

ACTIVE LISTENING SKILLS

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CONCEPTUAL FRAMEWORK

From a biopsychosocial context, why do patients consult a doctor? Patients consult for two reasons: they have physical symptoms—the biomedical reason—and they are anxious about the physical symptoms—the psychosocial reason. However, between the physical symptoms and the anxiety, it is usually the anxiety that motivates them to consult. Proof of this is the common phenomenon of patients who have serious illnesses and feel physical symptoms but do not consult because they do not realize how serious their illness is. So if the patient does consult, the doctor can be fairly certain that the patient (or someone in the patient’s family) is anxious about the symptoms. Therefore, if the doctor concentrates only on treating the physical symptoms but does not address the anxiety, the patient will come away from the consultation feeling that he was not really treated—even if the treatment given by the doctor was scientific, rational, and evidence-based.

This is the rationale for having Level 3 individual interventions—providing not just health education but psychosocial support as well—which is another way of saying that a patient should be treated with compassion and should be dealt with as persons rather than as diseases. Unfortunately, traditional medical education, while paying lip service to the need to be compassionate and person-centered, rarely teaches the skills necessary to meet the needs.

This is where the **active listening skills** come into the picture.

The active listening skills come from the humanistic client-centered counseling model of psychologist Carl Rogers. He was a great believer in empathy—putting yourself in the shoes of the other person so that you can see what he sees and feel what he feels. When a client feels the empathy of his therapist, he feels understood, rapport is quickly built, the client is more willing to reveal himself to the therapist, and the therapist is better able now to understand where the client is coming from and to help him. In the same way, if a patient feels the doctor’s empathy, the patient will want to reveal more of his internal world to the doctor allowing the latter to see where the anxiety is coming from and to address it in a compassionate and timely way.

Invariably, it will be found that the patient has certain critical misperceptions of his symptoms which cause him emotional pain (i.e. he perceives his headache to be due to a brain tumor even though in reality it is just a migraine.). The active listening skills are used to bring these misperceptions out in the open so that the doctor can correct them more easily. Identifying and correcting these misperceptions will be dealt with in a subsequent chapter.

Briefly, the active skills consist of **attending, bracketing, leading, reflecting content, reflecting feeling, reflecting experience, and probing.**

I. ATTENDING SKILLS

Attending skills thus refer to the way in which we use our bodies to communicate the message nonverbally that “I am listening to you” (or, as the term suggests, I am paying “attention” to you).

Leaning forward towards the patient as he speaks, tilting or nodding the head or raising the eyebrows when the patient makes an important point, maintaining eye contact--all of these gestures communicate the message of openness and understanding. On the other hand, leaning backwards, looking away from the patient, crossing one's arms--these communicate the message that one is not interested in what the patient is saying.

Certain habits of movement which we may have-- such as habitually twirling pencils, scratching, or tapping our feet--may detract from the message of wanting to understand and therefore should be avoided.

Distance from the patient can be a positive or negative factor. Staying too close to the patient can be threatening while staying too far away can be interpreted as an unwillingness to get involved. Many of us operate from behind a desk in our consultations, and as a practical guide, such a distance would be appropriate in most situations and would also be expected by the patient.

Sitting directly in front of the patient may be threatening to quite a few and as a rule, it is better if the patient is seated at a 45 degree angle from you as you speak with him. Such an angle allows for good eye contact while at the same time giving the patient the option of gazing away from you when he needs to.

II. BRACKETING

Bracketing is not so much a verbal or nonverbal skill as it is a mental skill. Frequently, when we listen to someone speaking to us about his problem, we automatically want to ask for more information, we make hypotheses in our minds as to what the problem might be, and we start thinking of what we want to say to the patient once he stops talking. Sometimes, our view of the problem is colored by our biases and prejudices, our pre-conceived notions about the patient or about the situation that he is describing. Sometimes, our perceptions are colored by our own experiences in dealing with situations similar to what our patient is describing especially when such experiences elicit in us much emotion.

