PART 3   Creating Therapeutic Encounter

The is the Part 3 of a three part manual.

PART 1 The Space Around:   Purpose, Predicament and Possibilities.

PART 2 The Space Within:   The Human Healing Response

PART 3 The Space Between: Therapeutic Encounter
PART 1  THE SPACE AROUND

STEP 0  BEFORE WE BEGIN – THE SPACE AROUND THE ENCOUNTER.
What now? - What is Your Core Purpose? - The Predicament - The New Conversation, and The Old Map. - Integrative Care.


STEP 1  POSSIBILITIES. Creating The New Map.
Imagine - Can you draw? L&R - The Fish Bowl - Thinking upside down


PART 2  THE SPACE WITHIN: THE HUMAN HEALING RESPONSE

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STEP 1  POSSIBILITIES: HUMAN CARING HOW?

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PART 3  THE SPACE BETWEEN: THE THERAPEUTIC ENCOUNTER

The Space Between - The Therapeutic Relationship - I/We - Evidence Based Poetry – Conditions & Therapeutic Encounter - Empathy, Enablement & Outcome, - ORIDL - Three links in the chain - Costing Journeys - Conditions for Effective Therapeutic Process - 10 Dimensions of CARE - A Quiet Personal Revolution.

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PART 3

THE SPACE BETWEEN: THE THERAPEUTIC ENCOUNTHER

And now it all comes together. The history, the culture, the system, the physical space, the expectations and hopes and dreams. And us.

Let’s begin by looking at some of the conditions that impact the therapeutic relationship.
The Therapeutic Relationship

Our biology interweaves with our consciousness. We are struggling to integrate this subjectivity, this ‘first person” into our “third person” objective post-modern post-industrial world map.

This self-relationship in turn is touched by the relationship with other people - the “second person”. A skilled sensitive and aware other person forms a meld from which unexpected change can emerge. The second person can bridge the hot subjective world with the cool objective world. Or they can trample all over the situation.

Other primates have been observed to tenderly kiss the injury of a wounded friend. This drive to care comes naturally. In humans it is amazing that we visit people we do not know at the most vulnerable time of our lives and ask for help. It is equally amazing that many of us devote our working lives to being there for them.
When Nobel peace prize winner, poet and Buddhist scholar Tich Naht Hahn was asked the difference between Illness and Wellness he wrote both words on the board and circled the first letter of the first word, and the first two letters of the second.

If the core layer of our work is the shift in experience for the person and their own self-relationship, then the main surrounding layer is the therapeutic encounter and relationship. Let’s turn to the healing space between us, connecting us, beginning with some help from research on the aspects of relationship that determine the quality of experience and the outcome of care. A lot of work has been developed here in recent years. First a brief word on the nature of evidence.
In looking at research that enquires into human healing in this way can be to wonder off the dominant Evidence Based Medicine map - at least as EBM is often expressed. No randomised double blinded study can capture the depth of complexity of a relationship, of a life changing meeting. But much can be done.

An over narrow interpretation of EBM has evolved - which was not the originators intention. Professor Sackett opens his seminal book on Evidence Based Medicine with "Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values." (How to Practice and Teach EBM. Churchill Livingstone. 2000). Our understanding of evidence is evolving, seeking a balance between literature appraisal, clinical evaluation and experience, and human caring (e.g. see http://www.cche.net/usersguides/ebm.asp#31). EBM is not a method to use the first of these factors to dominate the other elements.

In the end of course, only the person themselves knows if they feel better or worse. You know if the poem works for you.

PROMs (Patient Recoded Outcome Measures) are beginning to come to the fore (and PREMs – measuring experiences).

(If you would like a copy of a presentation introducing PROMs let me know).
Conditions & Therapeutic Encounter
Here is a study looking at the interaction between the person and the practitioner, and in turn the impact on the patient, and the subsequent outcome of care.
Two hundred people at the Centre for Integrative Care filled in these and other questionnaires after a first consultation.

On the left is a measure of some elements of the encounter experience. This a broad reflection of ideas of empathy. It was later further modified to the current CARE score. Studies show it is useful independent of - the following link has current information on CARE, and the normative values that would allow you to compare your scores (best to take at least 50 cases) with results in general practice.
http://www.gla.ac.uk/departments/generalpracticeprimarycare/research/caremeasure/.

On the right is the PEI – Patient Enablement Instrument - a measure of the resultant impact of the encounter. It gives a sense of the person being activated, empowered, enabled in dealing better with their situation and being able to help their health and themselves.

Empathy and enablement together have been used to measure “interpersonal effectiveness”
Here are some results of the enablement scores. Individual practitioner can use a PROM to get a sense of how the feedback from their patients compares to other colleagues and services. Caution is required here. Insensitive use could generate destructive misunderstanding. For example the PEI score shown here is highly context dependant – varying the baseline situation of the patients you are dealing with. Patients beginning from a point of, for example, greater co-morbidity and chronicity, would be expected to give lower initial PEI scores.

In contrast the CARE measure – which measures a quite different domain of the care process - is much less context dependant.
There were good levels of enablement in this study. What predicted this?

1) **Expectation:** If you expect trivia, you get trivia.

2) **Therapeutic Relationship:** The practitioners sense of a growing therapeutic relationship.

3) **Empathy:** By far the strongest factor in this study is perceiving the practitioner as empathic. Note the descriptions in the earlier slide. It is not about the practitioner feeling the person’s pain, but it is about authenticity, genuine listening and a real effort to try to understand the experience of the person. We will look at the the 10 dimensions of the current CARE score later.
Empathy & Enablement

- Empathy did not necessarily result in enablement
- But – it was a necessary pre-condition
- There were no cases (i.e. not 1 in 200) of high enablement with low empathy.
- Since confirmed in >8000 cases.


If there is a failure of experienced empathy – you can almost forget it in terms of the person reporting enablement. This has now been confirmed in the more than 8000 CARE result to date.

We can give the person all the correct information, leaflets, web links, prescriptions etc. and yet fail to have a useful effect. This may explain in part the earlier point about half of all prescribed drugs not being taken.
Do factors like empathy and enablement affect the outcome?
Before showing some results that help answer this question, we will look at an example of a PROM outcome measure.

An Example Outcome Measure – ORIDL
When I first looked around in the mid 80’s for a measure that reflected the outcome of care from the patient’s point of view - I could not find one. There was stuff on medical outcome, and stuff on the idea of quality of life, but nothing that combined these in the way that an individual values.

The concept I explored, having just worked in general practice, was to use the typical dialogue there between practitioner and patient to model a PROM:

*Well how has gone? Was what we did any good?*
Oh yes doctor it definitely helped.

*OK, but was it enough to make a difference? Has it been any good to you day to day?*
Oh yes, I mean I can get out to the shops now.

