ELSEVIER

Patient Education and Counseling 67 (2007) 319–323

Patient Education and Counseling

www.elsevier.com/locate/pateducou

Beyond content analysis and non-verbal behaviour—What about atmosphere? A phenomenological approach

W. Langewitz *

Division of Psychosomatic Medicine/Internal Medicine, University Hospital Basel, Hebelstr. 2, CH-4031 Basel, Switzerland

Received 7 March 2007; received in revised form 2 April 2007; accepted 11 April 2007

Abstract

Objective: Basic research and careful observation of clinical practice have yielded a vast amount of empirical data on communication in health care. This research has been guided by the assumption that good communication will be better understood and easier to teach when its single constituents are identified. This paper points to the limitation of this approach.

Methods: Based upon the terminology of phenomenological thinking grounded in neo-phenomenology (Hermann Schmitz) contradictory findings from the literature on patient-centred communication in Internal Medicine and Oncology are used as a starting point to elucidate different paradigms in conducting research in clinical communication.

Results: The phenomenological approach of the German philosopher Hermann Schmitz (*1928) is briefly presented. It is based upon experiences that 'on the average everybody can vividly access or retrieve from his memory'. Empirical research does not provide unequivocal advice how to communicate with an individual patient. Likewise, researchers note unexpected reactions from real patients—they do not behave as the expert would assume. The inclusion of the phenomenon of a certain *atmosphere* is proposed referring to the impression of 'something in the air' that sometimes can be identified during communication or upon entering a room. Even though it can be sensed with high evidence, it cannot be deduced from particular observations. Instead, the atmosphere is part of a *situation* in which meaning is dissolved in chaotic manifoldness. Sensing an atmosphere is a function of the lived body (Leib) as opposed to phenomena that are mediated by the senses.

Conclusion: Current research and teaching models cover only part of the phenomenology of professional communication. How research and education might profit from the addition of Schmitz' philosophical approach will be outlined in this article.

Practice implications: Including perceptions of the lived body (Leib) should improve research in clinical communication and teaching courses.

Keywords: Neo-phenomenology; Hermann Schmitz; Atmosphere; Lived body; Leib; Research paradigm; Communication skills training

1. Introduction

This paper will deal with a certain dimension of interactions between patients and health care providers that in my view merits more sustained attention. It might be criticised as a relapse into a time when research in human communication was more a matter of taste than of sound empirical methods. Nevertheless, I hope to be able to show that there is room for yet another approach to the essence of communication without running the risk of arbitrariness. To do this however, the theoretical foundation of such an approach should be clearly stated. If the approach itself generates new terms and procedures that have not been defined previously it runs the risk of tautological clauses. The terms that I shall use are established and well described terms based upon the philosophical approach of Hermann Schmitz (*1928) who formulated a philosophical system [1] that develops philosophical questions from everyday experiences that 'on the average everybody can vividly access or retrieve from his memory' [2, p. 33]. One central assumption is that evidence cannot be deduced from strong and rigid principles; instead, it develops when for example in sudden shock or in intensive happiness evidence forces the individual to accept its existence [2, p. 53]. I hope that my attempt to apply some of his thinking to the field of patient–professional communication will demonstrate that talking about atmospheres does not necessarily mean to open the floodgates to a long forgotten speculative approach. That there is some room

* Tel.: +41 61 265 53 18; fax: +41 61 265 32 28.
E-mail address: wlangewitz@uhbs.ch.

0738-3991/$ – see front matter
doi:10.1016/j.pec.2007.04.009

for improvement could be derived from a recent paper by Beckman and Frankel [3] who warned researchers and teachers that their theories can diverge from the reality of day-to-day clinical communication. The recent paper by Linda Zandbelt et al. is a good example for unexpected findings in that patients' behaviour contradicts the experts' assumptions: physicians' 'blocking behaviour' did *increase* the number of concerns and cues voiced by patients [4].

Following phenomenological reasoning, I shall introduce this paper by referring to a day-to-day experience that will be quite familiar to readers who teach communication skills to physicians, students, nurses, or other professional groups in health care.

