

**Use Of Empathy By Healthcare Professionals Learning Motivational Interviewing:
A Qualitative Analysis**

by

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Abstract

Background. Many chronic health conditions like diabetes and hypertension require patients to make life style modifications such as changing dietary and exercise habits and taking medications. Healthcare Providers (HCPs) often don't empathize with patients' concerns and this can affect patients' motivation to engage in life style modifications and HCPs resort to advising patients even though the effectiveness of advice giving is as low as 5-10%. This study focuses on the empathic behavior of HCPs while learning motivational interviewing and empathy is considered as the foundation for the effectiveness of motivational interviewing.

Objective. The main objective of this exploratory study was to identify the problems that HCPs have in empathizing with and addressing patients concerns while learning motivational interviewing.

Sample and settings: The study sample consisted of videotaped consultations of HCPs who were learning motivational interviewing at Auburn University Motivational Interviewing Training Institute (AU MITI) during 2007 and 2008. A total of 136 video consultations were studied comprising 82 HCPs interacting with standardized patients.

Method. This was a qualitative study using discourse analysis to identify the problems that HCPs have in empathizing with and addressing patients' concerns. A total of 55 consultations were transcribed within which 20 consultations were fully transcribed and 35 were partially transcribed to illustrate the patterns of HCPs' responses to trained standardized patients' concerns.

Results. The problems that HCPs face in empathizing with and addressing patients' concerns were (a) examining patients knowledge, (b) supporting self-efficacy without empathizing with their concerns, (c) running/forcing a predetermined agenda, (d) treating patients as a source of information, (e) discounting patients' concerns, (f) generalizing patients' concerns, (g) focusing on superficial details and not on the motivational issues, and (h) not making connections for patients while eliciting or providing information. Empathizing with patients' motivational issues was observed to be important in the effective use of other MI skills.

Conclusion. This study suggests that empathizing with patients' motivational issues is crucial to MI not only in terms of reducing relational resistance in patients but also in initiating and supporting the process of addressing issue resistance in patients.

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List of Notations

| | |
|-------------|---|
| HCP | Healthcare Provider |
| P | Patient |
| [| |
| [| Two separate left brackets denote overlapping or simultaneous talk by two successive speakers. These two brackets indicate the onset of overlap of speech between two speakers |
|] | |
|] | Two separate right brackets denote the end of overlapping utterances by two successive speakers |
| = | An equals sign represents connecting speech. Equal signs come in pairs and indicates that the first speaker was continuously speaking while the second speaker talked and there was no interruption in the first speaker's speech |
| ... | Short pauses are denoted by three dots |
| WOrd | Loud talk is denoted by upper case letters |
| Word | Bold letters indicate vocal stress on that word |
| () | When some or all of an utterance is in parentheses, for example, it indicates uncertainty on the transcriber's part about what was said, but represents a likely possibility |
| (()) | A double parenthesis for example indicates transcribers' description of events rather than representations of them |

(XXX) The uppercase letter X in parenthesis denotes inaudible speech. The more the number of X's, the longer is the speech that was not audible

- A hyphen after a word denotes a break or self-interruption

Uh huh Creative spelling is used to approximate the phonetics of vocal output not in the form of words. This transcription convention is often used to represent backchannels

Hmmm Repeated letters represent sounds that stretch speech. The more repeated letters, the longer is the stretch in speech

I. INTRODUCTION

Patient-Centered Care. Patient-centered health care has been reported to improve clinical, economic and humanistic outcomes for patients and health care systems (Starfield, 1981; Stewart et al, 2000). A patient-centered approach requires Healthcare providers (HCPs) to collaborate with patients and come to an agreement about treatment options by involving the patient in the decision-making process. Patient-HCP agreement on the treatment approach and follow up visits has been reported to improve treatment outcomes in terms of recovery from diseases (Starfield, 1981; Stewart et al, 2000). Patient-centered care has also been reported to markedly reduce diagnostic costs, referrals and subsequent HCP visits, thereby reducing medical expenses (Stewart et al, 2000). Patient satisfaction also showed improvement with patient-centered care (Mallinger, Griggs & Shields, 2005). Thus, study results suggest that patient-centered care positively affects both the physical and mental health of patients as HCPs pay attention to patients' perspectives of illnesses and treatments.

More specifically, as stated by Wagner (2005), sending patients home with prescriptions alone will not suffice, because it is important to ensure that patients have sufficient knowledge *and* motivation to adhere to treatment regimens. Consequently HCPs should assess patients' motivation to adhere to medication regimens and to make life style changes. Such assessments should include the exploration of patients' concerns and perspectives about their illnesses and treatment options. A patient-centered approach developed by Miller and Rollnick that focuses on patients' concerns, assesses

their motivation, and tailors therapy according to the unique needs of each patient is known as motivational interviewing (MI) (Miller & Rollnick, 2002).

Motivational Interviewing (MI). Motivational interviewing is a patient-centered approach to counseling patients based on Rogers' person-centered theory (Miller & Rollnick, 2002), while still being directive or guided in nature when providing medical and health information to the patient. For example, HCPs would be directive while prescribing the number of doses or while sharing information or precautions with patients when they are prescribed a medication. It is patient-centered because HCPs offer guidance and tailor medication regimens and life style changes according to patients' goals and expectations. Patients' feelings are acknowledged, and ambivalence and resistance is explored while legitimizing patients' concerns by being empathic to their emotions. There are five principles underpinning MI. These principles according to Miller & Rollnick (2002) are:

1. Express empathy:

Being empathic is to accurately perceive and acknowledge another's perspectives and emotions with a non-judgmental attitude (Miller & Rollnick, 2002). A MI provider empathizes with patients' feelings (including ambivalence and resistance) by using reflective listening and a non-judgmental attitude. HCPs seek to understand patients by being respectful of their feelings and by acknowledging their perspectives. However, this does not imply that HCPs agree with patients' perspectives. It means that HCPs are respectful and accepting of patients' rights to have their unique experiences and feelings. For example, an empathic response to a patient with heartburn who is doubtful about the efficacy

of his/her medication could be “So it seems to you like the medication is not working since you aren’t getting any relief from heartburn.” Thus, patients feel understood and become more open to receiving medical information addressing their concerns. Empathizing with the patient avoids triggering resistance in the patient and legitimizes medical information provided by HCPs. When patients feel understood and cared for by their HCPs, the information that follows is more likely to be viewed as supportive of that caring.

2. Roll with resistance:

Rolling with resistance refers to exploring and understanding the cause of a patient’s resistance instead of disagreeing with the patient’s resistance. This approach is based on the assumption that the patient is an expert about his/her problems (Miller & Rollnick, 2002). For example, rolling with resistance with a patient who resists quitting smoking could be, “What makes quitting difficult for you?” MI considers resistance to change and/or ambivalence about change to be natural patient responses that need to be acknowledged and explored. The acknowledgement of patients’ feelings helps patients to feel understood and to give up their need for defenses. In other words, MI recognizes that arguing with patients about their resistance and ambivalence only produces more resistance. By accepting resistance/ambivalence as natural and focusing on the patients’ underlying issues, HCPs invite patients to resolve ambivalence and resistance.

3. Avoid argumentation:

Arguing with patients is avoided in MI as it could reinforce the negative health behaviors of patients. When HCPs argue for change by offering the

advantages of making a change, patients are likely to argue for not making a change. Thus, arguing for change could force patients who are not ready to be more adamant and unwilling to change. Therefore MI providers avoid argumentation and instead address patients with thought provoking questions that elicit from patients their own reasons for making a change and help patients focus on the underlying issues.

4. Develop discrepancy:

MI providers explore how a patient's current health behaviors relate to the patient's broader goals and values. For example, if one of the cherished interests of a patient with high blood pressure is to spend time playing with her grandchildren and see them grow, the MI provider carefully may ask how her active involvement with her grandchildren is supported by her behavior of not taking medications regularly, thereby putting her at a greater risk of a heart attack or stroke. A MI provider highlights this discrepancy between her current behavior and her personal goal to allow the patient to reflect on how important it is for her to make a behavior change in order to achieve her goal. This approach is known to increase a patient's motivation without HCPs having to pressure or persuade patients to make behavioral changes. Thus, developing discrepancy and creating dissonance elicits from patients their intrinsic motivations to change rather than having the HCP impose various reasons for making a change.

Another way to create dissonance is by helping the patient make the argument for change. For example, if a patient needed to lose weight, a HCP could say, "If you were to lose the weight you wanted to lose, what would you

like about that? What would be the benefits?” The HCP would then listen carefully and reflect back his/her understanding. The patient would now be making the case for change. Dissonance would be created if the patient did not engage in weight loss activities, as a result.

5. Support self efficacy:

MI providers reinforce patients’ positive health behaviors and express confidence in the patients’ ability to implement any additional steps directed towards improving their health. Thus, supporting self efficacy puts the onus on the patients to act in their best interests and infuses confidence in implementing those actions. Even when a patient expresses willingness to consider making a change in the future, a MI provider reinforces the patient’s positive step of even considering making a change.

These five principles are abbreviated as the acronym, READS. This acronym results from the first letter of each of the five skills (Roll with resistance, Express empathy, Avoid argumentation, Develop discrepancy, Support self-efficacy). Among these five principles, being empathic is foundational for the effectiveness of MI in eliciting patients’ intrinsic motivations to make positive behavior changes (Miller & Rollnick, 2002). Empathy is the foundational skill because empathy helps patients to feel understood, decreases their defensiveness, increases their awareness of the beneficial and detrimental aspects of their own behaviors, legitimizes the information provided by HCPs and thereby helps patients in making well-informed choices.

Empathy. Empathy is the translation of a German word ‘Einfühlung’, meaning “feeling oneself into”, which was used to describe aesthetic experiences (Goldstein &

Michaels, 1985; Wiseman, 1996). The importance of empathy was recognized by Sigmund Freud in establishing a good relationship with patients (Barone et al., 2005). Empathy, as a concept in therapy, was brought into prominence by Carl Rogers (Barrett-Lennard, 1981). Rogers defined empathy as:

“Being empathic is to perceive the internal frame of reference of another with accuracy and emotional components and meanings which pertain thereto as if one were the person, but without ever losing the ‘as if’ condition. Thus it means to sense the hurt or pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. If this ‘as if’ quality is lost, then the state is one of identification” (Rogers, 1975, p.2).

Thus, empathy implies witnessing patients’ emotional worlds, but not getting entangled in their emotions. According to Rogers, “being empathic” is characterized by being non-judgmental, being comfortable in patients’ worlds and being sensitive to patients’ feelings (Rogers, 1980). Rogers’ definition of empathy was simplified by Barrett-Lennard by breaking it down into three phases for practical purposes.

Barrett-Lennard (1981, 1993) conceptualized the process of empathy into three phases: resonance with the patient, communication by the HCP and reception by the patient. The first phase of resonating with patients’ feelings is crucial for the effectiveness of the other two phases of empathy as accuracy in perception could only add value to its being communicated to patients and patients’ feeling understood. The accuracy of perceiving patients’ feelings can be enhanced through attentive listening and being non-judgmental.

Rogers emphasized the process of perceiving the client's world by listening deeply:

“I find both in therapeutic interviews and in the intensive group exercises which have meant a great deal to me, that hearing has consequences. When I truly hear a person and the meanings that are important to him at that moment, hearing not simply his words, but him, and when I let him know that I have heard his own private personal meanings, many things happen. There is first of all a grateful look. He feels released. He wants to tell me more about his world. He surges forth in a new sense of freedom. He becomes more open to the process of change” (Rogers, 1980, p.10).

To Rogers (1980), hearing deeply means hearing on all levels: the words, the personal meaning that the client is conveying, and the meanings that are beyond the awareness of the client. Such deep hearing, as expressed by Rogers, has a tremendous positive impact on patients, though seemingly simple. Unfortunately, hearing patients' perspectives about illnesses and its treatments, and exploring their motivation to adhere to treatment regimens have been given less importance in healthcare due to the widespread use of interviewing approaches that focus solely on symptoms and diagnostic information.

The therapeutic effect on a patient of being deeply heard and understood by a healthcare provider (HCP) has been recently acknowledged by Suchman, Markakis, Beckman and Frankel (1997). First of all, it gives hope to patients when their concerns and feelings are understood by another, and also it tends to open them up to share their feelings with others, leaving them more expanded. Secondly, listening without judgment

helps patients to listen to their own inner feelings more acceptingly and this in turn makes them more congruent with their experiencing (Rogers, 1980). This is because they tend to become respectful of their own feelings and do not deny them as unworthy, and thus become aware of moment-to-moment experiencing of feelings. Moreover, this awareness of one's own experiencing brings the possibility of making positive modifications to the pattern of one's thoughts and behaviors.

The importance of listening and resonating with patients' feelings is growing in importance in healthcare. Generally people are not used to expressing their own emotions or another's emotions in words, because most emotions are communicated (consciously or unconsciously) in the tone of voice, facial expressions, posture, and bodily movements; therefore, it becomes important to train HCPs to verbally communicate empathy with patients' emotions. Training programs that focus on empathic skills have been developed for both HCPs and student professionals.

Summary of Studies on Empathy Training in Healthcare. Many studies of empathy training approaches in healthcare (DasGupta & Charon, 2004; Henry-Tillman, Deloney, Savidge, Graham, & Klimberg, 2002; Larson & Yao, 2005; Shapiro, Morrison, & Boker, 2004) have focused on helping HCPs to respond emotionally to patients by gaining an emotional understanding of patients' suffering through various methods such as reflective writing, emotional labor, shadowing patients throughout their medical visits, reading poetry and prose, etc. All of these approaches could be beneficial in making HCPs more compassionate towards patients while offering medical care; yet there is no evidence that these attempts to make HCPs more emotional and compassionate actually help them in their accurate discernment of patients' affective states and contents of their

feelings. Rogers defined empathy as not getting entangled in patients' emotions and feelings, but as moving about freely in the patient's world. He stated: "To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition (empathy) we are endeavoring to describe" (Rogers, 1957, p. 98).

The above cited studies of empathy training in healthcare use two different approaches to train HCPs to be empathic, namely 1) nurturing humanness in medical care as an approach for better understanding of patients, and 2) communication skills training. The approach of nurturing humanness in trainees is apparently based on the presumption that HCPs' indifferent attitudes towards patients' emotions is the major cause for lack of empathy in patient-HCP relationship, but there is no clear evidence whether a compassionate and caring attitude would be sufficient to comprehend and reflect patients' perspectives and feelings. It is not unlikely that an emotional and compassionate HCP may have hesitation in being empathic to patients because of fear that they could get entangled in patients' emotions and may have difficulty in gaining insights of patients from patients' own frame of reference

Communication skills training focuses on developing a broad range of skills such as 1) asking open ended questions instead of closed ended questions, 2) psychosocial probing, 3) appropriate ways of responding to patients' questions, and 4) reflecting patients' perspectives. These skills are usually learnt by watching the videotaped recordings of patient-HCP interactions, by doing role plays in groups, by interviewing standardized patients or real patients. Participants also get to watch videotapes of their counseling standardized patients and receive feedback from instructors and or

standardized patients. Trainees are instructed to respond to patients empathically by reflecting patients' feelings. The problem with this training approach is that it is not based upon evidence about what difficulties are experienced by HCPs as they learn to be empathic. Exploring patterns associated with poor empathic responses could then be taken into consideration while designing training programs for empathy. This would be an evidence based approach to empathy training.

The knowledge of communicative patterns that undermine HCPs' empathy should be based upon observation of HCPs learning to empathize in either a real or simulated patient-HCP interaction. Prior studies of patient-HCP interaction in health care settings have identified a number of problems with respect to HCP empathy. These studies suggest that HCPs:

- Do not acknowledge 70% of patients' emotional expressions (Easter & Beach, 2004).
- Speculate about patients' feelings (Roberts, Wass, Jones, Sarangi, & Gillett, 2003).
- Often disregard patients' explicit emotional expressions as well as implicit emotional cues (Suchman et al, 1997).
- Often overlook even patients' repeated emotional expressions with escalating intensities (Suchman et al, 1997).
- Interrupt patients' emotional expressions with premature empathy (expressing understanding before patients could express themselves fully) (Suchman et al, 1997).

Thus, there is a lack of sensitivity and motivation to empathize with patients' affective states. This low motivation to empathize with patients' concerns could be because HCPs do not see the importance of being sensitive to patients' experiences of their illnesses. HCPs generally have a technically sound knowledge about various diseases and treatment remedies including medications and life style changes. As a result there is a tendency to recommend everything that the patients' ought to do to manage their illnesses without exploring patients' perspectives of their illnesses or their level of motivation to adhere to HCPs' recommendations. When HCPs do not see the importance of being sensitive to patients' experiences of their illnesses, then the HCPs' motivation to use empathic skills (even after training in reflective skills) would be low. These HCPs could be more benefitted with a training approach that initially helps them to realize the significance of empathizing with patients' perspectives in improving treatment adherence, before imparting training in empathic skills.

Training in reflective listening skills would be helpful for HCPs who are sensitive and motivated to empathize with patients but lack the necessary skills to communicate their understanding. These HCPs may be impeded by tacit everyday language practices implementing a persuasive approach to influencing a patient instead of eliciting patients' motivation in adhering to treatment regimens. The results of the preceding studies on patient-HCP interaction indicate the need for identifying the attitudinal, skill based and communicative factors that undermine empathic communication in trainees. This exploratory study endeavors to identify patterns that either undermine or facilitate HCPs' ability to be empathic with patients.

Purpose of Study. In view of the findings that HCPs place very little importance on understanding patients' emotional expressions, and often minimize any opportunities for patients' emotional expressions during medical interviews, this study would propose to answer the following questions:

- What problems do HCPs have in learning to empathize with patients' perspectives/concerns about their illness and its management?
- What problems are faced by HCPs in learning to address patients' perspectives/concerns?
- How do HCPs respond when patients express their feelings ?
- How do HCPs coordinate empathy with the other READS skills?

Significance of the Study. Understanding common problems faced by HCPs in empathizing with patients could help in developing teaching strategies in empathy training programs. This study could highlight common problems faced by HCPs in terms of verbal and nonverbal responses along with attitudinal issues that hinder good empathy. Thus, training programs could be made more holistic by ensuring that HCPs not only learn a set of skills, but also are knowledgeable of their attitudes (expert attitude, disease oriented approach or patient-centric attitude) that are reflected in their responses. The trainees could be made aware of everyday language practices that result in poor empathy, thereby avoiding common pitfalls experienced by learners in being empathic. The understanding of a patient's feelings is essential for building a good therapeutic alliance between the patient and the HCP (Berger, 1990, 1993). Patients would also be less burdened with information if HCPs are able to specifically serve patients' unique needs. Identifying the problems faced by HCPs while learning to express empathy could allow

for any necessary modification of empathy training in the Auburn University Motivational Interviewing Training Institute (AU MITI). AU MITI offers an intensive training program in MI skills at Auburn University. This training program is briefly described on page 33. It could promote efficient use of resources invested in this training program as well as other empathy training programs.

Uniqueness of the Study. This study will be the first of its kind to look at difficulties experienced by health care HCPs in learning empathic behavior in the context of motivational interviewing. This study examines not only whether HCPs identify and reflect patients' concerns/perspectives accurately but also whether they address these concerns. In clinical counseling, patients not only need to feel understood but also need to know how to manage their illnesses. For example, a patient may express her belief that she doesn't see the need to take her medications each day as she feels perfectly healthy. In this case, HCPs should address the patient's misconceptions after expressing understanding of the patient's concern about taking medications. Merely acknowledging the patient's concern would leave the patient still strongly believing that she doesn't need her medications. This makes it important for HCPs to address patients' concerns/misconceptions about their illnesses or its management in an empathic way. This study also focuses on understanding communicative patterns that impede HCPs' abilities to be empathic, especially when trying to overcome their past reliance on the biomedical approach to counseling patients. The biomedical approach of counseling patients considers HCPs as experts who offer medical advice to patients and therefore patients are expected to be compliant (Choice, 1994). Also, in this approach the health care HCP is the expert and assumed to know what is best for the patient. Thus,

understanding patients' perspectives of illnesses is not considered necessary for treatment.

Contribution to the Literature. This study could highlight communicative barriers to an accurate empathic understanding of patients. The attitudinal factors and communicative practices that may be affecting HCPs' empathic behavior could be described, so that future empathy training programs in healthcare focus on the development of attitudes and skills simultaneously. It could identify patterns of HCP responses and could generate hypotheses for HCP characteristics associated with patient-centered behaviors.

II. LITERATURE REVIEW

Empathy in Healthcare. Empathy is considered to be the most essential element of all helping professions (Reynolds, Scott, & Jessiman, 1999). In healthcare, empathy has been found to improve treatment outcomes (Book, 1988b; Larson & Yao, 2005), patient satisfaction with healthcare services and HCP job satisfaction (Book, 1988a; Larson & Yao, 2005) and adherence to medication regimens (Coulehan et al., 2001; Kim, Kaplowitz, & Johnston, 2004; Squier, 1990; Stepien & Baernstein, 2006). The ability of a physician to understand the personal meanings of a patient is considered to be the foundation for a good physician-patient relationship. It improves treatment outcomes by timely diagnosis, efficient treatment planning and avoids needless diagnosis, prescriptions, and even hospitalizations (Bellet & Maloney, 1991). In nursing, empathy has been suggested to increase nurse HCP's job performance and reduce absenteeism (Herbek & Yammarino, 1990).

Empathy Training in Psychotherapy. One approach to empathy training in psychotherapy called didactic-experiential training was developed by Truax, Carkhuff and their research group. It was comprised of the following modules (Goldstein & Michaels, 1985):

- Reading list: Reading materials on theories and practices on psychotherapy from different orientations.
- Tape library: Tape recordings of therapeutic counseling sessions

- Discrimination practice: Here the trainees rate the above counseling sessions on accurate empathy scale.
- Reflection of feelings: Here the trainees learn to reflect the feelings by using interchangeable responses of the therapist.
- Live role play: It involves participants taking the role of therapist and patient.
- Feedback: The above role play was recorded and rated by group members who shared their feedback.
- Therapeutic interviews: Trainees interviewing actual patients were tape recorded.
- Feedback: The above recorded psychotherapeutic sessions were used for offering feedback.
- Quasigroup psychotherapy: The trainees had regular group meetings from the beginning of the training where they shared their feedback about each others' affective functioning.

Later in 1969, Carkhuff devised another didactic-experiential approach with two phases of empathy training. The first phase was the discrimination phase, where the trainees learn to discern patients' feelings through discussions on empathy, listening to video tapes, rating them and ending with discussions where trainees share the reasons for their ratings. The second phase focused on communicating empathy, which involved responding to taped conversations, role plays, interviewing actual clients and sharing feedback (Goldstein & Michaels, 1985).

Another approach to empathy training called Interpersonal Living laboratory was developed to teach empathy and other interpersonal skills (Goldstein & Michaels, 1985). In this method, the participants in a small group commit themselves to simultaneously

learning theoretically about these skills and practically implementing these skills in the group. The participants explore their behaviors in the group, while attempting to establish relationships with others, and later share their feedback about their group members' strengths and weaknesses. This approach gives the trainees an opportunity to experiment with new interpersonal styles. It teaches accurate empathic understanding through attending and listening to group members with respect and genuineness (Goldstein & Michaels, 1985).

The prior described empathy training methods originated in psychotherapy. The significance of HCP empathy in health care was recognized, with results showing that empathy improved treatment outcomes (Book, 1988b; Larson & Yao, 2005), patient satisfaction with the health care services, and adherence to medication regimens (Kim, Kaplowitz, & Johnston, 2004; Squier, 1990; Stepien & Baernstein, 2006). This awareness of the significance of empathy in healthcare brought about a shift in the HCP's style of interviewing patients from a biomedical approach (HCP-centered) to a more patient-centered approach of being empathic with patients. Patients' perspectives about their illnesses and treatment approaches began to be viewed by HCPs as important in improving therapeutic outcomes. A more collaborative approach to counseling patients evolved emphasizing egalitarian patient-HCP relationships. This change in perspective of the health care community about the way HCPs should relate to their patients further led to the introduction of patient-centered skills training programs that taught HCPs to respond to patients with empathy.

Empathy Training in Healthcare. The purpose of describing the following studies conducted in healthcare is to suggest that empathy training programs have mainly focused on teaching HCPs:

- To be sympathetic to patients by various means such as reflective writing,
- To respond emotionally, and
- To communicate their understanding to patients.

Henry-Tillman's study in 2002 looked at improving empathy among first year medical students through the Navigator project (Henry-Tillman, Deloney, Savidge, Graham, & Klimberg, 2002). The project required each student to assist a patient throughout the patient's medical visit. Eighty percent of the students assisted patients in navigating through the hospital wards (while 20% could not find patients) and observed their interactions with physicians. After one week of medical visits, students met in groups of five to six students to share their experiences with a surgeon and program evaluator. The students reported that they experienced the emotions that usually patients undergo during their visits and learned to see patients as individuals and not just as numbers or diseases. However, the 13 item scale which was administered to measure any differences in empathy between pre-test and post-test showed no significant differences, which was attributed to ceiling effects. Also, there was no indication about the validity of the scale as well as the students' perceived definition of empathy. This approach to teaching empathy is based on the assumption that empathy increases when individuals experience similar emotions to those with whom they wish to be empathic.

Another study (Shapiro, Morrison, & Boker, 2004) looked at teaching empathy using poetry and prose related to patients and doctors. This study measured empathy by

both quantitative and qualitative analysis. The participants were volunteers who were first year medical students and the intervention consisted of eight one hour sessions over a period of four months, where students met in small groups to discuss poetry, skits and short stories. A cohort-control design was used to control for maturational effects and to control the effects of course curriculum on participants' empathy. The participants were randomly assigned to two groups and their baseline scores of empathy were taken. The scales used for quantitative analysis of empathy were the Emotional Construct Rating Scale (ECRS) and Balanced Emotional Empathy Scale (BEES), while for the qualitative analysis, their group discussions were tape recorded and transcribed. The qualitative part of the study helped in obtaining students' perceptions of empathy and their attitude toward the humanities. The study reported significant improvement in students' empathy after the intervention and also in the participants' belief that a humanities course could help them to become more empathic and thereby better professionals.

However, this study (Shapiro, Morrison, & Boker, 2004) relied on self-reported measures of empathy and therefore could have some bias in the empathy measures. Moreover learning about the experiences of illness and suffering makes one compassionate or sympathetic towards patients, but not necessarily empathic in nature. To be empathic, HCPs have to set aside their preconceived notions about illnesses and sufferings, which otherwise could lead to projection of one's own notions upon the patients and consequently lead to misrepresentation of patients' experiences and emotions.

Another approach (DasGupta & Charon, 2004) for teaching empathy involved reflecting on one's own personal illnesses. The underpinning of this approach to teaching

empathy is that when HCPs reflect upon the subjective experiences of their personal illnesses, they become aware of the feelings, emotions and vulnerability that are usually experienced by patients. This approach has been reported to help overcome the negative effects of medical education that makes students objective in understanding patients. The study participants involved sixteen self-selected second year medical students who opted to attend this seminar course among many other seminars. This study evaluated the effectiveness of seminars that were conducted on two consecutive years, each comprising eight participants. The participants wrote about their experience of illness or how they were affected by the illness of their loved ones. The participants had to expand their essays several times for the purpose of honors credit. The evaluation was based on seven questions that asked the students to offer insight about the choice of topic of their illness, writing and reading experience of their essay on illness, feelings they uncovered during the essay writing, their experience in listening to their group members' experiences and insights, and how their overall experience of the training method might help them to care for patients. The responses of participants were evaluated based on content analysis and thematic analysis using an iterative process.

Reflective writing helps in becoming aware of general emotions experienced by patients and helps in being compassionate to patients. However, it may lead the HCP to judge in advance and speak for the patient based on his/her personal experiences of illness thus affecting the accuracy of empathic understanding. The validity of the questionnaire or scale for measurement of empathy is not reported in the study, and also the evaluation process relied on the expertise of the researchers without the use of any standard measures.

Communication skills workshops have been used to enhance empathic skills among first-year medical students. In a study by Winefield and Chur-Hansen (2000), a communication skills workshop was employed in developing a repertoire of skills for interviewing patients with special attention on empathy. The participants initially completed a pencil and paper empathy test (modified Danish & Hauer empathy scale). After completing the test, they underwent a didactic session on the fundamentals of empathy and interviewing skills and thereafter attended skills training workshops in groups. Trained community members acted as standardized patients and the participants gained feedback from the standardized patient, their group members and the tutor. The sessions were videotaped and the students reflected upon their performance in order to perform better the next time, and there were a total of two workshops of 1.5 hours each. Thereafter the participants applied their skills in an actual interview with a community member, who was unknown to them before. The topics (with a few options) for the interview were related to psychological adjustment of the interviewee. The session was videotaped and a post-test was administered. This study reported significant improvement in students' empathic skills based on self-reports by participants on the Danish and Hauer empathy scale. However, this study acknowledges that the paper and pencil test measures student's knowledge of how to write an empathic statement, but not their ability to be empathic during interaction. In addition, the empathy measurement scale used was not valid and the study had no control group (Winefield & Chur-Hansen, 2000).

History taking by physicians has been suggested to enhance empathy (Spiro, 1992). Some other methods that are employed to enhance empathy levels in physicians include emotional labor, which deals with surface acting (acting empathic) and deep

acting (involves imagination and experiencing the patients' suffering) (Larson & Yao, 2005). Theater, literature and writing methods have also been employed to help students to know how it is to be a patient with varied illnesses, which would expand their ability to understand the patient from his/her perspective (Shapiro, Morrison, & Boker, 2004; Stepien & Baernstein, 2006).