All of these responses, while normal, detract from our empathy because, instead of really paying attention to what the patient is saying and feeling, we are paying attention to our own. Bracketing means setting aside these feelings and thoughts and judgments temporarily so that there will be space in our minds and in our hearts for what the patient is really saying.

III. LEADING

There are two kinds of leads: the indirect and the direct.

Indirect leads are open invitations made by the doctor for the patient to talk about anything that he wishes. The choice of what to talk about depends upon the patient and not upon the doctor. Indirect leads may consist of questions such as: "What would you like to talk about?" or "What can I do for you?"

Alternatively, indirect leads can also take the form of words or phrases, such as: "Yes," "Go on," "And then?". Sometimes, they do not even have to be words, as in the case of what are known as minimal prompts such as "Uh-hmm." Whatever form it takes,

the indirect lead allows the patient to go wherever he chooses and the doctor simply encourages him to continue.

Direct leads, on the other hand, require that the doctor make a judgment call as to where the patient should go and asks him to go in that direction.

Example:

Patient: When my chest hurts, I begin to think that I am having a heart attack, and then I become afraid of what might happen to my children if I die.

Direct Lead: What are you afraid might happen to your children?

Note, in the example, that the doctor does not introduce any new material other than what the patient has already brought up. In the example above, it would be tempting to ask the patient, “Are you afraid that they might not finish school?” or “Are you afraid that they might fight over your inheritance?” All of these are the doctor’s hypotheses regarding the source of the fear, but in the active listening mode, these thoughts should first be bracketed. The reason for this is that it better to let the patient tell the story rather than guessing since he is the one who is the expert in what is going on inside him.

There are many things to probe even in as short statement as the above, so how do you know where to probe? The rule of thumb is that wherever the feeling is greatest or most intense, that is where the doctor should go. So it is better in this case to probe the fear of what might happen to his children rather than to probe about what he knows about the etiology of chest pain or the pathophysiology of heart attacks—that can come later.

IV. REFLECTING SKILLS

The word “reflecting” here is not intended to mean “meditating” or “contemplating”. It can best be understood using the metaphor of a mirror reflecting back the image of the person gazing at it.

To help illustrate better the different reflecting skills, please refer to the vignette below taken from an actual clinical situation:

(45/M walks in the office, sits down, then stands up again and looks out the door to where his wife is sitting. He shuts the door and sits down again.)

Doctor, a month ago, I had this sore throat, so I went to a doctor and he gave me penicillin for it. So I took it for seven days and it went away. But a week later, I had the sore throat again.

(Patient shifts in his seat and looks down at the floor.)

The doctor gave me amoxicillin this time and I took it and the sore throat went away. But a few days ago...

(Patient takes his handkerchief and crumples it and pulls at it repeatedly.)

...the sore throat came back.

(Voice becomes softer; patient shakes his head.)

I just can't understand what is happening.

A. Reflecting Content

In this set of skills, the doctor takes the verbal content of what the patient says, repackages and rephrases it so that it becomes clearer, and gives it back to the patient. There are two ways of doing this: **paraphrasing** and **perception-checking**.

In **paraphrasing**, the doctor listens to what the patient is saying and then, using fewer but clearer words, summarizes to the patient what the latter has just said. Another way of putting it would be "to summarize in 10 words what it took the patient a hundred words to say." Patients who are confused or emotionally pained often struggle to articulate what is happening to them and what they say may be muddled up precisely because of that pain and confusion. But if the doctor paraphrases accurately what the patient is trying to say or having a hard time saying, the patient feels understood, which adds to the rapport and the trust between doctor and patient. This in turn makes the patient more willing to reveal personal information to the doctor which may be an aid to diagnosis and management.

In paraphrasing, one must be careful to capture completely the essence of what the patient is trying to say. One must also be careful not to add to the paraphrase anything which the patient has not mentioned.

Example--Paraphrase: This is the third time you have had a sore throat within a month and you can't understand why it keeps coming back.