In order to invite the patient's perspective [5] a central intervention goal could be described as: 'Don't be in the way the patient might be using!' One should think that the easiest way to do this is simply to keep your mouth shut, look at the patient, and wait whether she or he wishes to continue. Whereas seemingly more complex goals like mirroring or summarising [6] are easily accomplished, waiting turns out to be one of the most difficult tasks that raises concerns and resistance among trainees at all levels of experience. They question the appropriateness of waiting in general and are afraid to miss the moment when a pause is changing its meaning: from indicating sustained interest, to starting a power game in which the one who speaks first has lost.

2. What determines appropriateness in communication?

This observation from communication skills training courses points to an interesting phenomenon which is the topic of this paper: What makes us so sure – under daily life circumstances – when exactly a pause should be ended, when we should look down or, yet another example, when exactly we should let go another person's hand whom we have greeted with shake-hands? Only when someone is holding our hand for too long or too firmly we realise that shaking hands – as an example of a familiar 'bodily' interaction – is governed by an extremely precise sense of appropriateness that functions between the two interacting persons.

According to the most common research strategies understanding this type of appropriateness should lead to a search for minute signals that two interacting persons exchange. In doing so, this type of research aims at the identification of single observable units, be it verbal cues and concerns [7,8], non-verbal cues (Schmid-Mast, this issue of PEC), facial expression and body language (e.g. [9] or contextual parameters [10]). In general, this research is moving along a universe of *single items or particulars*. They can be arranged in a certain order, resulting in the definition of classes of phenomena that can then be localised in time or space. Underlying these approaches is the assumption that the identification of ever smaller elements with ever more precision will finally answer the question of appropriateness that has been raised above. This approach has a philosophical tradition with a prominent advocate: René Descartes who defined four methods for proper scientific research in his paper 'Discourse de la methode pour bien conduire la raison et chercher la verité dans les sciences' [11]. This method has four basic principles which read like:

1. ''The first [principle] is never to accept anything for true which I do not clearly know to be such; that is to say, carefully to avoid precipitousness and prejudice, and to comprise nothing more in my judgment than what is presented to my mind so clearly and distinctly as to exclude all ground of doubt.
2. The second method is to divide each of the difficulties under examination into as many parts as possible, and as might be necessary for its adequate solution.
3. The third rule is to conduct my thoughts in such order that, by commencing with the simplest and easiest objects of understanding, I might ascend little by little, and, as it were, step by step, to knowledge of the more complex; [...] assigning in thought a certain order even to those objects which in their own nature do not stand in relations of antecedence and consequence.
4. And the last principle, in every case, is to make my enumerations so complete, and my reviews so general, that I might be assured that nothing has been omitted.''

It is especially the second and the third rule that has guided research strategies in nature sciences and in the field of professional communication: In trying 'to get a grip' on the quality of communication, Descartes recommends to parse the interaction between two individuals into its single constituents and to start from these particulars in order to re-construct the whole.

2.1. The constructivist and the positivist perspective of communication research

Peter Salmon and Bridget Young have raised the critical question whether 'relationships can be *built*' [12, Italics from the author]. If this was so, research should identify the bricks and the cement that it takes to construct a relationship or – to sharpen the problem at stake – even to invoke trust and empathy. The assumption that this will ever be feasible stands in the tradition of positivist thinking—another foundation of research strategies in nature sciences with a long standing history (dating back to Auguste Comte (1798–1857)) claiming that there is a reality that can be ascertained if only enough effort is invested. The idea of 'putting together' good clinical communication by using good skills and avoiding bad habits possesses that patient and physician (and researcher and teacher) perceive a communicative action in a similar way, assuming that a certain behavioural skill is good or bad on its own. However, as Zandbelt et al. [4] and Salmon and Young (2005) pointed out:

> One is to ask to what extent patients' sense of relationship is, indeed, 'built' by clinicians' good communication, that is, arises intrinsically from within the relationship, or arises from patients' own needs and history. If the patient's sense of relationship is present in some form at the start, the doctor's

> communication task would be to recognise and work with this, rather than to set about building a relationship 'from scratch' [12].