*How much does that mean to you? How important is that?*
It is dramatic – nothing I’ve tried before now has made this amount of difference.
Here is the current version of ORIDL. The person rates the usefulness to them of any change, relating it to any effect that this outcome has on their daily life.

It is a generic core tool that can be used to ask about the experience overall, and/or aimed at specific aspects such as main complaint, general wellbeing, coping etc.
You will see this means that with a score of +2 or above (the threshold score) we can be sure of the value to the person, thus it is sensitive to what it is being measured – the patient’s opinion - but what is valuable to one person may not mean much to someone else.

The measure has face validity – it seems intuitively to measure what it sets out to do in a reasonable manner. Preliminary work has shown concurrent validity when compared to other established and validated methods such as MYMOP and SF12.
Three links in the chain are shown here, with an example measure for each:
1. the quality of the encounter,
2. The encounter’s effects, and
3. the eventual outcome.

These results show enablement at exit from a first meeting correlating to the health gain a year later. Note this enablement score is taken before any advice or treatment has yet been actioned. Later work has confirmed that as well as this indirect effect of CARE (i.e. through enablement) on outcome, it also has a direct effect. In general the research shows that CARE Measure scores predict better outcomes (both symptom improvement and well-being) in both high and low deprivation areas. Neither PEI nor verbal communication (MPCC) predicted outcomes.

QoTE Targets?
Imagine if the target culture measured stuff like this? Given the jargon of the day we could call it QoTE targets – Quality of Therapeutic Encounter. There is subliminal pun in there in terms of capturing peoples voices. (A small separate discussion paper is available on this idea).
Costing Journeys

Earlier we looked at the spiraling costs as cycles of prescribing and referring were triggered by time shortages in primary care. Audit work such as the above result from the in-patients at the homoeopathic hospital suggests that a more integrative approach may help break into and slow or even reverse these cycles. A recent study of CAM in Northern Ireland re-enforces this idea.

But patient-centred care needs patient-centred cost analysis. Costing events rather following a patient’s journey and total cost incurred gives a very false picture. Spurious impressions of efficiency in each event can hide an overall costly, fragmented and inefficient individual patient journey.
Conditions for Effective Therapeutic Process
There are millions of medical and care meeting happening constantly in the our worlds. They are the point when change can be seeded- if the conditions are right. Much change is self-generating from the right conditions. This slide shows some guidance on those conditions. Some are structural – like adequate time – others attitudinal, others skilled based. If these general ingredients are right, within the space they create we can then just get on and do and say the practical things our role requires.

These conditions can be studied and brought into our education. NES recently put a bid for grants to support teams in accessing such education. At very short notice they got 80 bids. The need is there and the interest is growing. A less developed field would be tracking the impact of such education and support, and the conditions it needs to sustain itself. This course is an evolving attempt to contribute. We are piloting a “practitioner enablement measure”.

“Inside” Therapeutic Encounter
Centre for Integrative Care - GHH
A QUALITATIVE STUDY

- Patients valued the TIME available, the WHOLE-PERSON approach, and being treated as an INDIVIDUAL
- They felt their “STORY WAS LISTENED TO” (often for the first time), and all their symptoms taken seriously
- They felt the doctors at GHH were TRUSTWORTHY, COMPASSIONATE and positive, often engendering HOPE
- EQUALITY of relationship was a major theme, with a strong sense of mutual RESPECT

Here are the aspects that patients score in the CARE measure. You will see the correspondence to the qualitative study in the previous study. It is not surprising that research shows that patients were more likely to re-attend the same doctor if verbal communication and empathy was high.

Bear these aspects in mind as we get ready now to reflect on the encounter in action.

### 10 Dimensions of CARE

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making you feel at ease ...</td>
<td>(being friendly and warm towards you, treating you with respect; not cold or abrupt)</td>
</tr>
<tr>
<td>2. Letting you tell your story...</td>
<td>(giving you time to fully describe your illness in your own words; not interrupting or diverting you)</td>
</tr>
<tr>
<td>3. Really listening ...</td>
<td>(paying close attention to what you were saying; not looking at the notes or computer as you were talking)</td>
</tr>
<tr>
<td>4. Being interested in you as a whole person ...</td>
<td>(asking/knowing relevant details about your life, your situation; not treating you as “just a number”)</td>
</tr>
<tr>
<td>5. Fully understanding your concerns ...</td>
<td>(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)</td>
</tr>
<tr>
<td>6. Showing care and compassion...</td>
<td>(seeming genuinely concerned, connecting with you on a human level; not being indifferent or “detached”)</td>
</tr>
<tr>
<td>7. Being Positive...</td>
<td>(having a positive approach and a positive attitude; being honest but not negative about your problems)</td>
</tr>
<tr>
<td>8. Explaining things clearly...</td>
<td>(fully answering your questions, explaining clearly, giving you adequate information; not being vague)</td>
</tr>
<tr>
<td>9. Helping you to take control</td>
<td>(exploring with you what you can do to improve your health yourself; encouraging rather than “lecturing” you)</td>
</tr>
<tr>
<td>10. Making a plan of action with you ...</td>
<td>(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)</td>
</tr>
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</table>
A Quiet Personal Revolution

We can each only do our best. Easy does it.

So we are ready now to look a bit more at the encounter itself. We have seen how the consultation begins before the consultation. It has been pre-shaped and its potential loaded - for example by our approach to the vision of what is to be done, and the surrounding conditions, and by our own preparation. But now it’s time to begin.
STEP 3 PRESENCE, BEGINNINGS & PREPARATIONS

"It is our attitude at the beginning of a difficult task which, more than anything else, will affect its successful outcome."

William James 1842-1910, Psychologist.

Neuroscience, and traditional wisdom systems, show that we process what we are presented with differently according to our state of preparation. We need to train, then prepare, then be.

There is a training mindset and trusting mindset – time to trust yourself.

Do you want to engage with the matter at hand? Are you ready to meet someone? This is not about denying how you are, just being real with it. If today is not a good day for us, let’s know that and raise a red flag with ourselves – may be we will not be at our best, so we can just consciously avoid doing harm.

If we were preparing for say a party, we know the care we would put into it. Attending to the set-up, the welcome, the environment, the music. Likewise when consulting - check the physical environment, any simple ways to make it more hospitable? Consider some triggers to begin to tune yourself to the job at hand. Maybe one good breath and sigh, or read the notes, or at least touch them. Like tuning an instrument. We can be unprepared by excess laxity and calmness – empty, or, excess focus on the wrong thing.

Performance: Commitment, Anticipation, Confidence. Marc de le Val - Heart Surgeon
Into The Meeting

As you walk down that corridor – how are you? What state are you are?

As we do this next chapter, consider each stage for yourself as a practitioner, and then as a patient.

