UNIT NO. 2

THE EXTENDED EXAMINATION

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ABSTRACT

The mind may be examined by using reflective communications which is also known as active listening. We pay attention to the modes, phases, and channels of communication; the purposeful use of unusual grammar forms; and we also create discrepancies to destabilise the patient's mind to get past his conscious mind and seek a deeper unguarded response from him. In extended reflections, we validate, track, and pace the patient's thoughts, emotions, and behaviour. We express affirmation, empathy and sympathy, and connection with the patient by the use of mirroring, modeling, and metaphors. Reflective communications, skillfully used, help the doctor to examine and understand the patient's mind, and it also helps the patient to gain insight to his problem.

Keywords: Active Listening; Paralanguage; Body Language; Phases of Communication; Channels of Communication; Unusual Grammar Forms; Reflective Communications.

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INTRODUCTION

The tool used for extended examination is **reflective communications**, also known as **active listening**. It describes the face-to-face interactive processes between doctor and patient involving strategic communication and responding to verbal and non-verbal cues.

Think of our usual clinical methods of physical examination. Certain manoeuvres are used to yield certain signs. An example is turning the patient to his right to tip the spleen. With extended examination, certain phrases said in a certain manner are helpful to yield more information. An example is when the doctor stops typing, sits back, makes eye contact, and says, "Tell me more".

EXTENDED COMMUNICATIONS

Communications with a patient in a consultation can be extended by:

1. Attention to the **multiple modes** of communication — paralanguage or body language, the **multiple phases** and the **multiple channels** of communication;

2. Intentional use of **unusual grammar forms**, such as pre-suppositions, tagged questions, and deletion or substitution of subjects and objects in a statement; and

3. Use of **discrepancies** in communication to "destabilise" the mind.

These tools help us elicit information, or reflection, from the patient's hidden and unknown Johari windows so that the therapeutic open window can be enlarged. See Unit 1 for a depiction of the Johari windows.

At times, these tools help to communicate directly with the patient's intuitive mind, bypassing the patient's cognitive surveillance. We usually screen the communications that we receive, to ensure our response is "socially correct". This cognitive screening can be bypassed if the communicator knows how to do it.

1. Multiple Ways of Communication

1.1 Modes of Communication

In spoken paralanguage, we focus on the use of silence, tone and emphasis in the way we speak. Sometimes, having a pause in between sentences, or maintaining silence after the patient has finished, may encourage him to continue talking. The emphasis and tone of our voice can be used for more effective communication.

It is often said that up to 70 percent of information between people is transmitted through body language; verbal communication only accounts for 30 percent. Using the same family of gestures employed by the patient will help to create rapport.

1.2 Phases of Communication

During the consultation, we may not want to reveal all the information to the patient at one point. Sometimes we may want to introduce a topic of interest and then go on to an unrelated topic before we develop the theme again later.

One example of phased communications is **sandwiching**. The main ingredient, the message, is served between two slices. The top slice is the preparation, where the doctor asks for permission to convey the message. The bottom slice is the follow-through phase, where the doctor invites feedback from the patient regarding his understanding of the message, his feelings in response, and behaviour which he may want to change because of the message.

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1.3 Channels of Communication[1]

In a consultation, the typical engagement is between the doctor's rational mode and the patient's rational mode.

Sometimes we need to engage the patient's intuitive, emotional system. For example, the patient's headache is mild but he is troubled by his upcoming prostate biopsy results. Without exploring beyond the surface, a prescription for paracetamol will not address his headache very much.

Because we have an emotional mode, certain phrases or topics can trigger a disproportionate emotional response. We have all had the unpleasant experience of pushing someone's wrong button.

2. Unusual Grammar Forms[2]

2.1 Adding Presuppositions

When our sentence begins with **adjectives** such as *happily*, *fortunately*, or *usefully*, everything after that may be presupposed by the patient. For example, "Fortunately we diagnosed the infection early, otherwise you would have been hospitalised." This statement evokes the conviction that hospitalisation would certainly have taken place, if not for the timely diagnosis.

Awareness verbs such as *know*, *realise*, *notice*, *show*, or *reveal* presuppose that what is said is true. For example, we might say, "Research shows that good sugar control will prevent you from developing complications from your diabetes." In the expert role, doctors often use these.