This quotation takes on a constructivist position: a relationship is subjectively 'constructed', unpredictable to some extent because the construction principles are grounded in the individual patient's and physician's history. If history is understood as covering all incidents prior to the conversation it embraces a whole range of items, including patients' experiences with physicians or with significant others that they were attached to [13,14], the information they had gathered immediately before the consultation, etc. It also comprises of what they sensed inside their body, and what they thought this meant. The same variety of experiences holds for the physician who might be more or less prepared to take on the role of an expert or a figure of trust depending on his own attachment history which does for example determine specialty choice [15]. Even if it would be possible to disentangle all single elements that might have had an influence on the course of a clinical interaction a posteriori, it is very unlikely that it actually determined what was said when during the conversation.

2.2. From particular items to situations

In order to overcome the limits of a constructivist perspective a research paradigm might be helpful that does not solely rely on single items but one that takes into account the observation that individuals have a clear perception of their environment or specifically of an interaction without being able to tell exactly, upon which particular elements this impression is built. Schmitz has called this different mode of being in the world *Situation*, defined as:

- *A unified entity* (*Gestalt*) that stands out from the environment.
- *Meaningfulness* consisting of facts, programmes, and problems; *Situations* 'have something to say'
- Diffusion within the *Situation*: not everything contained can be listed as single items; meaningfulness is dissolved in chaotic manifoldness [16., p. 21].

Two or more people interacting form an *actual Situation* that has a starting point and an end. In case of professional communication, this *Situation* stands out from the background of other interactions, for example because it fulfils a certain goal. Going back to such an exchange will produce memories: the situation has had something to say. Let's assume that the patient developed a sense of trust in this physician and yet, she will most probably be unable to describe exactly why she is willing to undergo chemotherapy under the guidance of this particular physician. The elements that brought about a feeling of trust were dissolved in the *actual common Situation* between her and her physician.

The most common type of research in communication could be localised outside of Situations, they consist of single items or particulars, arranged in a certain order.

Analysing phenomena within a so-defined *Constellation* means that single facts or programmes or problems are 'scooped' from the *Situation*, the remains are discarded as something that [at present] does not matter [17, p. 221].

Given the richness of phenomena that take place during a conversation it is impossible that two individuals interact just by perceiving and reacting to particulars. In my view the term *Situation* in the definition given above offers a chance to grasp, what else matters between two individuals: Both are embedded in a common or shared *actual Situation*, in which a multitude of meanings, problems and programs is contained. Patient and physician might be viewed as diving through chaotic manifoldness without paying attention to every single cue, emotion, or fact. However, within this metaphor, they are very well aware of a basic sense of safety and of trust in each other and in their technical equipment. I hope that this supports my assumption that a research paradigm that tries to re-construct conversation exclusively by collecting single findings does not exhaustively reflect the essence of an interaction. Instead, attention should also be paid to less particular constituents of a professional relationship. This of course is not a new idea; in a paper about the most fruitful attitude of therapists Freud recommended not to concentrate on single items [18]. He suggested that professionals abstain from too much activity when they wish to develop a sense of understanding of what the client is trying to say. He coined the term 'free floating attention' and described it as:

> However, this technique is a very simple one. It rejects all kinds of technical aids [...] even taking notes. It simply consists of an attitude of abstaining from remembering specific elements of what is said. Foremost is the willingness to meet what so ever is brought up with evenly sustained but free-floating attention. On the other hand, as soon as one deliberately strains attention to a significant extent, one starts to actively select from among the material being presented.

3. The idea of a second research paradigm

Clinicians as S. Freud and researchers have a common problem: should they pay attention exclusively to single items and their arrangement in space and time (*Constellation*) or should they try to (also) get an impression of what is happening within the framework of a *Situation*.

Referring to a qualitative paper by Wright et al. [19] Salmon and Young noted:

> 'When patients with breast cancer were asked about the elements of doctors' behaviour that they valued, they were concerned with their doctors' enduring attributes and not with behaviours, such as whether they communicated well', ... [Instead], patients 'tolerated or forgave a wide range of clinician behaviour, even interpreting communication that might objectively be termed 'poor' in ways that maintained or enhanced their perception of these enduring attributes in their doctors' [12].

