Responding to Patients’ Unanticipated Emotional Concerns

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In today’s world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

**Goals**

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

**How to Use the Modules**

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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SUMMARY ......................................................................................................................5
OBJECTIVES ..................................................................................................................5
    Key Features ..............................................................................................................5
    Core Competencies .................................................................................................5

CASE STUDIES ...............................................................................................................6

INFORMATION POINTS .................................................................................................7
    Background ..............................................................................................................7
    First Responding Skills ..........................................................................................8
    Validation Skills ......................................................................................................9
    Opening up Possibilities for Change with Psychosocial Problems .........................13
    Using the Situation in Which Emotions Are Revealed .............................................14

CASE COMMENTARIES .................................................................................................16

CONCLUSION ................................................................................................................17

REFERENCES ...............................................................................................................17

RESOURCES ...............................................................................................................17
SUMMARY

Frequently in family practice, patients present with unanticipated emotions or affect. Patients may mention these issues directly, or reveal them indirectly during a visit for a physical symptom, when the physician asks about a life situation (e.g., a crisis). Patients frequently present with physical symptoms (e.g., tiredness or pain) to legitimize their visit, or are unaware that they have physical symptoms related to emotional issues (e.g., shortness of breath and poor sleep related to anxiety). Anger, fear, worry, a sense of hopelessness, and sadness are some emotions that patients may bring. Because of time constraints or uncertainty about how to respond, patients’ unanticipated emotions can be a challenge for the family physician (FP) in a busy office practice. However, when the FP views such emotions in the context of crisis and change, they provide a great opportunity for helping a patient through a difficult time in his or her life. These emotions also offer a doorway to information that can have an impact on patients’ immediate and long-term health.

OBJECTIVES

After completing this module, you will be able to:
1. deal with a patient’s unanticipated affect in a respectful, timely, and effective manner.
2. apply skills in responding to and validating patients’ emotions.
3. introduce possibilities for change with patients who have psychosocial problems.
4. use situations in which patients present with a psychosocial issue to enhance the therapeutic relationship and/or support the patient and/or motivate him or her to address the issue.

Key Features
1. Unanticipated emotional affect is a common scenario in daily practice
2. Family physicians can utilize specific interviewing and communication techniques that can assist themselves and their patients through these difficult moments.

Core competencies
1. Display effective, professional and non-judgmental communication skills.
2. Employ rich mixture of techniques such as open-ended questions, direct questions, scaling, narrative.
3. Establish therapeutic relationship with patients and families.
4. Adopt a patient centered approach
**CASE STUDIES**

**Case 1: Ms. Anna Temple, aged 40**

Your receptionist asks you to see Ms. Temple, a “walk-in,” as the last patient of the day. You have seen Ms. Temple before for a minor medical problem. Your receptionist says that she seems upset. She is complaining of a severe headache, which she has had for the past three days. A brief examination reveals a blood pressure measurement of 130/80 mm Hg; a fundi and neurologic examination is normal. She looks depressed. When you ask her how things are going in her life, she breaks down in tears.

- **How would you proceed with the interview?**

**Case 2: Mr. Raj Patel, aged 56**

Mr. Patel is a regular patient in your practice. Recently he had abdominal surgery for suspected gallstones, but was found to have biliary cancer. The surgeon told him the cancer was inoperable, and that he had about six months to live. He is very angry about the incorrect initial diagnosis, and wonders how this mistake could have happened.

- **How would you deal with Mr. Patel’s anger?**
- **How does the patient’s anger affect the practitioner?**
- **How might you handle/contain/validate that anger?**

**Case 3: Ms. Sonia Josephs, aged 48**

Ms. Josephs is a long-time patient with a history of alcohol misuse. She stopped drinking eight years ago. She visits you for a Pap test and a physical examination. When you ask if she has any questions or concerns, she hesitates and then tells you, with embarrassment, that she has started drinking again.