Think of the vulnerability and issues at stake as a patient - journey up to that moment, of the nerves, the anticipation, the hopes. This starts the movement towards building empathy.
Calm Yourself

How is the inner environment? What level of sensitivity is present?

Your previous training in inducing calmer states can be called on now – at least as an orientation, if not an initial reality. Training, like the Heartmath shown earlier, can be used to set up habits of self-awareness, becoming aware of our current state, and so we begin to calm ourselves - say by consciously taking a breath and feeling it and bringing ourselves out of our head a bit and into the body.
Welcome. The Horizontal Smile?

The more survival is at stake, or thought to be at stake, the more our welfare or function is on the line, the more we are activated to scan the environment – and the person and system we are meeting. You cannot fool these biological systems, like an animal smelling the air. How authentic is this person? Am I safe? Do I trust? Will I speak for real? These opening seconds are making or breaking what will follow.

Some say people take 5 seconds to decide, 5 more to review their decision.

A warm welcome changes things. A genuine welcome creates what the body language people call an eye flash – where the eyebrows raise. A “professional” smile does not involve the eyes. One study compared greetings with and without the eye flash and found far greater satisfaction and better outcomes when it was present. Even if running a group, I have found a difference in how it begins if you greet each person at the door and say hello.
Intention is the pre-requisite - like a laser heading out ahead of us. It is the switch, it turns on the focus and makes course corrections to enhance attention.

Why are you meeting? In fact, why are you doing this job?

What is your intention towards me? Do you care? What do you want to do with me? Do you want to engage with me or comment on me?

As we soften on judgment, we reduce our projection on to the person, and start the process of building common ground.

Remember Procrustes?
Attention
Better the attention, the better the consultation. Not necessarily analytical thought-based attention, rather mindful alertness, still presence.

A combination of openness and conscientiousness (Ekman).

There is analogy with other states - such as listening to music. You have to bring yourself to it (through intention), deciding not to leave it in the background. Then, as you engage, left-brain analysis falls away and a natural state emerges of being able to hear it all at once, take in the whole symphony of details, noticing the totality of it, yet the nuances, the changes, the surprises.
When the Room Disappears

…and time stops.

We know these altered states from our life. Some are straight forward biological switches – like being absorbed in a movie. That state brings heightened suggestibility and less “filtering”. Words can penetrate deeply. The patient is already in an altered state. Words plant movies in the mind - often horror movies: “arthritis”, “degeneration” “have to live with it” “no treatment” “no scan”.

And think of those meetings that have altered your life, those junctional moments. The awareness has shifted. The external environment may have melted away. Time disappears.
Into The Now

These heightened states hold powerful creative potential. This is where the healing space can emerge.

With practice, the carer can learn to be aware of their own state, guiding it in a helpful direction. Mindfulness and meditative practice for example can help prepare us and train our mind. Yet formal training is not needed if, whenever we can, we use our day to day meetings as mindful practice. We bring ourselves to presence, free of distracting thoughts and intrusive analysis. We meet the other and begin to create shared space.

We drop out of the domination of the inner voice, the critic, the egoic commentator in our head. Facts are there, important of course, yes, but in a field of awareness. A calm and clear mind is a more effective one, and leaves space for creativity to emerge – the fresh thought, the new understanding, the right word, the helpful silence.

We have a triangle of processes - sense perceptions, thoughts and emotions. Outside of this we have a silent observer - a mindful awareness, presence, in the "now"

The meeting is a form of meditation - and has linked neural correlates
Presence – Activating Ourselves

"We have to learn the art of stopping... touching deeply the present moment, the fruits are always understanding, acceptance, love and the desire to relieve suffering and bring joy. Thich Nhat Hanh

At each moment she starts upon a long journey and at each moment reaches her end... All is eternally present in her, for she knows neither past nor future. For her the present is eternity. Johann Wolfgang von Goethe

In meditative states one of the changes in cerebral blood flow is an increases in the dorsolateral pre-frontal cortex - associated with decreases in the left superior parietal lobe 'which may reflect an altered sense of space during mediation' *. This may explain 'the room disappearing’ and the fact these were not induced in another study of passive relaxation (following tapes) re-enforces the importance of participants active engagement - it's not about 'spacing out'.

Building Trust - Listening Deeply

We are working towards building safety and so deepening connection, to form a space and relationship that is supportive of change, of release, of our core purpose.

Creating trust displaces fear. *Trust* from German *trost* meaning comfort (we are creating a comfort zone), similar to Old English *treowe* for faithful.. trust builds faithfulness, trustworthy relationship.

It must be built on questions and listening. Marshall Rosenberg, who created the Non-Violent Communication system, captures this in his questions: *What was/is alive in you? What needs are not being met?*

In turn, as we begin to understand, get some sense of this person’s experience and difficulties, empathy can begin to develop.
STEP 4 JOIN-UP

The connection grows, it is rarely instant. But, if we are present, our innate abilities help us know the degree of connection established, and deepen it. We spoke of listening to music, now its more like singing with someone, or dancing with them, it can only be mutual – or it’s a solo act, self-satisfying, but ineffective as a vehicle of change.

The term join-up is borrowed from Monty Roberts, the horse whisperer. When the non-verbal connection is made, the horse will follow the person, in connection. A number of points from his experience correspond with my own in human engagement (see Horse Sense for People).

Before join-up it’s information, after join-up the same facts given can enter inner space, the world of meaning. In the end, it’s not what happens to you, it is the meaning of what happens to you that counts.

We are building rapport, and creating a ‘therapeutic alliance’ – which is shoulder to shoulder, with shared goals, and bonds. This is important. But relationship is face to face, a 50:50 partnership. Not just as a means to an end, but meaningful in itself. Communication achieves join up and trust sustains it. If there is no trust, there no join-up. We know that patient participation improves outcome. Quoting Roberts: “If communication is adequate, the outcome will probably be satisfactory. Ambivalence is natural, expect it .. any response is a positive portal to creating change.. Begin a process of negotiation in a tranquil manner, consistent and caring”.

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Physiological Links? Resonance?
There may be a true physiological connection in these meetings, these shared spaces. We affect one another.

What do you bring without words?

As well as the claimed ECG-EEG links, there may also be EEG-EEG links - Wackermann J et al. Neuroscience letters 336 (2003): 60-64.

There may even be elements of resonance and entrainment. Like the connection between a tuning fork held in our hand vibrating to the piano note across the room.

Whatever the biology, we can be certain our state of calmness and presence (or otherwise) affects the other.
Growing Compassion

I consider compassion as a natural given in us - that can be blocked, and from which we can disconnect, but equally that can be released and enhanced. When we really begin to a sense of the predicament of another person, and open to our common humanity, getting our judgments out of the road – then the heart opens, compassion grows.

Can you train in compassion? Let’s look at some research.
Can You Train in Compassion?