Summary of Empathy Training in Healthcare. Most of the above cited studies apparently conceptualized empathy as 'being compassionate' and as an emotion, and mainly focused on enhancing communication skills, teaching participants to respond emotionally, providing participants' insight into the sufferings of patients during various illnesses, helping participants to see patients from a holistic perspective and developing humanness in medical care. Thus, empathy training programs in healthcare focus on teaching participants to cultivate compassionate and caring attitudes toward patients through sharing the real life experiences of patients, through humanist/artistic readings, through reflection upon personal experiences with illness, or through communication skill training.

Nurturing a caring attitude towards patients in HCPs could be valuable in creating a good relationship with patients. Communication skills training offers a broad range of skills to be empathic, while the approach of nurturing humanness appears to be based on the assumption that HCPs' indifferent attitudes towards patients' emotions is the major cause for lack of empathy in patient-HCP relationship, but there is no clear evidence whether a compassionate and caring attitude would be sufficient to comprehend and communicate patients' perspectives and feelings. According to Basch (1983), many demagogues, who have exploited people, had the ability to accurately identify and

resonate with another's thoughts and feelings, but they utilized this ability to meet their own selfish ends. In other words, one need not be compassionate to be empathic nor does one who is compassionate need be empathic. Thus, empathy training should identify the root causes (or factors) that impede HCPs' ability to be empathic, including both reflective skills and attitude. One way of looking at factors that undermine HCPs' empathy could be based upon an analysis of patient-HCP interaction to identify patterns of HCP responses. Patient-HCP interactions have been studied in healthcare as well as in other kinds of settings using the method of discourse analysis.

Discourse Analysis and Empathy. Discourse analysis method comprises various approaches to studying interactions between people in order to gain insights about the nature of talk and human behavior. One such approach involves studying recorded face-to-face spoken interaction in order to identify generalizable patterns in the use of words and non-verbal behaviors (Fitch & Sanders, 2005). This approach could help in identifying any commonalities in the nature of the interactional processes used by HCPs that impede their empathic behaviors.

Discourse analysis typically involves the following steps. The first step is to gain insight into the practice that is being analyzed, for example, patient counseling practice in a community pharmacy. The purpose is to understand the culture of the practice setting, the ideals of practice, and also to get a sense of practice behaviors that are relevant to the focus of a study. Insights into practice could be gained by recording the discourse activity and watching the recordings. The next step involves identifying the segments of practice that need to be transcribed and this would depend upon the problem that is being studied. A study focusing on empathy would pay attention to segments where there is an

opportunity for a HCP to express empathy, for example, a segment where a patient expresses his/her concerns. The next step is to minutely analyze the segments of practice, giving attention to the speech acts, the choice of words, intonations, pauses, repetitions, facial expressions such as anger, shock, etc. The segments are interpreted and described in rich detail (Fitch & Sanders, 2005). The transcribed segments are then classified based on their similarities in practice behavior. For example, segments of practice where HCPs express their understanding of patients would be classified together.

The method of discourse analysis has been widely used in studies of physician-patient interaction to describe how physicians facilitate patients in telling their stories, how physicians respond empathically, and how physicians elicit patient information (Heritage & Maynard, 2006). Studies have also reported physicians spending time in useless argumentation (Korsch, Gozzi, & Francis, 1968) and in speculating about patients' feelings instead of eliciting them (Wass, 2003). Discourse analysis has also been used in observing approaches used by patients in telling their problems to the physician, in displaying their understanding of medical information and in questioning the physician's authority (Cordella, 2004). Discourse analysis methodology has been used to study empathy in patient-HCP interactions. The following summary of the findings of studies highlight the barriers and facilitators to good empathic communication in a patient-HCP interaction.

Roberts (2003) examined the differences between good and poor communicators in a sample of student physicians and reported that good communicators were attentive to patients' feelings, which is a characteristic of the 'resonation' phase according to Barrett-Lennard's empathy cycle (Barrett-Lennard, 1981). The research methodology used in this

study was discourse analysis. Empathy was stated to be one of the characteristics of good communicators in the study. Some of the reported barriers to good communication associated with empathy were making assumptions about patients' emotions, not trusting patients, and trained empathy (Roberts, 2003).

Assuming patients' feelings is based upon HCPs presupposing that they know what their patients are thinking or feeling before patients had an opportunity to express themselves fully. In essence then, the HCPs' empathic responses could be projections of their assumptions and judgments instead of accurate reflections based on attentive listening. Distrusting patients is also a hindrance to empathy. HCPs who doubt patients are less likely to acknowledge patients' view points and may be less inclined to address these concerns. According to Frank (2004), disbelieving patients makes patients' suffering worse.

Trained empathy and the use of standard phrases were also reported to be counter-productive in this study (Roberts, Wass, Jones, Sarangi, & Gillett, 2003). Trained empathy refers to the use of formulaic phrases for expressing empathy that negate the need for deeply hearing the patient such as "I understand that". Empathic responses in this study could have been a superficial display of understanding rather than a heartfelt response to patients' feelings; however this study did not report the reasons for the failure of trained empathic responses. Also, incongruence between HCPs' attitudes and their formulaic expression of empathy could result in damaging patients' trust in these HCPs. The strength of this study was a large sample size consisting of 179 participants and an analysis of a total of 309 consultations. However the definition of empathy was different from Roger's definition of empathy. Empathic styles were defined as also including

participants reassuring patients as in “You don’t have to worry”, participants getting the cooperation of patients for joint problem solving, contextualizing (asking the right questions at the right time) and face saving. Clearly this definition of empathy is broader than Rogers’ classic definition of empathy.

Easter and Beach (2004) used discourse analysis methodology to examine physician-patient interactions for how physicians responded to opportunities to empathize with their patients when these patients essentially asked for empathy, understanding or support. Thus, their conceptualization of empathy was broader than Rogers’ definition of empathy as it also included the supporting of self-efficacy by physicians as in responses like “That’s great”. The study reported that:

- Only 30% of the total opportunities for expressing empathy with patients were utilized by physicians.
- Physicians focused on treatment options instead of diagnostic information.
- Physicians were reported to be careful in avoiding naming disease conditions such as cancer and in avoiding any questions that would elicit patients’ feelings or emotions.
- The questions asked by physicians were objective in nature focusing on symptoms and treatment options.
- The physicians also failed to acknowledge the unique experiences of patients, and instead resorted to generalizing patients’ feelings leading to discounting of patient suffering.

A limitation of the preceding study (Easter & Beach, 2004) was a small sample size consisting of eight physicians and sixteen patient-physician interaction recordings.

In another study of empathic communication in a medical setting, Suchman and colleagues (1997) observed empathic opportunities by focusing on how patients expressed their emotions, how physicians responded and what the interactional outcomes were. This study found that patients' emotional expressions were usually subtle and implicit in nature with few explicit verbal expressions. Physicians usually did not acknowledge or explore patients' feelings (implicit as well as explicit) and instead responded by shifting the topic of discussion to obtaining diagnostic information, usually through objective questions and a biomedical interviewing approach. Some patients were observed to re-express the same emotions that were previously ignored by physicians, sometimes with greater intensity (Suchman, Markakis, Beckman, & Frankel, 1997). This phenomenon clearly shows how much patients long to be truly heard and understood by their HCPs. Yet the basic pattern was that physicians did not respond to the majority of patients' feelings, much less empathize with these feelings. Another finding of this study was the importance of the timing of an empathic response. It was reported that when empathy was expressed prematurely, it led to interruption of the flow of patient communication (Suchman, Markakis, Beckman, & Frankel, 1997). Premature empathy means expressing understanding before letting patients express themselves fully. For example, a patient may open up to express his/her fear about the side effects of chemotherapy and before the patient could complete the sentence, the HCP interrupts to acknowledge the patient's feelings.

Another study (Hall, Roter, & Rand, 1981) using discourse analysis examined communication of affect between patient and physician. The study analyzed audiotapes for patterns in physician-patient interaction during regular medical visits. There was a

total of 50 patients analyzed interacting with two physicians. The patient-physician interaction was examined in three separate ways: original speech in the audiotape, transcripts, and filtered speech (that makes words unintelligible by eliminating certain bands from the speech, leaving behind nonverbal characteristics of speech such as intonation contour, speed and rhythm). The study reported that the nonverbal aspects of the HCP's voice contribute to understanding of feelings and emotions more than words (Hall, Roter, & Rand, 1981). The findings of this study are important as nonverbal aspects of a HCP's voice are critical parts of responding to and empathizing with patients' feelings and emotions. This might suggest that empathy training programs might need to place as much importance on nurturing an empathic attitude (of nonjudgmental listening, being respectful of patients concerns and a motivation to address their concerns, etc.) as it does on developing reflective skills in trainees.

Korsch (1968) reported that physicians spend very little time in exploring and listening to patients' feelings and lose much time in needless argumentation with patients. Physicians were observed to be correcting patients on technical aspects of medical science like medical terminologies, which results in patients becoming defensive and dissatisfied with care (Korsch, Gozzi, & Francis, 1968).

All of the above mentioned studies on empathy were conducted in the healthcare sector. There are studies on empathy using discourse analysis methodology in different areas, other than in healthcare such as political negotiations and mediations, which are summarized next.

Martinovski, and colleagues (2006) found that empathy was often rejected when it was perceived that there were ulterior motives behind the empathy. This study though not

in a healthcare setting seemed to be of relevance in patient-HCP interactions. In this discourse analysis study on the rejection of empathy in negotiations, it was reported that empathy is closely associated with trust (Martinovski, Traum, & Marsella, 2006). For example, when individuals trust each other, empathy is well received. On the other hand when individuals perceive covert intentions in others' reflective listening, they are less likely to be receptive. Even though HCPs may be adept at reflective skills, they may not gain the trust and receptivity of patients if they use their understanding to manipulate patients' decisions (like getting a patient to quit smoking although the HCP may have accurately reflected the patient's need to smoke in order to relieve stress).

Preece (1994) studied typed empathic communication in online communities. A wide variety of communities were examined such as emotional support communities (with members suffering from same disease condition), sports communities, and religious communities. This study comprised two sub-studies, one of which examined 500 messages from a single online community to identify the number of empathic messages versus other types of messages like factual, hostile messages etc. The second sub-study sampled messages from 100 online communities to examine if the results obtained about the percentage of empathic messages in the first sub-study were representative of other online communities as well. In addition, this study also looked into factors that contribute to empathic communication. The results suggested that while empathic communications are common in online communities, empathy is greater in emotional support groups and in moderated communities where moderators set and enforce a more positive and less hostile tone. The presence of women in online communities was also found to increase empathic communication (Preece, 1999).

Summary of Literature on Empathy Using Discourse Analysis. As previously discussed, the literature on empathy suggests that:

- Only 30% of the total opportunities for expressing empathy with patients were utilized by physicians.
- HCPs focus on diagnostic information and ignore patients' emotions.
- HCPs carefully avoid using the names of life threatening disease conditions.
- There is a lack of recognition of patients' unique experiences (Discounting).
- HCPs spend a lot of time in meaningless arguments with patients.
- Patients' emotional expressions are usually subtle and implicit in nature.
- HCPs do not explore patients' implicit emotional cues and disregard explicit emotional expressions, even when repeated with greater intensity.
- Premature communication of empathy leads to interruption of the flow of patient communication.
- Nonverbal aspects of a HCP's voice convey emotions more than the words.
- HCPs make assumptions about patients' feelings instead of attentively exploring patients' feelings.
- HCPs distrust patients and trained empathy was found to be counter-productive.
- If empathy by a HCP is perceived by the patient as contrived, this empathy is often rejected.

Research Questions. In view of the findings that HCPs often

- overlook patients' emotional expressions,
- avoid emotions and focus on diagnostic information,
- ignore patients' emotions even when raised again with an escalating intensity,

- interrupt patients' emotional expressions,
- discount patients' feelings,
- speculate what patients' feelings must be,
- carefully avoid naming newly diagnosed life threatening conditions like cancer and thereby make exploring patient reactions more difficult, and
- engage in meaningless arguments with patients,

this study would explore the following research questions:

- What problems do HCPs have in learning to empathize with patients' perspectives/concerns about their illness and its management?
- What problems are faced by HCPs in learning to address patients' perspectives/concerns?
- How do HCPs respond when patients express their feelings?
- How do HCPs coordinate empathy with the other READS skills?

III. METHODOLOGY

Study Design. This study is exploratory and retrospective in nature, intending to examine the problems faced by HCPs in expressing empathy in the course of learning motivational interviewing. More specifically, this study will systematically explore the discourse characteristics of empathic responses by a sample of HCPs (nurses, pharmacists, and social workers) during videotaped interaction with standardized patients as the final mode of assessment during their training in motivational interviewing

Study Sample. This study sample is comprised of a convenience sample of videotapes of healthcare professionals and student pharmacists. The videotaped interactions of healthcare professionals primarily include nurses and pharmacists, with a few social workers, who were trainees at one of several motivational interviewing training programs conducted by the Auburn University Motivational Interviewing Training Institute (AU MITI) during 2007 and 2008.

AU MITI offers an 18-hour intensive training program and includes:

- Didactic teaching:
 - The didactic teaching includes delivery of lectures on the theoretical concepts, principles and strategies underpinning motivational interviewing
- Writing exercises:
 - Writing exercises involve two stages. In the first stage, working in small groups, HCPs begin by discussing and writing short empathic responses to

- the given patient emotional statements in the exercise. In the second stage known as “Transition exercises”, HCPs put themselves in the place of patients and imagine how the patients might respond to their empathy. Thus, in the second stage, they develop a written dialog with three to four exchanges between patients and themselves.
- Role playing:
 - Role playing involves trainees acting as a HCP while another trainee acts as a patient. The acting patients and HCPs are given a case for consideration with all the details of a patient including patient profile such as age, weight, blood pressure, etc, patients’ disease states, medication profile, the patient’s life style and attitude towards medications or disease management. Trainees are given a few minutes to ponder over the case before playing their roles in five minutes. Trainees acting as a HCP obtain feedback about their performance from the instructors along with all the members of the group, who are undergoing training. When not acting as a HCP, they are observing, evaluating and giving feedback to others as they role play.
- Interviewing standardized patients in a videotaped OSCE:
 - In this phase, HCPs apply their knowledge and skills learned over the period of training to counsel two standardized patients using motivational interviewing. Each standardized patient has different disease states and different attitudes towards managing their disease. Standardized patient #1 has diabetes and blood pressure while standardized patient #2 has

gastroesophageal reflux disease (GERD). Patient #1 relies mainly on exercise and some diet management to manage her illnesses while patient #2 relies only on medication to manage his illness. Patient #1 dislikes the idea of taking medication while patient #2 dislikes the idea about changing his life style such as diet and exercise. Appendices 1 and 2 contain the profiles of these two standardized patients as provided to the AU MITI participants prior to the OSCEs, whereas appendices 3 and 4 contain the complete profiles of these two standardized patients as provided to the actors playing the standardized patients. The time allotted for each interview was five minutes and these sessions were video recorded with the permission of trainees. These videotaped interviews were then analyzed in order to provide feedback to trainees and to make further modifications in the training program.

During these two OSCEs, HCPs were expected to use the READS skills (rolling with resistance, expressing empathy, avoiding argumentation, developing discrepancy, and supporting self-efficacy). Because being empathic to patients is considered the foundation for the effectiveness of motivational interviewing, participants were highly encouraged to be genuinely empathic and non-judgmental. “Early empathy” is a phrase used by the AU MITI instructors to highlight the necessity to be empathic first before applying the repertoires of other MI skills and techniques when patients express their feelings including resistance and ambivalence. This is because when HCPs empathize with resistance, patients tend to give up their defenses and become more open to change. This further helps in exploration of a patient’s resistance or unwillingness to change.

Thus being genuinely empathic is the foundation of the motivational interviewing approach and participating HCPs were expected to demonstrate empathy extensively during these two OSCEs.

Methods. Discourse Analysis methodology was used to analyze the videotaped OSCEs in this study. This method has been used in healthcare in the past for investigating physician-patient interaction (Cordella, 2004; Heritage & Maynard, 2006; Korsch, Gozzi, & Francis, 1968; Wass, 2003).

The first step in this study involved getting acquainted with how HCPs were trained in MI and how they went about interviewing the standardized patients in the OSCEs. For example, systematic attention was paid to how they greeted patients, how they informed patients about the purpose of counseling, how they invited patients to express their concerns, how HCPs acknowledged patients' concerns, and how they addressed those questions, etc. This understanding was obtained by watching videotapes of HCPs' conversations with the standardized patients.

The next step involved identifying the segments of videotapes that could help in understanding empathic behaviors of HCPs. As this was an exploratory study of empathy, the focus was on identifying the segments with empathic opportunities where patients expressed their feelings and concerns. After these segments were identified, the HCPs' responses were examined to determine whether or not the patients' feelings and concerns were reflected, empathized with and then addressed by the HCPs.

Initially this study focused only on the HCPs' first few responses to patients' concerns, i.e. whether the concerns were overlooked or empathized with by reflective listening. However, later it was observed that although some HCPs were good at

reflecting patient concerns accurately, these HCPs didn't subsequently address patient concerns and as a result had difficulties in implementing MI later in the interaction. As a result of this observation, the study focused on larger segments of patient-HCP interactions to allow for the examination of how empathic responses to patient concerns led to addressing those concerns. HCPs who just reflected patient concerns and then digressed to other issues were not considered to be using empathy to set up the exploration and resolution of patient ambivalence and resistance that is central to MI.

The segments of video tapes were then transcribed without taking into consideration the identity of the HCPs or the patients. Some of the details of the talk are represented by notations and they are as follows:

The utterances were numbered consecutively. The speaker roles were indicated by the notation HCP and P where:

HCP represents 'Health Care HCP'

P represents 'Patient'

Short utterances by a listener such as uh huh, yeah, okay, etc. in response to the speaker were often not transcribed as separate utterances, but were indicated in parentheses. For example:

P: You know I am getting this heartburn attack at night (HCP: Yeah) even after taking my medicine every day (HCP: Uh huh), so I am wondering if this medicine is working anymore

In the preceding example, the patient speaks continuously and the HCP acknowledges the patient's experiences as indicated in the parentheses by saying "yeah" and "uh huh".

[
[: Two separate left brackets denote overlapping or simultaneous talk by two successive speakers. These two brackets indicate the onset of overlap of speech between two speakers.

]] : Two separate right brackets denote the end of overlapping utterances by two successive speakers.

For example:

- 1 HCP: You might know that smoking can aggravate your illnesses. You should seriously consider quitting smoking if [you wish to]
- 2 P: [Well I don't] think I can quit. Its just a stress reliever

In the preceding example, the onset of utterances 1 and 2 is indicated by the left brackets where there is an overlap in the utterances of the two speakers. The end of overlapping utterances of the two speakers is indicated by the two right brackets.

= : An equals sign represents connecting speech. Equal signs come in pairs and indicates that the first speaker was continuously speaking while the second speaker talked and there was no interruption in the first speaker's speech.

Example:

- 1 P: I prefer to rely less on my medicines as it makes me feel drowsy
- 2 HCP: I see. May be you need more education about your medicine so =
- 3 P: [Well
- 4 HCP: = that you will take them every day as prescribed.

The HCP spoke continuously as in utterance 2 and 4 while the patient's utterance "well" did not interrupt the HCP's speech.

... : Short pauses are denoted by three dots.

WORD : Loud talk is denoted by upper case letters.

Word : Bold letters indicate vocal stress on that word.

() : When some or all of an utterance is in parentheses, for example, it indicates uncertainty on the transcriber's part about what was said, but represents a likely possibility. This should not be confused with listener's utterances like Uh huh, yeah, okay, etc. that are also indicated in parentheses and are called backchannels. The back channels can be differentiated from utterances in parentheses indicating uncertainty as they are responses by the listener while the other one (indicating uncertainty) are utterances by the speaker.

(()) : A double parenthesis for example indicates transcribers' description of events rather than representations of them.

(XXX) : The uppercase letter X in parenthesis denotes inaudible speech. The more the number of X's, the longer is the speech that was not audible.

- : A hyphen after a word denotes a break or self-interruption

Uh huh : Creative spelling is used to approximate the phonetics of vocal output not in the form of words. This transcription convention is often used to represent backchannels.

Hmmm : Repeated letters represent sounds that stretch speech. The more repeated letters, the longer is the stretch in speech.

The transcripts were assigned a code based on the month and year during which the interactions were video recorded, the standardized patient, the videotape number and the HCP. For example a transcript identified as July08_p1_t2_3 indicates that:

1. It was transcribed from the video recording of the trainees who attended the AU MITI program during July 2008 (July08)
2. The patient who was being interviewed was patient #1 (_p1)
3. The video tape used for this recording was tape #2 (_t2)
4. The HCP who was involved in counseling was HCP #3 (_3)

When a segment of a transcript is used as an example, the segment is indicated in parentheses by utterance numbers, for example (Utterances 3-11).

The next step involved minutely analyzing the transcriptions and videotaped segments giving attention to interactional sequences, speech acts, the choice of words, intonation, pauses, repetitions, facial expressions such as anger, shock, etc. The transcribed segments were then classified based on similarities in how HCPs responded to patient concerns. For example, segments where HCPs discounted patient concerns were classified together. This classification of HCPs' responses was based on a consensus between three investigators out of which two were experts in the field of motivational interviewing and are instructors/co-founders of AU MITI. Detailed analysis was then conducted to specify the central pattern at the heart of these similar segments.

Some of the questions that guided the detailed analysis were:

- How do HCPs respond when patients express their concerns to HCPs?
- How did HCPs coordinate empathy with the other READS skills?

- The answers to these analytical questions provided an understanding of the nature/direction of the motivational interviewing process. A detailed analysis of how HCPs responded to patient expressions of feeling indicated that the HCPs could:
 - Empathize with feelings at many different levels
 - Superficially
 - Deeply
 - Ignore the feelings
 - Interrupt the patient
 - Interrogate the patient with open or closed ended questions
 - Overlook (unintentionally) the feelings
 - Discount the feelings
 - Reframe the feelings to provide a new insight to patients

Also, a HCP who immediately interrogates the patient may reflect an interviewing approach centered on the HCP solving the problem for the patient. Here is an example of such an approach:

P: I have been having frequent heartburns at night and occasionally at day times.

HCP: Ok...mainly at night. *So what time do you eat at night?*

P: Usually I eat between eight and nine

HCP: *And what time do you go to bed?*

P: I am pretty regular going to bed at 10

HCP: So you haven't given much time for the food to digest?

P: Hmm...

HCP: Do you mind if I offer some suggestions that some of my other patients have found to be helpful in reducing the heartburn?

In the above example, the HCP immediately starts looking for the cause of the heartburn at night and later on offers some suggestions. The immediate probing in this example highlights the problem solving interviewing approach. A HCP with a problem-solving approach is less likely to empathize with deeper feelings. Overlooking patients' deeper feelings could result in not addressing the core issues of patients. For example, a patient with heartburn says that he has a very hectic job and that he mostly eats at fast food restaurants because his job requires him to travel throughout the day. A superficial empathic response could be "Sounds to me like you have a very busy life". On the other hand an empathic response addressing the deeper issue could be "Sounds like your job doesn't allow you much time to control your diet in a way that could prevent your heartburn".

The data obtained during the analysis could help in developing a better conceptualization of the problems faced by HCPs as they learn to empathize with patients during the course of motivational interviewing. This refined conceptualization of problems encountered in learning to empathize with patients could help in developing further research hypotheses. This approach would then be a data driven method to analyze the problems faced by HCPs in being empathic.

This study would like to find out how the use of motivational interviewing is affected by the nature of HCPs' empathic responses and to observe any differences in the progression of interaction towards understanding patient concerns and in its joint

resolution with respect to the nature of HCPs' responses. For example, an accurate empathic response may save interview time as the HCP may arrive quickly at the core issue that needs to be addressed while an immediate diagnostic examination may cause the interview process to digress from addressing patient concerns in favor of objective evaluation of illnesses. It was found that there were only a few occurrences of well formulated empathy. Consequently attention was restricted to problems HCPs had in using empathy in MI. Hypothetical examples of well formulated empathy have been cited in the results section in italics in order to help the readers to see the contrast between actual HCP responses and well formulated MI responses. The results of this discourse analytic investigation of problems experienced by health care HCPs in learning to use empathy during motivational interviewing are discussed in the following chapter.

IV. RESULTS

As you recall, motivational Interviewing (MI) is a patient-centered approach for assisting patients with behavior change by exploring and resolving ambivalence and resistance. MI is based on five foundational skills known as the READS skills (Miller & Rollnick, 2002). The five skills are:

- Roll with resistance (R):
 - Rolling with resistance involves exploring and understanding the cause of a patient's resistance to change, rather than disagreeing with the patient's resistance or trying to persuade the patient to change (Miller & Rollnick, 2002).
- Express empathy (E):
 - Being empathic is to accurately perceive and acknowledge another's perspectives and emotions with a non-judgmental attitude (Miller & Rollnick, 2002).
- Avoid argumentation (A):
 - Arguing with patients is avoided in MI as it could reinforce the negative health behaviors of patients by causing patients to defend the behaviors in question. When HCPs argue for change by offering the advantages of making a change, patients who are resistant or ambivalent are likely to argue for not making a change. Therefore MI HCPs avoid

- argumentation and instead elicit from patients their own reasons for making a change (Miller & Rollnick, 2002).
- Develop discrepancy (D):
 - MI HCPs explore how a patient’s current health behaviors relate to the patient’s broader goals and values. A MI provider highlights the discrepancy between a patient’s current behavior and his/her personal goal in order to prompt the patient to reflect on how important it is for him/her to make a behavior change in order to achieve the goal. Another way to create dissonance is by helping a patient to make the argument for change. Dissonance would be created if the patient did not engage in the behavior change process, as a result (Miller & Rollnick, 2002).
- Support self-efficacy (S):
 - Supporting self-efficacy refers to reinforcing patients’ positive health behaviors and expressing confidence in their ability to implement any additional steps directed towards improving their health (Miller & Rollnick, 2002).

Together these skills constitute the “basic toolbox” used by HCPs to elicit patients’ concerns, explore their ambivalence and resistance and elicit change talk from the patients.

Empathy. According to Miller and Rollnick (2002, p.37), empathy is foundational for the effectiveness of MI because it helps in expressing one’s understanding of patient concerns. When patients feel understood, they become less defensive and resistant and are more likely to engage in problem solving. They are more

likely to openly discuss barriers to change and be open to assistance. Consequently they become more willing to reconsider their viewpoints in light of new information provided by health care providers (HCPs) because they don't interpret the new information as a way to negate their viewpoint. Also when HCPs echo patient perspectives, it allows patients to be introspective and to reflect upon the ideas they just expressed, thereby increasing the likelihood of self-initiated behavior change.

Here is a hypothetical example of an appropriate use of HCP empathy. Please note that all hypothetical examples will be italicized. Here 'HCP' stands for the HCP and 'P' stands for the patient:

- 1 *HCP: Hi Mrs. Jones. How are you today?*
- 2 *P: Okay...I understand you have my lab results...How do they look?*
- 3 *HCP: I do have them. Let's see...Your A1C is 8, which is high and your blood pressure is 145 over 95, which is also quite high.*
- 4 *P: Really? I am surprised that they are still up because I exercise daily and watch my diet, so I thought the levels would have come down.*
- 5 *HCP: Exercising and watching your diet are significant steps in reducing your blood pressure and A1C levels. You are surprised and disappointed that the levels didn't come down with all your efforts in exercising and controlling your diet.*
- 6 *P: Exactly. I was hoping to see the levels go down.*
- 7 *HCP: Uh huh... Would it be ok if we explore a little bit to see why the levels didn't go down and continue to remain high? (P: Sure) There are three*

things you can do to manage your diabetes and blood pressure and they are diet, exercise and taking your medication as prescribed. You are exercising daily and watching your diet. How are you doing with your medications for your diabetes and blood pressure?

In utterance 3 of this example the HCP reported the latest blood pressure and A1C results and noted that each of these results was still high. The patient's response in utterance 4 involved several elements, namely:

- a) The patient was surprised that the BP and A1C results are still high.
- b) The patient exercised daily and watched her diet.
- c) The patient expected much better results.

Utterance 5 is an example of the HCP integrating these three elements in the course of supporting self-efficacy, expressing empathy, and developing discrepancy. This integration is critical because it demonstrates understanding of the patient's frame of reference. The HCP supported self-efficacy by reinforcing the positive steps taken by the patient in terms of exercising and controlling her diet. Then the HCP empathized with the patient's surprise and reframed it also as "disappointment." This feeling of surprise and disappointment has dissonance in it because there is inherent discrepancy between the results the patient was hoping for and the results that she just received. Highlighting this discrepancy between the patient's goals and her current health behavior helps to further reinforce the dissonance, which in turn can serve as the motivational basis for the patient's considering further health behavior changes. In utterance 5, the HCP asked the permission and cooperation of the patient in identifying the factors that might be contributing to her blood pressure and A1C levels still remaining high. Thus, by

empathizing with and legitimizing the patient's surprise, and then following with requesting permission to explore further the patient's concern, the HCP made it clear to the patient that he/she is intending to help the patient to achieve her goals.

The application of discourse analysis methodology to the study of the transcribed OSCE counseling sessions led to the identification of several major patterns in how HCPs try to respond empathically to their patients. These patterns of responses affected the HCPs' ability to understand and address the patients' concerns. Please note that the order in which these patterns are presented in the results section reflects more the order in which they were identified and analyzed. This order neither reflects the hierarchy of frequency in which these patterns occurred nor its significance in the MI process. These patterns will be described in the next several sections supported by examples from the transcripts of HCP-standardized patient interaction. The examples from transcripts are often followed by hypothetical examples that suggest how the HCPs could have responded differently to the patient and how a more empathic response could have helped in addressing patients' concerns more clearly and effectively. Each pattern concludes with a summary of findings that suggest how a specific pattern impacted the HCP-patient interaction.