Thus, cancer patients seem to apply another set of criteria if they evaluate communication with a health-care provider. Within the realm of *Situations* the scientific community could try to develop an understanding of patients' and physicians' non-explicit and not directly observable impressions. What could the material be like, that this refers to?

Without further definition the term 'impression' is not helpful because it can refer to a single ex-pression that im-pressed a listener. However, within a *Situation* we are dealing with *Myriad* [multi-facetted] *Impressions* of the type we have upon entering a room or meeting an unknown person [2, p. 19]. In a gothic church for example or in a pre-historic cavern sometimes an atmosphere is present that cannot be deduced from single elements and yet, it is definitely there (H. Schmitz; 1998c, p. 224ff). Recent empirical research has shown that indeed objects in the room that are not directly perceived nevertheless influence participants' behaviour [20]. Talking to another person also creates a certain atmosphere that sometimes might be described as dark or solemn, motivating a person to lower her head and speak with a dull voice etc. Levinson's research on the surgeon's tone of voice and its relation to malpractice suits could be viewed as a good example for the power of the human voice to create atmospheres [21]. Even if we do not know anybody, upon entering a room we can have the *immediate impression* of a certain mood, of something 'in the air'. If trouble is brewing, there is heaviness in the air; the room is, so to say, soaked with an unpleasant atmosphere. When we have such an immediate impression, we can almost instantly understand and enact the appropriate behavioural response: laughter freezes on the face; the hand stops moving in the air. If I am right assuming that we all have had experiences like the ones listed above, then they are part of our everyday existence. It seems artificial when our research paradigms do not include this part of our (communicative) world.

4. How does this translate into communication skills training?

Sensing an atmosphere helps to have an idea of which behaviour is appropriate. This is especially important and easy to understand in the task of giving information. In oncology, one of the most difficult issues is the question of how to achieve a balance between telling the truth (being honest) and yet leaving room for hope [22].

Recent studies in this field [23–27] can be summarised as follows: even though absolute numbers differ substantially (e.g. between 53 and 80% in the Kaplowitz study), a majority of patients or relatives want precise information concerning the time course of the disease, they view the competent clinician who dares talking about prognosis the one who is promoting hope best. Empathy or communication skills do not get high marks from cancer patients—a somewhat embarrassing finding as Salmon and Young have noticed, as well [12].

What does this mean for the teaching of communication skills in general and in Oncology specifically? In my view an answer can be found if we assume that health care provider and patient both contribute to form a *Situation*, they provide and receive Myriad (Multi-facetted) impressions, and both parties are embedded in an atmosphere. Receiving information cannot be dissected from the S*ituation* in which it was given. If patients declare their interest in plain information, giving little credit to communicative skills, they might ignore the importance of the *Situation* in which information was offered. As patients are non-experts concerning medical facts they can hardly know for sure, whether they received the essential information or not. Against which knowledge background could they compare what they have heard from the expert? I think that patients do indeed 'know for sure' whether they could trust a nurse or whether the physician is competent, but that this security is based upon something different than the quality and the amount of information they received. Within the framework of a *Situation* it is rather the result of a sense of appropriateness that has developed between patient and health care provider: with how much information or truth [22] can an interaction be loaded. If we understood where to search for this sense of appropriateness, we might render communication seminars for oncologists more successful.