Yes. “Recent brain imaging studies using (fMRI) implicated areas in the empathic response to another's pain. Voluntary generation of compassion was compared while novice and expert meditation practitioners generated a loving-kindness-compassion meditation state. …we presented emotional and neutral sounds during the meditation and comparison periods...(there was) greater detection of the emotional sounds, and enhanced mentation in response to emotional human vocalizations for experts than novices during meditation. Together these data indicate that the mental expertise to cultivate positive emotion alters the activation of circuitries previously linked to empathy and theory of mind in response to emotional stimuli. The presentation of the emotional sounds was associated with increased pupil diameter and activation of limbic regions (insula and cingulate cortices) during meditation (versus rest) ….”

The Two Journeys – The Outer & The Inner

We have seen how the encounter needs to take account not just of events, but the meaning to the individual of these events. Failure to do so can result in therapeutic failure. Without this, the practical will go less well, with less concordance there will be less uptake of our suggestions and treatments.

We are beginning to speak now of ‘the patient’s journey’ in health care. It would be helpful to recognise there are two journeys: the outer event-based one, which we should aim to be an efficient and effective care pathway; and the inner journey where suffering and wellbeing are being shaped. The outer journey exists to serve the inner one. The inner one leads to success or failure in the patient’s eyes, and so determines the success of the outer one.
Sympathy-Empathy-Compassion

We cannot feel another’s pain. When we seem to do so it is our projection, and caution must be exercises as this can be a drama that separates us from them – now there are two people in pain. Sympathy is a man experiencing labour pain as his wife gives birth – no use to either of them. The genuine effort to listen deeply, to seek to understand, is experienced as empathy by the other – and is a pre-requisite for an enablement reaction. In us it begins to open us, settle our own busy mind and create space for the other. As we open, we see the other as a real person, we become aware of our common humanity, and our empathy and so compassion begins to flow. This touches us both in a healing way. Sympathy drains us, compassion nurtures. Research (eg Stewart Mercer’s) has shown that GPs who valued empathy had significantly lower burn-out scores and empathy was positively related to job satisfaction.
Empathy

Word coined by Tichener in 1909 - from Greek em and pathos (feeling into). It is iterative.. improved through learning cycles with the other:

1. THINK IN Cognitive focus.. 'enter into' perspective and experiences (but hold your own perspective)
2. FEEL IN Emotional focus.. 'walk a mile in the patient's shoes' - resonant or surrogate feelings
3. CHECK IN [ TILL YOU GET IT] AND CYCLE Action focus.. using feedback.. 'I have got this right?'

Building Empathy

QUERIES
Would/could you tell me a little more about that? What has this been like for you? Is there anything else? Are you OK with that? 'Hmmmm'

CLARIFICATIONS
Have I got this right? I want to make sure I really understand what you are telling me. I am hearing that.. I don't want to go any further until I am sure I've gotten this right. When I am done, if I've gone astray, I'd appreciate if you would correct me, OK?

RESPONSES
That sounds very difficult. Sounds like.. That's great! I bet you feel pretty good about that. I can image that this might feel.. Anyone in your situation would feel that way. I can see that you are...

1.ACTIVE LISTENING
2.FRAMING OR SIGN POSTING .. if picked up a cue. let them know.. 'Sounds like?'
3.REFLECTING THE CONTENT.. facts, feelings, concerns and conflicts
4.IDENTIFYING AND CALIBRATING THE EMOTION.. Tell me how you are feeling about this? I sense you feel strongly but I do not understand clearly, can you tell me? Sad: That must have been a pretty painful experience, you sound like it was very sad. Fear: Sounds like you were really frightened when you discovered that lump. Anger: It really got you didn't it? Trust: It seems you are not sure if you should trust me further after I didn't get that test result. Ambivalence: It seems to me as if you feel caught in a bind about whether to stop smoking or not.

May need red-blooded adjectives like enraged, tormented, overwhelmed, terrified, or weak affective words like bother, annoy, upset, uneasy and apprehensive... match these up. They may be out of touch with their feelings, your enquiry may help them tune-in and connect. But may still be factors against this like rejection, denial, or disguise especially in somatization (frozen) or compensation or strong cultural taboo.

5. REQUESTING AND ACCEPTING CORRECTION Did I miss anything? Continue round the cycle until 'confirmation'. 'Yes doctor, exactly, that is how I feel'.. if not, your not done

"Let me see if I have this right." : Words that build Empathy. Annals of Internal Medicine 2001;135(3):221-227
**Seeing Clearly**

Compassion here is referring to something quite beyond emotions. Emotions may have arisen in one or both of you, be that as it may. The compassion is an awareness of our shared humanity. This is a deeper and stiller place than emotions. We see the predicament, we understand it is real, we see that some aspects may be beyond change. Yet we realise that the person is not their predicament, their thoughts or their feelings, there is something in them that is their full humanity. We hope for their release from their suffering as much as possible. Our awareness of their integrity and wholeness, despite their current life situation, transmits itself in a helpful way.

This description of course represents deeper work, in more challenging circumstances. It is not called for or needed in much of our day to day routine work. Yet everyone of us in our professional life, and of course personal life, will meet the moments when this level of engagement is vitally helpful. Actions are informed from a level beyond the reflex.
Small Things With Big Effects

A central theme from our opening extracts was the idea of nurturing, of stimulating, of supporting, the built-in potential in people for repair and growth as a new vision in health care. An important realisation is that if we create the right conditions - the plant “knows” how to grow. All the steps discussed up to now are supportive and are often more than sufficient in themselves to germinate change. The next step on our map – The Dance – at times does not come into conscious play, its effects are automatic, under the surface, emerging from the general conditions and natural flow into the stages of Germination, Growth and Journey.

What now follows has some more developed aspects to it that may or may not be for you in your work. Your job is to extract general principles that operate in any meeting, any dialogue. So it is important to not feel de-skilled by talk of more “advanced” therapeutic dialogue and techniques. Your courtesy, conscientiousness and genuine efforts to understand, coupled with your current technical skills and roles represent a powerful and often effective combination. That said, there is an endless enjoyable and valuable learning in exploring how we can develop our awareness and skills in the therapeutic engagement – in The Dance.
STEP 5 THE DANCE

The joined-up relationship is now engaged in the matter at hand. The participants are working in partnership – The Dance.

The point is to achieve some movement, some change. Creative relationship is the container for emergent change, the catalyst of emergent transformation, a point when change can be seeded - if the conditions are right.

A key condition: we must make sense and meaning, on the journey towards change. Some will be cognitive and narrative based, some more in the realm of awareness, outside of thought. You could think of this as left and right brain both being satisfied in their need to be understood and understand. The left brain is a story generator – always wanting to ‘explain things’ however scant the information. When the right brain is active we experience directly, not through commentary or narrative, and as it comes on-line, access to the speech centre decreases. So some of our most powerful experiences – of meaning, of love, of pain, of beauty, of the spiritual cannot be put in words. This is where images and metaphors are so important – by coding whole experiences. Words in this state have a poetic power.