- **How do you respond in a way that validates Ms. Joseph’s ideas, feelings, and/or behaviour?**
INFORMATION POINTS

Background
1. While FPs may be reluctant to ask about the psychosocial aspects of people’s lives, delving into this area may be beneficial to both the patient and the physician:
   - It helps the FP get to know the patient.
   - It makes the FP aware of wider determinants of health that may have an impact on the patient’s life.
   - It can greatly enhance the therapeutic relationship, which will affect patient motivation, comfort, trust, and communication.
   - It allows the FP to treat the full range of physical and mental health issues more effectively.
Several assumptions about the physician are relevant to this discussion:

2. The physician is somewhat interested in, curious about, and concerned about the patient's life, and open to hearing from the patient when issues are of great concern to him or her. In addition, the physician is aware of the impact of the patient’s emotional experiences and state of mind on the medical condition, adherence to treatment, response to stress, etc., and knows that medical conditions also affect the patient’s state of mind. The physician also is willing to enter into two-way communication with the patient. Last, because the interaction will be a conversation, verbal skills are important, and these can develop further over time.

3. The key attributes for effective counsellors have been defined as accurate empathy, genuineness or congruence, and unconditional positive regard.\(^1,2\) In a family practice context, accurate empathy requires the FP to understand the patient; this understanding can be achieved through a patient-centred approach. Genuineness or congruence (i.e., being the same inside and outside) is more challenging for physicians, whose medical training emphasizes clinical objectivity. Nevertheless, being somewhat more affectively open with patients when they talk about personal problems is helpful and appropriate. Finally, finding a way to develop and maintain a stance of unconditional positive regard is easy with likeable patients and difficult with “difficult” patients, but these latter patients are often the ones who need our support most. Learning more about a patient’s background, through the completion of a psychosocial genogram or questions about his or her personal history, usually increases our understanding and effectiveness in providing medical care. Frequent experience of this shift in our perspective eventually reveals that all “difficult” patients must have good reasons for being so.

4. Therapists use the terms “countertransference” and “counterreaction” to describe feelings the practitioner has while working with patients. “Countertransference” feelings are those that arise from our own personal sensitivities, which result from our life history. These are inevitable at some point with certain patients, but if we recognize them, we can deal with
them so they do not interfere with treatment. Examples might be a patient who reminds us of one of our parents, or has qualities that have been troublesome to us in our lives.

“Counterreaction,” on the other hand, comprises feelings that arise in anyone who encounters a particular emotionally laden situation—sadness when one is relating to a person in distress, fear for a person who is facing serious illness, or distress at hearing of traumatic events. While these feelings are not as strong as the patient’s, they can certainly affect us; they are a sign of our humanity and caring. Seeing them in this light will help us resolve or manage these issues and help us help our patients.

5. In the patient-centred approach, the acronym FIFE is used to describe areas on which the physician should focus in an attempt to understand the patient’s perspective. This acronym stands for Feelings, Ideas, Functioning, and Expectations. The model includes a description of specific skills that could be used in conversation with a patient in a medical context. Even more specific and complex skills are needed when one is responding to psychosocial and biopsychosocial problems. Examples of psychosocial issues are “problems of living,” such as adjustment to a new life stage, relationship problems, parenting issues, grief, worries, low self-esteem, and habits that may affect functioning negatively. Examples of problems that can have both biomedical and psychosocial (i.e., biopsychosocial) aspects are severe mental illness, major depression, anxiety disorders, substance use, somatization, and behaviours that affect health.

First Responding Skills

6. In a discussion of psychosocial issues, a patient's reaction may be unexpectedly emotional. The interaction that takes place cannot be fully planned, and the physician will need to use tacit skills that he or she has learned previously through life experiences or training. Tacit skills are those that, once learned, become unconscious but can be freely applied as needed (e.g., swimming, bicycle riding).

The 10 tacit skills listed in Table 1 are fundamental to all types of therapy and counselling. When they are used properly, they do no harm and typically do a great deal of good. Therapist Bill O'Hanlon describes the two most important steps in psychotherapy as validation and opening up possibilities for change. These distinct steps provide a useful way of grouping these tacit skills.

