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COMMUNICATION AND EMPATHY WITHIN PERSON-CENTERED MEDICINE: A DEVELOPMENTAL POINT OF VIEW

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ABSTRACT

Communication between patients and health care providers (HCP) is at the heart of medicine and even more within its person-centered paradigm. Within a person-centered medicine (PCM) perspective, it is thus crucial, for both the HCP and the patient, to build on a relationship with the objective to establish a therapeutic alliance and share decision making related to the patient's health issues and to integrate the subjective aspects (and not only the objective aspects) of these health issues.

After showing that the effects of communication go beyond mere cognitive and affective sharing, particularly in highly emotional relations, this paper's objective is to understand more thoroughly what is transmitted in the patients/ HCP relation and how some of the child and adolescent developmental psychiatry processes (i.e., early mother–baby interactions and transgenerational transmission of attachment) provide good models to understand this transmission.

Building on these models, the paper will discuss how and at which conditions, the HCP's narrative empathy plays a major role to access to the patient's subjectivity through the HCP's subjective experience.

It concludes that, therefore, subjectivity of the HCPs should not be seen as a negative side effect of the patient–HCP (or the patient–team) relation but as a crucial clinical tool in person-centered diagnostics and cares if HCPs are properly trained and educated to use their feelings and representations as tools in individual or collective deliberations. But one has to be aware that there is no empathy without subjectivity.

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BACKGROUND

According to McCormack et al. [1], person-centeredness is “an approach to clinical practice that is established through the formation and fostering of therapeutic relationships underpinned by values of respect for persons and the individual right to self-determination, mutual respect and understanding.” Recently, the term “therapeutic relationships” has been changed to “healthful relationships” [2], which are relationships that contribute to the promotion of health.

Communication between patients and health care providers (HCPs) is at the heart of medicine and even more so within this adapted person-centered paradigm. In person-centered medicine, the person of the patient comes first. This means that when someone seeks health care, his or her needs, preferences, beliefs, and values should also be considered when discussing complaints and considering a treatment. Person-centered communication allows the patient to express experiences, thoughts, and ideas, and makes it possible for the HCP to adapt the communication to the patient’s emotional and informational needs [3].

Following person-centered principles, equal attention is given to the frequency and severity of physical symptoms as to persons’ (and their carers’) experiences and concerns evoked by these symptoms. Apart from that, positive health-related aspects, reflected for instance in a person’s resilience, extended social network, positive mood, and healthy lifestyle, are taken in consideration as well.

When HCPs and patients meet, all these aspects need to be discussed as part of a “healthful relationship.” Obviously, this places high demands on the communication skills and attitudes of the HCP. Being trained to solve medical problems HCP can experience feelings of uncertainty and of loss of control when they shift to a more egalitarian HCP-patient interaction in which treatment decision making and adherence depend much more on reaching consensus than on simply providing unidirectional advice. Yet, in person-centered medicine, the person of the HCP counts as much as that of the patient.

Daily confrontations with pain and suffering can make HCPs vulnerable, stressed, and sometimes even indifferent. Although such mechanisms are understandable and sometimes even self-protecting, they also appear to be associated with a higher risk of burn-out, job satisfaction, and suboptimal care [4]. Remarkably,

the answer to the question on how to avoid these negative effects lies in the problem itself. Although it may be hard and counterproductive for HCPs to show compassion with patients in their everyday work, it can also protect them from becoming too stressed and indifferent. Research shows that being compassionate and involved in meaningful relationships with patients may even contribute to the well-being of a HCP [5]. Being compassionate and involved is not the only way to go. Self-compassion, and self-understanding also seems to be associated with HCPs experiencing more positive work engagement, feeling less emotionally, physically, and cognitively exhausted due to work demands, and being more satisfied with work [6]. This indicates the importance of not only taking care of one's patients and of maintaining a good HCP–patient relationship but also of taking good care of oneself as HCP. This underlines the importance of looking after both persons involved in a health care relation: the person of the patient and the person of the HCP.

Within a person-centered medicine (PCM) perspective, it is thus crucial for both the HCP and the patient to build on a relationship with the objective (1) to establish a therapeutic alliance and share decision making related to the patient's health issues and (2) to integrate the subjective aspects (and not only the objective aspects) of these health issues.

This paper will discuss how and at which conditions, communication and empathy play a crucial role to reach this objective.

COMMUNICATION

In a narrow sense, communication has been defined as the transmission of cognitive information through language (mainly verbal). More broadly defined, it also includes [7]:

- Digital and analogic (verbal and nonverbal) transmission
- Emotional and cognitive dimensions
- Contextualized and interactive relations

There is ample evidence for the importance of this broad definition in clinical situations, e.g., the length of time a patient is listened to before being interrupted by the professional, changes drastically the patient's experience of the medical interview (i.e., his feeling of being understood by the professional increases when the longer he is allowed to talk) [8–10].