Let’s code the main elements then as

- the old story heard in compassion,
- then the new story emerges
- the whole of this opening up a germinative space and process that lies outside of story, loosening its bonds.
Integrative Process

"reduces fragmentation and increases coherence, wholeness, within a person/and or their care"

This is the heart of it, and while the deeper underlying process cannot be easily defined, we can described the behaviour, markers, conditions around this ability of life and living organisms to move towards wholeness and balance – to grow and heal. Our issue here is as gardener, catalysing this process. Within consciousness, it is characterised by a change of meaning, a new understanding. Create a fresh perspective of the world, and explain in a new way the world unknown to you. Dziga Vertov 1923, Soviet film director. But our cinema is internal. Neuroscience shows that "top down" regulation of drives and reactions, help remodel the brain - neuroplasticity - consciousness led brain changes.

The space opens: “What if….?”
The Turnaround – Freedom from Threat

This old view – new view turnaround is the pivot point uniting many systems of care – for example:

**Western Models.** Hypnosis: rests on “find the mistaken idea (believed-thought) and help the person change it. While this is Cognitive/L Mode, like a central schema of CBT, it is mostly addressed through imaginative rehearsal and images. NLP formalises this in it’s “switching” between alternate depictions of the problem and the release. Mostly we do need hypnosis – the consultation is already an active zone, the person in a heightened state of suggestibility and vulnerability.

**Eastern Models:** Mindfulness awareness changes how we view our thoughts - “we are not our thoughts, or feelings, or mind” This is more R Mode. This is entering the West now through approaches like MBCT and MBSR.

Mindfulness 1) helps people see how thoughts cause suffering, experience and behaviours and 2) realise that these thoughts are not the self. The true self is seen as the consciousness in which thoughts arise and in which they can be observed. For example Byron Katie’s The Work is an elegant systemetised and accessible approach (www.thework.com) condensing some of this. There is a usually a sense of perceived threat somewhere behind suffering.

Another description, adapted from The Blissful Brain by neuroscientist Shanaida Nataraja: Often there is a

1. Question: An existential question is posed - what does this mean? (life, death, illness, my situation etc). [framed as..]

2. Conflict: Explored between two opposites, irreconcilable - good+evil, love-hate.

3. Resolution: A resolution is presented. May be as an image – the Trojan Horse with its new pattern - the big picture, a holistic intuitive processing. A ‘turnaround’ thought or idea. If it is helpful, the recipient experiences the resolution of the problem in the myth at a deep level existential level leading to a resolution of internal conflict.
The Old Story - Compassionate Listening

Now hold it, don't rush to re-assure. The Plan? – have no plan for a moment. Let the space of the expressed story be honoured. “It's all right to cry, just let it come, you are safe”. Often we do not have time to hear the whole narrative, and it may not always be constructive to do so – especially in someone stuck in re-telling it. The main point is that this is after join-up, and in the safety of relationship, our general approach and our empathic mirroring let’s the other person feel heard. Listening with compassion can help the other person to suffer less.

This can generate change in itself, as the individual feels the validation of their experience. Allowing, what we will call here, this old story, is both a pre-requisite for any transformation in perception – to a new story – but also can be therapeutic in itself. The person is not just telling this to re-live, but disclosing in a context of safety and intention of change. This means they also hear or witness their own story, beginning to waken up a “second person” perspective in them selves rather than just being caught in the first person re-living. In addition to these pathways, there may also now be the opportunity for re-framing or challenging the old story – but not until these other aspects have taken place. At times getting them to imagine another person in an empty chair who has their story wakens up this second person perspective – more later on this.
The New Story – If You Were A Plant?

If just telling people what is good for them and what they should do – like the fourth wave – worked for today’s problems, well that would be good! Shame it doesn’t work very often. In contrast, earlier we modeled the use of an image within a safe relational dialogue – “if you were a plant what state are you in?” And then built that dialogue by asking “What is water and sunshine for this plant?”, leading to a self-confronting of the “state of the gardening”. As Monty Roberts put it: “You must” is not an answer to anything. unless we fully understand where a person is coming from, and take them through simulated experiences that allow them to learn trust, we cannot expect them to alter their behaviour.

"Whatever words we utter should be chosen with care for people will hear them and be influenced by them for good or ill” Buddha (563 to 483 BC) This is especially true within the powerful environment of a professional meeting.

Finding your own way with this takes time, and it is reasonable to begin by modeling practitioners with experience. Gather offerings that you might make in these moments of potential change – stories, images. The common language beneath culture is often of images of nature. The other key source of language is the person you are working with– picking up its images and words and building. Indeed beware of any word they have not introduced, and bring such new terms with aware monitoring and negotiation (this has been called using “clean language”).

We are aiming to soften the grip of the self-hypnotising Cinema of the Mind around any issue that is causing distress and poor self-care. “Safety scientists distinguish between “celebrated stories” (usually composed by or for the media, and most often tragic and emotional) and the underlying “second story,” which is generated by a thorough, multi-factorial, multi-disciplinary analysis of accidents”’ BMJ 2003;327:1424-1427. We can question the initial dramatic-celebrated thoughts - Is it True? This can help us change the map. It can also help us step right off of maps: into awareness of “It is only stories - and we are not our stories.. waves cannot damage the ocean”. This is the space under our story, outside of it. Who are you without your story?
A 2,300-year-old seed found 1982 in an ancient tomb near Hiroshima, Japan.

Professor Hiroshi Utsonomiya of Yamaguchi University soaked it in water, sowed it with loving care and nature finally took course.

By October 1992, the seed was a 7 ft tree with several buds. In April 1993 - one opened to reveal a delicate white flower with eight petals

I Once heard About..  
A story like this heard in ordinary consciousness may be dismissed as trite. Heard at a certain moment - perhaps when we have been heard in our feelings that part of us died years ago, - such an image can be transformative, bringing hope and a reminder of our potential.

80-90% of brain works and associates in sensory images.. 2% in words and word-based thoughts.. Howard Berg

"The brains of human beings seem built to process stories better than other forms of input . . . they seem to offer a solution—a way to extract some meaning and redemption from tragedy by preventing its reoccurrence.”

There are more examples of working this way in the manuals of The WEL programme – downloadable from www.thewel.org.

