting the patient's perspective. In the current research on provider patient communication terms, such as person-centered, and more frequently patient centered [3, 4] and relationship centered [5] communication are key concepts. The person-centered approach represents a shift of focus from symptom to person, from disease to illness [6].

The narrative

In a person-centered doctor-patient relationship it is important to listen to the patient's story, the patient's narrative. The doctor should give the patient an opportunity to tell his/her story, to present a narrative rather than simply respond to closed ended questions.

A narrative approach represents a special attitude to clinical interview beyond simply inviting the patient tell his or her story. It implies a particular way of understanding the patient's story. Perhaps the most important contribution to an understanding of the narrative in medicine is given by Rita Charon in a number of important articles [7, 8]. She makes a distinction between what she calls logico-scientific knowledge and narrative knowledge. The logico-scientific knowledge is characterized by a detached observer, who generates or comprehends replicable and generalizable events, and attempts to illuminate the universally true by transcending the particular. In the construction of narrative knowledge on the other hand a participating observer attempts to understand local and particular single events, and attempts to illuminate the universally true by revealing the particular. Narrative knowledge is what one uses to understand the meaning and significance of stories through cognitive, symbolic, and affective means [7].

What is the impact of a narrative approach? For the patient, narratives may contribute to the healing process. This has most explicitly been studied in the expressive writing tradition by Pennebaker and collaborators. These researchers have for instance found effects of expressive writing in terms of a reduction of rumination and depressive symptoms [9] and positive effects on immune functions in HIV patients [10].

The patient narrative, in and of itself, although rich in information, does not necessarily clarify what are the most important concerns of the patient. The narrative approach requires actively listens for the—sometimes hidden—meaning and significance of the particulars in the patient story.

Cues and concerns

Patients often do not explicitly convey what is most important and most emotionally salient for them in the consultation with a health care provider. Emotional concerns are rather expressed in terms of verbal or non-verbal cues. Cues occur relatively seldom in medical consultations, and they are often missed by the doctor [11]. Recently, cues and concerns have been extensively studied by research groups in the Verona network for Sequence Analysis [12]. In their work a distinction is made between cues (hints to a hidden emotion) and concerns (explicit expression of worries and negative emotions; Zimmermann et al., under review).

A group of researchers in Rochester, NY, has conceptualized cues and concerns in a similar way in terms of empathic opportunities [13], as potential empathic opportunities (cues) and more explicit empathic opportunities (concerns). A presentation of their model is given in Figure 1. Our research group has applied the model in a study of consultations in oncology [14]. Our data confirm that important concerns are often communicated indirectly as subtle hints or cues. We also found that cues often are missed by physicians (unpublished data). A person-centered approach would be to show sensitivity to patient cues and facilitate expression of the underlying emotion.

Recent research in social neuroscience has indicated that putting feelings into words may actually have a positive effect on affect regulation. In a number of brain imaging experiments verbal labelling of emotion was associated with attenuation of amygdala activation typical of negative affects and was correlated with an increase in the activation of the right prefrontal cortex and the anterior cingulate cortex, indicating that higher centres in the frontal cortex overruled the more primitive affective ones [15, 16]. The findings could indicate that by letting the patient express cues and concerns the doctor helps the patient to regulation of emotional processing in the brain, by a down regulation of negative emotions and a corresponding relief of stress [17]. Thus, a person-centered approach may have positive effects for the patients also on a biological level.

Empathy and healing

A key phenomenon in the person-centered response to the narratives and the associated emotions patients is empathy. Empathy may occur both as a product of engaged listening to patient narratives and as responses to empathic opportunities when patients present cues to what is important and emotionally salient. Empathy may be