Additionally, many researchers consider that the effects of communication go beyond mere cognitive and affective sharing, particularly in highly emotional relations, that is to say in relations involving the intense feeling of understanding and sharing with the other [7].

Patient–professional (or carers) relations are frequently highly emotional, allowing them to include a holistic appraisal of the person of the patient through the creation of a more or less temporary common space. In this common space the border between the patient and the professional (or carers) is temporarily porous and confused. However, they are not eradicated, i.e., they do not lose sight of the otherness of the other (its "alterity"). Yet, communication does not take place in a vacuum but is part of a context [11].

MODELS OF TRANSMISSION

To understand more thoroughly what is – besides the communication of cognitive and affective information – transmitted, other less well-known theoretical models can be helpful. Child and adolescent developmental psychiatry provides such models among which two are particularly relevant:

- The model of early mother–baby interactions in the subjectivation process
- The model of the transgenerational transmission of attachment

1. The model of early mother–baby interactions in the subjectivation process

This model aims to explain how babies evolve from a fusional state to individuation and subjectivation, and how this process develops in the "mother"–baby interactions at an early stage of the baby's life (fig.1) [12]. It also helps to explain how, in this process, babies acquire very complex and sophisticated social abilities on the basis of rather simple and limited innate abilities. It is an example of the type of process Berthoz named "Simplexity" [13].

Three dimensions are involved in these interactions (12): (1) behavioral: the body, the voice, the gaze; (2) affective: progressive affective attunement; and (3) imaginary (fig. 2).

The interactions pertaining to the imaginary dimensions are not objective but, nevertheless, conceptually necessary to describe what is happening in the mother–baby or the parent–baby dyad: an interaction of conscious and unconscious representations. The interactions pertaining to these dimensions give also access to transgenerational and cultural influences through the parents, whatever are the biological mechanisms supporting this transmission.

The addition of this third dimension introduces a crucial conceptual complexification of the subjectivation process and can explain how a rather simple process (as everyday behavioral and affective interactions) can lead to the transmission of very sophisticated and complex dimensions and values, on the ground of baby's innate intersubjective capacities [14].

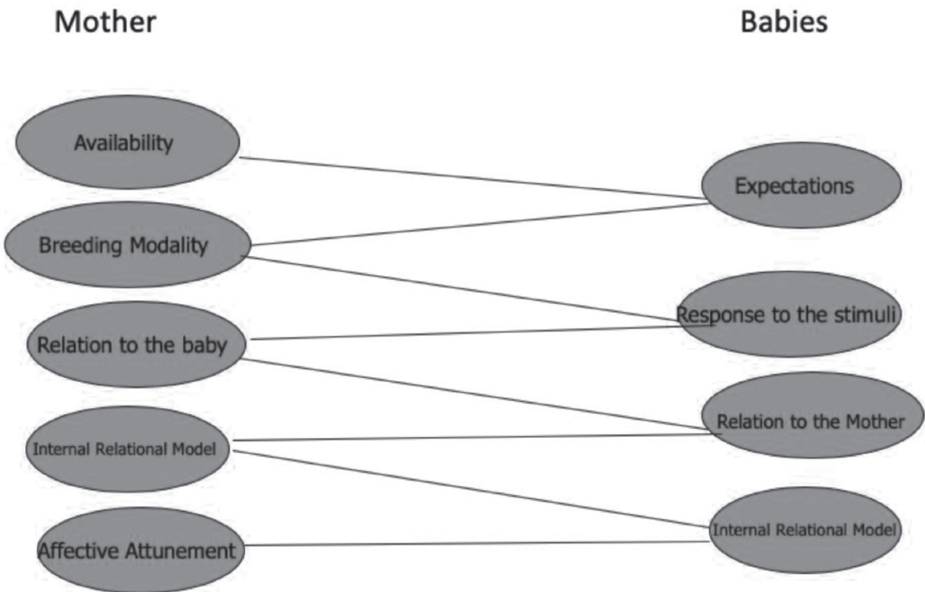

Figure 1. Early interactions: the Bobigny Model (Lebovici)