Miller Mair - I believe, that words-in-relationship lead us to places we would not otherwise go. Our acts of telling are, at times, acts of primary inquiry. We are led to understandings and misunderstandings through the things our words shape as we / they speak our experience into tangible forms…. Here we come to recognise that creative fictions allow expressions of psychological life that mere facts can never achieve.... inquiring make believe. http://www.oikos.org/mairstory.htm
Opening Self-Compassion. Why Change? The Empty Chair

As explored in Part II perhaps the deepest transforming change is when the relationship to being alive is restored with a sense of value – not because of what we are or have done – but just because we are. Self-compassion and self-care are keys. This takes us beyond our problems, and sparks a self-learning journey.

Here’s an example, using “the empty chair”. Hear, and note, some of the person’s self-talk about the problem. It is usually negative. “You are a failure, weak, stupid, ugly, pointless” etc, or notice their view of their body/their disease – self-hatred, anger, blame, or, describe their (lack of) self-care regime. Then ask the person to say this/recommend this to someone similar to themselves sitting in another chair. If they cannot do that, get them to imagine someone else saying these things to the person in the chair. You can speak for one of them. As they watch this in their mind’s eye - ask them what is the effect on that person? They’ll describe the damage – often in words that echo their own story. Ask them what would their instinct would cause them to say. Write that down, it is often their self-prescription. “I’d never treat someone like that, it would destroy them. I would listen and re-assure them, tell them they are good enough.”

Or use an image of vulnerable life – a plant needing water, a child, an young animal. Something that breaks through to their compassion. Find out how come they feed their pets, or care for their children or water a plant - even if tired or tense or unwell. If we find this out and bring it to our self - the rest will follow naturally.
How Is Your Self-Care?

While the this page is from the WEL programme – it’s included here as an example of ‘dance’ – but also for your self-care.


Before we begin, let’s check in with how we have been running our lives. Do you need any practise in the skills of managing stress and increasing inner soothing and wellbeing? The three ovals above can be thought of as three systems of our mind. You are going to give each system a mark out of 10 for how strongly it has been built up over the years – a bit like how much muscle it has developed through how much you have exercised it. So what score for strength would you give your:

Threat/Fear System?
Active/Busy/Reward System?
Soothing/Calm/Safe System?

Do your scores seem in balance? Is any system over-developed? Is the last one your weakest system? How have your self-soothing skills been over the years? Please note this is not the same as pleasures derived from busy achievements and award seeking behaviours (this Busy system is the addiction pathway).

Recall that thoughts and drives arise from automatic pilot. We need to develop awareness and so true control – we can then choose to do the “physiotherapy of the mind” (as Paul Gilbert calls it) and build up the strength in our self-soothing skills and system. The part of you that notices these scores, like the space around the ovals, we have been calling your consciousness, your awareness, the observer.
STEP 6 GERMINATION
Healing growth and adaptive change are water from the same well. At a deeper level, I don’t know what life is, or why it behaves this way, but it does.

In our context we have seen from our own experience, and on the course in the cases and the science how an integrative approach creating the right conditions and nurturing that spark a natural inherent process that moves towards greater coherence, wholeness, integrity - the healing response. This is what is described in the diagram as the automatic enablement.

We can also work in a more directly creative way. In particular our believed thoughts (maps) and their consequences often block these process. In some ways we are just clearing away obstructions to allow the emergence of life’s ability, of creativity. This is the crafted element, reflected in our discussion of say the use of images, or cognitive challenge, or mindful awareness - helping create a clearer mind brings a clearer heart, and so natural life respecting ways.
The Real Thing – The Course Teachers – Their Stories

The course video cases and transcripts come from a large series of case studies used to build the foundations of this course. The idea is to hear afresh the healing changes that are possible. It might be fruitful to re-read Gordon’s transcript at this point. In time the transcripts of the other seminar video’s will be put up on the web site.
Preparing For The Journey. Demedicalise & Support

Something useful has happened – what now?

Medicalise where necessary, and de-medicalise everything else. Do we need to intervene now? It is ideal if we can hold off any interventions initially, at least those that might also produce a similar response to the one we are after – obviously only if this ‘masterful inactivity’ is safe, acceptable and wise. If this is possible it avoids the person attributing subsequent improvement to an intervention (“those tablets were wonderful”) and so gives them a new reference point: useful change arising from their within themselves. This enables, and reduces dependancy. This needs picked up and pointed out at the follow-up.

People need help to see that it is not the size of change that matters, rather, that anything happening points to potential (like the story of the magnolia seed) – “you don’t judge a germinated seed by its size”.

Plan what can be planned, and then trust the process to develop in ways we cannot plan for, but learn with and adapt to – a maybe unfamiliar creative chaos. We start a new cycle, with the a vision of what is possible and thoughtfulness about conditions and beginnings. Fortunately, the process is very strong, and things will emerge spontaneously – the plant knowing how to grow. But initial insights and changes may go back under the surface quite quickly. We are making ready for the journey phase and the work and time that will involve.

From before we met the person and at each step thereafter we have adopted a vision that sees their strength and potential. This has maximised the chance they are starting to get the central idea of their role as self-gardener.
STEP 7 GROWTH – THE JOURNEY
In Part I we spoke of the study of the stages of emergence and retraction. They fluctuate in the therapeutic journey. This final and fundamental phase merits a course part in itself. Until that is ready, a few remarks will be made here, and a couple of sample pages are included used in The WEL programme touching on “after the course”.

www.davidreilly.net
States & Stages of Change

Like the outer journey, the inner journey has its stages and signposts to diagnose and work with. The core purpose and vision we have worked remains central – the emergent self-activation, self-management, self-care, self-recovery. We listen to the immediate state of the person, the current story, but this is less helpful that perceiving the stage they are at on this graph - like frozen-shock, denial, defrosting-awareness, germination of change, growth with "weather and seasons" of set-back and loss of hope. We aim to support a mindful perspective – the sailor in a storm, the gardener in winter, the chick out of the egg, acknowledging the current storm as an expected and normal stage, doing what is needed – especially keeping basic self-care alive. Our role is re-anchoring awareness to journey when they are stuck in current state and stories. Often this stepping back in the partnership dialogue helps the person re-establish a bigger picture, stop drowning in the current set-back, and leave re-motivated and more settled.

Here are two example academic models – with the idea of tailoring interventions to the patient's stage. For example the PAM patient activation measure.( Health Serv Res. 2005 December, 40(6 Pt 1): 1918–1930. doi: 10.1111/j.1475-6773.2005.00438.x.) has 4 stages: Believes an active role is important, Confidence and Knowledge to Take Action, Taking Action, Staying The Course Under Stress. These stages have some similarities with the stages of change in the Transtheoretical Model (Prochaska and DiClemente 1983; Prochaska, Redding, and Evers 1997), which includes Precontemplation, Contemplation, Preparation, Action, and Maintenance stages. This model emphasizes motivation and readiness and does not explicitly deal with issues of skill and knowledge. Further it focuses on one behavior at a time and requires the development of a measurement tool specific to that behavior.
How’s The Gardening Going?

