THE USE OF COUNSELING SKILLS IN HEALTH EDUCATION: THE C.E.A. METHOD

Allan R. Dionisio MD
Assistant Clinical Professor
Department of Family and Community Medicine
University of the Philippines College of Medicine

In the previous chapter, the skills for active listening were elucidated. How does one insert the active listening skills in a consultation?

Before answering this question, it is important to back-track a little and talk about why patients consult in the first place. Patients consult for two reasons: they have physical symptoms, and they are anxious about the physical symptoms. 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.

There is another practical reason for dealing with the emotional impact of the illness. Patients who are anxious have difficulty absorbing our attempts to educate them. The greater the anxiety, the less chance there is for our explanations to register in the mind of the patient. Better then to deal with the anxiety and get it out of the way first, then deal with pathophysiology and pharmacology afterwards when the patient is more predisposed to listen.

There is a third reason for dealing first with the anxiety. It must be remembered that emotions have their root in the patient's perceptions about the reality he is experiencing. By listening to the emotions and probing for the perceptions behind them—something that we can do through the use of the active listening skills—the physician can work backwards from the anxiety to the perception that has caused the anxiety. If such a perception is incongruent with reality as the physician perceives it—if it is a misperception—then the doctor can immediately intervene by correcting the misperception, hence allaying the anxiety and comforting the patient as well as educating him.

For example, a patient may be extremely anxious about what appears to be a mild headache. From the point of view of the physician, the signs and symptoms point to a migraine headache. From the patient's point of view, however, it is a sign of brain tumor, and he has made this association because only a month ago, a

close cousin had died from a brain tumor which manifested initially as headache. The reality is migraine; the perception is brain tumor; the emotion as a result of the misperception is an exaggerated anxiety. In this case, unless the doctor directly confronts the "brain tumor" misperception, he will not get very far in allaying the patient's fears or in gaining his cooperation. But this assumes that the doctor has sufficiently listened to the patient to realize that the latter is afraid of a brain tumor. So it is critical to listen first in order to identify the misperception before doing any education.

Patients may have many misperceptions about their illness, but one or two of them will cause the greatest amount of anxiety. Through the use of active listening, the physician can accurately identify the misperceptions that are most anxiety-provoking—what we refer to as the ECMs, or the Emotionally Critical Misperceptions—and deal with them ahead of other misperceptions in order to produce the greatest comfort in the shortest possible time—certainly something very useful in the context of a consultation where only 10 to 15 minutes can be allotted due to the other patients waiting to be seen.

CATHARSIS.

All of the above are the reasons then why in the "CEA" model, the"C" stands for catharsis. Catharsis is not about crying, although some release of emotion is part of it. Catharsis is also about becoming aware of the hidden emotion, giving it a name, and coming to a realization of what is behind it.

To promote catharsis, a physician can focus on four basic steps, to elicit the required information and to promote the ventilation of emotion:

1. What came to your mind when you started feeling your symptoms? (Ano ang naisip mo noong nakaramdam ka ng sakit?)
2. What feelings came out when these thoughts came to your mind? (Ano ang naging damdamin mo noong naisisp mo ang mga ito?)
3. What consequence of your illness makes you feel this way the most? (i.e. If the feeling is fear, the doctor can ask "Ano ang pinakanakakatakot na maaaring mangyari dahil sa sakit mo?) In most cases, the answer to this question is the ECM that will be the focus for patient education later.
4. Summarize the ECM and the emotions associated with it. (Ex. Naisip mo na baka mayroon kang sakit sa puso at natakot ka dahil baka mamatay ka at kawawa naman ang mga anak mo na maiiwan.)

While going from one step to another, but particularly in step 3, it is important to paraphrase, check perceptions, and reflect back and probe feelings. The result of all this is the identification of the ECM, which is articulated for the patient in step 4.

By going through the steps, hopefully, two things will have happened. First, he will have articulated and ventilated his emotions. Second, since he is no

longer preoccupied in trying to keep a lid on his feelings, he now has enough space in his mind to be able to listen to what the physician has to tell him about his illness. This is the emotionally appropriate moment to educate—not before.

EDUCATION.

It is usually tempting at this point of the consultation to launch into a short lecture about the pathophysiology of the illness and the pharmacology involved in its treatment. This is important, but it is better to begin with the ECM before anything else.

The ECM is the misperception that is causing the greatest emotional upset. It is the misperception that has created the emotional force that has brought the patient to the doctor. It therefore deserves priority attention. If, for instance, the patient's fear is that he will die of his illness, but the reality is that death is a distant possibility, then a straightforward statement to that effect, followed by a simple explanation of why death is unlikely, will provide the greatest emotional relief in the shortest period of time, and therefore gives the doctor the "biggest bang for his buck". Also, ddressing the ECM right away communicates to the patient that the doctor has been listening to him and understands his concerns, and the emotional "connection" that this brings into the doctor-patient relationship can be very significant.