Also important is noting the following about use of these skills:

- In the “first responding” situation, validation skills take precedence. These are intended to provide the base of support needed for the establishment of a deeper trusting relationship.
- The first six validation skills are useful in any situation, while the last four “opening possibilities” skills are useful primarily with psychosocial problems.
- While individual situations may call for any of these skills, the first two
skills (listening and validation) are required, and often sufficient, elements.
- Only a few of these skills are used in any one patient encounter.
- In a first responding situation, the FP works within whatever time is available; even short interactions can have significant impact.

### Table 1

**Summary of First Responding Skills**

<table>
<thead>
<tr>
<th>Validation skills</th>
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<tbody>
<tr>
<td>1. Listen actively (a required component).</td>
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<tr>
<td>2. Validate the patient’s ideas, feelings, and/or behaviours (a required component).</td>
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<tr>
<td>3. Reflect content back to the patient.</td>
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<tr>
<td>4. Respond empathically.</td>
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<tr>
<td>5. Help the patient identify his or her feelings.</td>
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<td>6. Address risk or safety issues, if necessary.</td>
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<thead>
<tr>
<th>Opening up possibilities for change*</th>
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<tbody>
<tr>
<td>7. Listen, validate, and ask after what the patient thinks he or she wants to do.</td>
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<tr>
<td>8. Listen, validate, and ask after if the patient would be interested in hearing some different or slightly different perspectives on the problem.</td>
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<tr>
<td>9. Listen, validate, and ask after if the patient would be interested in learning what some people do when they have this kind of problem.</td>
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<tr>
<td>10. Listen, validate, and invite the patient to return to talk with you about this issue some more.</td>
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* Primarily for psychosocial problems

### Validation Skills

7.1. **Listen actively (a required component).** This involves showing genuine interest verbally (e.g., with “Uh huh” or “Go on”) and nonverbally, and encouraging the person to continue. Ask questions as necessary. A stance of kindness and curiosity is helpful. However, **do not try to solve** the problem at this time: just listen.

Listening conveys respect and interest, and it has two other benefits. Patients find relief in venting feelings to a receptive person, and, equally important, **patients gain clearer ideas about their situation from hearing themselves.**

7.2. **Validate the patient’s ideas, feelings, and/or behaviours (a required component).** Validate, value, accept, acknowledge, and give permission for the patient's experience (feelings, sensations, fantasies, automatic thoughts, core sense of self), without necessarily agreeing with hopeless or
overly negative perceptions. This approach also conveys that the patient has a right to these feelings and reactions, and that they are understandable under the circumstances.

Validation is also a prominent feature of dialectical behaviour therapy, a treatment that has been successful for people diagnosed with borderline personality disorder.  

O’Hanlon and Beadle distinguish “experience/feelings” from “ideas” (points of view, explanations, beliefs, or stories about oneself or events) and from “behaviours” (actions, including talking). Not all ideas and behaviours should be validated or supported, as some are helpful/constructive and some are not. Unhelpful ideas can be called into question. Unhelpful behaviours can be discouraged. Examples of validating statements are shown in Table 2.

In the area of addictions, ideas such as “I can stop drinking” or “taking one day at a time,” and behaviours that result in abstinence or reduced substance use are obviously constructive. The following is an example of a physician’s validating statement: “We all know it takes a lot of work to change an addiction, so it really is significant that you’ve stayed off booze for eight days now.”
Table 2
Examples of Validating Statements*