Perception-checking is used when the doctor is not certain if he understood the patient correctly and would like confirmation from the patient. It is a skill which is similar to paraphrasing in content but which differs from it because it is phrased in the interrogative.

Example--Perception check: This is the third time you have had a sore throat within a month and you can't understand why it keeps coming back. Is that it?

Note that the same words are used, but the words "Is that it?" provides a tentative flavor to the intervention and invites the patient to correct the doctor's perception if it is wrong. Such a correction serves several therapeutic purposes. First, it reorients the doctor toward the right direction. Second, it allows the patient to restate, in clearer terms, the particular issue that is troubling him. If, however, the perception check was accurate to begin with, then it has the same therapeutic advantage as an accurately worded paraphrase.

B. Reflecting Feeling

It will be noted in the vignette that the patient is obviously feeling a lot of emotions, but nowhere does he clearly articulate what those emotions are. In such a situation, the doctor can articulate the feeling for the patient.

Example--Reflecting feeling: You seem to be quite anxious about your sore throat.

Helping the patient articulate his feelings serves several therapeutic purposes. First, by giving a name to his feeling, he becomes more aware of the emotion. Cognitive awareness is always an advantage because then the feeling can be consciously examined and the perception behind the feeling can be uncovered. Such perceptions may actually be misperceptions of reality—and, when medical in nature, can add focus to the health education efforts of the doctor. (This will be discussed in the chapter on the CEA model of health education.)

Secondly, being able to express feelings that are usually hidden allows emotional catharsis and provides relief. Ventilating the emotions decreases the disturbance to thinking that these emotions produce, thus helping the patient to have a clearer mind to accept the advice of the doctor that will eventually be given.

Thirdly, when feelings are accurately reflected back, the patient feels understood and the rapport with the doctor increases and the patient feels encouraged to tell the doctor more.

C. Reflecting Experience.

In the vignette, it will be noted that the patient is has many gestures that indicate some underlying feeling or perception. He sits down then stands again and looks out the door at his wife then shuts it. He shifts in his seat. He looks down at the floor. He takes out his handkerchief and crumples it and pulls at it. Towards the end, his voice becomes softer and he shakes his head. Any of these nonverbals can be reflected back to the patient.

Example--Reflecting experience: I noticed that a while ago, you looked out at the door at your wife then you shut it. Could you tell me what was behind that action?

The value of reflecting back these nonverbals is that these are often done unconsciously and patients are not aware that they do them. But precisely because they are unconscious, they are a valuable clue as to what is going on inside the patient emotionally. By pointing out the nonverbals, the doctor allows the patient to become aware of how he is behaving. Once aware, he can now consciously process the behavior and by so doing, gain insight as to the feeling or perception behind the gesture.

V. PROBING

Probes are questions that are asked in order to elicit more information and doctors are usually very good at probing for clinical detail. In the context of probing for psychosocial impact, however, probes are underutilized. While there are many things that can be probed psychosocially, suffice it to say that the most useful probes that a physician can use are variations of the following three questions:

How does that make you feel?
Can you tell me more about that feeling?
What is it that makes you feel that way the most?

By adding probes for emotions and inviting the patient to talk more about them, it is possible to provide catharsis for the patient and vital information for the doctor about what perceptions (or misperceptions) are causing these emotions so that he can address them better when he finally gives his education and advice.

SUMMARY

The active skills are an adjunct to the usual history and physical examination that doctors routinely perform. They turn a biomedical consult into a biopsychosocial one and allow the doctor more leverage and flexibility in providing not just rational and scientific medical management but also compassionate and empathic care.

How these skills can be put together in the time-limited setting of family practice will be discussed in the next chapter.

REFERENCES:

Brammer L. THE HELPING RELATIONSHIP. 2nd ed. Englewood Cliffs, N.J.: Prentice Hall, 1979.

Egan G. THE SKILLED HELPER. Monterey, California: Brookes/Cole Publishing Company, 1982.

Rogers RC. ON BECOMING A PERSON. Boston: Houghton Mifflin, 1961.