1. HCPs support self-efficacy without empathizing with patients' concerns.

Sometimes HCPs primarily focus on supporting self-efficacy as a single skill and thereby miss the opportunity to respond to the patient in an empathic and integrated fashion. The following examples show how the patient-HCP interaction is affected as a result of not being empathic to patients and due to too much reliance upon the skill of supporting self-

efficacy. The following is a simple example of a HCP supporting self-efficacy without empathizing with the patient's concerns.

Example 1

July08_p1_t1_3 (Utterances 1-11)

- 1 HCP: Hi, Miss Lester.
- 2 P: Hi
- 3 HCP: Glad you could come in today. I just want to go over your lab results and your exam results with you and talk a little bit about that. Is there anything that you'd like to talk about first?
- 4 P: No, I know the doctor had had had me do some tests and had said that I needed to come back in to talk about them and you know my hopes are that the numbers are down.
- 5 HCP: mmhm, okay. ... Well, you ready to hear the results then?
- 6 P: [Sure
- 7 HCP: [and go from there. Um your hemoglobin A1c is 8. Oh, I see by your expression that you're not happy with that. So you... you know what your target is.
- 8 P: Well, he had mentioned last time when I was here that he'd really like to see that number below 7. (HCP: mmhm) I, ya know, I know that number is ... 7 is supposed to be the magic number.
- 9 HCP: Okay, well it would be good if we could get it down in that range. What kind of things are you doing to help move that number? And what's your understanding of what kind of things you can do to move that number?

10 P: Ah, well, I'm exercising. I'm going to the gym and I'm walking three or four times a week for at least 30 minutes and you know I'm doing those things. And I'm not overweight. So I guess it kinda surprises me that you know that with all that the number's still higher than it should be.

11 HCP: Well those are good things. ... Can you tell me a little bit about your diet?

In utterance 10 of this example, the patient expressed all the positive steps she had taken to manage her illnesses in addition to maintaining a normal weight. Patient then added that she was surprised because her blood pressure and diabetes levels still remain high. In response, the HCP ignored the patient's surprise and disappointment, responded by supporting self-efficacy and moved on to explore the patient's diet.

Thus, not empathizing with the patient's concern and surprise affected the interview in the following ways:

- The patient's concern was ignored leaving the patient less understood.
- The discussion digressed away from the patient's concern to discussing her diet. Thus, the patient's concerns were never addressed.
- The patient's experience of dissonance was not explored. The patient was experiencing dissonance because on the one hand she was doing some good things like exercising and she was maintaining her weight and on the other hand all her good efforts were not reflecting on her lab values for diabetes and blood pressure.
- There was loss of time. The interview finished in five minutes, but the patient's concern about how her lab values remaining high despite all her good efforts was not addressed.

The next example starts from utterance 13. Before this, the HCP greeted patient #1 and later explored the patient's knowledge of her medications and the lab results. The patient's response indicated that she doesn't know much about her medications other than their names and indications. Thereafter the patient-HCP discussion proceeded as follows.

Example 2

May07_p1_t1_1 (Utterances 13-27)

13 HCP: And what were the results... did he discuss with you the results of the of your blood pressure and your ah A1C I understand.

14 P: Ah no that it's just a little bit high which I was surprised really

15 HCP: You were surprised when **your A1C** or your **blood pressure** was high?

16 P: Well both, to be honest because I exercise and don't eat that bad and so I was a little surprised.

17 HCP: Well I think that's very good that you don't eat bad and that you exercise. ahh how often are you exercising?

18 P: ahh I usually try to walk or either go to the gym maybe three or four times a week and um you know I can get on the elliptical machine and get my heart rate up to a 150 easily, so.

19 HCP: Oh that is that is very good. A lot a lot of people have trouble with exercising and it sounds like this is a part of your normal daily life.

20 P: It is ah you know depending on my work schedule it's routine.

21 HCP: umhm ah ... when when Dr. Smith gave you the information, do you remember what your blood pressure and your A1c what the values were?

22 P: No I don't.

- 23 HCP: And he did tell you that it was high and that surprised you.
- 24 P: Yes I was surprised because I am not overweight and I eat relatively well.
- 25 HCP: And hm ... diet and exercise ... you said you ate well ... diet and exercise
can go a long way in managing your diabetes and it sounds like you do
those very very well.
- 26 P: I try, I try.
- 27 HCP: Well that's great. Ah ... wha...So Dr. Smith didn't discuss what the what
the results were?

Utterance 14 of this example provided an opportunity for the HCP to empathize with the patient and explore further; instead utterance 15 by the HCP was a request for clarification about the cause of the patient's surprise, NOT an empathic response. The vocal stress, the tone of voice and the facial expression all showed that the HCP was uncertain about whether it was her high blood pressure or high A1C levels that surprised the patient. In utterance 16, the patient informed the HCP that she was surprised about both her high blood pressure and high A1C levels. The patient seemed to be experiencing dissonance because on the one hand she was exercising and watching her diet in order to manage her conditions and on the other hand her blood pressure and A1C values remained high. Empathizing with the patient could have helped the patient to feel understood and could have set a common ground of understanding between the HCP and the patient to explore further the factors that may be contributing to her high levels of blood pressure and A1C. Thus, an empathic understanding of the patient could have helped in identifying and addressing the patient's concerns. In utterance 17, the HCP supported self-efficacy for the patient's positive behaviors (exercising and watching her

diet) and moved on to explore the patient's exercise habits. The patient's disappointment and dissonance were overlooked and the discussion strayed away from exploring and resolving the patient's concerns. In utterance 19, the HCP again supported self efficacy and in utterance 23, the HCP didn't relate the patient's positive behaviors (exercise and diet management) to her surprise and the patient repeated the reason for her surprise in utterance 24. In utterance 25, the HCP again digressed from the patient's disappointment and dissonance and supported self-efficacy. From the beginning of the interview until line 27, nearly three minutes out of the total five minute interview had elapsed and the discussion didn't address the patient's concern, although the patient had repeated her concern twice in utterances 16 and 24.

Thus, not empathizing with the patient's concern in example 2 affected the interview in terms of:

- Not identifying the patient's concern and therefore failing to address it
- Digressing from the patient's concern to reinforce the patient's positive behaviors
- Wasting time
- Not fully supporting the relationship.

In the following example, the HCP and the patient (patient #1) exchanged greetings and the conversation proceeded as follows.

Example 3

May07_p1_t1_02 (Utterances 5-13)

5 HCP: Last time we talked about your blood pressure and your diabetes and you were showing me hmm telling me about your concern about being able to

eliminate some of those foods... those high carbohydrate foods in your diet because they are so enjoyable to you. How you doing with that?

6 P: I am doing better. I very (XXXXX) that I can, that is one thing I can change ah but not totally give up

7 HCP: Awesome well congratulations that's a-that's a big thing those-those pastas and those breads (P: Oh yeah) those are feel good foods

8 P: Oh yeah yeah and I have to have them sometimes

9 HCP: Well excellent that's good that's good. You should be very proud of yourself (P: Thank you). Your ah blood pressure I would like to take a look at here... it looks like it's up just a little bit... it's 145 over 95 today.

10 P: Really? (HCP: Uh huh) I am [surprised].

11 HCP: [XXXX]. Are you (in an understanding tone and not a questioning intonation). Why why it is that it surprises you?

12 P: Well because I am not over weight and I am doing some things that are different and it surprises me I guess that it's still up a little bit.

13 HCP: Well it's ah do I can I share something with you about other things that could be affecting your blood pressure? (P: Sure). You are doing an excellent job with your diet, your your weight, your exercise, those things are excellent and they will help control that blood pressure and they also help control the diabetes, so you are doing what you need to be doing along that line...that's excellent. Hm sometimes our family history plays a big role an we can't change that... that's why its even more important for you to continue your exercising, your nutrition, your healthy eating and

keeping your weight down, so you need to feel good about those things... you are doing an excellent job (P: Okay alright) excellent job (P: Thank you). There ah there may be few things along your nutrition and your your eating that you might be able to hm take a look-take a closer look at down the road and ah I would like to give you a couple of suggestions if that's okay (P: Okay). Sometimes ah it's not so much as what we eat, is that how much we eat. How how do you do with your portion sizes?

In utterances 7 and 9, the HCP supported self-efficacy for the steps the patient had taken to manage her diabetes. Although the patient's blood pressure was really high, the HCP minimized the severity of the patient's disease state by informing her that it was just a little bit high. This was in a sense not providing accurate information to the patient even though it may have been said with good intention. Minimization of the severity of the patient's disease state could negatively affect the patient's motivation to make health behavior changes. In utterance 11, the HCP acknowledged and explored the patient's surprise. The verbal and the nonverbal expressions of the HCP in utterances 11 indicated an understanding attitude and she seemed genuinely interested in knowing the reason behind the patient's surprise. In utterance 13, the HCP digressed away from the patient's concern to support self-efficacy and to provide information that was not relevant to the patient's concern. The patient believed that she should not have high blood pressure since her weight was normal and also because she had taken some steps towards managing her illnesses. The HCP did not explore the steps the patient had taken nor did she explore the patient's understanding about her illnesses and the ways to manage them. The information provided was not relevant to the patient because the HCP never tried to

explore what caused elevated blood pressure and went on to provide information about diet in spite of the fact that in utterance 6 the patient had already expressed that she was doing better with her diet.

The analysis of this example has established that:

- By not empathizing with the patient's reasoning for her surprise, the HCP digressed from the patient's concerns in order to support self-efficacy and to provide information not targeted to the patient's concerns.
- The patient's dissonance was not enhanced.
- The patient's understanding of the nature of her illnesses and other treatment options to lower her blood pressure and A1C was never explored nor addressed.
- There was loss of time. One minute and 40 seconds passed in discussing diet and nutrition which otherwise could have been used in informing the patient how blood pressure is a symptom free disease and may not show any symptoms until it is too late.

In the next example, the HCP asked patient #1 what the doctor had said about the lab results for her blood pressure and then the dialogue continued as follows:

Example 4

Jan07_p1_t1_4 (Utterances 4-7)

- 4 P: I think it was 145 over 95? ... something [like that?
- 5 HCP: [Yes, Yes... that is what she said.
- 6 P: I was a little surprised because I feel fine and I am not over weight and so I [XX].

7 HCP: [No you are not... certainly you are doing a good job... I saw the
(XX)-that you are exercising and ... really proud of you ... that's a lot to do
with it

8 P: I enjoy that

9 HCP: Yeah ... do you remember what she said about your diabetes?

In utterance 7 of this example, the HCP supported self-efficacy and reinforced the patient's behavior of managing her weight and exercising. Empathizing with the patient's surprise and the reason for her surprise could have been helpful in drawing out the patient's misunderstanding that her blood pressure should be normal because she is in good shape and also because she feels fine. This could have been followed by the provision of accurate information to address the patient's misconceptions. In utterance 9, the HCP deviated from the patient's concern about her lab values and started inquiring about diabetes while the patient's concern about her blood pressure values remained not addressed.

Thus, because of not empathizing with the patient's reasoning for her surprise and instead supporting self-efficacy,

- The HCP digressed away from the patient's concerns about elevated blood pressure to support self-efficacy and then followed by exploring her diabetes.
- The patient's experience of dissonance was not explored.
- The patient's misconception was not explored. The patient's misconception that feeling fine and being not over weight is an indication of normal blood pressure did not receive the HCP's attention.
- There was loss of time. The five minute interview concluded without the patient's

concerns and misconceptions being addressed.

In the next example, the HCP and patient #1 exchanged greetings and thereafter the discussion followed.

Example 5

Jan07_p1_t2_17 (Utterances 1-6)

- 1 HCP: The doctor had ah any suggestions for you or do you understand what he said to you today before you left?
- 2 P: Hmm... yes I mean I-I was- I was little surprised ah about some of the numbers and hm
- 3 HCP: Well I-I see you know that your labs have come back but you know couple of things that are concerning to you, you as well as concerning to us... so hm... I know I hear that you are saying you are concerned (P: Nods) and so maybe we can alleviate some of the concerns or make sure that you are leaving here today with some of the tools you need to address those concerns (P: Okay). What concerns you the most?
- 4 P: Well I you know I am a little concerned that because my blood pressure is still up and I am surprised because I am doing some really good things and I am not overweight and you know of course the high blood pressure I don't want a heart attack or a stroke.
- 5 HCP: That's wonderful I mean you really you know sounds like you are really motivated, you understand you know what the dangers could be and you know keeping your weight down and all... that's wonderful you know (HCP starts smiling)...next time you come you have to tell me how you are

doing that exactly (P: Smiles) you know but some of the skills that you are using for keeping the weight down ah can also help you with keeping the blood pressure down-absolutely the way it does affects the blood pressure (XXX)... so if you think you are keeping your weight down and-and are you exercising as well.

In utterance 2 in this example, the patient expressed her surprise about the lab values being high. In utterance 3, the HCP responded by expressing her own concern over the lab values and by acknowledging that the patient was concerned. The HCP did not specifically explore the patient's feeling of dissonance, which was inherent in her surprise and again asked the patient what concerned the patient the most. This could be because the HCP was not certain about the cause of the patient's surprise although the patient had expressed it in utterance 2. Thus, the HCP was not accurately empathic in utterance 3 and this became more apparent in utterance 5. In utterance 4, the patient repeated that she was surprised, explained the cause of her surprise and added that she wanted to avoid the risks of a heart attack or stroke. The feeling of surprise indicated dissonance and it was an opportunity to empathize and enhance the dissonance between the patient's expectations in regard to her health related goals and the actual health status. The patient's health related goal was to avoid the risk of a heart attack or stroke. The actual health status was that the patient's lab values remained elevated despite her good efforts in taking care of her health. The HCP neither empathized with the patient's surprise and fear of stroke nor enhanced the patient's dissonance; instead the HCP commended the patient for managing her weight and for her knowledge of her disease states. Throughout the interview the HCP did not explore the patient's surprise or her

concerns (about not taking medications and her ambivalence about quitting smoking). As a result, much of the interview time of five minutes was spent in supporting self-efficacy and asking the patient to quit smoking.

Thus, not empathizing with the patient's concern in this example affected the interview in the following ways:

- The patient's surprise was not explored.
- The patient's line of reasoning was not explored and addressed. The HCP did not explore the reasons why the patient is not taking her medications.
- HCP lost an opportunity to enhance the discrepancy between the patient's current health behaviors (not taking medications and smoking) and her current health condition (elevated blood pressure and diabetes).
- The patient's fear was not acknowledged and as a result an opportunity to elicit change talk from the patient in order to allay her fears of a heart attack or a stroke was lost.
- HCP digressed away from the patient's concern to reinforcing the patient's positive behaviors.
- There was much loss of time. Five minutes of the interview time passed and the patient's concern was never addressed.

The following example shows an appropriate way of empathizing with patient concerns and supporting self-efficacy as a contrast to the previous five examples. The HCP and the patient exchanged greetings and the discussion proceeded as follows.

Example 6

July08_p1_t2_16 (Utterances 1-9)

- 1 HCP: How are you feeling today? How are you doing?
- 2 P: I feel okay
- 3 HCP: Did your doctor tell you anything about how your diabetes and your high blood pressure is doing?
- 4 P: Well he... I have been back in to get you know retested for those things and he did give me numbers and you know he you know he- I was a little disappointed of course that the numbers are still higher than what he would want and what I want, so other than that you know that's a little concerning to me.
- 5 HCP: Okay so the numbers are still a little elevated and that kind of makes you disappointed because you tried to make some big changes in the way you eat and maybe some exercise that you are doing [
- 6 P: [Yeah yeah I thought that would make a big difference and and the numbers are still up there and so I'm-I'm concerned
- 7 HCP: So tell me a little bit about some of those changes that you have made?
- 8 P: Well I started exercising. I try to walk at least three or four times a week (HCP: Uh huh) and go to the gym if I can and may be 30 minutes and hm you know ah one of my favorite thing is the elliptical machine and I could get my heart rate up to 150 quick on that ah but... you know I have done that and so I thought that would help a lot.
- 9 HCP: Yeah sounds like you are doing some really good exercise as far as getting your heart rate up and ah ah ... you know kind of doing some different

things and going to the gym and that's really great. Hm some of the other things that ... in managing high blood pressure and diabetes is in addition to exercise are diet and medication and how are you doing with your diet... hm how are you doing with your diet right now?

In utterance 5, the HCP empathized with the patient's concern and her dissonance about not getting her illnesses under control in spite of all her efforts in exercising and managing her diet. In utterance 9, the HCP supported the positive steps taken by the patient in managing her blood pressure and diabetes and moved on to inform and explore about diet and medication, which are the two other means by which the patient could manage her disease states. In contrast to the first five examples, the HCP in example 6 empathizes with and addresses the patient's concern. Empathizing was also followed by supporting self-efficacy thereby reinforcing the patient's positive behaviors, yet not digressing from the patient's core concerns. In the first five examples, the HCPs often supported self-efficacy when the patient expressed her concern about the high lab values. This was often followed by digressions from the patient's concerns and as a result the concerns remained unaddressed. Therefore example 6 is a more integrated and appropriate use of empathy in motivational interviewing than the first five examples.

In summarizing the first six examples, HCPs' supporting self-efficacy without empathizing with patients' concerns affected the patient-HCP interaction in the following ways:

1. HCPs did not acknowledge patients' dissonance-based feelings. For example the feeling of "surprise" went unacknowledged and instead the HCP only supported self-efficacy.

2. As a result of not acknowledging the dissonance-based feelings, the opportunity to enhance discrepancies between patients' health behaviors and health related goals was missed.
3. As a result of only supporting self-efficacy, the patient's motivation for change may have been diminished. This is because HCPs miss opportunities to elicit change talk from patients as they ignore the dissonance felt by patients (the feelings of fear, disappointment, etc.) and focus mainly on the positive steps taken by patients. By only supporting self-efficacy there could be a sense of complacency in some patients.
4. As the HCP's focus was only on supporting self-efficacy, the discussion digressed away from patients' concerns to the positive health behaviors, and so patients' concerns remained neither explored nor addressed.
5. As a result of digression from patients' concerns, a lot of the interview time was lost in less productive HCP-centered discussions.
6. When HCPs digressed away from patients' concerns, patients often repeated their concerns and could feel less understood when their concerns were overlooked.
7. Sessions in which HCPs gave educational information without identifying patients' concerns were not productive.
8. HCPs ignored patients' misconceptions about their illnesses or treatments and as a result the patients' misconceptions remained unaddressed. Ignoring the need to identify and address patients' misconceptions may be because of HCPs' concerns about creating resistance from patients.

9. Supporting self-efficacy and not empathizing with patients does not fully support the patient-HCP relationship. In fact, not empathizing with the patient's core concern may actually hurt the relationship.

This summary ends the analysis of the first discourse pattern identified, namely, supporting self-efficacy without empathizing with the patient's concerns. The next section describes the pattern of HCPs running their own agenda.

2. HCP running/forcing a predetermined agenda. Often times HCPs have predetermined goals for patients like getting them to take their medications as prescribed or changing their life styles. As a result of having predetermined goals for the patients, HCPs assign less importance to understanding patients' concerns and problems in managing their illnesses. This is because the HCPs have already decided what the patient ought to do regardless of patient perspectives about the recommendations provided by HCPs. Thus, HCPs run their own agenda during interviews instead of determining what the patient is willing to do or helping patients to attain their goals.

The following example begins from utterance 7. Before this, the HCP and the patient (patient #2) exchanged greetings and this discussion followed.

Example 7

May07_p2_t1_3 (Utterances 7-12 and 23-29)

- 7 HCP: Yeah yeah and it look like you are still having trouble with your heartburn.
- 8 P: Yeah I am still getting some some attacks at night.
- 9 HCP: Oh really?
- 10 P: Yeah

11 HCP: Well ah tell me you know you were started on a medication for-for the heartburn ... so has that medicine worked for you before ... at the beginning?

12 P: When I first started taking it... it seemed to help quite a bit (HCP: Uh huh) but recently it just doesn't seem to be working as well because I am getting heartburn attacks at night and there was even a couple during the day but mainly at night.

In between utterances 12 and 23, the HCP examined the patient's understanding of his medication and how he takes it. On finding out that the patient is adherent to his medication regimen, the HCP explored the patient's understanding of how his diet could affect his GERD (gastroesophageal reflux disease). On exploration, the HCP realized that the patient had no idea about the impact of diet on his illness and went on to provide information about how caffeine in coffee could aggravate his illness, as seen in the utterance 23.

23 HCP: Okay well coffee for one is you know is always hmm one of the things that one of the foods that can aggravate your symptoms, so how is your coffee drinking, do you drink coffee? Would you [XXX

24 P: [I-I drink coffee every morning (HCP: Uh huh) it gets me going in the morning.

25 HCP: Uh huh so do you think you will be able to make some changes in that drinking?

- 26 P: I don't know I my ah... my coffee gets me going in the morning. I really need it. Its only one cup of coffee a day I drink (HCP: Okay) that's all I drink.
- 27 HCP: Okay well what about the what's the effect that it could do to you if you don't drink coffee. Have you tried that?
- 28 P: No I (nods the head) I mean I don't understand how coffee would-would affect me in the evening anyway.
- 29 HCP: Uh huh uh huh... well it's it's still the caffeine in the coffee you know (P: Uh huh) so you know the when you take your medications in the morning and you still have coffee and you drink that coffee then it's still the caffeine, it's still in your system and it also affects your... ah the symptoms (P: Nods) and the other ah ah food that could affect is the high fatty foods, so do you eat a lot of fried foods, things stuff like that.

In utterance 26, the patient expressed reluctance to give up his coffee in the morning because the coffee seemed important to him. Moreover he asserted that he was drinking only one cup a day. In utterance 27, the HCP did not express empathy and instead tried to persuade the patient to give up his coffee drinking behavior. Since the patient experienced heartburn mainly in the evenings after his dinner, he did not understand the HCP's view point about the relationship between his morning coffee and the heartburn at night. Thus, as the interview proceeded further, the patient became unwilling to make any changes. The patient ended up more resistant to changing his dietary habits.

As a result of the HCP not empathizing with the patient's perspective and instead pushing an agenda:

- The patient-HCP relationship was negatively affected. Throughout the rest of the interview the patient continued to remain defensive and tended to support his health behaviors (eating spicy food, eating fried and greasy foods, eating late at night and not exercising), which were adversely affecting his illness.
- The HCP could not elicit positive change talk from the patient as she argued for change to meet her own agenda instead of letting the patient assess his behaviors and talk about the possibilities of change. This could be because it seemed to the patient that the HCP was finding fault with him and seemed unconcerned about addressing his concerns about the effectiveness of the medication.
- The patient's concern about the effectiveness of his medication was neither empathized with nor addressed throughout the interview. Thus, having an agenda could affect the interview by overlooking patients' concerns and perspectives about their illnesses and treatments. It is also likely that patients will be less inclined to accept the HCPs' recommendations when they don't address their concerns. For example, here the patient was under the impression that the ineffectiveness of the medication was responsible for his heartburn while the HCP ignored the concern and suggested that he change his diet. Thus, by not addressing the patient's concerns there is less likelihood that the patient will adhere to the recommendations.

In the preceding example, the patient complained of having heartburn at night and was concerned if the medication was effective or not, but the HCP was not paying

attention to the patient's concern. An appropriate hypothetical HCP response for example 7 could have been the following.

1 HCP: *What brings you in today?*

2 P: *Last couple of weeks I have been experiencing some heartburn attacks at night and I am not sure if the medication is working anymore.*

3 HCP: *So you have been having attacks at nights and you are wondering if the medication is still working.*

4 P: *Yeah... I know it was working when I first started taking it but last couple of weeks I have been having attacks and it made it difficult for me to get to sleep at night.*

5 HCP: *So the medication initially seemed to help but now it's difficult for you to get to sleep.*

6 P: *That's right.*

7 HCP: *May I ask you a few questions to address your concern about why the medication seems to have stopped working mainly at night?*

8 P: *Sure.*

9 HCP: *The diet could impact the way the medication helps in preventing heartburn. Certain foods like fatty foods, greasy and spicy foods can work against the medication and drinks containing caffeine such as coffee could aggravate GERD. Since you have heartburn mainly at night, what are your evenings like in terms of what you eat and your activities?*

10 P: *I usually reach home around 6 o'clock and watch a little TV and take my dinner between eight and nine.. For dinner I cook something quick like a*

TV dinner or sometimes I will go out to the restaurant and I like Chinese food, fried chicken and things like that. I am pretty regular going to bed at 10.

11 *HCP: I might know what the problem might be.*

12 *P: Okay. Go ahead.*

13 *HCP: Uh huh when you eat your dinner between eight and nine and go to bed at 10, your stomach continues to produce acid to digest the food that you ate and when you lie down, the acid tends to come up in your esophagus and causes heartburn. So you could really reduce your heartburn at night by eating your dinner earlier, leaving at least 3 hours between your dinner and bed time. How does that sound to you?*

14 *P: I probably could eat my dinner a little earlier between six and seven.*

15 *HCP: That sounds great and it would significantly reduce your heartburn at night. Also, may I share some information about how your diet could influence the effect of your medication?*

16 *P: Sure.*

17 *HCP: On one hand the foods that you eat increase acid production in your stomach and on the other hand your medication works to reduce the acid in your stomach. So your food negates the effect of the medication in your body. What are your thoughts about making some changes to your diet, so that you can reduce some of the heartburn attacks at night?*

18 *P: I didn't know that the food that I eat could impact the way the medication works. I guess I could eat less of the fried foods for dinner.*

In the previous hypothetical example, in utterances 3 and 5, the HCP empathizes with the patient's concern about the effectiveness of his medication while in the example 7, the HCP examined the patient's medication habits, while overlooking the patient's concern about the ineffectiveness of his medication. In the hypothetical example, the HCP's empathizing with the patient in utterances 3 and 5 established a mutual understanding, which then helped in further explorations. On the other hand asking questions following a patient's concern could harm the relationship because the patient may feel ignored and may feel that the HCP is finding flaws in his life style habits. In utterance 9 of the last hypothetical example, the HCP made it clear to the patient that dietary habits have a significant impact on the way the medication works and then goes on to explore the patient's dietary habits and evening activities. Thus, the patient likely understands the logic behind the HCP's examinations and is likely to cooperate in addressing his concerns. The HCP did not persuade the patient to give up his coffee, but made it clear to him how his coffee and the gap between his last meal and bed time could affect his illness. Thereafter he explores the patient's willingness to make changes regarding his diet and bed time. Thus, empathizing with the patient and addressing the patient's concerns helped in setting a stage for creating dissonance in utterance 17 of the hypothetical example. If an empathic relationship was not built initially, this skill of creating dissonance could have been viewed in a negative sense. The HCP elicited the patient's motivation instead of using persuasive approaches. The patient's trust and autonomy was maintained because the HCP did not decide or prescribe what the patient ought to do but helped him see his behaviors in a new perspective, which actually helped him realize that it was not in his best interest. In short, early empathy helped in building

trust and a collaborative relationship and this in turn helped in reducing any relational resistance. This further helped in reducing any resistance on the part of the patient in understanding the HCP's recommendations. Patient did not feel the need to be defensive when the HCP did not use any persuasive strategy.

In the next example of the HCP running an agenda, the patient (patient #1) is concerned about the side effects of her blood pressure and diabetes medication and wanted to make sure that the long term side effects do not outweigh the benefits of the medication. The patient feared the long term effects of her medicines and preferred to take care of her illnesses mainly by exercising and diet management. Before utterance 16, the patient expressed her concern about taking medications when she "feels healthy" and she thinks that she doesn't need her medications when she feels good. Thus, the patient believed that she needs her medications only when she experiences some symptoms.

Example 8

May07_p1_t1_06 (Utterances#16-25)

16 HCP: ...just just tell me that there is not enough side effects tell me the side effects to to offset the benefits I guess is one of my big things.

17 HCP: Okay so you are concerned about the side effects of the medication.

18 P: (Nods)

19 HCP: Okay have you had any side effects right now, is there anything that's been [

20 P: [Well every now and then I have spells where I feel dizzy and I feel light headed (HCP: Uh huh) but every now and then.

- 21 HCP: Okay so when you feel light headed, dizzy like that what what do you do... what kind of?
- 22 P: Hmm you know I guess I thought it might be the result of the medication and (HCP: Okay) you know I think of it that way you know you know I usually just keep going and drink something (HCP: Hmm) you know its just time for me to eat or something like that.
- 23 HCP: So you might feel like... have you heard of the hypoglycemia the low blood sugar...do you think it might be causing you to have low blood sugar?
- 24 P: I never thought about that.
- 25 HCP: I might I am wondering that might if that's what your concern is and that's what is making you not want to take it (P: Nods). Hm the-the issue is though that still something is missing something because that A1C is still high. Tell me what you are willing to do... what are your thoughts about taking the medicine every day? You are still concerned?

In utterance 17, the HCP acknowledged the patient's concern about her medication and goes on to explore further in utterance 19 about her experiences of having had any side effects. In utterance 21, the HCP wondered if the patient is experiencing low blood sugar, which might be responsible for her dizziness. This could have given an impression to the patient that she need not take her medications because it causes low blood sugar. However, in utterance 23, the HCP digressed away from the patient's concern about experiencing side effects to persuading the patient to take her medications every day. This was because the HCP wanted the patient to take her medications despite

her fears of side effects and her experiencing dizzy feelings. The HCP did not try to address the patient's concerns before suggesting the patient take her medications. Thus, the HCP has already predetermined that the patient should take her medications irrespective of whether her fears about side effects were addressed. Therefore this HCP has a predetermined agenda for the patient to adhere to her medication regimen regardless of the patient's desire or goal of not having any side effects.

It is important for the HCP to not only acknowledge or empathize with the patient's concerns but also to address her concerns. A truly empathic HCP, who understands the problems faced by a patient and sees why the patient is stuck, should address the concern as well. Thus, the HCP having an agenda in the preceding example affected the patient-HCP interaction in the following ways.