The follow-ups check any technical stuff we have to do, and check the state of the underlying therapeutic process. The vocabulary and stories we have developed together with the patient act as short-cuts to go straight to the core issues. It’s very useful to have put shorthand reminders in their case notes of the images, ideas, diagrams etc you used together – they way you would record their drugs. In they come, How’s the gardening? – and your off!  Set-backs and relapse are seen as chances to learn, building knowledge of maintenance and self-care skills, and a deeper understanding of the underlying cycles, a re-enforcement that compassionate self-care is the foundation, not working against the laws of cause and effect (If I fight reality, I only lose 100% of the time. Byron Katie). To the extent that it is possible, we can offer commitment for companionship, review, coaching, guidance when you can - on their journey. There must be no false promises, and a realistic guidance on what role we can play, not feeding an practitioner-ego model. Remind them “You did this, well done. How did you do it?”

Treasure your mistakes - they are the way we learn…. Failure is not falling down, it is staying down..  As Bert Stein puts it It is inevitable that some defeat will enter even the most victorious life. The human spirit is never finished when it is defeated... it is finished when it surrenders. ”

Encourage life-enhancing activity and attitudes e.g.:
From Bhuddism:  Love and equanimity, compassion and joy (re-joicing)

From Chrisitianity: Love your neighbour, as yourself. Note how people in a western culture do not hear the second half of this commandment and its embracing compassion – it has distorted to more like ‘ignore yourself, you are unworthy’

From the Okinawa Centenarians by Bradley and Craig Wilcox – they live longer than industrialised people:  An engagement with life, staying optimistic, cultivating a sense of humour, an open mind, a willingness to learn..

Here’s a couple of sample pages from this approach from The WEL programme (again marked )
The WEL “PART 5” – The Journey

Tourist: *How can I get to the path up that mountain?*
Passer By: *Oh, I wouldn’t start out from here!*

Let’s close with a few words on the journey ahead. It’s with you now, and the help you seek out – you need to make your own “Part 5” of this foundation course. Perhaps you have already begun to change the conditions and your self-care in the direction of healthy nurture, or perhaps you recognise you are further back than than and will need to seek help to get you started. Or may be you feel change has started, even blossomed over the time of the course.

Where ever you are is where you are, journey from there. Be honest about this, and the reality of the journey of recovering your spirit and wellbeing that may lie ahead. We journey for life.

In truth it’s not so much what we do, as how we do it. Do we bring a spirit of loving acceptance and encouragement and courage, or do we condemn and attack ourselves and life? Peace comes only in the moment, where we are now.

Consider a kit-bag of support materials for yourself. May be you could take ideas from the IFF’s Kit-bag http://www.internationalfuturesforum.com/iff_kitbag.php - it has things like a 1 minute egg timer to take a single minute break or meditation, a CD of inspiring relaxing music, a meditation CD, a private notepad and a pen for getting stuff out so you can have a look at it, inspiring photographs, something to touch like a shell, something to smell like an aromatherapy, and some prompt materials like cards with useful reminder or inspiring phrases on them. May be you could make a special place somewhere at home, with special objects – like feathers, beautiful stones, scared symbols. All these are ways to guide the wandering mind in the direction you want it to go and grow.

A steady supply of positive and encouraging books and audiobooks and CDs can be really helpful. The old brain pathways of suffering and stress have grown so strong they are multi-lane motorways. The brain will keep going there out of habit. In fact let’s talk about handling when this happens.
The Journey & The Graph – Expect Bumps & Relapses.

Here we are battered in the storm. Worse, we are for now consciously cut off from connection to the plant, and for now we have lost any experience of our earlier improvements. Our mind now tells us the snake is real and our suffering is caused by outside of ourselves. We have fallen down again and our face is in the mud. So lying there, when we open our eyes all we see is mud – proving the mind’s script of the movie.

Now all the study and practice in the world will not stop these cycles. The issue is not falling down. We all fall down. The issue is getting up as quickly and with as little drama as we can muster.

Remember we are not talking about controlling pain or other sensations, but about suffering – our inner world’s reactions, our movies, our journeys that our old maps take us on.

This can be a real time of learning. The time of compassionate acceptance that we have tripped up. The time of knowing the movie is so strong we cannot turn its volume down. The best we can do sometimes is accept this predicament and weather it like a storm. They say good sailors only emerge in storms – who learns to sail well when the water is only calm? To any extent that we can, we can support ourselves in remembering this is a storm, and all storms pass. No need to sink your ship.

Time for that kit-bag? Or that talk? Or a visit to that healing place? Or just time for time and patience – with a “red flag” up, knowing this is not an easy era and we need to weather it until it passes. As soon as you are able – re-establish some support practices, and get some of the driving thoughts down on paper – and question them. Are they true?
Hit a Bump

Here’s some reminder phrases of how normal it is to have ups and down.

It would be a funny gardener that in winter gives up, forgetting that winter is normal and is always followed by spring. The gardeners peace needs to lie inside, not in controlling the weather. That is their primary job. But their practical gardening, which is important of course, is of secondary importance to the inner gardening.

Enjoy the gardening!
The previous WEL pages and other plus videos are on the web site.

**Outcome – How Long Is The Journey**

We have touched already on the Evidence Based Poetry of patient-centred measures of e.g. enablement, empathy, objective changes, outcomes, coherencies.

How long does it take? As the video cases have shown there can be rapid and immediately useful germination. Journey from there is so variable – was this preventative work, or fishing people out the water who were drowning? What stages of change were they at?

For those chronic complex co-morbid stuck patients who present with a range of problems and often unexplored, even consciously buried, past trauma – well frankly, the goal may be stopping decline to some degree. But I have seen that from such dark places there is often a 2 to 5 year overall journey. Another reason the self-caring, self-management is so critical. Yet life’s ability to re-generate amazes me – sometimes physically, always mentally and spiritually. As practitioners we need to know this and see inspiring examples, and gain guidance, or else our horizon stays too low – matching the under-achieving of the patient – with both parties satisfied that the best has been done, unaware of what is possible – sharing the same map.
The Full Map

Well we have touched on most aspects of our map. This is reproduced in full in the separate references-summary handout.

Now we end where began by reminding ourselves on how maps are useful, but they can trap us and obscure our ability to see the real territory in front of us. Fortunately every person we work with can take us back, re-connect us and teach us a fresh.
A, not the, Summary

It is not easy to summarise this area. Here are a few reminders.
Here is another one.

I wish you well in your life and work.

Please don’t hesitate to contact me, or put a comment on the dialogue page of the web site. There may be space for you to sit on a WEL group – and some StaffWEL groups can be organised. Some people also join me sitting with patients as we consult together.