5. The sense of appropriateness—a phenomenon of the lived body

In the German language two words exist that refer to the English word body: der Leib and der Körper. The English term 'lived body' refers to der Leib; a similar combination of noun and adverb has been used by Merleau-Ponty who referred to Leib as 'Le corps vivant' [28, p 90]. A convenient way to introduce the idea of the lived body is to refer to common experiences everybody has: one cannot only perceive one's own body by use of the eyes, hands, etc., but one can also perceive other qualities in the region of the body without the mediation of the senses. Typical examples are hunger, thirst, anxiety, lust, tiredness, being at ease [29, p. 5]. Whereas the kneecap can be localised precisely at 62 cm below my hip, tiredness or being at ease may sometimes have a preferred locale where they could be felt most intensely, but this is lacking the precision of strictly bodily (in the sense of Körper-) phenomena. Following H. Schmitz the concept of the lived body is central to the idea of appropriateness [30, p. 58ff]. Going back to the example of giving information it seems clear that a physician will always tell the patient less than she knows. How does she decide on the explicitness and the amount of information? She will have to find out with every individual patient and even with the same patient again and again, when she is seeing him on repeat consultations during the course of his disease. I propose that a sensitive physician knows 'when it is enough' much like we all know – without checking our watch – when it is time to leave a sick person alone. Such an unequivocal sense of the right moment to be silent or to continue giving information, of the length of a pause or a gaze cannot be localised in a 'hot spot' in our body, it is a typical phenomenon of the lived body.

5.1. The lived body in communication skills training

Communication skills training should enable participants to pay attention to the resonance phenomena that a certain atmosphere is creating within their lived body. This takes time.

Therefore, the recommendation to *offer* time to patients should be completed with the advice to professionals to *take* their time, as well. What is meant here, are repeated time periods of few seconds each. This is often sufficient to realise that something unexpected has happened and enough time to 'get a taste' of what a patient has said. This would introduce a third focus of attention in training courses: besides the patient and the task to be accomplished, the lived body of the professional comes into play. Thus, good communication might be viewed as finding a balance between these three elements. In-experienced students and many physicians often focus on the task – neglecting the patient and themselves; sensitive medical students sometimes pay too much attention to the patient – forgetting about the clinical diagnosis that they were supposed to find and about their own contribution to the situation. If they become aware of perceptions within their lived body they realise how difficult it is to find words for these typically vague phenomena.

Medical students and physicians have been trained to identify particular items and to turn a *situation* into a *constellation* – distilling facts out of chaotic manifoldness. Talking about the lived body is asking for a more poetic and a less prosaic explication – something that the daily business in medicine and medical journals do not favour. Incorporating these issues into communication aspects in health care, calls for a more colourful and less deterministic language—something that most professionals will find difficult to apply to their clinical practice and research. Psychoanalysts would probably call many of these phenomena counter-transference phenomena [31], neglecting however their non-psychological 'bodily' nature. Furthermore, transference and counter-transference typically refer to dyadic interactions between individuals between whom there is a (therapeutic) relationship. The term atmosphere as defined by Schmitz and used in this paper is much broader. As we have seen, it does also apply to situations in which no human being is creating the atmosphere; an old forest can breathe hostility or freedom, as many of us will have perceived reading Lord of the Rings by J.R. Tolkien. Curricula in medicine and nursing might profit from an attempt to widen the array of personal awareness by also including ways to improve the sensitivity of their students for their own lived body.

References

[1] Schmitz H. System der Philosophie (System of Philosophy), 3rd ed., Bonn: Bouvier Verlag; 1998.

[2] Schmitz H. Der unerschöpfliche Gegenstand–Grundzüge der Philosophie (The Inexhaustible Object—Main Features of Philosphy), 2nd ed., Bonn: Bouvier Verlag; 1995.

[3] Beckman HB, Frankel RM. Training practitioners to communicate effectively in cancer care: it is the relationship that counts. Patient Educ Couns 2003;50:85–9.

[4] Zandbelt LC, Smets EM, Oort FJ, Godfried MH, de Haes HC. Patient participation in the medical specialist encounter: does physicians' patient-centred communication matter? Patient Educ Couns 2007;65:396–406.

[5] Delbanco TL. Enriching the doctor-patient relationship by inviting the patient's perspective. Ann Intern Med 1992;116:414–8.

[6] Langewitz WA, Eich P, Kiss A, Wossmer B. Improving communication skills—a randomized controlled behaviorally oriented intervention study for residents in internal medicine. Psychosom Med 1998;60:268–76.