- The HCP digressed away from the concern about side effects because of having an agenda.
- The patient's concern remained unaddressed. Consequently, the patient remained concerned about side effects of her medication and she remained worried about her dizzy spells, which she believed resulted from the medication.
- The patient's fear was only reinforced because of not clearly addressing her fear of side effects. The HCP's informing the patient that it could be due to low blood sugar only reinforced the patient's belief that the low blood sugar was as a result of her medication since the medication lowers her blood sugar levels to control diabetes.
- The HCP's agenda to get the patient to take her medication despite the patient's

experiencing dizzy spells shows that the HCP was not focused on what the patient is thinking about her medications. The HCP had concluded that the patient should take her medications regardless of any fears the patient had about side effects of those medications.

Coercing patients to engage in a health behavior that concerns them contradicts the patient-centered approach of motivational interviewing.

A hypothetical example of appropriate MI responses to the patient in example 8 could be as follows.

- 16 *HCP: ...just just tell me that there is not enough side effects tell me the side effects to-to offset the benefits I guess is one of my big things.*
- 17 *HCP: Okay so you are concerned about the side effects of the medication and would like to know that the benefits outweigh the side effects.*
- 18 *P: Nods ((meaning yes))*
- 19 *HCP: You are concerned about the prospects of side effects or have you had any side effects with the medications?*
- 20 *P: Well every now and then I have spells where I feel dizzy and I feel light headed (HCP: Uh huh) but every now and then. I am also worried about the possibilities of side effects in the long run.*
- 21 *HCP: So you had some dizzy spells and you are wondering if it is due to the medications that you are on and also you are cautious about the prospects of side effects.*
- 22 *P: Exactly*

- 23 *HCP: May I provide you with information that would address your concern about the dizzy spells?*
- 24 *P: Sure*
- 25 *HCP: The dizzy spells probably occur due to fluctuations in blood sugar... when the medication is taken intermittently, the blood sugar suddenly fluctuates between high to low and both rise and fall below the normal blood sugar could cause dizzy spells. When medications are taken regularly, the fluctuations in blood sugar levels are reduced and so the chances of spells can be reduced. Some of the possible side effects of your medications are coughing, weakness, headache, drowsiness. Taking medications regularly is extremely important in reducing the risk of having a heart attack or a stroke. What are your thoughts about taking your medications as prescribed knowing the benefits and side effects of it?*
- 26 *P: I definitely want to avoid a heart attack or a stroke and maybe I need to be more regular with my medications.*

In the previous hypothetical example, in utterances 17 and 21, the HCP empathized with the patient's concern about side effects. In utterance 25, the HCP provided information about the causes of dizzy spells and also about the benefits and side effects of medications. Then she went on to explore the patient's thoughts about changing her health behavior in light of the new information provided. Here the HCP made it clear to the patient that taking medications regularly is crucial in managing her illnesses and at the same time provided the necessary information to address the patient's concerns. Thus, it sounded reasonable to ask the patient about her intentions of taking her medications

when the necessary information had been provided to the patient to make an informed decision. This last hypothetical example differs from the example 8 because the HCP values the patient's goal of not experiencing side effects and provides information to allay her fears. She gives the information requested by the patient, namely the pros and cons of taking her medications in utterance 25 and as a result the patient's concerns are addressed in an empathic way. Thus, this HCP has placed high priority on understanding and addressing the patient's concerns and on not imposing an agenda on the patient by ignoring the patient's fears or concerns.

In the next example, the patient (patient #1) expressed her surprise at the high lab results for her diabetes and blood pressure because she had been exercising and managing her diet. The patient also expressed her fear of having a heart attack or a stroke if these numbers continue to be high. In response to the patient's concerns, the HCP supported self efficacy for the patient's understanding of the risks associated with her illnesses and went on to explore the patient's exercise habits and adherence to her medications. The patient informed the HCP that she takes only half the doses of medication prescribed by her physician and in response the HCP decided to provide information about the necessity of taking medications as prescribed without exploring the reasons why the patient is not taking her medications. The discussion then digressed to smoking as in utterance 10 in the following example.

Example 9

Jan07_p1_t2_17 (Utterances#10-16)

10 HCP: I see too though on the questionnaire that ah you mentioned that you are smoking sometimes. Can you explain to me what that means?

- 11 P: Well I have a real stressful job and ah (HCP: Nods) that's a stress reliever for me and ahh I you know sometimes during those those stressful moments I smoke three to five cigarettes you know a day. Hm some of the work I am involved in is seasonal so sometimes it will go up to even half a pack.
- 12 HCP: Nods wow. so it sounds like you know it's a stressful job and ah you know I can hear that you know when you talk about it that you almost sound stressed you know I can see your face gets a little bit more flushed (P: Uh huh uh huh (nods and smiles). So perhaps we can talk about some of the things that might be ways of dealing with stress... right now you are using cigarettes to help you with the stress [
- 13 P: [Yeah...it's just a stress reliever.
- 14 HCP: And what do you think the benefits are.... to using cigarettes... to... you know keep your ah blood pressure or keep your stress-keep your stress down. What do you think the benefit is to taking cigarettes?
- 15 P: [Well... you know I know that's something I need to work on but I don't think that I can totally quit (HCP: Nods) it's just a stress reliever (HCP: Nods) and I know that it doesn't help the blood pressure.
- 16 HCP: Oh that's wonderful you know I mean you do recognize it's not really something that is helping the blood pressure and ah perhaps you know- have you... you know you are so good about doing the exercise and things hmm what do you think you could do ah what would make you want to

reduce or even stop smoking... is there anything I could say you or if I handed you an envelope today what would it have to say you know that would make you stop you know (P: Smiles) smoking.

In utterance 12, the HCP expressed her understanding of the magnitude of stress in the patient's job, but did not acknowledge the importance of smoking in relieving her stress. In addition, the HCP also offered to explore with the patient some other means of relieving stress. The patient was not even asked if she was willing to explore other options to relieve her stress instead of using cigarettes. In utterance 13, the patient defends her behavior of smoking. In utterance 14, the HCP wanted to hear from the patient the negative effects of smoking in managing her illnesses although she asked the benefits of smoking for her illnesses. In response, the patient made it clear that she was not ready to quit smoking and that she was aware of its negative effects on her illnesses. In utterance 16, the HCP was very selective in recognizing the patient's perspectives. This is because she supported the patient's understanding about how smoking affects her illnesses, but ignored the patient's insistence that smoking helps her and that she was not ready to give it up. Thus, the HCP acknowledged only those aspects of patient's perspectives that were consistent with the HCP's viewpoints and her predetermined goal of getting the patient to stop smoking. The HCP wants the patient to stop smoking as seen in utterance 16 and she completely overlooks the patient's desire to continue smoking. In other words, the patient's decisions or goals are not valued and the HCP selectively affirms only those aspects of patient's speech, which were in accord with her own goal to get the patient to stop smoking. Therefore the HCP has an agenda for the patient that ignores the patient's interests and goals.

Thus, having an agenda in the preceding example affected the patient-HCP interaction as follows.

- The patient's surprise about the high lab values for her illnesses was neither explored nor resolved.
- The patient's concern about taking the medications as prescribed by the physician was neither explored nor addressed.
- The HCP's agenda to get the patient to quit smoking caused the discussion to digress away from the patient's concerns about smoking.
- The more the HCP coerced the patient to meet her agenda (quitting smoking), the more the patient affirmed that she could not quit smoking.
- The HCP's pursuing her agenda by means of indirect questions and selective affirmations seemed to make the patient more resistant, although a direct suggestion that smoking could increase her chances of heart attack or stroke could have been more helpful in terms of helping the patient to weigh the pros and cons of smoking.
- There was loss of time. In the five minutes of interview, the patient's concerns were not addressed.

An appropriate hypothetical response to the patient's utterance #11 in the above example could be as follows.

- 11 P: Well I have a real stressful job and ah (HCP: Nods) that's a stress reliever for me and ahh I you know sometimes during those-those stressful moments I smoke three to five cigarettes you know a day. Hm some of the work I am involved in is seasonal so sometimes it will go up to even half a

pack.

- 12 HCP: *It sounds like smoking helps you to relieve your stress and it's important for you especially during those stressful moments.*
- 13 P: *Yeah...it helps... my job can be too stressful at times.*
- 14 HCP: *May I tell you what concerns me?*
- 15 P: *Sure*
- 16 HCP: *On one hand you are exercising hard and giving up the many foods that you like to reduce your risk of a heart attack or a stroke and on the other hand smoking increases your chances of getting a heart attack or a stroke. What are your thoughts about that?*
- 17 P: *I guess I could cut down a little but I can't totally quit.*
- 18 HCP: *Cutting down could significantly reduce your risks of heart attack or stroke and it will definitely be helpful for your overall health. Talk to me about the ways you will be able to cut back.*

In the preceding hypothetical example, in utterance 12, the HCP empathized with the patient's perspective about the significance of smoking in managing her stress levels. As a result of empathizing with the patient, the HCP validated the patient's concern and set the stage for requesting permission to share his/her concern. Empathizing with the patient also helped in creating dissonance in the patient by highlighting how smoking works against her goals of reducing the risk of a heart attack or stroke. Empathizing followed by creating dissonance is less likely to make the patient feel manipulated. Later in utterance 16, the HCP created discrepancy between the patient's positive health behaviors and her smoking in reducing the risks of a heart attack or a stroke. The decision

to make changes in her smoking behavior was left to the patient after providing necessary information to help the patient to make an informed decision. In utterance 18, the HCP reinforced the patient's willingness to make changes.

In the next example, before utterance 13, the HCP explored the patient's (patient #1) surprise about her lab values being high. However, before the patient could finish telling the reasons for her surprise, the HCP interrupted to support self-efficacy for the patient's weight management and exercising habits. The HCP also explored how the patient took her medication to which the patient said that she doesn't take her medications regularly because she doesn't see the point in taking medications when she feels fine. The discussion then continued as follows.

Example 10

Jan07_p1_t2_15 (Utterances 13-15)

- 13 HCP: Okay... I heard you say earlier that you just don't like taking medicines that you don't need.
- 14 P: I don't. I just don't... I just you know... the side effects or the possible side effects of the medicine make me... not like it
- 15 HCP: Okay... so the side effects are concerning to you. (P: Hm) Okay... could we talk a little bit more about the side effects and may be a little bit more about the importance of why you should take these medicines on a regular basis as prescribed?

In utterance 14, the patient revealed that she was worried about the possibility of experiencing side effects from her medications and therefore she took less than the prescribed doses of her medications. In utterance 15, the HCP initially empathized and

also added that she could provide information about the importance of taking medications as prescribed. This shows that the HCP has already concluded that the patient should take her medications as prescribed once the information is provided. The patient needed the information about the side effects and instead of providing information about the side effects, the HCP had concluded that the patient should take her medications as prescribed, irrespective of whether the information addresses her concerns about medications or not.

Thus, having an agenda that the patient should take her medications as prescribed affected the interview as follows.

- The patient's concern about side effects was not clearly addressed. There was no information provided to the patient to address her fears about the side effects. This is because the HCP's interest was solely in getting the patient to take her medications irrespective of how the patient felt about the medications.
- The HCP did not explore the patients' misconceptions about her disease state, namely her belief that she need not take her medications as she is not overweight.
- There was loss of time. Throughout the five minute interview, the patient's concerns about the lab values being high remained unexplored. The other concern that the patient had was about the possibility of side effects, which also remained unaddressed.

An appropriate hypothetical response to the patient in utterance 15 could have been the following.

13 HCP: Okay... I heard you say earlier that you just don't like taking medicines that you don't need.

- 14 P: I don't. I just don't... I just you know... the side effects or the possible side effects of the medicine make me... not like it
- 15 HCP: *You do not like to take your medications as prescribed because you are concerned about the prospects of side effects.*
- 16 P: *Yeah... I am worried about the long term side effects of the medications.*
- 17 HCP: *May I provide you with more information about your medication including the common long term side effects and the medication's long term benefits?*
- 18 P: *Yeah that would be helpful.*
- 19 HCP: *Some common side effects reported were drowsiness, headache, weakness, dizziness. The benefit from your medication is that it significantly reduces your risk of a heart attack or stroke. How do you feel about the information about your medications?*
- 20 P: *I guess those side effects are tolerable considering that it could reduce some serious risks of heart attack or stroke.*

In the utterance 19, the HCP's providing information about the side effects reduces the patient's anxiety about the unknown. Also, when the HCP has not predetermined that the patient is going to take her medications as prescribed, the patient could think on her own, and it increases the likelihood of adherence with the medications because there is greater ownership of the decision. When HCPs have an agenda or in other words when they have predetermined the health behaviors the patients should engage in regardless of the patients' concerns about engaging in that behavior, then the likelihood that the patient would be self motivated to engage in that behavior is reduced.

In summary, having an agenda impacted the patient-HCP interaction in the following ways.

- Directly arguing for making changes affected the patient-HCP relationship in a negative way. Patients often became defensive and were more likely to support their negative health behaviors.
- HCPs were less able to elicit positive change talk from the patients when they had an agenda or advocated for changes
- Patients' concerns (like the dizzy spells or ineffectiveness of the medication) were often overlooked as discussions digressed away from the patients' concerns to HCPs' agendas.
- HCPs' empathic responses to patients' concerns were of only a little value when the empathic responses were not followed by addressing those concerns. As a result of having an agenda, HCPs moved on to discuss issues they thought were important leaving aside patients' concerns after responding empathically to their concerns.
- Patients' were less accepting of HCPs' recommendations when they had an agenda and they would be less likely to be motivated to adhere to those recommendations.
- Empathizing with patients' concerns but not addressing those concerns could be harmful to the patients. This is especially true when patient concerns are due to misconceptions about the nature of their diseases or treatments. When patients express their misunderstanding associated with their illnesses or treatments and HCPs reflect it empathically without addressing that misunderstanding, then those

misconceptions could be reinforced. Thus, empathizing with patients' misconceptions should be followed by providing information to correct those misconceptions.

- Having an agenda that directly or indirectly coerces patients to engage in a health behavior that concerns them contradicts the patient-centered approach of motivational interviewing.
- There was a loss of time in discussing issues other than exploring and resolving the patients' concerns.

3. HCPs provide or elicit information without establishing its relevance to patients' concerns. In the following example, before utterance 14, the HCP informed the patient (patient #1) about the lab values for her blood pressure and A1C levels. On hearing that the blood pressure and A1C was still elevated, the patient grimaced but her grimace was ignored by the HCP. When the HCP explored the patient's adherence to her medication, the patient informed the HCP that she was not consistent in taking her medications. The HCP explored the barriers that the patient might be experiencing in being adherent to her medication regimen, and then the discussion proceeded as follows.

Example 11

July08_p1_t1_5 (Utterances 14-17)

- 14 P: Um, you know, to be honest with you, I just don't like to take medicine and I worry about the side effects. Other than that, I I guess another factor is I feel fine. I feel like you know I'm not overweight. So I guess I feel like what's the point? And so I try to take it every now and then. But I just don't like to take medication.

15 HCP: I was wondering too ... have you a blood pressure cuff and a glucose monitor?

16 P: Ah no.

17 HCP: And what do you want to see happen with your blood pressure and diabetes over time?

After utterance 17, the HCP moved on to discuss diet, exercise and smoking; the patient's concern about taking medications was never addressed.

In utterance 14, the patient expressed her dislike of medications owing to the fear of side effects and her thinking that she needed her medications only when there were symptoms of illnesses. The HCP asked the patient if she had a blood pressure cuff and glucose monitor, so that the patient could check her blood pressure and glucose levels regularly at home that would help check her blood pressure and A1C levels and that in turn could indicate to her the need to be more consistent with her medications. The HCP realized that the patient wanted to see some indications of her illnesses in order to be consistent with her medications. However, the patient may have not understood the relationship between the HCP's question in utterance 14 and her concern about taking medications when there were no signs of illnesses.

Thus, as a result of not linking the patient's concern about taking medications with the subsequent exploration, the patient-HCP interaction was affected as follows.

- From the patient's perspective, her concerns were ignored although the question asked by the HCP in utterance 15 was directed towards addressing one of her concerns about taking medications when there were no signs of illness. The patient could have felt ignored by the HCP.

- The exploration that followed the patient's concern may not have made any sense to the patient and could have appeared unrelated to her concern. It could affect the patient's motivation to check her blood glucose and blood pressure levels.
- Empathizing with the patient's concern could have helped the HCP to stay focused on addressing the concerns. Instead the HCP digressed to talk about diet, exercise and smoking and the patient's concern about taking medication remained unaddressed. The patient's fear about side effects and her belief that she needs medication only when she feels unhealthy remained unaddressed. Thus, there was a loss of time in discussing issues other than addressing the concerns.

An appropriate hypothetical example for example 11 could have been as follows.

14 P: Um, you know, to be honest with you, I just don't like to take medicine and I worry about the side effects. Other than that, I I guess another factor is I feel fine. I feel like you know I'm not overweight. So I guess I feel like what's the point? And so I try to take it every now and then. But I just don't like to take medication.

15 HCP: *So you don't like to take medications because you are concerned about side effects and also because you are not sure if you really need them when you feel that you are healthy and in good shape.*

16 P: *Right... I am concerned about the possible side effects from the medication*

17 HCP: *Uh huh... May I provide you some information about side effects?*

18 P; *Sure*

- 19 HCP: *Other patients have reported head ache, drowsiness and weakness. Have you had any of these side effects?*
- 20 P: *No I didn't. Sometimes I had these spells when I felt a little dizzy and sluggish.*
- 21 HCP: *Uh huh... so you had some spells and you are wondering if it was because of the medication?*
- 22 P: *Uh huh yeah*
- 23 HCP: *May I give you some information that would address your concern about spells?*
- 24 P: *Sure*
- 25 HCP: *The spells that you experience are because of the fluctuations in your blood sugar levels... either when it is too high or too low.*
- 26 P: *Hmm okay*
- 27 HCP: *May I tell you what concerns me?*
- 28 P: *Sure*
- 29 HCP: *I am concerned that on one hand you are disappointed that your lab values for diabetes and blood pressure continue to remain high and on the other hand you take your diabetes medication intermittently that causes fluctuations in your blood sugar level in turn causing spells that you experience. I am also concerned for you because you expect to see some symptoms of diabetes and blood pressure to motivate you to take your medications regularly and on the other hand your illnesses are silent*

conditions, which means that you will never see any signs of illnesses unless it leads to a heart attack or stroke. What do you think about that?

30 P: *Uh huh... (the patient continues)*

In the preceding hypothetical example, the HCP empathized with the patient's concerns and addressed those concerns. The important aspect is that the HCP made it clear to the patient that her responses were intended to address the patient's concerns while providing the necessary information.

In the next example, before utterance 7, the patient expressed his concern about the effectiveness of his medication as he was experiencing heartburn mainly at night, although he was adherent to the medication. The HCP explored if there had been any changes in the patient's overall health, dietary habits and weight. In response the patient informed the HCP that his weight had increased and that it had been happening from the time he hit forty. Although, the patient had expressed his concern initially, the HCP further explored if the patient had any concerns in utterance 7 as follows:

Example 12

May07_p2_t1_10 (Utterances 7-14)

7 HCP: Okay alright hm tell me a little bit about what your concerns are you know today?

8 P: Well I am just concerned that the medicine doesn't seem to be working like it did when I first started taking it... hm... I have been getting this heartburn at night... its waking me up a couple of times or it is making it difficult for me to get to sleep sometimes.

- 9 HCP: Okay so the heartburn is mostly at night (XXXX) that's pretty rough then.
(P: Yeah) You are trying to get up and go to work after not sleeping well
(P: Nods) ... Tell me a little bit about what you are eating you know during
the day... what kind of foods?
- 10 P: Well I eat a light breakfast... its usually just a toast and jam and a cup of
coffee. If I am real hungry I will grab an egg with muffin on the way to
work (HCP: Okay). Hm for lunch I don't like to be away from the office
for too long so its something fast food you know burgers and fries and you
know chicken sandwiches and fries. Hm dinner, I come home and eat
about kinda eight or nine o clock hm and I really don't like to cook so its
whatever I can microwave or sandwiches and chips... sometimes I will run
up to the restaurant quickly... but that's about it.
- 11 HCP: Okay so your diet consists of a lot of fast foods
- 12 P: [Yeah a good portion of it
(smiles) yeah
- 13 HCP: Okay it's easy to prepare things ah sometimes these foods are little bit
higher in fat content than other foods ah... what would you think about
may be ah cutting back of some of the fat in the diet which would
probably help with regard to ah the burning all... will that be a possibility?
- 14 P: Hm well depends hm I might hm what do you mean cutting back

In this example, the patient expressed his concern again about the effectiveness of his medication and the pain he experienced during the night. In utterance 9 the HCP acknowledged the patient's heartburn during the night and the associated difficulties due

to it in his life, and then moved on to explore his diet. The patient was unaware that his diet works against the benefits he derives from his medication and he believed that his medication alone could take care of his illness. On one hand the HCP was exploring the possibilities of cutting back some of the fats in his diet as a way to reduce heartburn and on the other hand the patient was wondering how it related to his concern about the ineffectiveness of the medication. The HCP could have informed the patient about the importance of diet in treating GERD and could have suggested him that his activities in the evening such as the gap between his last meal at night and bed time could negatively affect his GERD and thereby decrease the quality of his sleep.

Thus, as a result of not empathizing with the patient's concern about the effectiveness of the medication and of not making a clear connection between his concern and the following discussion,

- The patient could have felt that his concern was ignored.
- The patient may continue to remain under the misconception that his medication was ineffective and he might even discontinue taking the medication as prescribed.
- The patient's concern about the ineffectiveness of the medication remained unaddressed and the discussion that followed focused on less important issues like the restaurants that provide less fatty foods and much time was spent in exploring hereditary factors such as the patient's late father's health.
- There was much loss of time because the patient left the interview with very little information to manage of his illness. He was not informed the need to eat his evening meals at least 2 hours before bed time, which was very crucial for the

patient in getting sleep at night. The medication was effective because he rarely had any heartburn during the days, which too was not informed to the patient.

An appropriate hypothetical response to the patient could have been as follows.

1 P: Well I am just concerned that the medicine doesn't seem to be working like it did when I first started taking it... hm... I have been getting this heartburn at night... its waking me up a couple of times or it is making it difficult for me to get to sleep sometimes.

2 HCP: *So you are having problems with heartburn at night and you are concerned that the medication is not effective.*

3 P: *Exactly*

4 HCP: *May I ask you a couple of questions to explore what causes you to have heartburn at night and why the medication seems to be ineffective?*

5 P: *Sure*

6 HCP: *How do you take your medication?*

7 P: *I take it every morning before I eat or drink anything.*

8 HCP: *That's exactly the way it should be taken... As your heartburn is mainly at night, may we explore your evening activities? Since factors such as the kind of diet you are on, the time gap between your last meal and bed time, exercise and weight affects your heartburn, let's explore your evenings if you don't mind.*

9 P: *I usually reach home in the evenings around 6 o'clock, watch a little TV, read some newspapers. I eat my dinner between 8:30- 9:00. I don't like to cook a big meal, so I usually have some quick meals like TV dinners,*

French fries, and sometimes I go out to restaurants and I like to have Chinese foods, fried chicken and this like that. I am pretty consistent going to bed at 10.

10 HCP: *May I share with you what concerns me?*

11 P: *Sure*

12 HCP: *What concerns me is that on one hand you are taking your medications consistently to reduce the acid production in your stomach and on the other hand your diet increases the acid production and works against your medication. My other concern is that there is not a long enough gap between your last meal and bed time. Consequently there's a lot of acid still in your stomach and the acid flows into your esophagus when you lie down and causes heartburn. Usually the stomach needs at least two to three hours to digest the food... What are your thoughts about that?*

13 P: *I didn't know that my diet and meal time could have such an impact on my GERD...*

In the preceding example, the HCP empathized with the patient in utterance 2 and before exploring further, made clear to the patient that the explorations were relevant to the patient's heartburn and concerns about the effectiveness of the medication. Thus, when the HCP's responses were connected to the patient's concern, the patient was able to understand the purpose of the discussion. It helps in improving the collaboration between the HCP and the patient.

In the next example, the patient expressed his concern about heartburn attacks at night and the HCP explored the patient's understanding of his medication and his

adherence to the medication. Later the HCP provided information about foods that could aggravate GERD and tried to persuade the patient to change his dietary habits. The patient responded with resistance and argued against making changes. The discussion then proceeded to exploration of the patient's daily routine including his food habits. On listening to the patient's daily routine, the HCP responded to the patient in utterance 33.

Example 13

May07_p2_t1_3 (Utterances 33-42)

33 HCP: Uh huh and you said you eat late at night? [XXX

34 P: [It's about eight or nine o'clock
when I have dinner.

35 HCP: Yeah yeah and then after you have dinner, what do you usually do?

36 P: Ah watch a little TV and I I am pretty regular about going to bed about 10
o'clock.

37 HCP: Uh huh uh huh and that's not give you a whole lot of time between your
eating dinner and your going to bed time [XXXXXX

38 P: [About an hour and a half
sometimes ((patient didn't seem to think that the time between his dinner
and bed time was less))

39 HCP: Yeah so ah would you be willing to make some changes with your habits
=

40 P: [XX ((patient seemed to feel resistant))

41 HCP: = regarding your eating?

42 P: Like what? ((patient expressed defensiveness and seemed offended))

The patient in the preceding example was unaware of the fact that the time gap between his last meal and bed time is in any way related to his GERD symptoms. In utterance 35, the HCP explored further what the patient does after his dinner, although the patient was not informed about the purpose of these explorations. This reduced the patient's willingness to adhere to the HCP's recommendations because he was just sitting there answering the queries directed at him by the HCP. In utterance 37, the HCP informed the patient that he doesn't get ample time between his dinner and bed time and the patient's nonverbal response in utterance 38 indicated that there was sufficient time between his dinner and bed time. The patient was yet unaware why the HCP was asking him to make some changes in his habits and patient expressed defensiveness and experienced face loss as was clear from his nonverbal expression in utterances 40 and 42.

Thus, as a result of not making connections between the patient's concern and the HCP's responses, the patient-HCP interaction was affected as follows.

- The patient had to answer the queries and listen to the recommendations of the HCP without understanding their relevance to his concerns.
- The patient was likely to be disappointed with the interview because from his perspective his concerns remained unaddressed. The HCP never empathized with his concern nor informed him that her intentions behind the explorations were related to his concerns.
- The collaborative relationship between the patient and the HCP was damaged as was clear from the resistance expressed by the patient.
- The patient became unwilling to make changes as he didn't see the purpose behind the changes.

An appropriate hypothetical HCP response to the patient could have been the same as in the hypothetical example 2 (see p.43)

1 HCP: *As your heartburn is mainly at night, may we explore your evening activities? Since factors such as the kind of diet you are on, the time gap between your last meal and bed time, exercise and weight affects your heartburn, let's explore your evenings if you don't mind.*

9 P: *I usually reach home in the evenings around 6 o'clock, watch a little TV, read some newspapers. I eat my dinner between 8:30- 9:00. I don't like to cook a big meal, so it's usually something cook. I am pretty consistent going to bed at 10.*

10 HCP: *May I share with you what concerns me?*

11 P: *Sure*

12 HCP: *What concerns me is that there is not a long enough gap between your last meal and bed time and [as*

13 P: *[It's usually an hour and a half between my dinner and bed time. I don't know if I really need to eat earlier than this.*

14 HCP: *So you are feeling comfortable with the time gap as it is now (P: Uh huh). May I share with you some information about what would be an optimal gap between meals and bed time if you don't mind?*

15 P: *Go ahead*

16 HCP: *Usually the stomach needs at least two to three hours to digest the food. When you go to bed earlier than this time frame, there's a lot of acid still*

in your stomach and the acid flows into your esophagus when you lie down and causes heartburn.... What are your thoughts about that?

17 P: *Alright, that makes sense. I could eat may be around 7 in the evening*

In the previous hypothetical example, in utterance 14, the HCP empathizes with the patient's perspective about the time gap between his dinner and bed time instead of making judgments about the patient's life style as in example 13. The HCP's judgments such as "you eat late at night" in utterance 33 or "are you willing to make some changes with your habits" in utterance 39 created defensiveness in the patient to defend his habits and caused face loss for the patient.

To summarize, because HCPs often failed to make clear to patients how the HCPs' questions and recommendations were connected to the patients' concerns, the patient-HCP interaction was affected in the following ways.

- The patients had to answer queries and listen to the recommendations of the HCP without understanding their relevance to their concerns.
- The patients were likely to be disappointed with the interview because from their perspectives their concerns were never unaddressed. The HCP never informed the patients about their intentions behind the explorations or recommendations.
- The collaborative relationship between patients and HCPs were affected and some patients have expressed unwillingness to make changes suggested by their HCPs because they were never informed how the changes were relevant to their concerns.
- The patients' misconceptions about either their medication or illness remained unaddressed. These misconceptions were not related to the information that was

provided to them. The patient who was thinking that his medication was ineffective might even lose the motivation to continue taking it as prescribed.

- There was much loss of time because the concerns remained unaddressed from the view points of patients.

4. HCPs examine patients' knowledge without empathizing with their concerns.

HCPs begin to examine patients' familiarity with their illnesses or the methods to treat those illnesses following patients' expression of their concerns. Although examining patients' awareness about their illnesses is important before providing medical education to patients, it is best done after acknowledging patients' concerns. Sometimes HCPs respond by scrutinizing patients' knowledge following patients' concerns in order to identify flaws in patients' knowledge. Thus, the concerns go unaddressed and patients are reduced to sources of information whose job is merely to answer the HCPs' questions and listen to the recommendations put forth by their HCPs.