<table>
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<tr>
<th>Validating feelings</th>
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<tr>
<td>“Your reaction is definitely understandable, given the possibility of being laid off at work.”</td>
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<tr>
<td>“No, I don’t think you’re going crazy. You’re just going through a rough time. In fact, if you weren’t reacting, I would worry.”</td>
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<tr>
<th>Validating an idea</th>
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<tr>
<td>“I agree with you that you were not at fault when you were sexually assaulted.”</td>
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<tr>
<th>Validating behaviour</th>
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<tr>
<td>“Given your father’s sudden death, it’s pretty amazing that you’ve done as well with your daughters as you have in these last few weeks. I don’t know many people who could have done better.”</td>
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<tr>
<th>Validating behaviour by asking a question</th>
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<tr>
<td>“Have you done anything that you are pleased about during this difficult period?”</td>
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<tr>
<th>Validating ideas by asking a question</th>
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<tbody>
<tr>
<td>“What do you see as your positive qualities?”</td>
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<tr>
<th>Invalidating some ideas and validating others</th>
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<tbody>
<tr>
<td>“Well, it’s pretty natural to doubt yourself, given your mother’s criticism, but I’m not sure she’s right about a lot of it. I certainly see a lot of positive qualities in you as you talk.”</td>
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* Each of the statements would, of course, be tailored to the particular person and situation.

7.3. Reflect content back to the patient. Summarize or clarify the content as you understand it. The main purpose is to check your understanding of what the patient has said. Summarization also confirms for the patient that what he or she has said is understandable to another person. Sometimes this approach helps the patient understand the problem more clearly or in a different way. For example, you might say, “So what I’m hearing is that you’d like…,” or “So let me tell you what I’m hearing…,” or “It sounds like….”
Summarizing what the patient has said can also be a way to pace the interview more effectively. Specifically, it can create more two-way interaction with patients who talk quickly for long stretches, or with patients who tend to be withdrawn.

7.4. **Respond empathically.** An empathic response involves feeling for the patient and expressing this feeling verbally, at least a little. Part of an empathic response is “being there” with patients, trying to feel some of what they may be feeling, from their frame of reference. Although we cannot know exactly “how the patient feels,” as we are not actually in his or her situation, we can know something of how he or she might be feeling. The experience of sharing difficult or painful emotions, and feeling as if one is understood, is usually a great relief to patients because it breaks their isolation.

Empathy is “feeling with” the other person. While validation can be less emotional, expressions of empathy need to include some degree of emotion in tone, gesture, or content. For example, one might say, “This really is a difficult situation” or “My condolences on your loss.” Statements made with a flat affect, or ones that emphasize the patient’s feelings without some degree of feeling from the physician, can easily make the patient feel more alone or even judged or pathologized. For instance, on its own, the statement “I can see that you’re upset” says nothing about the physician’s feelings.

We also need to maintain some awareness of our own feelings, so we can deal with them more effectively (i.e., not simply act on them). This also helps us reduce the “residual feelings” we may experience after the interaction. Sometimes when they are not typical for us, the feelings we experience can be indicators of the patient’s mind state.

7.5. **Help the patient identify his or her feelings.** This needs to be done empathically. It requires more skill than reflecting back content, both in tuning in to feelings, and in addressing these with the patient. For example, the physician might ask, “How do you feel as you talk about this?” or “Is it sadness you're feeling?” Addressing the patient’s feelings might be particularly important in situations where the therapeutic alliance is blocked (e.g., “I understand that you’re angry about the long wait today; I wish it could have been otherwise”). Helping the patient identify feelings (especially in the first two examples) should not be used routinely, as the patient may find it overly intrusive. However, when good physician-patient rapport is present, clarifying feelings can be extremely helpful.

When patients are upset, their feelings are often confusing, because so many are present, or because they are so intense. Tentatively naming the feelings provides more control. However, feelings are not, in themselves, the problem, and a person cannot get rid of them by fighting against them. If someone tries to do this, he or she increases their power. On the other hand, if emotions are felt freely, they will shift or diminish fairly quickly.
7.6. **Address risk or safety issues, if necessary.** If doing so is appropriate, check suicidality and the potential for violence. Develop a safety plan. Use crisis intervention strategies when these are needed.

