Editorial

Why should patients and clinicians talk about emotion?

In this issue of Patient Education and Counseling we publish a paper by researchers from San Francisco and Pittsburgh, with the title “Why should I talk about emotion? Communication patterns associated with physician discussions of patient expressions of negative emotion in hospital admission encounters” [1]. The paper reports data from a mixed methods study of patients’ expressions of negative emotions and physicians’ responses in 79 audio-recorded admission encounters to two hospitals in the United States. Over the last couple of years a number of papers have been published in Patient Education and Counseling on how emotions are expressed and how clinicians respond to emotions in medical consultations [2–7].

Adams and her co-authors coded all direct and indirect expressions of emotions, based on previously developed coding procedures [8–11]. The distinction between direct and indirect expression of emotions is important and well known form of other studies [2,8]. For instance, Suchman et al. make a distinction between empathic opportunities (direct expressions of emotions) and potential empathic opportunities (indirect expressions of emotions) [8]. The Verona Coding Definitions of Emotional Sequences (VR-CoDES) apply a similar distinction between concerns (explicit expressions of emotion) and cues to negative emotions [2]. In the paper by Adams et al. in the present issue of PEC a direct emotion is characterized by being named, similar to definitions in other systems, whereas an indirect emotion is an emotional state referred to, but not named. There are differences between the systems in how indirect emotions are defined. For instance, in the VR-CoDES system an expression of uncertainty or hope is by definition a cue. It is not clear that whether or not the coding criteria of Adams et al. apply criteria that broad. It is therefore difficult to compare directly the number of indirect emotions from study to study.

The coding of the responses of physicians is similar to that of Suchman et al. [8]. Three different codes are given: (1) responses focusing away from the emotion (“terminators” in Suchman et al.’s terminology) (2) neutral responses (“continuences”) and toward responses (labeled “empathic responses” by Suchman et al.). The largest category of responses in Adams et al’s paper is neutral responses (43%). The VR-CoDES system on the other hand distinguishes first, between explicit and non-explicit responses and second, between responses providing or reducing room for further disclosure [3].

An interesting feature in Adams et al.’ study is the presentation of qualitative examples of dialogue [1]. Each of the three main response types is illustrated with typical sequences. A particularly interesting pattern of responses is a “toward response” followed by a response which focuses the discussion away from the emotion. In the example given in the paper the patient’s concern is about a very negative experience with ambulance personel. In this case the physician acknowledges the emotion, but moves quickly to a discussion about symptoms. On the other hand, when a patient expresses a negative emotion related to a symptom, the physician should actually respond to both. Sometimes – probably most often if at all – the response to emotions comes first, followed by a discussion of the symptom. Another approach would be to come back to the emotions after first having addressed the patient’s concern about the symptoms (“From what you say I understand that you worry about these symptoms”). It would be interesting to explore more systematically the different patterns: toward followed by away and away followed by toward. A conversation analysis approach might be an appropriate method to analyze such potential patterns in further studies [12].

Moreover, Adams et al. attempt to analyze qualitatively how physician responses to emotions have impact on further communication in the encounter [1]. They found that focusing the discussion away from emotion tended to have a negative effect on the physician – patient relationship and even contribute to create an antagonistic relationship between patient and physician. The “toward responses”, responses focusing the discussion toward emotion, were, unsurprisingly, associated with provision of emotional support in further communication in the encounter. But the authors also found that toward responses in some cases were followed by increased patient agreement to treatment plans. Physician–patient agreement, or establishing common ground between clinician and patient and integrating their respective agendas and perspectives, is one of the key elements in a patient centered approach [13]. There is evidence in the literature that providing patient agreement may be associated with positive effects on a number of outcomes, such as satisfaction, adherence [14] and symptom resolution [15]. The combination of quantitative and qualitative methods applied by Adams et al. appears to be a very fruitful approach to the study of emotional communication. In particular, the findings indicating that responses which follow up on the emotional cues and concerns may exert a specific impact on subsequent communication patterns in the consultation beyond the immediate emotional support, are quite interesting.

So, why should patients and clinicians talk about emotion? An obvious reason for being attentive to emotions is the patient’s need for emotional and social support. There is also evidence that opening up for patient emotions and providing empathic responses may be associated with positive patient outcome in
terms of reduced distress [16,17], patient adherence [18,19] and symptom resolution [20,21]. But the approach by Adams et al. to explore the effects of responses to patient emotion on subsequent communication patterns in the consultation may be a potential avenue for research on the effect of communication on health outcome. Following Street et al.'s model of proximal and intermediate outcomes [22], the findings of Adams et al should guide further research in investigating the potential effect on health outcome of responses to patient emotions in medical interviews.

References


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