The next example begins at utterance 12. Before this, the patient acknowledged that he experienced heartburn attacks at night. The HCP further explored if the patient experienced any relief from his medication initially to which the patient responded in utterance 12.

Example 14

May07_p2_t1_3 (Utterances 12-19)

12 P: When I first started taking it ((medication))... it seemed to help quite a bit (HCP: Uh huh) but recently it just doesn't seem to be working as well because I am getting heartburn attacks at night and there was even a couple during the day but mainly at night.

- 13 HCP: Okay... so hm... what is your understanding with that medication?
- 14 P: Hmm... the doctor said that taking it would help reduce the acid in my stomach (HCP: Uh huh) that was about he really said.
- 15 HCP: Uh huh and you take it as prescribed (P: Nods) on the right time and the right [XXX
- 16 P: [Every morning 30 minutes before I eat or drink anything ((patient was irritated))
- 17 HCP: Okay okay so what are you doing differently you think... because you said that it worked before and now it doesn't work [
- 18 P: [I haven't really (HCP: Uh huh) changed anything really (HCP: Uh huh)... everything is still the same
- 19 HCP: Uh huh so how about food? What is your understanding about the food that might cause some symptoms of your GERD?

In the preceding example, utterance 12 was an opportunity to empathize with the patient's concern about his medication; instead the HCP examined the patient's understanding of his medication. The HCP ignored the patient's perspective that his medication doesn't seem to work well in preventing his heartburn attacks. The HCP further explored if the patient was taking his medication correctly and this seemed to cause face loss to the patient as was clear from the patient's nonverbal in utterance 16. In utterance 17, the HCP again investigated where the patient might have gone wrong and attributed the failure of the medication in preventing heartburn to the patient's activities. Indirectly it meant that the medication was effective but there was something wrong with the patient. In utterance 19 the HCP explored the patient's understanding of his food

habits. Thus, the patient was reduced to a source of information and the HCP cross examined the patient to find the flaws in him. It is important to find the cause for the ineffectiveness of the medication but it could have been done after empathizing with his concerns. The HCP could have explained to the patient how his diet and the way he takes his medication are related to the effectiveness of the medication. The importance of making connections for patients before exploring or providing information was discussed earlier in section 3.

Thus, as a result of not empathizing with the patient and directly examining the patient especially to find flaws in his knowledge, the patient-HCP interaction was affected as follows.

- The patient's concern was never addressed.
- The patient didn't understand the relevance of the HCP's queries about his understanding of diet and medication to his concern about the ineffectiveness of the medication
- Five minutes of the interview elapsed and the patient's concern was never addressed.
- The patient was reduced to a source of information.
- There was loss of face to the patient. The patient felt as though the HCP was trying to find flaws with him.

An appropriate hypothetical response to the patient in the preceding example could have been as follows.

12 P: When I first started taking it ((medication))... it seemed to help quite a bit (HCP: Uh huh) but recently it just doesn't seem to be working as well

because I am getting heartburn attacks at night and there was even a couple during the day but mainly at night.

13 HCP: *So you are concerned that your medication is not working well as it initially did and now you are getting heartburn attacks mainly at night and some during the day.*

14 P: *Yeah (nods)*

15 HCP: *May I provide you some information about the possible factors that could affect the effectiveness of your medication?*

16 P: *Sure*

17 HCP: *There are some factors that could impact the benefits you get from the medication such as the way the medication is taken, the diet, how much time you leave between your last meal and bed time and things like that. Do you mind if I ask you a couple of questions to see if any of these is affecting the effectiveness of your medication?*

18 P: *Sure*

19 HCP: *How are you taking your medication?*

20 P: *I take it every morning before I eat or drink anything.*

21 HCP: *That's exactly how it needs to be taken. Let's explore your evenings on a typical day because your heartburn is mainly in the evenings.*

In the preceding example, the HCP explored how the patient was doing with his medication and diet, but it was done in a way that didn't make the patient feel that he had made a mistake. The HCP informed the patient the necessity of exploring the factors that

could affect the effectiveness of his medication and went on to explore them. This made it clear to the patient that the HCP was trying to address his concerns.

The next example begins from utterance 4. Before this the patient and the HCP exchanged greetings and HCP explored the patient's GERD. Later the discussion proceeds as follows.

Example 15

May07_p2_t1_12 (Utterances 4-5)

- 4 P: Well you know when I first started taking the medicine... it seemed like it helped a lot but lately hm I am starting to have heartburn again... so I am not sure its working hm mainly in the evenings... it's it's actually waking me up a couple of times at night and some nights made it hard for me to get to sleep.
- 5 HCP: What exactly is your understanding of GERD? ((HCP asked abruptly as though the patient doesn't have an understanding of GERD and its treatment. She didn't buy his perspective that the medicine is not working))

In the preceding example, the patient's concern about the effectiveness of his medication and the suffering due to heartburn was completely ignored, instead the HCP examined the patient's understanding of his illness. The HCP's nonverbal expressions suggested that she expected something wrong with the patient's understanding in treating his illness. The HCP asked the patient abruptly in utterance 5 and her voice intonation implied that there was some misunderstanding on the part of the patient in managing his illness.

As a result of not empathizing with the patient's concern and examining the patient's understanding, the patient-HCP interaction was affected as follows.

- The patient's concern was completely ignored and never addressed.
- As a result of ignoring the patient's concern, the patient remained confused about the effectiveness of his medicine.
- The discussion moved on to diet and the HCP offered recommendations to the patient about changing his diet. Thus, there was digression from the patient's concern.

The next example begins from utterance 5. Before this the patient and the HCP exchanged greetings and the discussion proceeded as follows.

Example 16

July08_p1_t1_1 (Utterances 5-16)

- 5 HCP: Okay. As I look over your record, it looks like your blood pressure now has... is 145 over 95. How do you feel about that?
- 6 P: Well, that concerns me a little bit. I'm surprised that it's still up a little bit.
- 7 HCP: Okay. Tell me what you've been doing at home to try to keep your blood pressure readings down.
- 8 P: Well I walk three or four times a week about thirty minutes. And I go to the health club and um you know I'm not overweight. So I'm doing ... I'm exercising and everything.
- 9 HCP: Okay. What about your medications?

- 10 P: Well, I guess you know I might not take my medicine everyday. I take the the blood pressure medicine maybe three or four times a week (P: umhm) and um you know I just I just don't you know see the point sometimes of the medicine.
- 11 HCP: Okay. Now your blood pressure is up uh and you only take your medicine as you stated about three or four times a week. Tell me what do you think may happen if you continue to take your medicine three or four times a week with your blood pressure still being above normal.
- 12 P: Well, you know I I ... really like I said, I'm surprised that it's still up because of the medicine and the exercising. I know that I have some family history of some problems with blood pressure and I know that I've had some relatives that have had some serious problems with stroke and things. And you know of course I don't want to see that happen.
- 13 HCP: Right, right (said softly) Tell me what you think would happen if you were to take your blood pressure every day ... your blood pressure medicine everyday as prescribed? How do you think that would result in your blood pressure readings?
- 14 P: You know, I don't know. I don't really like to take medicine in the first place. And I guess the big thing for me is I worry about the side effects. And um you know you just worry I just worry what it does to me ... the side effects does to me. And I guess if I knew that the benefits outweighed the negatives, I guess I could think about taking it more often.

15 HCP: What is your understanding about the blood pressure medicine you're taking?

16 P: Um, I just know it's a ace something ... and you know it it's supposed to you know to keep the blood pressure at a regular level . I think that's about it.

In this example, utterance 6 by the patient was an opportunity to empathize with the patient and explore further. Instead the HCP ignored the patient's feeling. Utterance 8 was an opportunity to support self-efficacy for the patient's positive health behaviors that went ignored. The HCP examined further how the patient was doing with her medications in utterance 9, and in utterance 11 she again examined the patient's knowledge of the consequences of not taking her medications. In utterance 12, the patient expressed her surprise the second time and also her concerns about stroke but these concerns were not empathized with. Instead the HCP went on with her agenda (as described in section 2 about HCPs having an agenda) to get the patient to take her medications. The patient responded in utterance 14 by expressing her fear of side effects and wanted to know more about the side effects and the benefits from her medications, so that she could be assured of its necessity and get over her fear of side effects. However, the HCP responded by exploring the patient's knowledge about her blood pressure medicine.

Thus, because of not empathizing with the patient and instead examining the patient, the interaction was affected as follows.

- The patient's concern about side effects was never addressed.

- The patient's surprise went ignored. The feeling of surprise was an indication of dissonance between the patient's expectations of her lab values being low and her actual lab values that were high. This was an opportunity to enhance the patient's dissonance in order to elicit the intrinsic motivation of the patient to change her health behaviors like taking medications and changing diet.
- The HCP had an agenda and went on with it ignoring the patient's perspectives.
- Examining the patient's understanding of her medications or illnesses when patient's express their concerns results in wasting of time when the concerns go unaddressed.
- The HCP lost two opportunities to develop discrepancy and enhance the patient's intrinsic motivation. One opportunity of creating discrepancy was when the patient expressed surprise twice and the other was when the patient expressed her fear of a stroke.

An appropriate hypothetical HCP response in example 16 could have been as follows.

5 HCP: Okay. As I look over your record, it looks like your blood pressure now has... is 145 over 95. How do you feel about that?

6 P: Well, that concerns me a little bit. I'm surprised that it's still up a little bit.

7 HCP: *So you are surprised because you expected your blood pressure to be lower. Can you tell me a little more why you are surprised?*

8 P: *Because I exercise very well and don't eat that bad, so I was surprised.*

9 HCP: *So on one hand you are exercising well and working on your diet and on the other hand your blood pressure remains high.*

- 10 P: *Yeah I thought it would have come down*
- 11 HCP: *May I share some information to help you lower your blood pressure?*
- 12 P: *Sure*
- 13 HCP: *There are a three things you could do to manage your blood pressure. They are taking your medication, managing your diet and exercising. You said you are exercising very well and watching your diet. How are you doing with your medications?*
- 14 P: *Hmm...I take my medication two to three times a week. I don't like taking medications because I worry about the side effects and if I knew that the benefits outweighed the side effects, I would consider taking it more often.*
- 15 HCP: *Uh huh... so you are concerned about the side effects from taking your medications and want to know if the benefits really offset the side effects.*
- 16 P: *Yeah that's exactly what I want to know*
- 17 HCP: *May I provide you some information about your medication... its side effects and benefits?*
- 18 P: *Oh yeah that would be very helpful.*

In the preceding hypothetical example, the HCP empathized with the patient in utterance 7 and created discrepancy in utterance 9. As a result of creating discrepancy the patient was naturally more interested in knowing ways to manage her blood pressure and the HCP explained to her the ways she could reduce her blood pressure. Later the HCP explored how the patient was doing with her medication and moved on to provide information that the patient needed in order to address her concerns about side effects and

her doubts about whether the benefits of her medicine really outweigh the side effects from her medicine.

In the next example, before utterance 5, the patient and HCP exchanged greetings and the discussion proceeded as follows.

Example 17

May07_p1_t1_3 (Utterances 5-13)

5 HCP: I am XXX Dr.Berger's nurse yeah

6 P: Nice to meet you

7 HCP: Okay last time you were here I think Dr.Berger had talked to you about diabetes... is that correct?

8 P: Yeah

9 HCP: Okay so can you tell me what is your understanding of diabetes? It looks like your last A1C is still 8... so it's still a little bit high so can you tell me what is your understanding of your diabetes?

10 P: Well ah I am a...I am a little surprised that it's still up and (HCP: Uh huh) and I know that diabetes is you know affected by what I eat of course (HCP: Uh huh hm) and you know I know that exercise can play a role and hm the things that I eat and its just you know the sugar levels in your body just not regulated and those things diabetes is is the result of that.

11 HCP: Uh huh hm so can we talk about your exercise? (P: Sure) How much of exercise ah

12 P: Hm its good hm I am usually trying to go to the gym or take a long walk

30 minutes to an hour may be three or four times a week and I can go to the gym and get my heart rate up to 150 easily on the elliptical machine so I do XXXX some exercise

- 13 HCP: Wow doing great with your exercise just keep it up (P: Thank you) that's good yes.... well so there must be something else that is affecting your hm sugar because it's still running high so (P: Uh huh) can you tell me about your diet... how is how is your]

Here utterance 9 indicated that the HCP considered it necessary to explore the patient's understanding of diabetes because her A1C value was high. The HCP examined the patient because she expected something wrong with the patient. Utterance 10 was an opportunity to empathize with the patient's surprise and explore further, but instead the HCP explored the patient's exercise habit ignoring the surprise. Later in utterance 13 the HCP moved on to explore the patient's diet. Thus, the interview was about examining the patient for finding the cause behind the high lab values while ignoring the patient's perspective.

Thus, as a result of not empathizing with the patient's surprise in utterance 10 and examining the patient, the interaction was affected as follows.

- The patient's concerns were never explored and therefore remained unaddressed. The patient was concerned about the side effects of her medications and also believed that she needed her medications only when she experienced some symptoms.
- The patient could have felt less understood because her surprise went ignored.

- There was loss of time. During the five minute interview, the patient's concerns were never explored because the HCP went on examining and making recommendations without understanding that the patient doesn't see the importance of taking her medications.

An appropriate hypothetical HCP response for example 17 could be as follows.

- 1 *HCP: I have your lab results. Your A1C is still high and its 8. We would like to see it come down to 7 and eventually 6. How do you feel about the results?*
- 2 *P: Well ah I am a...I am a little surprised that its still up*
- 3 *HCP: So you are surprised because you expected it to be lower than 8. Tell me more about what causes you to be surprised about it?*
- 4 *P: Hmm... I thought it would have come down because I exercise well, I don't eat that bad and I take some medicines, so I was surprised*
- 5 *HCP: So on one hand you are exercising well, watching your diet and sounds like you take some medicines as well to reduce your A1C level and on the other hand your A1C is still holding high.*
- 6 *P: Yeah that's right*
- 7 *HCP: May I ask you a couple of questions for us to see why your A1C continues to remain high?*
- 8 *P: Sure*
- 9 *HCP: There are three ways to reduce your A1C level... they are taking your medications as prescribed, exercising and managing your diet. Which one of these three would you like to talk about?*

10 P: *I am not regular about taking my medicines... I take around half the doses of medicine because I don't see the point in taking them when everything seems fine with me. Moreover I am concerned about the side effects.*

11 HCP: *So you don't see the need to take your medicine when you feel good. Also, you are concerned about its side effects.*

12 P: *Exactly*

13 HCP: *May I provide you with some information that would address your concern about why to take your medicine when you feel good, and then if you like I could give you some information about side effects?*

This discussion could proceed with the HCP providing more information to the patient about the nature of her illnesses. The HCP could inform the patient that illnesses like diabetes and high blood pressure may not show any symptoms and the very first symptoms could be a heart attack or stroke. The HCP could also inform the patient about the possible side effects from her medications.

In summary, examining patients without empathizing with them affected the patient-HCP interactions as follows.

- The patients' concerns were ignored and not empathized with as a result of examining their understanding about their illnesses or treatment options.
- Oftentimes patients remain unaware of the relevance of HCPs' examinations. The HCPs examine patients' understanding of their illnesses or medications but do not make it explicit to the patients that these examinations are intended to address their concerns. For instance patients may not understand the relevance of the

HCPs' queries about their understanding of diet and medication to their concern about the ineffectiveness of the medication

- There was loss of time because patients don't see why the HCPs were examining them and also there was loss of time when the concerns go unaddressed.
- The patients were reduced to mere sources of information.
- Patients may have experienced loss of face because they could feel as though the HCPs were trying to find flaws with them.
- There were instances of digressions from the patient's concern.
- Opportunities to enhance patient dissonance were overlooked. As a result, there was no change in patient motivation to change their health behaviors.

5. HCPs' discounting patients' concerns. HCPs sometimes discount patients' concerns instead of empathizing with them. They discount the concern by responding to it in a way that reduces the validity of the concern.

In the next example, the patient (Patient #2) expresses his concern about the ineffectiveness of his medication and about the pain and discomfort that he was experiencing mainly at night. In response the HCP explores the patient's understanding of his illness and later on provides him information about the factors that could affect GERD. The factors included weight, medication, exercise and diet. Later the HCP explored the patient's diet on a typical day and then the discussion proceeded as follows.

Example 18

May07_p2_t1_12 (Utterances 8-11)

- 8 P: Well ah I eat pretty light breakfast a toast and some jam, a cup of coffee
(HCP: Uh huh). If I am really hungry I will I will get an egg with muffin

on the way to work. Ah at work I don't want to be away too long so lunch it's usually some fast foods burgers and fries and soda, sometimes XXX and sodas and ah then dinner I am just now I really don't like to cook a big meal (P: Uh huh) so it's whatever I can microwave or sandwiches and some chips. Sometimes I will run out to the restaurant.

- 9 HCP: Well let's explore a little bit here...from what I hear you are eating some spicy food, you are eating some greasy food like chicken (P: Uh huh), you are consuming caffeine (P: Uh huh), things like that can cause GERD to ah to increase (P: Uh huh). I know it's not easy changing your diet completely (P: Uh huh), but if you can work on just everyday just eliminating may be some of these-some of these items that cause the problems (P: Nods). You might want to eat and keep a diary of what you eat each day and see when the GERD is worse worse with what you are eating or in other words may be the spicy foods are causing the worst problems (P: Uh huh), maybe the caffeine is causing the worst problems, maybe alcohol is causing you to have more of the acid production (P: Nods), but it is very the diet is extremely important. Ah your weight is is also important so you want to exercise (P: Nods) XXX an important component. Ah I mentioned all of the components concerning GERDs to help keep it under control (P: Nods) and I know that controlling all of them at the same time can be kind of daunting. (P: Nods). Do you think you can ah choose one or two of them and work on them?

- 10 P: Hmm ah I don't know ah... ah my diet has been the same for years, even before I had GERD ah you know ah my exercise has been the same ah... I haven't changed a whole lot.
- 11 HCP: I understand what you are saying but you are getting older, your weight can be fluctuating. Now I can't make you make any of these decisions, all I can do is give you recommendations (P: Nods). How important is to you on 1-7 scale that you control this GERDs? I don't know how really uncomfortable it is for you so first let's determine how uncomfortable is your GERD on a 1-7 scale with 7 being the most uncomfortable (P: Hm). How bad is the attacks?

In utterance 9 of the preceding example, the HCP informed the patient how his diet and weight could aggravate his GERD symptoms and explored his willingness to make some gradual changes in his life style. The patient was under the impression that his life style wasn't affecting his GERD since his routine had been the same for many years while the onset of heartburn was a recent problem. In response to the patient's uneasiness about changing his life style, the HCP discounted it in utterance 11. The initial HCP statement in utterance 11 "I understand what you are saying" was not an empathic response that was clear from the HCP's voice intonation. Moreover, the HCP's response of "I understand" was followed by "but" and a negation of the patient's argument. Thus, the patient's concern was negated and the HCP further discounted the patient's concern by arguing that it is not just his diet that could be contributing to his recent onset of heartburn, but there are other factors like age and fluctuating weight. The HCP suspected that the patient wasn't really interested in getting his heartburn under control and

assessed the patient's motivation to manage his GERD instead of acknowledging and addressing the patient's concerns in an empathic way.

Thus as a result of discounting instead of empathizing with the patient's concern, the patient-HCP interaction was affected as follows.

- The patient's concern about his life style not being a contributing factor of heartburn symptoms remained unaddressed. Instead the HCP said that his age and changing weight could be affecting him. It was not made clear to the patient how his age and weight was related to his heartburn and how diet management becomes more crucial as one grows older. It could have been said that as a result of aging, the linings of the esophagus and stomach undergo wear and tear and that's where it becomes more important for him to be watchful of diet as spicy and greasy foods could stimulate more acid secretion that would catalyze the wear and tear, exacerbating his illness.
- The discounting is likely to have caused face loss leaving the patient feeling hurt or defensive.
- The patient will be less likely to open up to the HCP to express his future concerns.

An appropriate hypothetical HCP response to the patient could have been as follows.

8 P: Well ah I eat pretty light breakfast a toast and some jam, a cup of coffee (HCP: Uh huh). If I am really hungry I will I will get an egg with muffin on the way to work. Ah at work I don't want to be away too long so lunch its usually some fast foods burgers and fries and soda, sometimes XXX and sodas and ah then dinner I am just now-I really don't like to cook a

big meal (P: Uh huh) so its whatever I can microwave or sandwiches and some chips. Sometimes I will run out to the restaurant.

9 HCP: *I apologize if we didn't inform you when you were diagnosed with GERD that what you eat and when you eat could affect your GERD.*

10 P: *But I have been eating the same way for years and I never had any heartburn before.*

11 HCP: *So you are not sure if it really is your eating habit that is causing GERD since you have been eating this way for years.*

12 P: *You are right.*

13 HCP: *May I share with you why you might have heartburn symptoms now and not before although your eating habits have remained the same?*

14 P: *Sure.*

15 HCP: *Foods that are spicy and fried affect the lining of the esophagus and also relax a valve in the esophagus called the esophageal sphincter that checks any acid reflux from the stomach. Many years of eating spicy and fatty foods, gradually erodes the linings of the esophagus and weakens the sphincter. And over a period of years the symptoms start manifesting. What are your thoughts about this information?*

16 P: *I see. I didn't realize that my eating could have been affecting me causing heartburn*

In utterance 11, the HCP empathized with the patient's perspective that his recent onset of heartburn may not be due to his eating habits. This conveyed that the HCP understood the patient. Later on the HCP informs the patient how eating habits gradually

affect the body, which at a later age manifests as a disease. Thus, the HCP gave the necessary information that would allow the patient to reconsider his perspective of his illness while being respectful of the patient's concern.

In the next example, before utterance 9, the HCP explored what the patient knew about her lab results to which the patient responded that she knew that her numbers were high, although she didn't know exactly what the lab values were for her blood pressure and diabetes. The HCP explained the lab results to the patient and the patient on hearing her lab values grimaced. The HCP did not explore any further about the patient's feelings and seemed to overlook her nonverbals, and the discussion proceeded as follows.

Example 19

July08_p1_t2_11 (Utterances 9-14)

9 HCP: ...Tell me how you are taking your medications if you don't mind.

10 P: Well I usually take my blood pressure medicine may be two or three times a week (HCP: Uh huh) and I take my ah diabetes medication usually may be four to five times a week I think.

11 HCP: Is there a particular reason why you don't take it every day or...

12 P: You know I guess if I have to say the two top reasons would be one I feel fine... I am not over weight and then the other one is that I just don't like to take medication... I get really worried about all side effects and all that going into the body and I guess those are the two things that are issues for me.

13 HCP: Okay well I can understand that... but are you interested in getting your blood pressure and sugar level down?

14 P: Yeah I mean to be honest with you I am surprised that they are still up because I am doing some things that I thought would make a difference in the numbers... so I am disappointed that they are still up.

In utterance 12 in the preceding example, the patient expressed her concerns about taking her medications. One of the concerns was about side effects while the other was that the patient didn't see the need of taking her medications everyday because she feels healthy. The patient didn't show much interest in taking her medications as prescribed because she is under the misconception that she is healthy and interprets having a normal weight as a sign of good health. As a result she didn't seem quite serious about taking her medications regularly. The HCP suspected the patient's interest in controlling her illnesses and discounts the patient's concern instead of empathizing and addressing it. The HCP's response in utterance 5 negates the patient's concern when she says "I understand that but" and then questions the patient's motivation to manage her illnesses. In utterance 6, the patient made it clear that she had been making some efforts and was surprised about her lab values.

Thus, as a result of discounting and not empathizing with the patient, the interview was affected as follows.

- The patient's concern about side effects from medication was unaddressed. The patient also remained unsure if she really needed the medication.
- The patient felt less understood by the HCP's response in utterance 5 and responds in utterance 6 by telling that she was really interested in managing her illnesses had been work on it.
- The patient is likely to have experienced face loss.

An appropriate hypothetical HCP response to the patient for the preceding example could be as follows.

- 1 *HCP: How are you doing with your medications?*
- 2 P: Well I usually take my blood pressure medicine may be two or three times a week (HCP: Hm...) and I take my diabetes medication four to five times a week.
- 3 *HCP: uh huh. Tell me more about it in terms of the problems you might have in taking your medications as prescribed.*
- 4 P: You know I guess if I have to say the two top reasons would be one I feel fine... I am not over weight and then the other one is that I just don't like to take medication... I get really worried about all side effects and all that going into the body and I guess those are the two things that are issues for me.
- 5 *HCP: So you concerned about the side effects of the medications. Secondly you don't see why you need them when you are not overweight and feel fine.*
- 6 P: *Exactly.*
- 7 *HCP: Would you be interested in knowing more about the side effects from this medication?*
- 8 P: *Sure*
- 9 *HCP: Some patients have experienced drowsiness, head ache, coughing and weakness. Have you had any of these side effects?*
- 10 P: *No. But I had some spells when I felt a little dizzy and sluggish.*
- 11 *HCP: May I share with you what I think might be causing these spells?*

- 12 P: *I am interested to know that.*
- 13 HCP: *When your blood glucose levels go up and down the normal range, it causes spells. When you take your medications intermittently, your glucose level fluctuates. So taking your medications every day as prescribed will certainly help you to prevent those spells. What are your thoughts about that?*
- 14 P: *I didn't realize that. But other than the spells, I usually feel healthy and don't feel like I need the medications.*
- 15 HCP: *You are not sure you really need those medications when you feel good.*
- 16 P: *Uh huh.*
- 17 HCP: *May I tell you what concerns me?*

This discussion can proceed further with the HCP informing the patient about the nature of the illness.

In the previous hypothetical example, the HCP empathizes and validates the patient's concerns about taking her medications in utterance 5. In utterances 7 and 9, the HCP addresses the patient's concerns about side effects from her medications. Similarly the HCP stays in tune with the patient and again goes on to address her concerns about spells in utterances 11 and 13. Thus, one after another, the patient's concerns were empathized with and addressed. The patient became more open to reconsider her decisions about taking her medications.

In the next example, before utterance 9, the patient expressed her surprise about the lab values remaining high and the HCP empathized with the patient's concern. The HCP offered further information to the patient about her lab results for hemoglobin A1C

(diabetes). Later the HCP asked the patient what she had been doing to manage her diabetes and the discussion continues as seen in utterance 8.

Example 20

Tape: May07_p1_t1_06 (Utterances 8-14)

8 P: Ah I have just been trying to watch you know the carbs and I like the carbs a lot (HCP: Uh huh) so pastas and things. I have been trying to watch those and (HCP: Uh huh) and you know taking my medicine may be four to six times a week and you know those are couple of things that I am trying to do. And I am exercising (HCP: Uh huh) I am exercising so you know those are some things that I am doing.

9 HCP: Okay, so you are trying to exercise and watch your carbs and taking your medicine and you said four to six times a week? (P: Uh huh). Can you tell me is there a problem with the medication that-that you are taking it infrequently and not everyday... is there some [

10 P: [No it's just that you know I have this hard time thinking of taking the medicine and then when I feel okay you know I am not over weight and I am doing some things that I feel like you know should correct the problem, I just you know forget or you know I feel like well you know it will be okay if I miss a dose here and there.

11 HCP: Okay so ah is your understanding of what the medication does is that something that you want additional information on or ahh =

12 P: [Well

- 13 HCP: = you help me understand you feel good so you think it might not be important to take the medicine?
- 14 P: Well you know I guess my-my philosophy is if you can tell me why it's important then you know tell me what the difference it's going to make you know may be maybe that I may change my mind.

In the preceding example, in utterance 10, the patient opened up by expressing her concern about taking her medications every day. The patient didn't see the importance of taking her medications when she feels healthy and so she tended to forget her doses. In response to the concern, in utterance 11 the HCP asked if the patient needed additional information about her medications implying that the patient lacked understanding of her medication to have raised this concern. Although, it may be true that the patient lacked proper understanding of the importance of being adherent to her medications due to her poor understanding of the nature of her illness, the HCP's judgmental response discounted the concern and seemed to make the patient feel embarrassed. Further in utterance 13, the HCP questioned the patient if she considered it unimportant to take her medications when she feels good. The HCP accurately identified the patient's concern, but the questioning intonation further caused face loss for the patient, which was clear from the patient's vocalic pattern and verbal response in utterance 14.

Thus, as a result of discounting the patient's concern instead of empathizing with it, the patient-HCP interaction was affected as follows.

- The HCP lost an opportunity to address the patient's concern about taking her medications. The patient later repeated that she would be interested to know about

the benefits and side effects of the medication, which again was only partially addressed.

- As a result of discounting the patient's concern, the patient again had to express her concerns later. This results in a waste of time when HCPs discuss issues not targeted to the patient's concern.
- The patient experienced face loss since her concern about taking her medications was made to appear to result from her ignorance.
- The patient became defensive in utterance 14.

Thus, in summary, discounting patient concerns instead of empathizing with them could result in the following.

- The patients' concerns that were discounted remained unaddressed.
- Discounting puts a stop to any further exploration of the patients' concerns. The patients could be less likely to open up again to the HCP during the later course of interview.
- Discounting was likely to cause face loss leaving patients embarrassed or hurt.
- Discounting could result in a waste of time when HCPs discuss issues not targeted to the patients' concerns.
- The patients could become defensive.

6. Generalizations and comparisons of patients' responses by HCPs. At times HCPs reduce the uniqueness of patients' concerns by generalizing patients' responses or by comparing the patient with their other patients. Here generalization occurs when a HCP identifies a patient's response or concern as a "universal problem". Such generalization implies that there is no real need for the HCP to understand the patient's

individual response to that universal problem. Comparing with other patients means that the HCP implies that the patient cannot really understand what is happening unless the patient understands how that problem is manifested in other patients. Thus, treating a concern or labeling a concern as a “universal concern” or “general issue”, etc. decreases the need for the HCP to fully explore this patient’s concern. Instead the HCP needs to explore only enough to identify that universal problem. At that point the HCP’s expertise entails that the HCP knows best what the patient ought to do to deal with this universal problem. Denying the uniqueness of the patient’s concerns centers the interaction on the HCP’s perspective rather than on the patient’s perspective. Hence, the uniqueness of the patient’s concerns are minimized or not attended to at all.