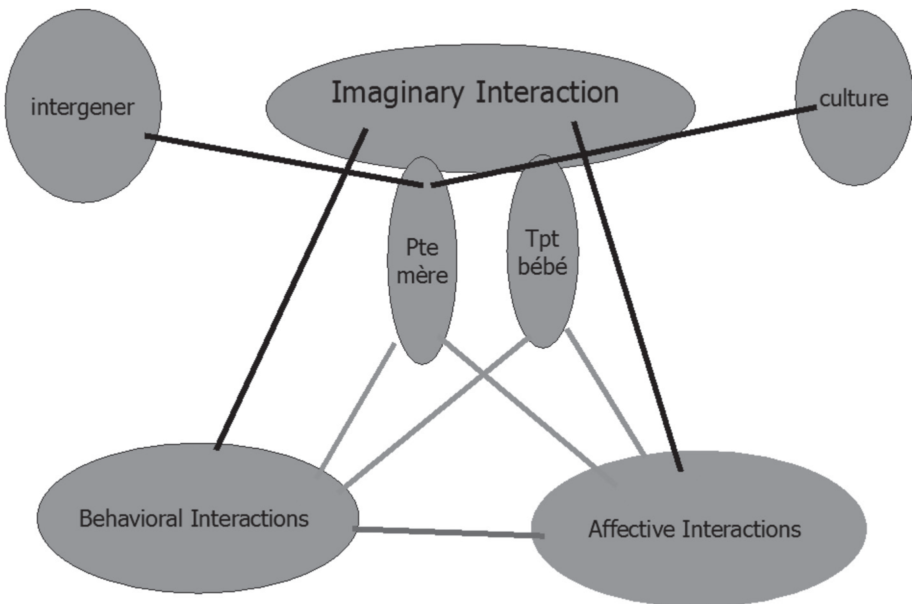

Figure 2. The three dimensions involved in early interactions

With the addition of the imaginary dimensions to the behavioral and affective interactions, communication undergoes a qualitative conceptual leap making it complex enough to transmit sophisticated subjective dimensions and values, through basic interactions.

2. The model of the transgenerational transmission of attachment

Attachment is a psychological notion aiming to describe the dynamic of interpersonal relationship on the basis of a behavioral and mental system directing the infant to seek proximity with the main attachment figure, generally one of the parents, whenever in a separation or alarming situation. Bowlby who was a well-known British psychoanalyst built a developmental theory on this notion [15], extending to the human infant what has been observed by ethologist in primates: a primary attachment system developing in the first year of the infant life on the basis of common innate needs expressed and taking various forms according to the style of attachment; this style results from the autoregulation provided by a set of mental representation Bowlby calls Internal Working Models.

Protocols and instruments were created by Bowlby's followers to evaluate these styles (i.e., The Strange Situation Protocol – SSP – in infants, and the Adult Attachment Interview – AAI – in Adults). These standardized instruments defined four dimensions of attachment [16]:

- Secure (AAI and SSP)
- Detached (AAI) or Avoidant (SSP)
- Preoccupied (AAI) or Ambivalent (SSP)
- Disorganized (AAI and SSP)

Additionally, further studies showed a strong correlation between the pattern of attachment of the mother (evaluated by the AAI) and the pattern of attachment of her infant (evaluated by the SSP). The finding that this strong correlation was not related to genetic transmission nor to the mere sensitivity of the attachment figures generated numerous theories and studies around what was then known as the "transmission gap." This soon became one of the main paradigms for examining the nongenetic transgenerational transmission in parents–infant's early relations [16].

Tackling this important issue, several studies brought converging clues on the role of microbehaviors in the transgenerational transmission [17]: while engaged in the highly emotional relation an infant has with his mother, he is sensitive to the microbehavior he observes on his mother's' face; to the point that he simulates them (using probably his mirror neurons system) [18]. This simulation acts as a

template on which he will build up his capacity to recognize emotions and their meaning, constructing his Internal Working Model on his “lived experience of invariably repeated schemes of interactions with the attachment object” [19]. In this perspective, the infant behavioral pattern of attachment would be the basis on which the Internal Working Model is built rather than the contrary. This model generates clear hypotheses to examine and embody, at a fine-grained level, the mechanisms of the transmission of attachment. Mutatis mutandis, it can also be a good candidate to shed light on the mechanisms involved in the interaction between two persons engaged in a highly emotional relation, reminding us of the frequently quoted statement by Shore [20]: “The child’s first relationship, the one with the mother, acts as a template that permanently molds the individual’s capacity to enter into all later emotional relationships. Small children look to a parent’s facial expressions and other nonverbal signals to determine how to respond and feel in a strange or ambiguous situation; it is the basis of empathy,” in other words, a basis for social neuroscience.

PRACTICAL APPLICATION FOR PERSON-CENTERED MEDICINE

As mentioned above, integrating personal subjectivity is a categorical objective of person-centered medicine (PCM). In this perspective, subjectivity is indeed a crucial part of the patient’s assessment and of the HCP’s engagement in his cares. However, subjectivity is not easy to measure or assess objectively and is therefore frequently neglected or even rejected by evidence-based medicine. It is one of the reasons why EBM tends to favor a disorder-centered perspective on health care.

One of the main endeavors of PCM is to address this issue, trying to find a “scientific” or at least “a nonmetaphysic” way to assess this hidden dimension in the patient, his carers, and the HCP. A starting point here is to describe as precisely as possible, how we do it naturally in settings in which – like in clinical situations – highly emotional relationships develop with highly complex ambivalent and regressive components of dependency (fig.3) [21].