**Opening up Possibilities for Change, with Psychosocial Problems**

7.7. **Listen, validate, and ask after what the patient thinks he or she wants to do.** After talking, the patient may have reached some conclusions about how he or she wants to proceed in dealing with the problem. This question returns the ownership of the problem to the patient, the time to the present, and the purpose of the counselling to finding the next steps.

7.8. **Listen, validate, and ask after if the patient would be interested in hearing some different or slightly different perspectives on the problem.** If the patient is not interested, do not proceed. If the patient is interested, share these perspectives as tentative observations, while checking the patient's reactions. They may or may not be acceptable to him or her.

One can normalize a problem without minimizing it, or present other hopeful or positive perspectives (e.g., the patient's strengths). However, if they are to be useful, these observations need to be realistic.

7.9. **Listen, validate, and ask if the patient would be interested in learning what some people do when they have this kind of problem.** This statement assumes we have some suggestions to make; often we will not. If the patient is not interested, do not proceed.

Any suggestions must be given tentatively, as we have limited information and the suggestions may not fit well with the situation or the patient. A risk also exists that the patient may feel misunderstood, or unduly pressured to act in a way that is not appropriate for him or her.

These are only suggestions or ideas, which the patient is free to act on or not. The patient may not be ready to take any action at all at this time (no contract for helping has been established), so use these sparingly. The patient may have wanted only to talk, or may have tried all these suggestions already.

The suggestions might be actions that the patient can take or potentially helpful community resources. (See Table 3 for suggested actions and resource guidelines.)

Avoid making decisions for the patient, even though you may feel pressured to do so—possibly by the patient. All decisions need to be left with the patient, even when he or she asks, “What should I do, Doctor?”

7.10. **Listen, validate, and invite the patient to return to talk with you about this issue some more.** This is an invitation. The patient can accept the offer or not, and the offer can be left with him or her for the future. If
risk is involved, the FP can move from an offer, to a recommendation, to a strong recommendation (e.g., in the case of spousal violence), to action (e.g., in the case of intended violence against another). (See Table 4 for a list of possible interview processes beyond “first responding” skills.)

**Using the Situation in Which Emotions Are Revealed**

8. In general, the situation in which a patient opens up a psychosocial issue, either spontaneously or at our invitation, can be used to support and bring relief to the patient, enhance the therapeutic relationship, and/or increase the patient’s motivation to address the presenting or underlying problems.

<table>
<thead>
<tr>
<th>Table 3</th>
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<tbody>
<tr>
<td><strong>Patient Actions and Resource Guidelines</strong></td>
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<tr>
<td><strong>Some key areas for action, which can be explored if time permits</strong></td>
</tr>
<tr>
<td>▪ Coping strategies the patient has used: What's helping the patient function despite the problem?</td>
</tr>
<tr>
<td>▪ Actions that have helped the patient reduce the problem or its effects in the past: “If something works, do more of it; if something doesn't work, do something different.”</td>
</tr>
<tr>
<td>▪ Support network: Can the patient talk to anyone else?</td>
</tr>
<tr>
<td><strong>Guidelines for providing resources</strong></td>
</tr>
<tr>
<td>▪ Become knowledgeable about available resources.</td>
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<tr>
<td>▪ Assess the fit between the patient's needs/wishes and the possible resources.</td>
</tr>
<tr>
<td>▪ Work with the patient's motivation level when considering a possible referral.</td>
</tr>
<tr>
<td>▪ Facilitate the linkage of the patient and the resource, as necessary.</td>
</tr>
<tr>
<td>▪ Monitor/support the patient's involvement with a resource, which may include liaison and/or joint planning, when such monitoring/support is helpful.</td>
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### Table 4

**Possible Processes, Beyond “First Responding” Skills, for a Single-session, Psychosocially Focused Interview**

- **Required (beginning):** Make a “contract” for this session. *(Note: “Contracting” refers to coming to agreement about a plan. In contracting, the patient’s agenda needs to be given somewhat greater importance than the physician’s.)*
- **Remain “patient-centred.”**
- **Create a “therapeutic space” that allows the patient to talk. Provide emotional support (listen, validate, etc.).**
- **Sort out undifferentiated problems.**
- **Provide psychoeducation for the patient and family members to destigmatize the issues and increase understanding.**
- **Use a problem-solving process.** Work within the patient’s motivation level (a precontemplative, contemplative, or active level). 8,9
- **Explore possible resources.**

Consider doing a three-generation genogram to help identify family history and patterns. If appropriate, provide counselling in preparation for a future referral for psychotherapy.