When we further add **adverbs** such as *deeply*, *surprisingly*, *readily*, or *easily* to the verbs, we reinforce the presupposition by focusing the patient on the nature of experience, and suggest that what follows did happen or must be true. We might say to an otherwise fit 75-year-old man with a fractured femoral neck, "The evidence clearly supports operative management and early rehabilitation for you."

2.2 Tagged Questions

A tagged question is constructed as a statement ending with certain phrases, such as "don't you think", "won't you", "aren't you", "did I", "is it right", and "am I right". For example, the expression "You are getting better" is a statement. "Are you getting better?" is the usual question. A tagged question, "You are getting better, am I right?" communicates a deeper meaning.

The first two constructions are processed by the rational mind. With the tagged question, the patient is asked to agree or disagree with the doctor's opinion. Depending on the doctor's role, whether comforting or challenging, detached or engaged, expert or collaborative, there are nuances to how the patient may answer the question. The information evoked can be used by the doctor to better understand the patient.

2.3 Deletions & Substitutions

We can delete subjects or objects in a sentence and then actively listen to the response and context of further communication. This is an indirect way to elicit information from patient's hidden or unknown Johari windows. For example, for the sentence "It must be difficult for you", we have substituted the subject with "it". If the patient is thinking of or feeling distressed by the subject, he may continue the conversation, soon revealing the nature of "it".

3. Creating Discrepancies to Destabilise the Mind

We can say, "You seem to be very willing to be healthy, but you're still smoking. What do you think?" This question to the patient is meant to confuse the patient a little, to break through his conscious mind, and seek a deeper response from him.

EXTENDED REFLECTIONS[3]

Observing the responses to extended communication can provide insights to the patient's mind. Here are some more useful tools.

1. Validation, Tracking, & Pacing

Reflection can convey that we understand the emotional message our patient is sending us. This is also called **validation**, and we do this by our body language or by the spoken word.

When **tracking**, we listen carefully to the patient's story to identify events and their sequences. This helps us to understand the interactive patterns surrounding an issue and gives us an idea of where to target intervention.

How quickly our patient tells us his story can be influenced by whether we explore his story further or whether we ask questions that focus him on something else. The way we **pace** him affects how much information we gather.

2. Affirmation, Empathy & Sympathy

We can affirm our patients directly, indirectly, or by seeding self-**affirmation**, by inviting the patient's perspective on how a positive unique outcome happened.

Reflection of emotions is called **empathy**. Empathy can be expressed in words or with gestures. A simple contextual statement, for example, "That must have been difficult", at a correct moment in time, can be cathartic. At other times, we mirror our patient's feelings by our body language during the flow of the consultation. Keeping an attentive silence is strategic when our patient is emotionally absorbed.

Sympathy for people is not the same as empathy. Feeling sympathy means you feel sorry for someone's situation as a fellow human being even though you may not have experienced his situation. For example, a man can sympathise but cannot say he empathises with the pain of childbirth.

3. Mirroring, Modeling, & Metaphors

Mirroring provides a reflection to the patient so that he can see himself in your communication, demeanour and behaviour. You may express grief to a patient when you speak slowly, quietly, and sombrely to a him. You can also lead the patient to mirror you by pacing him. In the right context, you can talk cheerfully and in an uplifting way if you want to transmit positive emotions.

Modelling the patient's preferred language also gains rapport. People use their preferred internal visual, auditory, or kinaesthetic sensory representation of the world to express their feelings and thoughts. If the patient says, "I see no future", "The impact was deafening", or "I had to carry the burden", you can reflect on his statement using the corresponding sensory mode, e.g., "On the contrary, I see your strengths in handling the problem" or "Yes, I hear that", or "Yes, I must add that you carry the burden with great fortitude".

Metaphors or figurative language, refer to the things that we compare our reality to. We also need to listen carefully to the patient's preferred metaphors.[4]

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LEARNING POINTS

- **The mind may be examined by using reflective communications.**
- **Extended communications entail paying attention to the modes, phases, and channels of communication, the purposeful use of unusual grammar forms, and creating discrepancies to destabilise the mind.**
- **Extended reflections involve validating, tracking, and pacing the patient's thoughts, emotions and behaviour, appropriate and timely expression of affirmation, empathy and sympathy, and connecting with the patient by mirroring, modelling, and metaphors.**
- **Reflective communications, whilst helping the doctor to examine and understand the patient's mind, also helps the patient to gain insight and can be used with the 4P's of problem, pattern, presence, and positive work.**