In the next example, the patient expressed his doubts about the effectiveness of his medication for heartburn as he had heartburn attacks mainly at night. The HCP empathized with the patient’s concern and the patient seemed to feel understood. This empathy was followed by the HCP exploring the patient’s daily routine in terms of his activities and diet. After listening to the patient’s routine, the HCP remarked that convenience sounded important to the patient because the patient had expressed his dislike for cooking and his dependence on fast foods and easy to cook foods. The HCP then explored the patient’s understanding of how his going to bed shortly after dinner affected his illness. The patient explained that he had been on the same routine for several years and it had never caused him any heartburn. The HCP wondered if the patient was ruling out the significant effect of diet on his heartburn and accurately reflected the patient’s response, and in addition to it, asked if the patient didn’t see any relationship between his diet and heartburn. Although, the HCP’s reflection was accurate, her tone of

voice was not empathic, in the sense it was expressed in a questioning and judgmental tone. The HCP then suggested the patient to consider the possibility of a relationship between his diet and heartburn and explored if there had been any changes in his life style or physical condition such as stress. The patient responds as seen in utterance 1.

Example 21

May07_p2_t1_6 (Utterances 14-17)

- 14 P: No not really...my job is lot of stressful as it always has (HCP: Uh huh). I haven't changed my exercise or anything (HCP: Uh huh)... pretty much don't exercise (smiles) so (HCP: Uh huh), so that hasn't really changed. Since I hit forty I put on a little bit of extra weight (HCP: Uh huh) but I mean not a whole bunch.
- 15 HCP: Okay little bit of extra weight... Well I did notice that we got your weight... your weight... you have put on 10 pounds (P: Yeah) from last month, so what are your thoughts about that?
- 16 P: Ah... you know I just think as I am gotten older my metabolism is slowing down or something because like I said my diet hasn't changed, my activity hasn't changed (HCP: Hmm) so I just attribute it to I am getting older... ever since I hit forty... its getting harder to keep those pounds off.
- 17 HCP: Well that's kind of a universal problem isn't it... I can understand that. (P: Yeah) Alright so as we are talking about this how important is it to you to get this (GERD) under control?

In utterance 4 of the preceding example, the HCP generalized the patient's concern about his difficulty in managing his weight after he was 40 years of age. The

issue was the left behind and the HCP went on to assess how important it was for the patient to manage his illness. It could have been helpful to acknowledge the patient's concerns as he experienced it instead of responding by generalization because it puts an end to further exploration to see any uniqueness in this patient's concern. Perhaps he was not like most people in his weight gain.

Thus, as a result of not being empathic to the patient and minimizing the importance of the concern, the patient-HCP exchange was affected as follows.

- The patient's concern about age as a factor for his weight was not given any importance, leaving the patient feel less understood.
- In the later part of the interview, much time was spent in persuading the patient to take his medications when the patient was already adherent to his medication.

Thus, not giving importance to the patient's concern by referring it as a universal problem and moving on to discuss other issues resulted in waste of time.

- As a result of not empathizing with patient's concerns, the HCP digressed to issues not relevant to the patient. HCP came to a wrong inference that the patient is not adherent to his medication although the patient was adherent. The HCP attributed the GERD symptoms to patient's poor adherence to his medicine. Thus, not empathizing with the patient resulted in misunderstanding of patient's concerns.

In the preceding example, the HCP could have been less picky in utterance 2 to catch the patient's mistake when he expressed he had gained *a little bit* of weight, although he had gained 10 pounds. The HCP could also have been less judgmental while

acknowledging the patient's perspectives. An appropriate hypothetical response to the patient's concern in utterance 3 could be.

3 P: Ah... you know I just think as I am gotten older my metabolism is slowing down or something because like I said my diet hasn't changed, my activity hasn't changed (HCP: Uh huh) so I just attribute it to I am getting older... ever since I hit forty... its getting harder to keep those pounds off.

4 HCP: *Uh huh so your food habits and physical activities have been the same for years. Since you don't see any changes in your life style, it makes you feel that your age is responsible for your weight gain.*

5 P: *Uh huh... Yeah*

6 HCP: *And you are finding it difficult to maintain a normal weight*

7 P: *Uh huh... Yeah*

8 HCP: *May I share with you some information about heartburn and weight?*

9 P: *Sure*

10 HCP: *When you to lie down to sleep at night, your excess fat exerts pressure that pushes the acid in your stomach into your throat producing the heartburn symptoms. What are your thoughts about that?*

11 P: *Okay... I was thinking the medication wasn't effective.*

12 HCP: *You were wondering if it was the ineffectiveness of your medication that was causing heartburn attacks at night.*

13 P: *Yeah*

14 HCP: *Since your heartburn attacks are mainly during the night, your medication seems effective in preventing attacks during the day times.*

15 P: *Yeah the attacks occur when I lie down to sleep although rarely during the days.*

16 HCP: *Uh huh... May I give you some information about why your medication doesn't seem to help you during the night?*

This discussion could continue further by HCP informing the patient about the time of meals and the types of food that affects GERD. In the preceding hypothetical example, the HCP empathized with the patient in utterance 4 instead of generalizing the concern as in example 20. The patient was then given information about how his weight could affect his GERD and in response the patient opened up by telling that he was under the impression that the medicine was ineffective. This helped the HCP to address the patient's concern about his medication. Thus, when patient's ambivalence about his medication and weight were addressed, the ambivalence gets reduced and motivational interviewing theory suggests that patients' become more positive about making behavioral changes when their ambivalence about change is resolved.

In the next example, the HCP initially explored the patient's understanding about his illness and the medication that he was taking. Later on when asked by the HCP, the patient expressed his concern about the ineffectiveness of his medicine and his experiences of heartburn mainly in the evenings. The HCP responded by asking the patient if there had been any changes in his life style recently, which she doubted could be responsible for the onset of his heartburn. This was followed by exploration of the patient's diet because the HCP noticed that the patient had put on 10 pounds after his last visit. The HCP suggested the patient eat smaller meals and eat earlier at night. The following discussion ensues after the patient acknowledged the HCP's suggestion.

Example 22

May07_p2_t1_16 (Utterances 24-27)

24 HCP: Ah also, the thing that concerns me is your weight... if may be you can get your weight down, it may help control the symptoms that you are having with the reflux and the burning. Ah is there anything you are willing to do to work on your weight? (P: Hmm...) as far as exercise may be?

25 P: Well... you know after a long day work the last thing I want to do is to go to the gym and work out and sweat

26 HCP: I understand that, and that's all a big problem with us. Hmm... Uh huh... have you ever thought about walking in the evening or walking at lunch or... anything that you can do to kind of increase that metabolism because you have mentioned earlier you know after your metabolism slows down. Anything we can do to increase that metabolism greatly affects [

27 P: [I may be able to take some walks here and there I think

In the preceding example, in utterance 25, the patient expressed resistance to engaging in exercising, which he seemed to feel was being imposed on him by the HCP. The HCP appeared to have experienced face loss due to the patient's refusal. In utterance 26, the HCP minimized the patient's concern by asserting that it's a common problem with all people. Moreover the HCP need not have labeled it as a 'problem' because dislike towards working out in a gym after a long day's work may not be a problem from the patient's perspective. Thereafter the HCP continued to suggest some forms of exercise to the patient without exploring with the patient some alternative ways of

reducing his weight. The HCP here had an agenda to get the patient to do some form of exercise despite his dislike of physical exertion. This approach of HCP's persuading patients to engage in a behavior without addressing their concerns was discussed before in the section "HCPs running an agenda". Characterizing the patient's problem as a common problem is a strategic move that justifies why the patient should abide by the HCP's agenda.

Thus, as a result of generalizing the patient's concern instead of empathizing with it, the patient-HCP exchange was affected as follows.

- The patient's concern about his dislike towards working out after a long day's work was not considered as a unique concern.
- The HCP lost an opportunity to explore and elicit the patient's motivation to reduce his weight. The patient consents to walk because of the HCP's persistent suggestion and not out of a personal understanding of the necessity of reducing his weight. The HCP could have explained to the patient how excess weight could affect his heartburn especially at night when he lies down to sleep.
- The HCP's response implies that she understands the patient not because she understands how patient feels it but because she has identified a common problem occurring with many people. In a subtle way, it is the HCP's frame of reference that has been asserted as the proper perspective in order to respond to the patient. This implication is the opposite of empathy.

The following is an appropriate hypothetical example of the HCP's response in terms of facilitating the patient's engagement with the behavior change of reducing weight. Here the HCP empathized with the patient's perspective about his dislike

towards any exertion in exercising in utterance 33, instead of generalizing his feeling. Moreover the HCP also elicited the patient's intrinsic motivation to engage in the behavior change by creating discrepancy in utterance 27.

24 HCP: *May I share with you what concerns me about weight and heartburn?*

26 P: *Sure*

27 HCP: *On one hand you are concerned about heartburn symptoms at night and on the other hand your additional weight puts more pressure on your stomach when you lie down to sleep causing the acid in your stomach to rise up to your esophagus and that is when you experience that pain. What are your thoughts about that?*

28 P: *Well I didn't know that my weight could be causing me this pain during the night.*

29 HCP: *Would you be interested in some suggestions to reduce your weight?*

30 P: *Yeah... go ahead*

31 HCP: *What are your thoughts about increasing your physical activities?*

32 P: *Well... you know after a long day work the last thing I want to do is to go to the gym and work out and sweat*

33 HCP: *So you would rather avoid doing something in the evenings that will tire you out and get you all sweated up. What are your thoughts about how you can increase your physical activity without exerting yourself in one strenuous exercise session? How you can add more physical activity sprinkled throughout the day? It could be even walking a few minutes or parking farther from your office and walking a little more, etc.*

In the last two examples, the HCPs generalized the uniqueness of patient concerns such that these concerns were not given any importance and were treated as a general problem. In the following examples, HCPs reduce the uniqueness of patients' concerns by comparing them with other patients. These HCPs understand patients not from patients' frame of reference but from the HCPs' frame of reference. The purpose of comparison apparently was to let patients feel that there were other patients as well who share their feelings and thereby to make the patients feel comfortable in having those feelings.

In the following example, before utterance 33, the HCP explored what the physician had told the patient about her medications and the lab results. The patient responded by saying that she just knew that her blood pressure was high and expressed her surprise about it because she had been watching her diet and exercising. The HCP supported self-efficacy for the patient's efforts in exercising and watching her diet although the patient's disappointment and surprise were overlooked. The patient repeated again why she was surprised later, which again was responded by supporting self-efficacy. This kind of HCP response has been explained before where HCPs overlook patients' disappointments or surprises and support the positive steps taken by their patients. Later on in the following interview, the patient expressed that she wanted to work harder in managing her illnesses and that she wanted to know more about the benefits from her medications because she doesn't take them as prescribed. Then the discussion proceeded as follows.

Example 23

May07_p1_t1_1 (Utterances 36-39)

36 P: Yeah just diet and exercise and taking medication you know on a regular basis..I I am not crazy about medicines and you know taking the medicine all the time.

37 HCP: So medication is is hm ... taking the medications sometimes is hard for you?

38 P: Ah sometimes I just don't see the need in it when I am not overweight and you know I feel good.

39 HCP: *(Nods) ((as an expression of understanding))* And I would say you know many people would feel why would they need a medication if they are feeling good. Ahm .. *((HCP was unsure what to say next))* with I understand that you have diabetes (P: Yes... yes) and what do you know about diabetes and how-how to best ah take care of it... Has Dr. Smith talked to you about that?

In the preceding example, in utterance 37, the HCP reflected the patient's concern about taking her medications. This was followed by the patient opening up further by telling the reason why she doesn't want to take her medications in utterance 34. She expressed her feeling healthy and being in good shape as reasons why she doesn't see the point in taking her medicines. In utterance 35, the HCP treated the concern as meaningful and sensible because many people would have felt the same way and not because the patient was experiencing it. Although, it was done with a good intention, it doesn't help much in eliciting the patient's feelings and viewpoints. The HCP examined the patient's

understanding of diabetes and how best to manage the illness. This indicates that the patient was not competent in managing her diabetes and this created face loss for the patient. Instead the HCP could have empathized with the patient's perspective about how her feeling healthy as a sign of good health. This could have helped in providing new information to the patient or creating dissonance that could have corrected the patient's misunderstanding without creating face loss.

Thus, as a result of comparing the patient with other patients instead of empathizing and exploring the concern, the patient-HCP interaction was affected as follows.

- The patient's concern was not explored further and it didn't help in a better understanding of the patient. Apparently when a HCP comes to a conclusion that a patient has the same concern like his/her other patients, then it is likely that the HCP may feel it needless to explore any further. It was observed that generalizations and comparisons usually brings an end to any further opportunity to explore a patient's concerns.
- The HCP's conclusion that this patient is like one of her many other patients could make it seem needless for the patient to share her experiences any further. Also, the HCP presumed to have understood it all and do not explore any further.
- In this example, the HCP never addressed the patient's concern, although minimizing the uniqueness of the patient's concern may not be responsible for this.

An appropriate hypothetical HCP response in the preceding example could have been as follows.

- 33 HCP: So medication is is hm ... taking the medications sometimes is hard for you?
- 34 P: Ah sometimes I just don't see the need in it when I am not overweight and you know I feel good.
- 35 HCP: *So when you feel good and are in good shape, you feel that you can manage your illnesses without taking your medicines regularly.*
- 36 P: *Yeah... and I just worry about the possibility side effects from the medicines.*
- 37 HCP: *So you avoid taking medications because you are worried about the side effects and also you are not sure you really need them when you feel good.*
- 38 P: *Exactly*
- 39 HCP: *May I tell you what concerns me?*
- 40 P: *Sure*
- 41 HCP: *I am concerned because diabetes and blood pressure may not show any symptoms for you to feel so that you know that you need to take your medications...hm... they are often symptom free illnesses... The first sign of illness that a patient might experience with high blood pressure could be a heart attack or a stroke. What are your thoughts about that?*

This discussion could proceed further by empathizing with the patient and educating the patient about the side effects and benefits from the medication. Here not treating the concern as a general concern for patients and appreciating the uniqueness of the patient's concern helped in further exploration of the concern, and therefore facilitated addressing those concerns.

In summary, ignoring the uniqueness of a patient's concerns instead of empathizing with them could result in the following.

- When HCPs express their understanding of a patient because the patient is like his/her many other patients or because the patient's concern is a general problem, the HCP is subtly shifting to making sense of the patient's perceptions from the HCP's own frame of reference. Thus, the counseling becomes less patient-centered and more HCP-centered. Comparisons with other patients may be useful if patients want to know whether other patients have had similar concerns or issues.
- The patients' concerns could go unaddressed when the concerns are treated as being universal in nature.
- The patient could feel disappointed when their concerns are not addressed and are rather regarded as a common problem.
- The brushing of an issue aside by referring it as a universal or a common problem could result in digression from the issue and therefore could result in waste of time.
- The HCPs' conclusions that a patient is like her many other patients could make it seem needless for the patient to share her experiences any further. Also, HCPs presume to have understood it all and do not explore any further.
- The HCPs' comparison of a patient with other patients could stop any further exploration of the patient's unique feelings and it may not help in a better understanding of the patient.

- The HCPs' comparison of a patient with other patients could also result in HCPs' offering recommendations not targeted to the patient.
- The HCP's comparison of a patient with other patients may lead the HCP to fail to provide a clear transition to subsequent exploratory questions. The patient may consequently feel that the HCP is interrogating the patient.

7. *HCPs treat patients solely as a source of information.* Sometimes HCPs treat patients as a source of diagnostic information. There is very little attention paid to understanding patients. For example, HCPs begin to explore patients' dietary habits, exercise habits or medication related information without paying attention to exploring or acknowledging patients' perspectives. These HCPs are trying figure out and fix the problem behavior. As a result they usually begin with exploration of patients' behaviors and end with making recommendations. In these situations, patients play a passive role and act solely as information supplier. Instead, it is more useful for HCPs to actively engage patients in exploration of their concerns and in negotiating solutions to their problems. The HCP's intention behind these explorations and their relevance to the patients' concerns should be made explicit.

In the next example, the HCP explored the patient's understanding of diabetes and informed her that her A1C is still high, which is the lab result for her diabetes. Then the discussion proceeded as seen in utterance 6.

Example 24

May07_p1_t1_3 (Utterances 6-9)

6 P: Well ah I am a...I am a little surprised that it's still up and (HCP: Uh huh)

and I know that diabetes is you know affected by what I eat of course
(HCP: Uh huh) and you know I know that exercise can play a role and hm
the things that I eat and it's just you know the sugar levels in your body
just not regulated and those things diabetes is-is the result of that.

- 7 HCP: Uh huh... so can we talk about your exercise? (P: Sure) How much of
exercise ah
- 8 P: Hm it's good hm I am usually trying to go to the gym or take a long walk
30 minutes to an hour may be three or four times a week and I can go to
the gym and get my heart rate up to 150 easily on the elliptical machine so
I do XXXX some exercise
- 9 HCP: Wow doing great with your exercise just keep it up (P: Thank you) that's
good yes... well so there must be something else that is affecting your hm
sugar because it's still running high so (P: Uh huh) can you tell me about
your diet... how is how is your

In this example, the patient expressed her surprise in utterance 6. Instead of
empathizing with her the HCP explored the patient's exercise habits. The HCP then
explored the patient's diet in utterance 9, after supporting self-efficacy.

Thus, as a result of treating the patient as a source of information, the patient-HCP
interaction was affected as follows.

- The HCP did not empathize with the patient's surprise.
- As a result of overlooking the patient's surprise, the HCP did not explore it
further. The exploration of the surprise may have elicited the patient's experience
of dissonance. This is because on one hand the patient was exercising really well

to manage her illnesses while her blood pressure and hemoglobin A1C levels continued to remain high. After empathizing, the HCP could have enhanced the patient's dissonance to facilitate behavior change.

- The HCP did not engage the patient actively in the discussion. She played a passive role as an information supplier. Also, the HCP never let the patient know explicitly why he/she was asking the questions he was about to ask. Telling this patient in advance that the purpose of asking these questions is to address her surprise about the lab values could have made the patient more receptive. The patient is more likely to be an active listener and would not misunderstand the HCP as trying to find flaws in her life style habits like diet, exercise, etc.

An appropriate hypothetical example could be as follows.

- 6 P: Well ah I am a...I am a little surprised that its still up and (HCP: Uh huh) and I know that diabetes is you know affected by what I eat of course (HCP: Uh huh) and you know I know that exercise can play a role and hm the things that I eat and its just you know the sugar levels in your body just not regulated and those things diabetes is-is the result of that.
- 7 HCP: *So on one hand you expected your diabetes levels to be lower and you are surprised that it's still high, especially when you have been working hard on exercising and watching your diet. On the other hand, your lab values are still high despite your hard work. What are your thoughts about this?*
- 8 P: *Well I thought it would have come down below 8 because I exercise at least 4 times a week for 30 minutes to an hour, I am trying to watch my*

diet and you know I also take my diabetes medicine about four to five times a week.

In the preceding hypothetical example, the HCP empathized with the patient and created dissonance in utterance 7, then went on to explore more about the reasons for the patient's concerns. Thus, the HCP stayed focused on the patient's core concerns and explored her dissonance. The patient was actively engaged in discussing her concerns instead of playing a passive role as a source of information. Notice that as a result the patient revealed information about her medication taking.

In the next example, the patient and the HCP exchanged greetings and the discussion proceeded as follows.

Example 25

July_p2_t1_1 (Utterances 6-15)

- 6 P: Well when I first started taking it, it was working really good. I wasn't having any more heartburn. But now I'm starting to get heartburn again.
(HCP: Okay) I'm worried that maybe the medicine is not working.
- 7 HCP: Has anything changed since you first started your medications till now?
Are your eating habits still the same?
- 8 P: Um yeah I think I'm eating pretty much the same as I was.
- 9 HCP: Okay, tell me when you take your medicine.
- 10 P: Ah I take it every morning a half an hour before I eat or drink anything.
- 11 HCP: Okay. (XXXXX). Okay. Tell me about your regular eating habits.
- 12 P: Um well I'm not a big breakfast eater. Usually you know I'll eat some toast and jam on the way out the door with some coffee. Or I'll hit

something from the drive through, maybe milk and a biscuit or something.
(HCP: Okay) For lunch if I'm at work I'll go to the cafeteria there and eat there. Or I'm on the road a lot with my job. So it's usually something from the drive through. I can eat quick. Coming home for dinner, I don't really like to cook. So if I eat at home it'll be a sandwich and chips, maybe a TV dinner. A lot of times I'll just pick up something from the drive through on the way home.

13 HCP: What time do you eat your last meal?

14 P: um, I probably get to eat between eight and nine.

15 HCP: Then what time do you go to bed?

In the preceding example, in utterance 7, the HCP explored what changes in the patient's life could have contributed to his heartburn. There was no empathy with the patient's concern that the medication may not be working. The HCP then went on to explore the patient's medication habits and food habits in utterances 9 and 11 respectively. This was again followed by explorations of the timing of his last meal and bed time.

Thus, as a result of treating the patient solely as a source of information, the interview was affected as follows.

- The HCP did not empathize with the patient's concern about the ineffectiveness of his medicine and lost an opportunity to address his concern.
- The HCP could not engage the patient actively in the discussion and the patient became a passive supplier of information.

- The HCP did not explain why she went on to examine the patient's eating habits and his sleeping habits.
- The patient would have felt disappointed because the subsequent discussion following his concern didn't seem to take into account or address the effectiveness of his medicine.
- The explorations could have given a feeling that the HCP is trying to find flaws in the patient instead of considering the possibility of the effectiveness of his medicine.

An appropriate hypothetical example could be

6 P: Well when I first started taking it, it was working really good. I wasn't having any more heartburn. But now I'm starting to get heartburn again.
(HCP: Okay) I'm worried that maybe the medicine is not working.

7 HCP: *Uh huh... So you are concerned that the medicine is not as effective as it was when you first started taking it because you are experiencing heartburn again.*

8 P: *Uh huh... that's right.*

9 HCP: *May I ask you some questions to see what might be happening so you might get some relief?*

10 P: *Sure*

11 HCP: *In addition to the medicine, what you eat and when you eat can affect your GERD. When do you normally eat your last meal and when do you go to bed?*

In the preceding example, although the HCP explored further the patient's medication regimen, it was done through a collaborative approach. The HCP empathized with the patient in utterance 7 and moved on to address his concern about the effectiveness of the medicine. The HCP explained why she was going to ask some questions. Thus, the patient was actively engaged in the discussion and was informed about the purpose of explorations. The patient is not likely to feel that the HCP is looking for flaws in him for his heartburn.

In summary, treating patients as a source of information could affect the patient-HCP interactions in the following ways.

- HCPs could fail to empathize with their patients' perspectives about their illnesses when their interest is limited to identifying their patients' problem behaviors and offering solutions to fix them.
- As a result of overlooking patients' motivational issues or core concerns, HCPs may not succeed in identifying and addressing patients' concerns.
- As a result of overlooking the motivational issue and the patient playing a passive role, the HCPs may fail to elicit or enhance patients' intrinsic motivation to facilitate behavior changes.
- Patients could feel disappointed when their concerns are not addressed.
- Explorations of patients' life style such as diet, medication regimen and exercise habits immediately following patients' concerns could give a sense that the HCP is trying to put the patient in his place. This is especially true when the HCP does not frame the reasons for the questions.

8. *HCPs acknowledge superficial details of patients' responses overlooking core issues.* Sometimes HCPs empathize with patients on a surface level and ignore core issues in the patients' concerns. There was a tendency to reflect some details of patients' responses while the central idea was overlooked. The following examples could explain how HCPs may tend to overlook important issues at the heart of patients' concerns and deal with surface details. In the next example, the patient and the HCP exchanged greetings and the discussion follows.

Example 26

Jan07_p1_t2_13 (Utterances 1-3)

- 1 HCP: I notice that... I got back some of your lab results and the blood pressure is still high and the A1C the the-the test that your doctor does for your blood sugar is also a little high.
- 2 P: I am a little surprised about that because I am not overweight and doing some good things.
- 3 HCP: No you are not... you are not overweight at all and I know the last time you were in you said that you exercise fairly regularly (P: Uh huh. Nods) and... that you have some concerns about taking medications that you expressed.

In this example, the patient expressed her surprise about her lab results in utterance 2. She was surprised because she had been exercising and making some effort along those lines to manage her illnesses. In utterance 3, the HCP overlooked the fact that the patient is experiencing dissonance between her positive health behaviors and her lab

results. The HCP did not see the relationship between the patient's weight and her surprise.

Thus, as a result of not empathizing with the core issue underlying the patient's concern, the patient-HCP interaction was affected as follows.

- The HCP overlooked the patient's surprise and failed to further explore the surprise.
- An opportunity to enhance the discrepancy between the patient's positive health behaviors and her lab results was missed.
- The patient assumed that being in good shape is a sign of being healthy and having glycemic control. This misgiving of the patient went unexplored as a result of not identifying the core issue.

An appropriate hypothetical example could be the following.

- 1 *HCP: I have your lab results. Your blood pressure is still high... it's 145 over 95 and your A1C, the the test that your doctor does for your blood sugar is also high, which is an 8.*
- 2 P: I am a little surprised about that because I am not overweight and doing some good things.
- 3 *HCP: So on one hand you have been maintaining your weight and have been making efforts to manage your illnesses and on the other hand you are surprised that your blood pressure and A1C continue to remain high. Is that correct?*

4 P: *Exactly.... I have been exercising for 30 minutes to an hour for at least 4 days in a week. (HCP: Uh huh), watching my diet and I take my medicines about 4 times a week.*

5 HCP: *Uh huh. Exercise and diet management that you have been doing certainly would help in reducing your blood pressure and diabetes levels. Do you mind if I explore a little bit about your medications to see why your lab values didn't come down?*

In the preceding hypothetical example, the HCP identified the patient's core concern, which was her experience of dissonance expressed in her emotion of "surprise". The HCP enhanced the patient's dissonance by empathizing with her surprise in order to enhance the intrinsic motivation to make behavior changes.

In the next example, before utterance 7, the HCP commended the patient for being adherent to his medications. The patient expressed his concern about the effectiveness of his medicine and the discomfort as a result of heartburn during the night. The HCP went on to explore what might have changed in the patient's life that could have contributed to his heartburn experiences. The patient expressed that there hadn't been any changes in his life other than some weight gain after he hit forty years of age. The HCP acknowledged it and went on to explore the patient's concerns and the discussion follows.

Example 27

May07_p2_t1_10 (Utterances 7-9)

7 HCP: ...Tell me a little bit about what your concerns are you know today?

- 8 P: Well I am just concerned that the medicine doesn't seem to be working like it did when I first started taking it... hm... I have been getting this heartburn at night... its waking me up a couple of times or it is making it difficult to get to sleep sometimes.
- 9 HCP: Okay so the heartburn is mostly at night (XXXX) that's pretty rough then. (P: Yeah). You are trying to get up and go to work after not sleeping well (P: Nods)... tell me a little bit about what you are eating you know during the day... what kind of foods?

In the preceding example, the patient expressed his doubts about the effectiveness of his medicine and the discomfort associated with heartburn at night. The HCP responded to the patient's experience of discomfort at night and went on to explore his diet during a typical day. The HCP overlooked the patient's core issue in the patient's concern that his medication is apparently ineffective.

Thus, as a result of overlooking and not empathizing with the patient's core concern, the patient-HCP interaction was affected as follows.

- The HCP never addressed the patient's concern about the effectiveness of his medicine and the patient would have left the interview with uncertainty about the effectiveness of his medicine.
- The later part of the interview digressed from the patient's concern to his diet. Also, the HCP went on to offer recommendations to change the patient's diet and explored hereditary factors.

- There was loss of time in discussing issues not relevant to the patient's concerns. Nearly 3 minutes of the interview was spent in discussing issues without relating it to the patient's concern.
- The patient is likely to feel less understood and could be less motivated to take his medicine when he thinks it is ineffective.

An appropriate hypothetical example could be as follows.

7 HCP: ...Tell me a little bit about what your concerns are you know today?

8 P: Well I am just concerned that the medicine doesn't seem to be working like it did when I first started taking it... hm... I have been getting this heartburn at night... its waking me up a couple of times or it is making it difficult to get to sleep sometimes.

9 HCP: *So you are concerned about the effectiveness of your medicine because you are not getting the same relief as before and the heartburn is making it really hard for you to sleep during the night.*

10 P: *Exactly*

11 HCP: *May I ask you some questions to see why your medication seems to be ineffective during the night?*

12 P: *Sure*

In the preceding hypothetical example, the HCP empathized with the core concern of the patient in utterance 9 about the effectiveness of his medicine and went on to address the concern in utterance 11. The HCP's acknowledgement of the patient's prime concern gives a sense of being understood and further explorations also makes sense to the patient as it was intended to address his concerns.

In the next example, before utterance 4, the HCP explored how the patient is doing with his heartburn after he was put on a medication during his last visit with the doctor.

Example 28

May07_p2_t1_5 (Utterances 4-12)

4 P: When I first started taking it, it seemed to be working really well, but I don't know if its working anymore... still getting some heartburn mainly at night

5 HCP: Mainly at night

6 P: Yeah

7 HCP: What time of the day are you taking your medicine?

8 P: Hm... Every morning 30 minutes before I eat or drink anything

9 HCP: Okay... do you remember or did we talk about many of the...some life style changes or things that you might consider doing in addition to taking the medicine=

10 P: [Hmm...

11 HCP: = did we go over any of those things

12 P: I can't recall

In the later part of this discussion, the HCP goes on to explain how to prevent heartburn during the night through life style changes.