My best wishes

David

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David.reilly@mac.com
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“When love and skill work together, expect a masterpiece.”
John Ruskin
PostScript – Other Maps

I have aimed to confine the material in the course to what I can speak about from personal experience and learning. It is therefore limited and coloured.

I’ll place in this appendix a few other maps. There is little direct research yet on the healing response in a care setting. There are a many models of the encounter.
Students Views

This is a map generated by Glasgow medical students triangulating the patient, the therapy and the carer around the potential in the situation. They wrote an interesting report, it’s on the web site.

http://web.mac.com/david.reilly/healing/Publications.html
The West has often ignored, or marginalized direct engagement with self-healing, but as the box shows, (adapted from reference below) anthropologists have seen that every human culture must engages these same dimensions, consciously or not.

Clarissa Hsu and colleagues in Seattle wanted to understand the views of patients and clinicians on the central concept of healing and to identify major facilitators of and barriers to promoting healing in primary care. A qualitative analysis of focus group data from primary care clinics of a large, integrated, health care system included 84 participants: 28 patients, 23 primary care physicians (19 family physicians), 20 registered nurses, 11 licensed practical nurses, and 2 medical assistants. They found remarkable concordance across focus groups and among types of participants in the definition of healing: **Healing is a dynamic process of recovering from a trauma or illness by working toward realistic goals, restoring function, and regaining a personal sense of balance and peace. Healing is a multidimensional process with physical, emotional, and spiritual dimensions.** Patients and health care team members share a vision of healing and agree on ways to enhance the process in primary care. [http://www.annfammed.org/cgi/content/abstract/6/4/307](http://www.annfammed.org/cgi/content/abstract/6/4/307)

**The key themes**

1. healing is multidimensional and holistic;
2. healing is a process, a journey;
3. the goal of healing is recovery or restoration;
4. healing requires the person to reach a place of personal balance and acceptance; and
5. relationships are essential to healing.

**Factors that facilitate healing**
help build relationships, improve communication, and share responsibility between the patient and clinician.

**Major barriers** are logistical factors that limit high-quality time with healing professionals. CONCLUSIONS Patients and health care team members share a vision of healing and agree on ways to enhance the process in primary care.
The projected aimed 'to describe the psychological and social construct of healing and to create a valid and reliable measurement scale for attributes of healing'.

From a domain analysis of theories of healing, brainstorming more than 220 potential items, they made a 54-item questionnaire, then a second development version of the instrument as a valid and reliable measurement scale for attributes of healing, which they named the Self-Integration Scale v 2.1

http://www.annfammed.org/cgi/content/abstract/6/4/355
John Scott and colleagues aimed to create a model that identifies how healing relationships are fostered. They concluded that Healing Relationships have an underlying structure and lead to important patient-centered outcomes.

**Three key processes** emerged:
1. valuing/creating a nonjudgmental emotional bond;
2. appreciating power/consciously managing clinician power in ways that would most benefit the patient; and
3. abiding/displaying a commitment to caring for patients over time.

**Three relational outcomes result** from these processes:
1. Trust,
2. Hope, and
3. A sense of being known.

**Clinician competencies** that facilitate these processes are
1. self-confidence,
2. emotional self-management,
3. mindfulness, and
4. knowledge.

**URL:** [http://www.annfammed.org/cgi/content/abstract/6/4/315](http://www.annfammed.org/cgi/content/abstract/6/4/315)
Larry Churchill and David Schenck’s useful summary of 8 key practitioner skills.

<table>
<thead>
<tr>
<th>Do the little things</th>
<th>Remove barriers</th>
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<tbody>
<tr>
<td>Introduce yourself and everyone on the team</td>
<td>Practice humility</td>
</tr>
<tr>
<td>Greet everybody in the room</td>
<td>Pay attention to power and its differentials</td>
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<tr>
<td>Shake hands, smile, sit down, make eye contact</td>
<td>Create bridges</td>
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<tr>
<td>Give your undivided attention</td>
<td>Be safe and make welcoming spaces</td>
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<td>Be human, be personable</td>
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<tr>
<th>Take time and listen</th>
<th>Let the patient explain</th>
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<tr>
<td>Be still</td>
<td>Listen for what and how they understand</td>
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<tr>
<td>Be quiet</td>
<td>Listen for the fear and for the anger</td>
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<tr>
<td>Be interested</td>
<td>Listen for expectations and for hopes</td>
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<td>Be present</td>
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<tr>
<th>Be open</th>
<th>Show authority</th>
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<tr>
<td>Be vulnerable</td>
<td>Offer guidance</td>
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<tr>
<td>Be brave</td>
<td>Get permission to take the lead</td>
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<tr>
<td>Face the pain</td>
<td>Support patients’ efforts to heal themselves</td>
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<tr>
<td>Look for the unspoken</td>
<td>Be confident</td>
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<tr>
<th>Find something to like, to love</th>
<th>Be committed and trustworthy</th>
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<td>Take the risk</td>
<td>Do not abandon</td>
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<td>Stretch yourself and your world</td>
<td>Invest in trust</td>
</tr>
<tr>
<td>Think of your family</td>
<td>Be faithful</td>
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<tr>
<td></td>
<td>Be thankful</td>
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Covey’s model of the nexus that allows one’s true voice and passion to emerge.

We bring our talent and passion to a need in the world or ourselves, predicated on our core values.

We need a sense of what is possible – our vision, to which we then commit – our mission.
One the one hand - may be the right-hand-left brain - is the linear flat analytical process of getting facts and content in the traditional history. On the other hand, may be the left –hand-right-brain, is what can seem to logic almost competing frustratingly indefinable and intangible qualities of human connection. Fortunately, in the consultation a living creative process synthesizes these in a way that is as exciting and challenging as doing major surgery, or creating an artistic work - building a flow of structure and relationship and creative process with the patient in a safe, compassionate and effective way. this is enormously rewarding.
Here are our colour codes of our map overlaid on to the the Calgary-Cambridge guidelines for consulting - “incorporating patient-centered medicine into both process and content aspects of the medical interview. These enhancements help resolve ongoing difficulties associated with both teaching communication skills and applying them effectively in medical practice”. Well that’s good eh?


“The four elements of communication behaviours presented as steps in a value chain model are: (1) establishing rapport, (2) patient disclosure of emotional cues and concerns, (3) the doctor's expression of empathy, and (4) positive reappraisal of concerns. CONCLUSION: The metaphor of the value chain, with emphasis on goal orientation, helps to understand the impact of each communicative element on the outcome of the consultation. Added value at each step is proposed in terms of effects on outcome indicators; in this case patients affect regulation. Neurobehavioral mechanisms are suggested to explain the association between communication behaviour and affect regulation outcome.”

Get that? Good. I don’t yet. You read from the top line and note the flows to the bottom line (the patient). Puts our movement from old story to new story (“positive re-appraisal”) in a linear model.