FIRST STEP: EMOTIONAL EMPATHY

Defined as the feelings induced by the contact with the patient through verbal and behavioral interactions, it is favored by “the affective permeability” induced by the process of constructing a common space in highly emotional contexts. We see it as the first methodological step to go behind the screen of the visible and a holistic way to approach subjectivity of the other as a holistic dimension.

SECOND STEP: METAPHORIZATION AND NARRATIVES

When the emotions behind the feelings are not actively rejected, the HCP captures these in narratives through his capacity to metaphorize these emotions and affects (put them into a story). These stories are of crucial importance because they are the best way for the HCP to access, acknowledge, and give meaning to his empathic subjective feelings. These narratives integrate (but are not reduced to) the patient's narratives to which the professional has to be attentive enough to include them among the data he "naturally" considers in the construction of his narrative.

This second step can then be defined as the transformation of Emotional Mirror Empathy into a Narrative (or Metaphorizing) Empathy [12]; it uses the professionals' representations and affects to approach and understand the patient subjectivity and integrate it in the assessment of his health status and shared decision making concerning his treatment.

THIRD STEP: WORKING THROUGH

To develop his narratives, the professional uses his idiosyncratic sensitivity to recognize and highlight specific aspects of the patient's subjective life. It is acceptable as long as the professional keeps in mind that this story is a construction, which he has to control and work through in his internal deliberation. The same is true, also, in an institutional setting where each team member uses his idiosyncratic

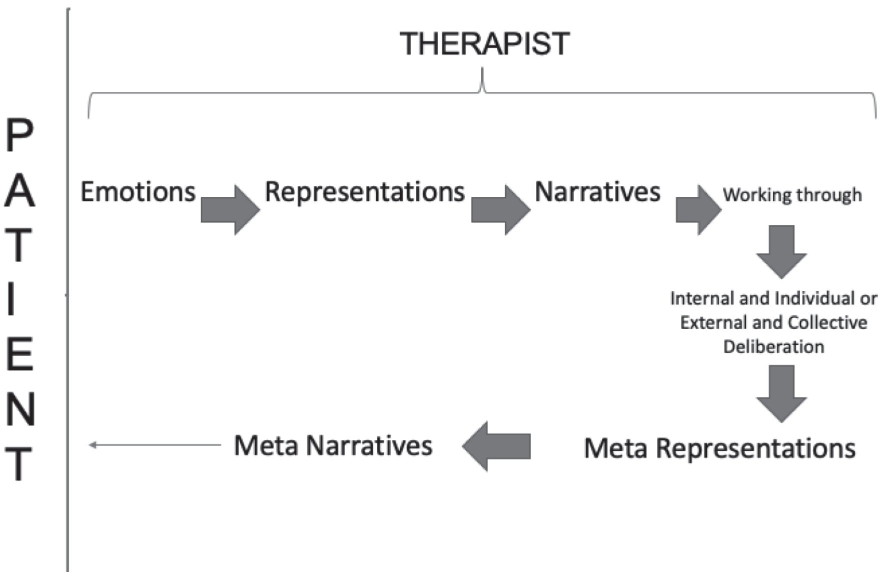

Figure 3. Narrative empathy process

sensitivity to enrich specific aspects of the patient's subjective life, leading to a collective deliberation through the team work. In both situations, the final product of this individual or collective deliberations is the development of a meta-narrative integrating more or less of each of the contribution to the development of the current state of the narrative on and with the patient.

It is the closest we can get to the double constraints we have to face to integrate subjectivity in a PCM perspective:

- Reduction of the ill-effect of eradicating the patient's subjective idiosyncratic feelings, particularly those remaining unexpressed or unconscious;
- Reduction of the ill-effect of idiosyncratic sensitivity of the professionals when they are abusively considered as a final truth.

CONCLUSIONS

Subjectivity of the HCPs is not only a negative side effect of the patient–HCP (or the patient–team) relation; it is also a crucial clinical tool in person-centered diagnostics and cares and should therefore be analyzed and controlled, with HCPs properly trained to use their feelings and representations as tools in individual or collective deliberations. Empathy is a crucial tool here: but we have to be aware that there is no empathy without subjectivity; in PCM, subjectivity of the HCP is crucial too. This has crucial consequences for clinical practices and organizations, particularly regarding medical and HCPs' education and training; instead of the tendency of current classical curricula to ignore the subjective dimensions in medicine at large – leaving the HCPs and carers alone to deal with it, in themselves and in the person they are attending –, medical education should recognize the importance of subjectivity in a person-centered perspective, and integrate a training to use and regulate properly the subjectivity of the HCPs.

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