In the preceding example, the HCP responded only to the surface details in the patient's concerns without empathizing with the core issue, in utterance 5. The patient is concerned that the medicine is ineffective but the HCP never addressed this concern

throughout the interaction. Although recommending life style modifications to the patient will help in preventing heartburn attacks at night, the patient may not be motivated to adhere to the medication regimen when he is feeling that his medication stopped working.

Thus, as a result of not empathizing with the patient's core issue, the patient-HCP interaction was affected as follows.

- The HCP never addressed the patient's core concerns.
- The patient would have felt less understood when the HCP moved on to explore his adherence to medication regimen and dietary habits (in the subsequent discussions) when he expressed his doubts about the effectiveness of his medicine.

In summary, not empathizing with patients' core concerns could affect patient-HCP interactions as follows.

- It could hinder any further exploration of the core concern when the core issue is ignored.
- Patients' concerns could go unaddressed and it could affect their motivations to adhere to the HCP's recommendations.
- The overlooking of patients' emotions such as surprise could be missed opportunities to identify and enhance their dissonance to facilitate behavior change.
- It could result in digressions from core concerns to less important issues like the impact of hereditary factors on heartburn, when a patient is not convinced about the effectiveness of his medicine.

- There could be loss of time in discussing issues that seem to the patient unrelated to his/her concerns
- Patients are likely to feel disappointed when subsequent discussions are not made pertinent to their concerns.

The following are the highlights of the patterns of HCPs' responses to patients' expressed concerns:

- HCPs support self-efficacy without empathizing with patients' concerns
- HCPs run an agenda
- HCPs provide or elicit information without establishing its relevance to patients' concerns.
- HCPs examine patients' knowledge without empathizing with their concerns
- HCPs discount patient concerns
- HCPs generalize or compare patient responses
- HCPs treat patients solely as sources of information
- HCPs acknowledge superficial details rather than core issues

V. DISCUSSION AND CONCLUSION

Being empathic is to sense the experiences of another and to communicate back that understanding with sensitivity in an objective and nonjudgmental way. Empathy came to prominence with Rogers' person-centered approach to counseling (Barrett-Lennard, 1981). Literature in the field of psychology (Barone et.al, 2005; Rogers, 1975, 1980) has claimed that empathy helps in building a therapeutic alliance between HCPs and clients. Consequently many counseling educators have developed training programs that teach empathic skills to counseling students (Goldstein & Michaels, 1985).

The value of empathy in building a therapeutic alliance was also recognized in healthcare (Berger, 1993). Studies have shown that empathizing with patients improves patient adherence to medication regimens (Squier, 1990; Stepien & Baernstein, 2006) and patient satisfaction with healthcare services (Book, 1988a; Larson & Yao, 2005). Empathy in patient-HCP relationships has also been reported to have improved HCPs' job satisfaction (Larson & Yao, 2005). As a result, empathy training has been introduced in healthcare.

Numerous studies of patient-HCP interaction have identified that HCPs have problems empathizing with patients (Easter & Beach, 2004; Suchman et al, 1997). These studies have suggested that HCPs often fail to empathize with their patients. Instead they may ignore patients' emotions, discount the uniqueness of their patients' experiences, and focus solely on eliciting and providing objective medical information. As a result they tend to provide solutions in the form of advice or

orders. When patients resist, these HCPs tend to engage in unproductive argumentation. Patients often feel ignored and are less willing to express their true thoughts and feelings to their HCPs. Consequently there has been a call for a more patient-centered approach in healthcare (Wagner, 2005).

Motivational Interviewing (MI) is a patient-centered form of counseling that originated in addiction counseling and has been introduced in healthcare intervention encounters. According to Miller and Rollnick (2002), empathy is the foundation for the effectiveness of MI. Therefore this thesis has focused on the difficulties experienced by HCPs as they learn to empathize with patients as a part of MI. Specifically the research questions were:

- What problems do HCPs have in learning to empathize with patients' perspectives/concerns about their illness and its management?
- What problems are faced by HCPs in learning to address patients' perspectives/concerns?

These questions were answered using qualitative discourse analysis of role played patient-HCP interactions videotaped at the end of an 18 hour motivational interviewing training program. The previous chapter presented eight distinctive patterns of difficulty encountered by HCPs in these videotaped role plays. These eight patterns are summarized and discussed in the following section.

Patterns of Difficulty in Using Empathy in MI

1. HCPs support self-efficacy without empathy. MI teaches HCPs not only to empathize with patients but also to support their self-efficacy by commending any positive health behaviors such as taking their medicine as prescribed (or even verbalizing

possible future behaviors). When standardized patients in the videotaped role plays both expressed their concerns and mentioned positive health behaviors, some HCPs failed to empathize with the patients' concerns and just supported self-efficacy. For example, if a patient said "I am disappointed that my heartburn has not subsided and I have been taking my medicine everyday as prescribed. I am not sure if this medicine is going to help me", the HCP would respond by saying "That's really great that you have been so committed in taking your medications every day." The patient's concern about the ineffectiveness of his medication and his disappointment over his continuing heartburn were completely overlooked in this response and never addressed in any subsequent responses. Often the HCP then digressed to explore positive health behaviors that the patient is already doing well. Because the HCP failed to acknowledge and never did address the patient's concerns, the patient's internal motivation to make further positive behavior changes was never enhanced and the patient continued to doubt the efficacy of the prescribed medication.

There may be several different reasons for HCPs engaging in this pattern. First, it is clear these HCPs are trying to use MI skills insofar as they have implemented supporting self-efficacy, one of the five foundational READS skills. Because supporting self-efficacy is cognitively simpler than empathizing with the patient's perspective, these HCPs may be listening for positive patient behaviors that can be reinforced simply and quickly. Second, these HCPs seem to be using one MI skill at a time rather than using combinations of MI skills. This simplistic approach is productive while HCPs are learning MI as long as they empathize with the patient's concerns in subsequent utterances. A third reason for this pattern of focusing only on the positive steps taken by

the patient may be a desire to cheer up or encourage a disheartened patient experiencing doubts about the medication and disappointment about the lack of results. These HCPs may be assuming that empathizing with this patient would only further reinforce the patient's doubts and disappointment. It is also possible that some health care HCPs have focused on negative aspects of patient behavior and when they learned supporting self-efficacy, they made a decision to consciously support positive behaviors and statements. Finally, these HCPs may be more focused on implementing skills and using new skills correctly rather than understanding the patient's motivational issues and addressing the patient's concerns. These HCPs do not seem to sense that empathizing with the patient's concerns and issues is the first step toward addressing and resolving these issues. MI training may need to show examples of how empathizing with a patient's doubts and concerns does not reinforce these concerns but rather facilitates dialogue that may resolve these concerns and lead to positive health behavior changes.

2. *HCPs run/force a predetermined agenda.* HCPs whose talk is focused on achieving predetermined goals for their patients often do not empathize with their patients' concerns. If the HCPs have predetermined what is best for their patients, then empathizing with and exploring their patients' perspectives is considered either superfluous or of secondary importance. For example, if a HCP has decided that the patient must quit smoking, then he/she may drive the conversation to accomplish that goal irrespective of the patient's ideas, feelings or barriers about quitting smoking.

Running an agenda is different from setting an agenda with patients. HCPs involve patients in setting an agenda while HCPs do not involve patients in running an agenda. HCPs having a desire that their patients should engage in positive health

behaviors is not running an agenda but wanting patients to engage in that behavior without exploring their willingness or ignoring their intention is running an agenda. Thus, setting an agenda involves patients and is collaborative while running an agenda is not collaborative and often overrides patients' intention. HCPs seem to perceive little need for empathy if they adopt the attitude that they are the sole source of expertise when interacting with patients. Their failure to acknowledge the expertise and autonomy of patients seems to lead HCPs to decide what is best for the patient and then to drive their conversations to meet this agenda. In contrast, MI is formulated as a meeting of two experts where patients are experts in knowing what is best suited to their life (what they know and understand about the illness and treatment, how they make sense of all of this, fitting everything into their lifestyle) and which treatment option they could best implement. HCPs have technical expertise about illnesses and their treatment. HCPs who are used to the traditional approach of advising or directing patients may find it difficult to perceive their patients as experts who could collaborate in decision making. It may be necessary in the course of MI training to show how facilitating the patient in making their own arguments for behavior change is more powerful and effective than running an agenda designed to force a patient to adopt a predetermined goal (which is often seen as intrusive when patients are not ready to do so). These HCPs need to see how empathizing with a patient's concerns is the first step in addressing these concerns and eliciting the patient's own arguments for change.

3. HCPs provide or elicit information without establishing its relevance to patients' concerns. Many times HCPs do hear their patients' concerns and immediately move on to try to resolve these concerns by either eliciting clinical information or by

offering advice or suggestions. However in doing so, these HCPs often do not explain the purpose of their explorations or suggestions and how they relate to the concerns the patient has expressed. The health care HCP knows why he/she is asking the questions he/she is asking, but the patient has not been let in on his/her thinking or rationale. For example, a patient might say that “I am not sure my medication is working anymore because I get heartburn symptoms during the night” and the HCP might respond by asking “When do you eat your last meal and what is your bed time?” In this example, the patient may not understand that these clinical questions are responsive to the patient’s experiencing heartburn symptoms at night. So the HCP needs to empathize with the patient’s concerns and then needs to create a clear transition establishing that the HCP’s questions are intended to address the patient’s concerns. In this way, the patient should be less likely to feel that the questions are intended to find fault with them and should be more willing to collaborate with the HCP. This could be done in this manner, “You are worried that your medication may not be working because you are getting symptoms at night (patient nods). Would it be ok if I asked you some questions so we can find out what may be causing this problem?”

HCPs may not engage in using empathy to create the context for their clinical questions for a variety of reasons. First of all, HCPs may assume that the connection should be obvious to the patients. Or HCPs may assume that there is no need to explain the relevance of their clinical questions because the patient should simply trust the expert’s lead. Or HCPs may be trying to save time and effort believing that all that the patient really needs to understand is the HCP’s final recommendations. In doing so, the HCP risks creating defensiveness or confusion in the patient and losing collaboration

with the patient. When patients know that the HCP understands their concerns and view the HCP's questions as a response to their concerns, it will be easier to address these concerns, resolve problems, and elicit change talk from the patients.

4. HCPs examine patients' knowledge without empathizing with their concerns.

HCPs can examine patients' knowledge about their treatment regimen as a response to patients expressing their concerns. This type of response often implies that there is some flaw in the patients' understanding of their treatment regimens; otherwise patients wouldn't have these concerns. For example a patient might say, "I am not sure my medication is working anymore because I get this heartburn during the night" and the HCP would respond "What is your understanding about your illness and how to manage it". In this example, the HCP did not acknowledge the validity of the patient's concern about the effectiveness of his medication and implied that the concern may be the result of some misunderstanding on the part of the patient. This pattern of failing to empathize with the patient's concern and attributing the concern to a lack of knowledge may sound accusatory and often creates face loss for the patient.

Examining patient's knowledge without empathizing with the concern could be due to a couple of reasons. One reason could be that some HCPs immediately judge the patients' misunderstanding. Also, HCPs may attribute patients' problems to their lack of knowledge.

HCPs do need to address and correct patients' misunderstandings (e.g., the ineffectiveness of the medication in the previous example), but this could be done in a nonjudgmental way without creating patient resistance or face loss. HCPs could empathize with patients' misunderstanding and then may ask permission to address their

concerns or to share information that would address their concerns. Patients would be less defensive and more likely to be receptive to new information that removes their misconceptions.

HCPs could be taught how to handle patients' misconceptions about their illnesses or treatments in a nonjudgmental way that does not create face loss for the patient. Given that patient misconceptions and misunderstandings occur fairly frequently, HCPs need to know how to surface these misconceptions in a nonthreatening way, while still correcting inaccurate information. There is a need for role plays with standardized patients who have mistaken notions about their diseases or treatment. These role plays could be video recorded and trainees could be helped to analyze their own responses and improve their empathic skills. One particular strategy that is congruent with the spirit of MI is for the HCP to assume some of the face loss involved with the misunderstanding by apologizing to the patient for not having made the original information clear enough ("I should have been clearer about that"). Then the HCP can ask for permission to share the correct information with the patient.

5. *HCPs discount patient concerns.* Discounting patients' concerns is about HCPs undermining, minimizing or ignoring the significance of patients' concerns. For example a patient would say "I don't think my diet is responsible for my heartburn because it has been the same for years and I never had heartburn before" and the HCP would respond by saying "Yes, **but** are you motivated to reduce your heartburn?" Here the patient's perspective was discounted and made to appear insignificant 1) by the "but" immediately after the reference to the patient's belief, and 2) by the HCP questioning the patient's interest in managing his illness. The HCP's response implied that the patient

was not serious about managing his illness and that this lack of seriousness was a big part of the problem. Empathizing with the patient's concern or confusion that his diet should not be a contributing factor for his continuing heartburn would have allowed the HCP and the patient to explore which factors probably best account for his continuing heartburn in the evening and at night.

HCPs may discount patients' concerns because they are skeptical about patients' motivation to engage in behavior change. In other words, suspecting the genuineness of patients' concerns could have been a factor leading these HCPs to verbally discount the patients' concerns. These HCPs might have assumed that their patients brought up concerns as a way to evade the HCPs' recommendations about behavior change. As a result such HCPs invalidate patients' concerns because they hear these concerns as predetermined excuses or justifications and not as valid reasoning. These HCPs seemed to be HCP-centered because they didn't address any patient issues that made no sense from their position as the healthcare expert. They seemed to see no benefit coming from exploring how patients were making sense of their illnesses or treatment regimens. Health care HCPs might also respond this way because they do not believe that the patient really understands what is going on and so their concerns are discounted.

6. HCPs generalize across patients or compare patients. Some HCPs gave the appearance of responding positively to their patients' concerns by validating that concern as a common concern shared by other patients. On the surface this type of comment sounds supportive (and may be viewed as such by some patients). However, such a comment puts an end to the possibility of any further clarifications from patients and these HCPs do not see the need to hear anything more from their patients in order to

handle their concerns. For example a patient might say that “I have been finding it difficult to manage my weight since I hit forty. My diet is the same and I think my metabolism has slowed down after I became forty” and the HCP would respond by saying “That’s kind of a universal problem, isn’t it? I can understand that. Let’s discuss your evening meals”. Here the patient’s concern was generalized as a “universal problem” that the HCP was presumably already well acquainted with. Therefore, it was implied that it was unnecessary for the HCP to explore to see if there is anything unique about this patient’s situation. Generalizations seemed to put an end to HCPs exploring and addressing the patients’ concerns. It also put an end to a discussion of the patient’s willingness to change his eating habits or food choices, given this slow down in metabolism.

There are several possible reasons for why HCPs generalize their patients’ perspectives.

- HCPs may doubt the genuineness of patients’ concerns. They perceive patients’ concerns as an excuse (or substitute for taking action) given by patients for their health problems. So these HCPs manage these perceived excuses by generalizing them across patients.
- When patients express resistance, HCPs may also become resistant and fail to empathize with patients. Instead these HCPs may generalize patients’ concerns.
- Some HCPs may seek to support their patients’ concerns by offering comparisons with other patients who feel the same way. These HCPs do not seem to be sensitive to how their experience with these other patients overshadows the uniqueness of this patient and ultimately may decrease the autonomy of this

patient. Generally speaking, comparisons to other patients should only be made when the patient asks for the comparison to feel less alone or less “abnormal”.

7. HCPs treat patients solely as sources of information. Some HCPs treat patients solely as a source of information and the patient role is limited to answering HCPs’ queries. Patients play a passive role and HCPs take the responsibility to decide what is best for their patients. These HCPs focused on identifying their patients’ problem behaviors and in fixing them by offering recommendations. This preoccupation with solving patients’ problems is indicative of an expert stance. When HCPs take an expert stance, they do not see the need for collaborating with patients. Patients play a passive role as an information HCP and HCPs understand patients from their own expert frame of reference and are responsible for making sense of patients’ illnesses. Once these HCPs diagnose the patients’ health problems, they give their recommendations. They evaluate patients and decide what is best for them. This makes it needless for these HCPs to understand the illness or its management from the patients’ point of view. For example, a patient may say “I wonder if my medication is working anymore. I am having this heartburn mainly in the evenings when I go to bed” and the HCP might say “Can you tell me about your daily routine like what you eat during a typical day” Here the HCP did not empathize with the patient’s concern but started to explore the patient’s dietary habits. The patient’s perception of the effectiveness of his medication was ignored and the HCP began to collect more information from the patient that doesn’t address the patient’s concern.

These HCPs may not have grasped the significance of understanding patients’ perspectives. They maintained an expert stance and did all the sense making for their

patients. These HCPs might be shown the significance of exploring and resolving patients' concerns through videotaped examples. The advantage of exploring and addressing patients' motivational issues may be taught from a utilitarian perspective instead of just asking HCPs to empathize with and address patients' motivational issues. HCPs may be more willing and motivated to make changes when they see the significance of understanding patients as the point of entry into the patient making the argument for change. Otherwise just asking them to be empathic may not be as productive. Training programs could focus on enhancing HCPs' motivation to be more empathic instead of asking them to do so on ethical or humanistic grounds. This approach could help these HCPs to overcome their preoccupation with identifying and fixing patients' problems, which leads these HCPs to treat patients solely as a source of information

8. *HCPs acknowledge superficial details rather than core issues.* These HCPs reflected some details of patients' responses while the central idea behind patients' concerns was overlooked. HCPs focusing on less significant details often resulted in not empathizing with and addressing patients' central motivational issues. The flow of the patient-HCP interaction often digressed then to topics not relevant to patients' motivational issues. Motivational issues are thoughts or concerns that affect patients' motivation to engage in behavior changes. For example, a patient says "I am not sure my medication is effective as I get this heartburn at night and it makes it difficult for me to get to sleep during the night". The motivational issue is the patients' concern about the possible ineffectiveness of his/her medicine. If this issue is not addressed, then it may affect a patient's motivation to adhere to a HCP's recommendations. On the other hand

these HCPs may reflect some details of the patient's responses by saying "So you have heartburn during the night time" without reflecting back that the patient's doubts about continuing to take the medication.

These HCPs may focus on superficial details because it is harder to identify patients' underlying motivational issues that may only be hinted at indirectly. In addition, it is easier to reflect some aspects of patients' concerns without understanding the underlying reasoning behind these concerns. Such superficial empathy does seem to reflect a desire on the part of these HCPs to empathize with patients, because these HCPs did attempt to reflect patients' utterances. Perhaps they did not know what aspects of patients' concerns were important to empathize with in order to facilitate behavior change. HCPs could be taught not only to empathize with patients but how to empathize with and address patients' motivational issues. Moreover, these kinds of responses may occur because cross-examining the patient is often a major part of practitioner training.

The above eight patterns of difficulties that HCPs have in empathizing with patients in the course of learning MI seem to reflect a set of attitudinal problems and a set of skill based problems. The following sections will discuss these two underlying sets of problems.

Attitudinal Problems Underlying Difficulties with Empathy in MI

HCPs with attitudinal problems often showed an expert stance. For example, HCPs who had an agenda of what needed to be accomplished by patients directed their conversation with patients to meet that agenda. There was minimal empathy with patient concerns. There was little acknowledgement or exploration of any agenda the patients might have. Similarly HCPs who generalized concerns across patients, discounted

patients' concerns, and examined patients' knowledge seemed to invalidate patients' concerns. HCPs with an expert attitude didn't think it necessary to explore patients' concerns because patients were basically just sources of information enabling the HCPs to provide solutions for the patients to follow. Nor did such HCPs think it necessary for the patient to even understand the relevance of their questions and recommendations. These attitudinal problems all revolve around the assumed expert status of the HCP. Some of these patterns, such as running an agenda and discounting patient concerns, strongly assert an expert stance being taken by the HCP. Other patterns, such as eliciting information from the patient without establishing relevance to the patient's concerns, indirectly imply an expert stance by the HCP.

Other attitudinal problems seem to revolve around a negative view of the patient. Suspecting the genuineness of patients' concerns seemed to be a common problem underlying the patterns of generalizing patients and discounting patients' concerns. In both of these patterns, HCPs invalidated patients' concerns because they may have viewed these concerns as a justification by patients to not engage in behavioral changes. In both of these patterns, HCPs brushed aside the patients' concerns since the HCPs may have been skeptical about the patients' motivation to make behavioral modifications. Suspicions that patients lack serious motivation seemed to make it very difficult to dialogue with patients about their expressed concerns, which were treated instead by HCPs as excuses.

Both of these attitudinal problems create face loss for patients. If the HCP claims expert status, it creates face loss for patients because they are portrayed as uninformed and unable to make discerning decisions about their own healthcare. If the HCP displays

suspicious about patients' true intentions, patients may become thoroughly embarrassed or offended. In combination these attitudinal problems may create new relational resistance in the patient and thereby make MI extremely difficult.

Both the attitude of assuming an expert stance and the attitude of suspecting the genuineness of patients make it difficult for HCPs to empathize with their patients' concerns. Both attitudes are judgmental because they judge the patient as either not knowledgeable or not serious. In spite of the fact that most of these HCPs seemed to identify with learning MI, many of them still manifested evidence of these attitudes in their individual responses to patients. These attitudes seem to be deeply ingrained in their discourse habits, which probably cannot be undone by a theoretical discussion of how patients are experts as well as the HCPs. In addition it might be advisable for the MI training program to show videotaped examples of how these two attitudes show up in individual responses to patients and how they discourage behavior change by patients. These examples should help HCPs to hear when these attitudes are present in their own comments. In addition, there need to be examples of how MI uses empathy not only to reduce relational resistance but also to address and resolve a patient's concerns.

Another attitudinal problem HCPs had in empathizing with patients seems to reflect a desire to cheer up patients. When patients expressed any disappointments, frustrations or concerns, these HCPs focused on the positive aspects of patients' health (like normal weight) or life style (good exercise habits) instead of empathizing with the patients' concerns. This behavior of HCPs appeared to be because they don't want patients to feel discouraged or depressed. However, when HCPs did not empathize with patients' disheartened feelings and experiences, the subsequent interaction digressed from

reflecting and addressing these patients' concerns. Consequently patients may feel less understood because HCPs ignored their concerns while attempting to cheer up the patients. This behavior of HCPs could diminish patients' motivation to make behavioral changes because their concerns remained unaddressed.

This tendency of HCPs not to empathize with patients' disappointments in order to comfort them could be due to the following reasons:

- These HCPs might be uncomfortable reflecting and empathizing with negative emotions such as frustration, disappointment, sadness, depression, and shock. They may be assuming that empathizing with such emotions would only reinforce these emotions.
- These HCPs may not want their patients to lose their heart and their confidence in managing their illnesses.
- These HCPs may not be aware that empathizing with patients' disappointments and concerns could help to explore and address these issues. But avoiding addressing these issues underlying patient disappointments or frustrations leaves these issues unresolved.
- Time constraints could be an issue for HCPs who assume that empathizing with patients' disappointments or frustrations could needlessly consume HCPs' time.

This attitude of desiring to cheer up the patient is softer and more personable than the judgmental attitude associated with maintaining the status of expert and doubting the genuineness of the patient. However, both sets of attitudes are based on the assumption that the HCP must maneuver the patient in order to achieve health behavior change. Both sets of attitudes have the HCP in the driver's role. HCPs with these attitudes should come

to the realization that long-term health behavior changes are accomplished by patients and not by their HCPs. In addition, HCPs who try to console or cheer patients up should come to understand that empathy with patient concerns is the first step in addressing and resolving those concerns.

If feelings are not understood or acknowledged, patients may become stuck in those feelings and not move forward.

Skill-Based Problems Underlying Difficulties with Empathy in MI

The preceding section dealt with attitudinal problems in empathizing with patients. On the other hand, some HCPs had skill-based problems in empathizing with patients. This was clear since these HCPs tried to use MI skills although they didn't seem to know how to use these skills in a productive way. The interaction became unproductive in spite of using MI skills because the skills didn't help to address patients' concerns and therefore didn't facilitate behavior change. The HCPs' skill-based problems are discussed in the following sections.

Some HCPs support self-efficacy without empathizing with their patients' concerns. In effect, they focus only on reinforcing the patients' positive health behaviors. As a result of focusing only on the patients' positive behaviors and not empathizing with patients' concerns in the subsequent utterances, these HCPs digress from patients' concerns. In the end patients leave the counseling session with their concerns unaddressed. Some of the reasons why these HCPs overlook patients' concerns and only support self-efficacy could be as follows.

- These HCPs may have been preoccupied with the use of MI skills but may not have focused on identifying and addressing patients' motivational issues, which

are the thoughts or concerns that patients might have about changing their behaviors.

- Supporting self-efficacy is cognitively simple to perform. In contrast, empathizing with patients' motivational issues is more cognitively demanding because it requires greater social perspective taking than does supporting self-efficacy.
- These HCPs may not be aware of the significance of addressing patients' motivational issues. Empathizing with patients' motivational issues is the first step toward addressing these motivational issues.
- It is also possible that some health care HCPs have focused on negative aspects of patient behavior and when they learned supporting self-efficacy, they made a decision to consciously support positive behaviors and statements.
- These HCPs may be uncomfortable in empathizing with issues that are contrary to their own view points and instead may prefer to focus on patient responses that are in agreement with their view points. For example, a HCP who thinks that medications are indispensable and safe in treating diabetes may find it difficult to empathize with a patient who avoids taking medications or considers them unsafe. So these HCPs may be more comfortable supporting patient responses that are in agreement with their own view point. For example, HCPs may respond to a patient's positive exercise habits because it makes sense to them that exercising helps in the treating diabetes. These HCPs may prefer to avoid disagreements with patients because they may not know how to address patients' perceptions and thoughts with which they disagree.

Another skill-based problem that HCPs had in empathizing with patients involved reflecting superficial details of patient responses instead of reflecting patients' central motivational issues. For example, a patient might say "I don't like the idea of taking my medications every day because I am concerned about the side effects. Moreover I have been watching my diet and also I exercise for 30 minutes to an hour each day." The HCP might respond by saying "So you don't like to take medications as prescribed. Tell me more about how you are taking your medications and how many doses you might be missing." This HCP did reflect some of the patient's utterance but did not empathize with or explore further the patient's motivational issue, which is not taking her medication due to the fear of side effects. Thus, not empathizing with the patient's motivational issue limited the possibility of addressing this patient's fear of side effects. Some of the reasons why HCPs acknowledge superficial details but do not empathize with patients' motivational issues could be as follows.

- It is cognitively difficult to grasp the reasoning behind patients' concerns while it is simpler to understand and reflect some details of patients' concerns.
- These HCPs may not know what to empathize with when they hear patients' concerns. If through practice these HCPs are taught to identify patients' motivational issues, they may be better able to empathize with and address patients' motivational issues.
- These HCPs may be empathizing with patients because they were asked to do so during the training, but may not know the significance of empathizing with patients in enhancing their motivation to engage in behavior change.

Another skill-based problem that HCPs had in using empathy in MI was that they did not make it clear to patients how the discussions following an empathic response was related to their concerns. These HCPs would empathize with patients' motivational issues but would omit informing their patients how their subsequent utterances are intended to address patients' issues. Consequently, patients may not understand the significance of HCPs' explorations or recommendations in helping them to address their concerns. Some skill based reasons (and not attitudinal based reasons) for these HCPs not making connections for patients could be as follows:

- These HCPs may not know how to integrate patients' motivational issues to their subsequent utterances. For example, they would empathize with patients' motivational issues but may not know how to tie the patients' motivational issues to their subsequent explorations of patients' life style. As a result patients may misunderstand the HCPs explorations as intended to examine them and to find flaws in their life style habits. These HCPs could be taught to integrate empathy with other MI skills.
- These HCPs may view empathy as an isolated skill that needs to be used. They may not know how empathy ties in with other READS skills. These HCPs may be taught how empathy helps to make the best use of other MI skills.
- These HCPs might assume that they are saving time by not creating a transition for something that appears to be obvious to them. They need to see examples of how much time can be lost if the patient misperceives the intention of the HCP's questions.

An additional skill-based problem HCPs encountered was that they didn't know what to do after expressing empathy. These HCPs would empathize with patients' concerns but then would do nothing to address those concerns. These HCPs ended up digressing from patients' concerns and reverted to the comfort and certainty of following their own agenda. For example a patient might say "I am concerned about side effects and so I don't like the idea of taking my medicines" and the HCP might respond by saying "So you are worried about the possible side effects from your medications. Hmm let me ask you what is your understanding of a high hemoglobin A1c value?" While the question about the A1c value could reflect the negative attitudinal problem of running an agenda (which has been discussed earlier), it is also possible that the question about the A1c value could just reflect not knowing what to do with empathy once expressed. The difference between these two possible interpretations of the question about the A1c value would seem to be largely a matter of the tone of voice used to ask the question. A sharp negative tone might imply the attitudinal problem. In contrast, a neutral or more positive vocal tone would imply the skill based problem. HCPs might "orphan" a very competent expression of empathy if:

- They don't know what to do next after empathizing with patients' motivational issues,
- They view empathy as an isolated skill used primarily to build rapport with patients, and are unaware of how empathizing with patients' motivational concerns is the first step in further exploring and addressing those concerns.

As a result of not addressing patients' concerns, empathizing with patients' concerns became an end point because HCPs didn't know how to use other MI skills to facilitate

behavior change. All they understood was that they have to use empathic skills by reflecting patients' concerns but didn't know how it relates to facilitating behavior change in patients.