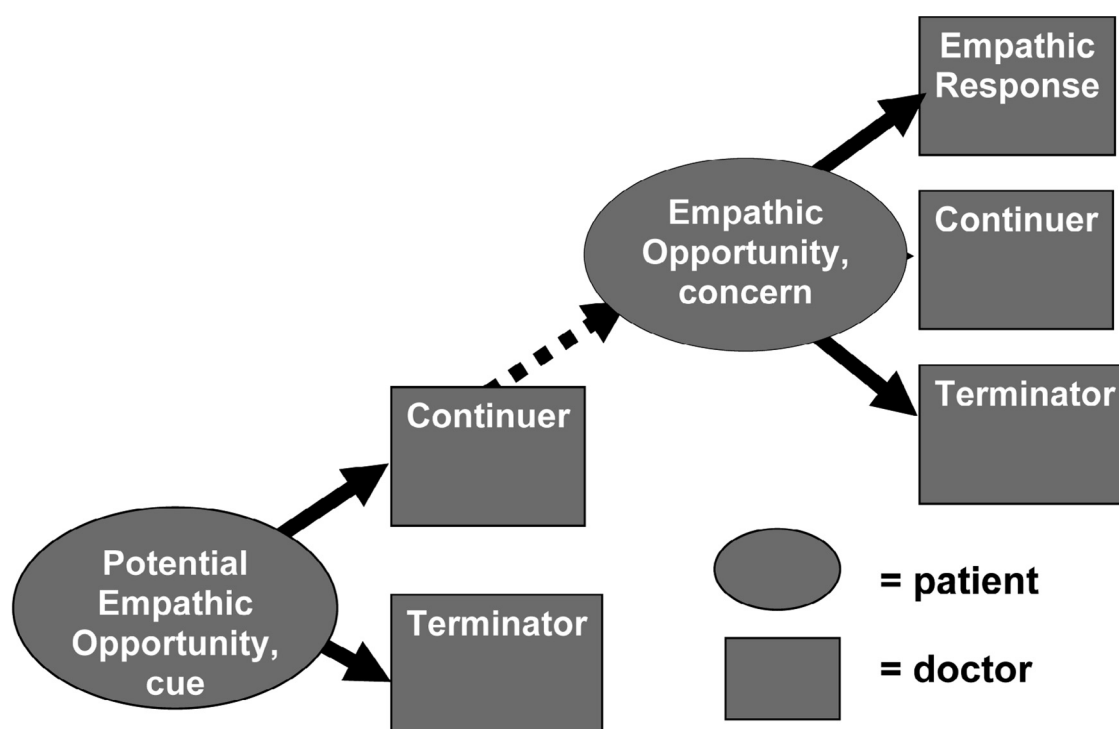


Figure 1. A model of empathic opportunities in the medical consultation. After Suchman et al., 1997 [13].

conceptualized in terms of three important elements: the ability to observe emotions in others, the ability to feel those emotions, and finally the ability to respond to those emotions. In a wider sense empathy may be used to denote abilities not limited to emotions, but also to understand other people's thoughts and intentions in general.

Empathy has recently been studied extensively in neurobiological research. Studies indicate that the brain activation patterns of the observer's perception of emotions in others (cognitive empathy) and the actual emotional experience of the observer (emotional empathy) may be differentiated. The ability to discern a specific emotion in another person is a special case of the 'theory of mind' phenomenon, the ability to attribute mental states to others. In a number of studies, the dorsomedial prefrontal cortex has been found to be crucial for the capability to infer the other person's cognition, both in terms of thoughts, intentions and emotion [18].

It has been suggested that the emotional aspect of empathy, or the contagion effect, when the observer shares the emotional experience of the observed person, is associated with activity in the mirror neuron system in the brain [19]. Mirror neurons were first described by Giacomo Rizzolatti and his group in Parma, Italy, and refer to neurons that fire when you observe an action, mirroring the neurons that are engaged in the same action in the person who acts [20]. It has been questioned whether mirror neurons are active in empathy, since a role for mirror neurons basically has been found in motor activities [16]. However, in contrast to most laboratory studies, empathy in medical consultations occurs in the context of social interaction with ample non-verbal mirroring. In the medical consultation empathy may be facilitated by mirror neuron activity associated with the face-to-face interpersonal exchange [17].

The potential effects of the health care provider's empathy in medical consultations as a factor in healing processes have been explored in a number of studies. For instance, Zachariae reported in a large study of oncology patients that higher scores of physician attentiveness and empathy were associated with greater patient satisfaction, increased self-efficacy, and reduced emotional distress following the consultation [21]. Our group found doctor empathy to be related to patient satisfaction in fibromyalgia patients, in particular among those with difficulties in expressing their own emotions [22]. Empathic behaviour has also been linked to increased adherence [23]. We may speculate that empathy may play a role in health promoting social processes, such as social support (See recent review by Adler [24]).

Concluding remarks

An important aspect of person-centered communication is the patient narrative, and a doctor attitude of active listening to the meaning and significance of the narrative, including sensitivity to patient cues and concerns. Both in the listening to the narrative and the exploration of cues and concerns the doctor may experience and display empathy, which is anchored in basic neurobiological mechanisms and may play a role in healing processes for the patient. These phenomena should be further explored in future research on the doctor-patient relationship.