AFTER the ECM has been addressed, it will now be appropriate to discuss pathophysiology and pharmacology because the patient is no longer distracted by his emotions which have already been dealt with. A few pointers are useful at this juncture:

First, the physician should speak in the language of the client—which is definitely not characterized by scientific jargon. Explanations must be as simple as is appropriate for the educational attainment of the patient. As a general rule, scientific terms should be avoided, except for those that the patient is already familiar with, and those that are absolutely necessary to the understanding of the illness.

Second, the power of analogy in explaining complicated concepts should not be underestimated. For instance, everyone knows how balloons burst when filled with too much air. Explaining the relationship between hypertension and intracranial bleeds becomes more understandable when using the balloon analogy. As physicians, we all know that the pathophysiology of intracranial bleeds is infinitely more complicated than that, but if the simple explanation motivates the patient to comply with his treatment, then the analogy would have served its purpose.

Third, while this is the age of evidence-based medicine, and while all of our interventions must be evidence-based, our patients generally do not speak the EBM language. Even educated patients are swayed by anecdotes and personal testimonies and many are actually turned off by the difficulty of trying to understand the principle behind randomized controlled trials. In fact, the most

enthusiastic and vocal proponents of expensive, irrational, and unproven herbal and alternative remedies are actually the "educated" segment of the population. This is what people in the advertising industry have known since time immemorial—that intellect and rationality is seldom the reason why people buy a product or a treatment. In motivating a patient to comply with a treatment plan, it is important—in fact, absolutely necessary—to provide scientific evidence. The physician, however, should not hesitate to use anecdote and testimony if that is what will convince the patient—as, for instance, when he tells a breast cancer patient who is afraid of an operation about his other patient who is a breast cancer survivor post-mastectomy/chemotherapy, and then encourages his patient to meet and talk with this survivor to hear her testimony. Such a combined approach is far more effective than simply quoting 5-year survival rates.

Fourth, one must remember that the misperception that causes the greatest anxiety may be only marginally related to pathophysiology or pharmacology. I recall a mother who brought her 3 year old son to my clinic complaining that her son was underweight and needed appetite stimulants. On evaluation, the child's body weight was within normal, but no amount of health education could allay the anxiety of the mother who continued to ask for appetite stimulants. But when I finally attempted to listen to her emotions, I found that what she felt was not fear that something would happen to her child, but rather fear that her in-laws would think that she was a bad mother because her child was "underweight". Further probing revealed that the children on her husband's side of the family were all rather hefty—in fact, overweight. The health education therefore took a different twist: I reassured her that she was, in fact, a good mother, and that her in-laws were the ones who were negligent about the health of their children. Only with this reassurance was she finally able to listen to my explanation of what "normal" body weight for age was all about. In this situation, psychosocial factors unrelated to pathophysiology clearly outweighed the biological factors, and sufficient attention to the psychosocial factors came about only as a result of listening more sensitively to the feelings (and the emotionally critical misperceptions) of the mother.

Finally, a word of caution about allaying anxiety: While a very anxious patient requires comforting, a complete absence of anxiety is not good either. There must be some minimum anxiety for the patient to comply with treatment protocols. It is therefore incumbent on the physician to titrate the amount of anxiety to a level where the patient is not paralyzed with fear, while at the same time ensuring that there is sufficient anxiety to energize the patient to take the right steps towards health. Sometimes, it may be necessary to increase the anxiety of a patient, particularly where the patient tends to minimize his symptoms and is not sufficiently motivated to comply with treatment. In such cases, the use of the family system may be a maneuver that can be done (but that is a topic for a subsequent article).

ACTION.

After educating the patient about the illness, the physician must now propose an action plan to relieve the patient of his ailment. Again, the emotionally appropriate time to explain the proposed treatment is after the ECM has been addressed—not before. Otherwise, the patient will just keep going back to the ECM and no forward movement can be accomplished in explaining the treatment.

Assuming this has been done, however, it must be remembered that patients may also have ECMs about the treatment, particularly when the intervention involves surgery or when the medicine being given has a "reputation" for side effects. Again, the active listening skills can be used to elicit these ECMs, and the ECMs can be addressed immediately.

It goes without saying that evidence-based principles must be used in recommending treatment. However, as was discussed earlier, the physician must also know when to use analogy, anecdote, and testimony to motivate patients to comply.

SUMMARY.

To summarize then: All patients who consult have two problems that need to be addressed—the physical illness and the anxiety that the patient feels as a result of his illness. Between the two, it is the anxiety that is usually the more powerful motivator for a patient to consult. A holistic, biopsychosocial approach to education requires that the patient be both informed and comforted. Active listening allows the physician to sensitively identify the emotionally critical misperceptions of the patient regarding his illness. By focusing our educative efforts on these ECMs, we can provide the greatest comfort and enlightenment to our patients with the least amount of time.

Because this model for patient education provides both cognitive input and emotional support to the patient, it can be classified as a Level 3 individual intervention.

At first glance, using active listening may appear to be more time-consuming, but in the end, skillfully used, active listening actually saves time and greatly enhances both educative efforts as well as doctor-patient intimacy. This only illustrates the adage that sometimes, "The longer way around is the shorter way home."