All of these preceding skill-based problems seem to be based on HCPs perceiving empathy as an isolated skill that is intended to make patients feel understood. These HCPs intended to use empathic skills but were not aware of its significance in facilitating behavior change in patients. As a result, either they empathized with some aspects of patient utterances while missing a complete understanding of patients' motivational concerns, or after empathizing with patients' motivational concerns, they didn't address those concerns. These HCPs didn't see the connection between empathy and other MI skills and did not see the importance of integrating them to help address patients' motivational issues. Often these HCPs lose sight of the motivational issues in their desire to use MI skills and their use of isolated skills does not help them in addressing patients' motivational issues. Thus, exhibiting the use of individual MI skills to meet a requirement of the role played HCP-patient role play does not allow these HCPs to practice using MI skills such as empathy to address patients' motivational issues.

HCPs could be taught how to integrate MI skills and how empathy could be used in coordination with other READS skills. The next section deals with the reasons why empathy should be integrated with other MI skills.

Problems integrating empathy with other MI skills to form a coherent flow

HCPs' integration of empathy with other MI skills is important in addressing patients' concerns and helping them to engage in behavior change. Empathy could be

integrated with the other READS skills of rolling with resistance, developing discrepancy and supporting self-efficacy

Integrating empathy with 'rolling with patients' resistance'. Rolling with patients' resistance is about acknowledging and exploring patients' defensiveness during interactions focusing on changing their health behaviors. In MI, resistance to change behaviors is considered natural. So HCPs are encouraged not to reject patients' defensiveness but to explore and address the motivational issues at the base of their resistance (Miller & Rollnick, 2002). This approach would start with HCPs empathizing with patients' resistance before proceeding to exploring their resistance. Once patients' resistance is empathized with by HCPs, patients are more likely to be cooperative in responding to explorations of their resistance. In this study, it was observed that when exploration immediately followed patients' concerns without prior expression of empathy, patients often became defensive. Patients could not understand the intention behind HCPs' exploring questions when the HCPs did not make it explicitly clear that they were seeking to address the patient's motivational issues. When HCPs tried to explore resistance without previously expressing empathy, the intention behind their exploration could be easily misinterpreted as an attempt to find flaws in patients' knowledge of their illnesses or their treatments. Such misinterpretation can result in patients becoming more resistant. Thus, empathizing with patients' resistance should precede rolling with resistance and exploring resistance. Patients should be informed that exploratory questions are designed to help the HCP address patients' concerns. HCPs not empathizing with patients before exploring patients' resistance could be due to:

- These HCPs may have branded their resistant patients as difficult ones to handle and may not have felt any empathy for them. Empathizing with defiant patients is indeed difficult for HCPs and it may need some special training.
- These HCPs may be assuming that patients understand the purpose of their explorations and may not see the need to make their intentions explicit.
- These HCPs might have taken an expert stance and may not see the need to inform patients of their intentions behind the explorations. They would have expected patients to cooperate with their explorations since they are the experts and patients should follow them unquestioningly.
- Lack of time could be another possible reason for not explicitly integrating empathy with the skill of rolling with patients' resistance.

Integrating empathy with 'developing discrepancy'. Developing discrepancy is about creating dissonance in patients by drawing patients' attention to the inconsistency between their goals/values and their current health behaviors. The dissonance thus created could act as a motivational drive to facilitate behavior change in patients so that their behaviors are consistent with their goals or values (Miller & Rollnick, 2002). Being empathic to patients' concerns in order to establish a nonthreatening patient-HCP relationship is significant before proceeding to highlight any discrepancies between patients' goals and health behaviors. This skill of developing discrepancy could otherwise be misinterpreted by patients as a way to embarrass them and could make patients even more resistant to changing their health behaviors. When HCPs empathize with patients, the patients are less likely to misunderstand HCPs' intentions behind creating discrepancy, which is to elicit patients' motivation for behavior change.

HCPs not empathizing with patients before creating discrepancy could be due to the following:

- HCPs may not be aware that an empathic and a non-threatening climate is constructive for creating discrepancy in patients.
- HCPs may assume that patients will interpret HCPs moves in a positive way.
- Lack of time in expressing understanding of patients' concerns could also be a factor for not empathizing before creating discrepancy.

Integrating empathy with 'supporting self-efficacy'. Supporting self-efficacy is about enhancing patients' confidence in engaging in behavior change by reinforcing the positive steps taken by patients. It is productive to integrate empathy with the skill of supporting self-efficacy since:

- *Only* supporting of self-efficacy of patients' positive behaviors without empathizing with patients' concerns could result in digressions from patients' motivational issues.
- When the patients' motivational issues remain unaddressed, it results in a waste of time because patients' ambivalence about behavior change remains unresolved.
- HCPs supporting self-efficacy without empathy could diminish patients' motivation to engage in behavior change because patients may feel that they have made the behavior changes expected from them when HCPs' focus only on commending the positive health behaviors. It could create a sense of complacency in patients and they may feel contented with the small steps they have taken to manage their illnesses.

The skill of supporting self-efficacy should be integrated with empathy in order to address patients' concerns while also ensuring that patients sustain their positive behaviors that they have already taken.

Thus, integrating empathy with other READS skills could help in creating a non-threatening climate where patients' resistance could be explored and resolved. Empathizing could help avoid instances of face loss for patients because patients are less likely to misunderstand HCPs' exploration of resistance or HCPs' creating discrepancy in patients. Patients would be motivated to engage in behavior change while also maintaining the positive steps they have taken to manage their illnesses when empathy is combined with supporting of self-efficacy. Empathizing with patients' concerns and addressing them was also observed to avoid waste of time during interviews. HCPs who didn't empathize with patients did not identify and address patients' motivational issues. As a result the discussions digressed to persuading or recommending patients to make behavior changes. This was often unproductive and resulted in loss of interaction time.

The Value of Empathy in Motivational Interviewing

As discussed previously, in healthcare, empathy has several implications in counseling patients using MI. Some of the main implications of empathy for HCPs using MI are:

- 1. Empathizing helps reduce relational resistance.* One of the well known implications of empathy based on the literature is that it helps patients feel understood. As a result patients feel comfortable in discussing their perspectives about their illnesses or their treatment.

2. Empathy acts as an entry point for HCPs to identify patients' motivational issues. This study suggests that it is not only important to teach HCPs to reflect patients' feelings but they should also be taught to pay greater attention to reflecting patients' motivational issues. HCPs who reflected *only* the superficial details of patients' concerns were observed to be ineffective in addressing patients' problems. HCPs should be trained in identifying patients' motivational issues and reflecting them back to patients. HCPs' identification of patients' motivational issues is crucial for engaging patients in behavior change.

3. Empathy connects patients' motivational issues to HCPs' subsequent explorations. HCPs who didn't empathize with patients but explored patients' life style habits or medication regimen could not link the patients' concerns to these explorations. Although HCPs might be engaging in such an exploration with an intention to address patients' concerns, patients may not understand that. Instead they could misinterpret the HCPs' explorations as a means to find faults in their life style, eating habits, weight management, etc. Thus, empathizing with patients' concerns allows HCPs to make subsequent connections back to these concerns. It is important for patients to realize that HCPs are in fact helping them to address their concerns rather than making them look bad about their weight, eating habits, etc.

4. Empathy helps for rolling with patients' resistance. Empathizing with patients' resistance is the first step towards addressing patients' defensiveness to engage in behavior change. The next step would be exploring their resistance and helping them to address it. Empathizing with patients' resistance helps in understanding the motivational issues that negatively affect patients' motivation to change their behavior.

Empathy firms grounds the exploration of patient resistance in mutual recognition that the HCP has listened to the patient and has heard the patient's concerns.

5. Empathy helps for creating dissonance in patients. Empathizing with patients helps to create dissonance between patients' current health behaviors and their goals or values. When HCPs highlight the discrepancy between patients' goals and their unhealthy behaviors without empathizing with their motivational issues, patients are less likely to experience dissonance and instead could misinterpret HCPs' intentions as trying to embarrass them. Creating dissonance in patients is a delicate skill which if done without empathy could be counterproductive. HCPs could be misunderstood by patients as insensitive and patients could experience face loss.

6. Empathy could be combined with supporting self-efficacy. Supporting self-efficacy could be integrated with empathy when patients express both their concerns and the positive steps they have taken to manage their illnesses. HCPs solely focusing on supporting self-efficacy and overlooking patient concerns were observed to be unproductive. Sole focus on supporting self-efficacy often resulted in digressing from patients' concerns and in patients' motivational issues remaining unaddressed. Patients could not feel understood when their concerns go addressed. In addition HCPs could create a sense of complacency in patients because they feel satisfied with the small steps they have taken to manage their illnesses.

7. Adherence to recommendations is facilitated by grounding those recommendations in empathy with patient concerns. When HCPs do not empathize with and address patients' motivational issues but go on to offer recommendations, patients may not understand the relevance of HCPs' recommendations. As a result they would be

less likely to adhere to HCPs' recommendations. It is really important for HCPs' to express their understanding of patients' motivational issues before offering recommendations to address those issues. Patients are more likely to adhere to those recommendations when they realize that it is relevant to the concerns that they raised with HCPs.

8. *Empathizing saves time.* It is often thought that empathizing with patients is time consuming and empathizing with patients may seem not feasible considering HCPs' work load. Pharmacists or nurses may not feel that they have much time to devote to reflecting each patient's emotions or utterances. Generally if HCPs could offer a lot of information and recommendations to patients in a short span of time, it is believed that they have done their job well. But if patients do not adhere to those recommendations, it would be a loss of time. In other words, it is the patients' readiness to adhere to those recommendations that decides the productivity of the time spent in the interaction. This study suggests that HCPs' could save their time by expressing empathy. The time spent during the interaction could be reduced if:

- HCPs identify and empathize with the patients' motivational issues.
- If HCPs address those motivational issues explicitly.
- If the recommendations offered to patients are consistent with patients' motivation to engage in behavior change.

Unfortunately it was observed that often HCPs neither empathized with nor addressed the patients' motivational issues. Nor did they assess patients' motivation to engage in behavior change. As a result these HCPs offered recommendations to unmotivated patients whose concerns about behavior change were unresolved. So it is

important for HCPs to be targeted to the needs and motivation of patients when interacting with them. Empathizing with patients' motivational issues could save time that otherwise is wasted in persuading patients or providing too much information or recommendations to patients.

Implications for training

This study was intended to explore the difficulties HCPs have in empathizing with and addressing patients' concerns. Considering the attitudinal and skill based difficulties faced by HCPs in empathizing with patients in the preceding sections, the next section focuses on how these problems faced by HCPs could be dealt with.

1. Raising awareness about the significance of empathy. The first step in empathy or MI training programs should be to help HCPs recognize the significance of empathy in counseling patients. HCPs should be made aware that empathy helps to:

- Build an understanding relationship.
- Understand patients' motivational issues.
- Explore the logic behind patients' motivational issues.
- Address patients' motivational issues.
- Elicit patients' motivation to engage in behavior change by integrating empathy with the skill of 'developing dissonance'.
- Explore and address patients' resistance to behavior change by integrating empathy with the skill of 'rolling with resistance'.

Increased awareness of the significance of empathy could be brought about by showing videotaped examples of how empathizing with patients helps in facilitating behavior change. Unless trainees recognize that empathy not only helps in building a

good rapport, but also helps in identifying and addressing patients' motivational issues, and in increasing patients' motivation to engage in behavior change, the trainees may not be motivated to sustain empathic skills.

2. *Raising awareness about attitudes that detract from empathizing.* Training programs should expand HCPs' awareness of:

- Attitudinal problems in empathizing with patients such as taking an expert stance, suspecting patients, cheering up patients, and becoming defensive at patients.

This could help them understand how these problems restrict empathic behaviors.

- Skill based problems in empathizing with patients such as the use of empathy as an isolated skill, problems integrating empathy with other READS skills, not addressing patients' motivational issues after empathizing with these issues, not making a clear transition from empathy to exploring and informing, and losing sight of motivational issues due to preoccupation with skills.

HCPs' awareness about the difficulties in empathizing with patients could be raised by demonstrating with videotaped examples how these attitudinal problems impede empathic skills, and how these skill based problems orphan empathy as a single act unrelated to addressing and resolving patient's motivational issues. These videotaped examples should provide clear illustration of how empathizing with patients' motivational issues facilitate patients making their own argument for change.

3. *Encouraging self-analysis or introspection.* The next step would be to help HCPs to analyze or reflect upon their own or their colleagues counseling behaviors to identify if they have any of the preceding attitudinal or skill based problems in empathizing with patients. This could be done by letting trainees watch their own

videotaped counseling sessions or by offering structured feedback from trainers. Perhaps the best option is to stimulate discussion of these problems as they are manifested during role playing in a small group context.

4. Overcoming problems. Once these attitudinal or skill based problems are identified, HCPs could be prompted to consider how they could change what they said in order to empathize more clearly with patients' motivational issues and then to use that empathy as the entry point to addressing those issues. HCPs could be helped to see that changing attitudinal problems would need them to change their approach of relating to patients as experts. During role plays in groups, instructors and peers could bring trainees' attentions to their approach of relating to patients as experts or their attitude of suspecting patients. Trainees could be asked to redo the role plays so that they learn to change their attitude towards patients and learn to treat them on an equal level. Trainees could be taught to identify patients' motivational issues during role plays and then to address those motivational issues before providing recommendations to patients. Role plays offer the advantage of getting feedback from not only the instructors but also the other members of the group, which could be an enriching experience. Also giving scenarios with standardized patients which helps in addressing trainees unique attitudinal or skill based problems could greatly help. For example, HCPs who judge patients' misconceptions could be given opportunities to interact with standardized patients who would express misconceptions about their illnesses or treatment. This could be viewed as an approach of sensitizing trainees to a certain stimuli to which they are reactive until they learn to overcome their own reactive impulses like making judgments. Training

programs should make sure that HCPs not only empathize with patients but also address patients' concerns or motivational issues.

5. *Self-supervision.* HCPs should be made aware that learning empathic skills or MI skills is a process that takes a long time and does not usually make one empathic by the end of the training program. This may be especially true for attitudinal problems that may not be overcome by a single workshop on MI or empathic skills. In order to sustain the skills and attitudes learned during training, the trainees may have to evaluate their own skills and attitudes on a regular basis. HCPs who following a MI training workshop attended a telephone coaching based on their audio recorded interactions with real patients in work place settings improved their effectiveness in the use of MI skills (Bennett et al., 2007).

However, learning of skills may not be sufficient to overcome attitudinal problems of judging patients or relating with patients as experts. Being deeply inspired by the ideal of an egalitarian relationship between patients and HCPs may be needed to change attitudinal problems of relating with patients. This would mean that trainees should be self-motivated to achieve this ideal and work towards it on a regular basis.

If these attitudinal and skill-based problems do exist in the real practice settings, then this study's findings have implications in actual practice settings. When AU MITI trainees were acquainted with the attitudinal and skill-based problems identified in this study, they responded by affirming that they did experience these problems in real practice. Additional research is warranted to further validate whether these difficulties exist in real practice.

Limitations of the Study

This study's conclusions are limited to identifying the problems HCPs have in using empathy during the course of learning MI. There were too few well formulated empathic responses by HCPs to allow for identification of patterns of positive HCP responses to patients' concerns. Consequently attention was restricted to identifying the problems HCPs had in using empathy in MI.

This study's sample was comprised of videotaped role plays of HCPs with standardized patients. The limitation with standardized patients is that the conclusions of this study must be confined to the patterns of HCPs' responses and it cannot include the patterns of patients' responses. However, the advantages of using standardized patients are as follows:

- It allows for greater range of comparison of HCP responses to a standard patient response. Each HCP responded to a relatively standard set of patient responses, which made it possible to compare the wide array of HCP responses to these standardized patient responses. But in real practice settings, the variations in HCP responses to patients' concerns could be attributed to differences in patient demeanor. This makes the use of standardized patients beneficial in making comparisons across HCP responses.
- It allowed for exploring the different possible HCP responses to a standard patient response.
- It makes it easier to identify which HCP responses helped in addressing patients' motivational issues and which didn't work.

In this study, the HCPs' responses to patients' concerns could have been affected by HCPs' knowledge of their interactions being video recorded. Some HCPs could have become nervous when they were video recorded. Increased nervousness may have restricted the ability of HCPs to listen attentively to the standardized patients, and to integrate various MI skills effectively into a smooth coherent flow of interaction. If nervousness could increase the frequency of such problems, it assisted this study in identifying these problems. As this study does not attempt to describe the frequency with which HCPs have problems in using empathy as part of MI, being videotaped doesn't appear to threaten the validity of the central research focus of the thesis.

This study used a convenience sample that could affect the generalizability of the findings compared to the use of a randomly selected sample. The sample of HCPs comprised of nurses, pharmacists, counselors and social work case managers but there were no physicians. There was also an unequal representation of HCPs from various fields like nursing, pharmacy, etc. Most of these HCPs had extensive experience in counseling patients in a variety of health care settings. Pharmacy residents seemed to have the least patient counseling experience that occurred mostly during patient care rotations in their fourth year of pharmacy school and during their residency. As a result, the conclusions of this study may need additional verification for its applicability to training health care students during the early years of their professional training prior to extensive supervised patient contact in clinical settings. Professional students might differ from these experienced HCPs in the following ways: Firstly, students have no prior training in listening to patients or in responding to them in a professional way. Secondly, the emotional maturity of students may be less than that of these HCPs. Thirdly, students

may find it easier to learn new interactional skills compared to these HCPs who are habituated to using the traditional counseling approach. Finally, students may not necessarily maintain an expert stance like these HCPs and may be less prone to suspecting or discounting patients' concerns. Research is needed to investigate whether professional students learning MI as part of their academic curriculum experience the same problems in using empathy as part of MI as do the HCPs studied in this thesis.

This study used discourse analysis methodology to explore the problems that HCPs have in empathizing with patients. This method is based on the sensitivity of researchers to identify patterns of HCPs' responses to patients' concerns. So the possibility of bias in this study's findings could not be overruled as the judgment of researchers could have affected the way the HCPs' responses were classified. To minimize the chances of bias in classifications, these response patterns were classified based on consensus among three researchers. Also, examples have been cited for each pattern to allow for external verification of the researchers' judgments.

Need for Future Research

This study's findings need further verification using quantitative analysis with a coding scheme generated from the results of this study. For example, using coding scheme, the patterns of HCPs' responses could be quantified. If done in a real practice setting, patients' responses too could be quantified. This could help in understanding whether there is any relationship between HCPs' responses and patient responses across a range of HCPs. Research could focus on how professional students learning empathy as a part of MI may differ from these HCPs in this thesis. Future studies could also verify using quantitative studies whether empathizing with and addressing patients'

motivational issues could help increase patients' motivation to engage in behavior change. Also, the time spent in empathizing with and addressing patients' motivational issues could be quantified to confirm whether empathizing could save HCPs' time by avoiding digressions from patients' concerns or useless arguments with patients.

Conclusion

This study intended to explore the problems HCPs have in empathizing with and addressing patients' concerns while learning MI. The sample participants comprised of HCPs (nurses, pharmacists, counselors, social work case managers) who were learning MI. Discourse analysis was used to identify the problems experienced by HCPs in empathizing with and addressing patients' concerns. This study identified eight patterns of difficulty in using empathy in MI, namely:

- HCPs support self-efficacy without empathy.
- HCPs run an agenda.
- HCPs provide or elicit information without establishing its relevance to patients' concerns.
- HCPs examine patients' knowledge without empathizing with their concerns.
- HCPs discount patient concerns.
- HCPs generalize across patients or compare patients.
- HCPs treat patients solely as sources of information.
- HCPs acknowledge superficial details rather than core issues.

This study also concluded that the above eight patterns may be attributed to underlying attitudinal and/or skill-based problems that negatively affect HCPs' ability to be empathic. The attitudinal problems included HCPs maintaining an expert stance

during their interactions with patients, HCPs suspecting patients' intentions and motivation to engage in behavior change and HCPs comforting patients instead of empathizing with their concerns. These three attitudinal problems seemed to result from the HCPs' need to maneuver patients toward health behavior change. Some of the skill-based problems included HCPs' preoccupation with using MI skills resulting in losing sight of patients' motivational issues. As a result these HCPs focused on using one skill at a time while overlooking patients' motivational issues. HCPs' not making connections for patients was another skill based problem where HCPs do not establish the relevance of their explorations or recommendations to patients' concerns. HCPs' not integrating empathy with the other MI skills was another skill based problem where they do not combine empathy with supporting self-efficacy, rolling with resistance or creating discrepancy in patients.

This study emphasizes the importance of empathizing with patients in MI. As Rogers (1975) originally suggested and numerous studies (Barone et.al, 2005; Larson & Yao, 2005) have validated, empathy helps in improving patient-HCP relationships when patients feel that their concerns are understood and validated. In other words, empathy helps to avoid creating relational resistance and to reduce already existing relational resistance in patients. Empathy creates a safe interpersonal environment that allows patients to stop defending themselves and to actively examine the motivational issues that discourage them from engaging in more constructive health behaviors. Many HCPs in this study struggled with empathy apparently due to their long standing habit of adopting the expert role in their relationship with patients.

This study found an additional reason for the centrality of empathy in MI that has not been previously identified in the literature about MI. Empathizing with patients' concerns about their illness and its treatment not only reduces relational resistance but also starts and undergirds the process of exploring and addressing issue resistance. Issue resistance here refers to patients' resistance or disinclination to engage in a behavior change. Empathizing with patient's concerns is the crucial entry point to identifying and addressing issue resistance. If patients know that the HCP understands their concerns, they are more willing to explore and reassess their line of reasoning about engaging in constructive health behavior change. Many HCPs seemed to assume that patients should realize that they are understood when in fact it is difficult for the patients to realize this without any explicit expression of empathy. Thus, empathizing with patients' concerns acts as an entry point to elicit and address issues that affect patients' motivation to engage in behavior change.

Once the explicit expression of empathy has started the process of addressing patients' motivational issues, reference back to that empathy provides the motivational context for HCPs' exploration of the motivational issues and then the subsequent provision of information and recommendations. If HCPs prematurely launch into exploring patients' knowledge, habits and behaviors without making it clear that they are responding to patients' concerns, patients may easily misunderstand the intent of that exploration as an attempt to find fault with them. Similarly, providing information and recommendations without connecting back to the HCPs' desire to respond to patients' concerns only creates new relational resistance. So empathy serves as the relational foundation allowing for the exploration and resolution of issue resistance. As HCPs

move through the process of exploring and addressing patients' issue resistance, they need to tie each new step back to their desire to respond to patients' concerns. Assuming that this is obvious to patients risks creating new relational resistance that would terminate the process of addressing issue resistance. Many HCPs empathized with patients' motivational issues but then failed to use that empathy as the explicit foundation for their subsequent exploring, informing and recommending. They seemed to regard the expression of empathy as an isolated single event. As a result they found it difficult to advance the process of addressing issue resistance.

Some implications for empathy training in MI have been discussed including improving the awareness of HCPs about the importance of empathy in creating rapport with patients and in initiating and supporting the process of addressing issue resistance. Trainees should be encouraged to identify any attitudinal or skill based problems that they might have in using empathy followed by helping them to overcome those problems during role plays or interactions with standardized patients. Role plays could be effective in addressing trainees' unique attitudinal or skill based problems since they obtain feedback not only from their instructors but also from their peers. Training programs should encourage trainees to analyze their own counseling behaviors on a consistent basis after the training program since a short workshop may not be enough to overcome attitudinal problems.

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APPENDICES

Appendix 1

AU MITI OSCE

PATIENT#1

Background

Pat Lester is a 40 year old Caucasian female. She is average build. She has high blood pressure and diabetes. Pat does not like taking medicine and generally “feels” ok, so this makes it difficult to remember to take the medicine. She exercises fairly regularly, taking long walks and going to the health club. Since Pat is in relatively good shape, she doesn’t “see the point of taking a bunch of medicine.” She eats a relatively healthy diet. Pat knows that she needs to keep the amount of sugar and “carbs” in her diet down, if possible. She does love bread and pasta, so cutting that out has been difficult. She does smoke occasionally; mostly when she is stressed or anxious. Usually this is not more than three to five cigarettes a day, but sometimes she smokes a half pack per day when her job gets stressful. She works for a food manufacturer that has especially stressful times during seasonal and holiday periods.

Vitals

Blood pressure is 145/95

A1c is 8

% body fat is 23% (normal range)

Notes:

- Really does not like taking meds.

- Takes medicine for diabetes (once a day drug) more often (60% of the time) than antihypertensive med (ace inhibitor and mild diuretic) (40% of the time).
- Patient feels fine. Has “spells” every now and then but they generally pass.
- She says she “would be willing to do anything other than take medicine. You just hear about all the bad side effects a lot of medicines can have. Who knows what it’s doing to your body.”

Appendix 2

AU MITI OSCE

PATIENT#2

Background

Terry Gentry is a 40 year old Caucasian male. He has GERD (gastro esophageal reflux disease). He takes a proton pump inhibitor every day as prescribed, “30 minutes before I eat or drink anything EVERY morning,” he will tell you. Terry is starting to lose faith in the drug because he is still having heartburn and reflux attacks at night and some heartburn during the day. Terry is 25 pounds overweight and is not very conscientious about his diet. He eats a lot of fast food, fries, and sodas. Terry likes his cup of coffee every morning. He will tell you, “It’s just one darn cup of coffee for goodness sake. I need it to get going.” Terry gets very little exercise and has found “keeping the weight off to be harder and harder since I hit 40.” He eats dinner around eight or nine at night and goes to bed around 10 pm. He lives alone and likes to come home and relax and read the paper before he eats dinner. When he doesn’t cook dinner (usually TV dinners, sandwiches and chips, etc.) he usually stops at a fast food restaurant and picks up something to eat.

Vitals

% body fat is 28%

BP 125/80

Cholesterol panel is very good

Notes:

- Patient is concerned that medicine may not be working anymore. It worked better when he started taking it.
- He has gained 10 pounds since he started taking the medicine about a month ago.
- The patient's test for H.pylori came back negative.

Appendix 3

Standardized patient#1 notes

- If HCP inquires about adherence, tell him/her that you probably miss a dose of your once a day high blood pressure medication three to four times a week and you miss a dose of your twice a day diabetes medicine about the same....sometimes, maybe four to six doses a week.
- If asked, you cannot recall the names of your medicines...you only remember that someone told you that your high blood pressure medicine is an “ace something.” If they say “ace inhibitor,” say, “Yes, that sounds right.”
- If asked, tell them that you go to the health club or take long walks at least three to four days a week for at least 30 minutes to an hour. You love the elliptical machine and really get your heart rate up (over 150).
- If asked, right now you really don’t monitor your blood glucose. You “don’t see the point” since you aren’t overweight anyway.”
- If asked, tell them you do have “spells” during the week where you feel a little sluggish or sometimes a little “off.” (Sometimes a little light-headed)
- **THINGS YOU ARE WILLING TO WORK ON:**
 - Trying to take your medicine more often (but only if they explain to you why that is important, even with the amount of exercise you do and the carb control and explain the relatively low risk of serious side effects).

- Continuing to cut back on cigarettes, even though, “I don’t smoke much anyway.”
- Trying to eat smaller portions of bread, carbs
- Might be willing to monitor blood glucose “every now and then, maybe every other day” if they explain the importance.
- THINGS NOT WILLING TO WORK ON:
 - Totally giving up carbs
 - Monitoring blood glucose every day (“I’ll think about it”).
 - Giving up cigarettes when you are really stressed.
- OTHER CONSIDERATIONS
 - You are concerned when you hear that your blood pressure is still elevated and somewhat dangerous (you are very surprised since you feel fine and you are not overweight).
 - You don’t want to have a stroke or heart attack.
 - You are concerned when you hear that your blood glucose (A1c) is still elevated.
 - Your heart elevation during exercise combined with high blood pressure could be a serious concern.

Appendix 4

Standardized patient#2 notes

- If HCP inquires about adherence, tell him/her that you might miss a dose once, maybe twice a week. When you miss a dose, you are usually at work by the time you remember so you just skip it. And occasionally you take a dose and eat immediately.
- Only if they ask what you mean by occasionally, tell them maybe once a week.
- If they tell you that you can take the dose as soon as you remember or when you get home, tell them that would be great, you didn't know you could do that.
- **THINGS YOU ARE WILLING TO WORK ON:**
 - Eating earlier (you get home at 6p, you just don't generally eat right away...you like to unwind)
 - Getting some exercise....but you don't like vigorous exercise that makes you sweat...make them suggest walking, using the stairs instead of the elevator, etc. If asked, you are willing to walk a few days a week.
 - Cut down on fatty food...not cut it out completely. Would consider low-fat chips, etc. Eats fried chicken sandwiches and fries....would consider grilled chicken, but won't totally cut out fries.
 - Willing to drink liquids, **other** than your cup of coffee each day (sodas, etc.) that don't have caffeine.

- THINGS NOT WILLING TO WORK ON:
 - Won't give up "my one damn cup of coffee each day. It's just one cup for goodness sake."
 - Elevate head of bed..."That sounds weird..." "I'll add an extra pillow, but that's about it."

- OTHER CONSIDERATIONS
 - Reactions to body fat % and weight issues....somewhat defensive...repeatedly says that you have a very busy life...hard to work in exercise...has some free time on weekend.
 - Responds defensively to any righting reflex responses...you should, you need to, etc...
 - Responds well to education concerning effectiveness of medicine diminished without proper diet and eating late, eating earlier in the evening, the effects of weight on GERD...make them tell you why weight and fatty foods make it worse. If you get good explanations, tell them, "That makes sense."
 - If HCP tells you if you don't get any better relief after exercise and cutting back on fatty food, you may need to talk to your physician or pharmacist about switching...go along with this...as, "Is something else gonna work if this didn't?"
 - If family history comes up, just say your father had GERD, you think.... "He complained about heartburn..." No other history of chronic illness exists.