**Required (end):** Make a “contract” for follow-up or no follow-up care.
CASE COMMENTARIES

Case 1: Ms. Anna Temple, aged 40
In the absence of physical findings, you have diagnosed Ms. Temple with tension headaches. You invite her to tell you what is upsetting her. In doing so, you say something like the following: “You seem upset about something. Would you like to talk about it?” or “Sometimes it helps to talk about it. We have a few minutes.” She describes serious problems in her marriage, and conflicts with her teenaged son. After listening actively, you make a comment like the following: “Well, it’s certainly understandable that you’d be upset, given what’s happening.” After clarifying that no risk or safety issues are present, you ask whether she would like to talk to someone about this problem at greater length. She says she would, and you give her the phone number of the local counselling agency. You also offer to see her the following week for a follow-up appointment.

At the follow-up meeting, she thanks you for your kindness at the last appointment, and reports that she has phoned the agency and will attend counselling sessions, although the earliest appointment is in six weeks. You check with her about other supports in the meantime, and she identifies two friends who are supportive. You let her know she can make another appointment with you if she needs to before the counselling agency appointment, especially if she experiences a crisis. However, you do not attempt to form a strong counselling relationship with her. You realize the limitations in your time and skill level, and are concerned about diverting her from her intention of receiving counselling with the agency.

Case 2: Mr. Raj Patel, aged 56
Mr. Patel’s anger comes from a delayed diagnosis, which may or may not lead him to take medicolegal action. This is always a worry for the physician, and may certainly constitute a barrier to healthy communication. An appropriate approach is acknowledging Mr. Patel’s anger without necessarily accepting his position (e.g., with a statement such as “I understand that you must be feeling angry about what happened”). Validating his feelings and hearing his perspectives on the problem, while remaining empathic throughout, is a challenge. However, the physician can meet the challenge by using this interview technique and providing accurate information about the sequence of events in the evolution of the case, including discussion with the patient. These approaches usually have a positive effect on the patient. The goal here is to repair the doctor-patient relationship whenever possible (see Resources section).

Case 3: Ms. Sonia Josephs, aged 48
The fact that Ms. Josephs has come to see you and is letting you know about the problem is significant. Addictions create shame, so this disclosure would have required considerable courage on the patient’s part. She could have chosen to say nothing. You could respond by saying, “You have done well for quite a while. It took courage to come in to talk about it. I’m really glad you did. What do you want to do now?”
CONCLUSION

Situations in which a patient has a strong emotional reaction, or unexpectedly opens up a complex and emotion-laden psychosocial issue, can be challenging for FPs. The approaches described in this paper represent practical skills that are respectful, humane and effective. They serve as a “safety net” when one explores psychosocial aspects of the patient's world or responds to a patient’s distress. Likely outcomes of these practices are improved communication between the physician and the patient, the patient’s increased trust in the physician, and more effective longitudinal care.

REFERENCES


RESOURCES

1. Books


2. Websites

Empathy: The Human Connection to Patient Care. Cleveland Clinic. Feb 22, 2013.  [http://www.youtube.com/watch?v=cDDWvj_q-o8](http://www.youtube.com/watch?v=cDDWvj_q-o8)

Doctor-Patient Communication: The Universal Upset Patient Protocol. Dike Drummond. Aug. 5, 2012.  [http://www.youtube.com/watch?v=C1YsNGupQhI](http://www.youtube.com/watch?v=C1YsNGupQhI)