References

1. Haugli L, Strand E, Finset A. How do patients with rheumatic disease experience their relationship with their doctors? A qualitative study of experiences of stress and support in the doctor-patient relationship. *Patient Education and Counseling* 2004 Feb;52(2):169–74.
2. Krupat E, Frankel R, Stein T, Irish J. The Four Habits Coding Scheme: validation of an instrument to assess clinicians' communication behaviour. *Patient Education and Counseling* 2006 Jul;62(1):38–45.
3. Mead N, Bower P. Patient-centered consultations and outcomes in primary care: a review of the literature. *Patient Education and Counseling* 2002 Sep;48(1):51–61.
4. De Haes H. Dilemmas in patient centeredness and shared decision making: a case for vulnerability. *Patient Education and Counseling* 2006 Sep;62(3):291–8.
5. Beach MC, Inui T. Relationship-centered care. A constructive reframing. *Journal of General Internal Medicine* 2006 Jan; 21(Suppl 1):S3–8.
6. Mezzich JE. Psychiatry for the person: articulating medicine's science and humanism. *World Psychiatry* 2007 Jun; 6(2):65–7.
7. Charon R. The patient-physician relationship. *Narrative medicine: a model for empathy, reflection, profession, and trust.* *JAMA* 2001 Oct 17;286(15):1897–902.
8. Charon R. *Narrative and medicine.* *New England Journal of Medicine* 2004 Feb 26;350(9):862–4.
9. Gortner EM, Rude SS, Pennebaker JW. Benefits of expressive writing in lowering rumination and depressive symptoms. *Behavioral Therapy* 2006 Sep;37(3):292–303.

10. Petrie KJ, Fontanilla I, Thomas MG, Booth RJ, Pennebaker JW. Effect of written emotional expression on immune function in patients with human immunodeficiency virus infection: a randomized trial. *Psychosomatic Medicine* 2004 Mar–Apr;66(2):272–5.
11. Zimmermann C, Del Piccolo L, Finset A. Cues and concerns by patients in medical consultations: a literature review. *Psychological Bulletin* 2007 May;133(3):438–63. Review.
12. Del Piccolo L, Goss C, Zimmermann C. The third meeting of the Verona Network on Sequence Analysis: Finding common grounds in defining patient cues and concerns and the appropriateness of provider responses. *Patient Education and Counseling* 2005 May;57(2):241–4.
13. Suchman AL, Markakis K, Beckman HB, Frankel RA. A model of empathic communication in the medical interview. *JAMA* 1997 Feb 26;277(8):678–82.
14. Eide H, Frankel R, Haaversen AC, Vaupel KA, Graugaard PK, Finset A. Listening for feelings: identifying and coding empathic and potential empathic opportunities in medical dialogues. *Patient Education and Counseling* 2004 Sep;54(3):291–7.
15. Hariri AR, Bookheimer SY, Mazziotta JC. Modulating emotional responses: effects of a neocortical network on the limbic system. *Neuroreport* 2000 Jan 17;11(1):43–8.
16. Lieberman MD. Social cognitive neuroscience: a review of core processes. *Annual Review of Psychology* 2007;58:259–89.
17. Finset A, Mjaaland T. The medical consultation viewed as a value chain: a neurobehavioral approach. *Patient Education and Counseling* 2009 Mar;74(3):323–30.
18. Schulte-Ruther M, Markowitsch HJ, Fink GR, Piefke M. Mirror neuron and theory of mind mechanisms involved in face-to-face interactions: a functional magnetic resonance imaging approach to empathy. *Journal of Cognitive Neuroscience* 2007 Aug;19(8):1354–72.
19. Decety J, Jackson PL. The functional architecture of human empathy. *Behavioral and Cognitive Neurosciences Review* 2004 Jun;3(2):71–100. Review.
20. Iacoboni M, Molnar-Szakacs I, Gallese V, Buccino G, Mazziotta JC, Rizzolatti G. Grasping the intentions of others with one's own mirror neuron system. *PLoS Biology* 2005 Mar;3(3):e79.
21. Zachariae R, Pedersen CG, Jensen AB, Ehrnrooth E, Rossen PB, von der MH. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. *British Journal of Cancer* 2003 Mar 10;88(5):658–65.
22. Graugaard PK, Holgersen K, Finset A. Communicating with alexithymic and non-alexithymic patients: an experimental study of the effect of psychosocial communication and empathy on patient satisfaction. *Psychotherapy and Psychosomatics* 2004 Mar–Apr;73(2):92–100.
23. Kim SS, Koplowitz S, Johnston MV. The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions* 2004 Sep;27(3):237–51.
24. Adler HM. Toward a biopsychosocial understanding of the patient-physician relationship: an emerging dialogue. *Journal of General Internal Medicine* 2007 Feb;22(2):280–5.