[7] Del Piccolo L, Saltini A, Zimmermann C, Dunn G. Differences in verbal behaviours of patients with and without emotional distress during primary care consultations. Psychol Med 2000;30:629–43.

[8] Heaven CM, Maguire P. Disclosure of concerns by hospice patients and their identification by nurses. Palliative Med 1997;11:283–90.

[9] Beach WA, Easter DW, Good JS, Pigeron E. Disclosing and responding to cancer ''fears'' during oncology interviews. Soc Sci Med 2005;60:893–910.

[10] Bensing J, van Dulmen S, Tates K. Communication in context: new directions in communication research. Patient Educ Couns 2003;50:27–32.

[11] Descartes R. Discourse on Method and Meditations (Original: Discourse de la methode pour bien conduire la raison et chercher la verité dans les sciences' 1642). Dover Publications; 2003.

[12] Salmon P, Young B. Core assumptions and research opportunities in clinical communication. Patient Educ Couns 2005;58:225–34.

[13] Ciechanowski PS, Walker EA, Katon WJ, Russo JE. Attachment theory: a model for health care utilization and somatization. Psychosom Med 2002;64:660–7.

[14] Taylor RE, Mann AH, White NJ, Goldberg DP. Attachment style in patients with unexplained physical complaints. Psychol Med 2000;30:931–41.

[15] Ciechanowski PS, Worley LL, Russo JE, Katon WJ. Using relationship styles based on attachment theory to improve understanding of specialty choice in medicine. BMC Med Educ 2006;6:3.

[16] Schmitz H. Adolf Hitler in der Geschichte (Adolf Hitler in History). Bonn: Bouvier Verlag; 1999.

[17] Schmitz H. Phänomenologie als Anwalt der unwillkürlichen Lebenserfahrung (phenomenology as advocate of direct experience). Erwägen Wissen Ethik 2004;15:215–28.

[18] Freud S. Ratschläge für den Arzt bei der psychoanalytischen Behandlung (advice for the doctor in psychoanalytic treatment). Gesamtwerke 1912;376–87.

[19] Wright EB, Holcombe C, Salmon P. Doctors' communication of trust, care, and respect in breast cancer: qualitative study. BMJ 2004;328:864.

[20] Kay AC, Wheeler C, Bargh JA, Ross L. Material priming: The influence of mundane physical objects on situational construal and competitive behavioral choice. Org Behav Hum Dec 2004;95:83–96.

[21] Ambady N, Laplante D, Nguyen T, Rosenthal R, Chaumeton N, Levinson W. Surgeons' tone of voice: a clue to malpractice history. Surgery 2002;132:5–9.

[22] Surbone A. Telling the truth to patients with cancer: what is the truth? Lancet Oncol 2006;7:944–50.

[23] Kaplowitz SA, Campo S, Chiu WT. Cancer patients' desires for communication of prognosis information. Health Commun 2002;14:221–41.

[24] Mack JW, Wolfe J, Grier HE, Cleary PD, Weeks JC. Communication about prognosis between parents and physicians of children with cancer: parent preferences and the impact of prognostic information. J Clin Oncol 2006;24:5265–70.

[25] Hagerty RG, Butow PN, Ellis PM, Lobb EA, Pendlebury SC, Leighl N, MacLeod C, Tattersall MH. Communicating with realism and hope: incurable cancer patients' views on the disclosure of prognosis. J Clin Oncol 2005;23:1278–88.

[26] Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. J Clin Oncol 2001;19:2049–56.

[27] Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. BMJ 2004;328:1343.

[28] Merleau-Ponty M. Phänomenologie der Wahrnehmung (phenomenology of perception). Berlin de Gruyter 1945.

[29] Schmitz H. 3rd ed., System der Philosophie (System of Philosophy), II/1, 3rd ed. Bonn: Bouvier Verlag; 1998.

[30] Brenner A. Bioethik und Biophänomen. Den Leib zur Sprache bringen (Bioethics and Biophenomena). Würzburg: Königshausen & Neumann; 2006.

[31] Smith RC. Teaching interviewing skills to medical students: the issue of 'countertransference'. J Med Educ 1984;59:582–8.