ECRONICON OPEN ACCESS

EC PAEDIATRICS
Review Article

Empathic Communication, its Background and Usefulness in Paediatric Care

Cristina Lundqvist-Persson[1,2]*

[1]*Skaraborg Institute for Research and Development Skövde, Sweden*
[2]*Department of Psychology, Lund University, Sweden*

***Corresponding Author**: Cristina Lundqvist-Persson, Skaraborg Institute for Research and Development Skövde and Department of Psychology, Lund University, Sweden.

Received: September 15, 2017; **Published:** October 12, 2017

Abstract

Medical care today has made major medical achievements and this is welcome development. However, the development of medical technology has created increasing problems in health care such as distance from the human, the person behind the disease and feelings of inadequacy. This means that we cannot always practice the care and treatment we intended and wished for. The aim with this article is to describe a tool, Empathic Communication, which facilitates understanding the person´s experiences, feelings and needs. Two cases are presented which illustrate, by using the tool Empathic Communication you could increase the quality of care, develop us as helpers, reduce our feelings of inadequacy and awaken the staffs´ sense of meaningfulness at work.

Keywords: *Empathic Communication; Paediatric Care*

Introduction

A tool of empathic communication

Lisbeth Holter Brudal, clinical specialist in psychology, developed in 2004 a tool for empathic communication to be used in health care and schools. After 10 years of practice with the tool, she published a book about the method in Norwegian [1], which was then translated into English [2].

The purpose of this tool Empathic Communication was to "prevent unfortunate consequences of reckless and non- professional communication in healthcare and schools." She also stated that as a dialogue Empathic Communication is a kind of health promotion, because it creates conditions for change, growth and development in interpersonal relationships in general.

Empathic Communication is defined as clarification talks. It's not therapy, guidance, coaching or counseling.

The tool consists of 4 steps:

1. The person's narrative. The story wakes empathy with the helper
2. Affect consciousness of the person.
3. Clarification of the meaning for the person.
4. The staff is collaborator, which means "a consistent co-creation of new realities through the free exchange of new ideas and views".

Empathic Communication is based on mentalization [3], narratology [4] theories of affect [5], affect consciousness [6], theory about health promotion [7], and positive and existential psychology [8].

Already in Brudal´s book [9] entitled, "The art to be a parent", she wrote about some empathic basic conditions. There must be awareness that everyone does not see the world as I do. That everything is not as it seems to be, that something may be different. "There may be tears behind a smiling facade". We must believe in the possibility to share mental pain. "Shared joy is double joy, shared pain is half pain". We should not correct a person´s values or check what the other person says, just listen and then maybe the person starts to listen to himself. Instead of discussing or correcting the other person, we should ask, "what thoughts and feeling do you have" "what does this mean to you"? We are interested in the thoughts, ideas and values of the other person. We see the other as a protagonist. It is the other's mental reality that is central. It is the other's values that must come forth and thus become clear to the helper.

Background

The development of empathy

Empathy is a further development of what is called the theory of mind or what is often referred to as mentalization, which means that one can imagine other persons' intentions, imaginations, goals, needs, feelings, desires etc., but also their own [10]. Furthermore, empathy means the ability to take the others' perspective, to feel, understand and also to differentiate between the feelings of one's own and the other. The ability to mentalize develops gradually from early age and at the age of four most children have developed this ability. Many have formulated empathy and one is Schafer who already in 1957 [11] stated that empathy is the inner experience of sharing and comprehending the momentary psychological state of another person. Another is Kohut, who expressed himself as follows: "Empathy is the capacity to think and feel oneself into the inner life of another person" [12].

To be understood is a basic need for human beings and it is in relation to others that we become emotional humans [13]. Because we develop in relationship to others we may also need support from another person for changing our inner life. The latest research in neuroscience confirms that human beings are born with the conditions for the development of mentalization and empathy. What has attracted great interest and enthusiasm among researchers in the last two decades is the discovery of mirror neurons [14,15] which seemed to be associated with mentalization. However, one is keen to emphasize the complexity of mentalization, that several areas of the brain are committed. For example, Happé and Frith [3] refers to 4 different areas of the social brain involved, "four major networks of the social brain are involved and that is, Amygdala, Mentalizing, Emotion and Mirror networks." We also know that congenital injuries, disabilities of various kinds, major emotional deficiencies in early relationship for example, deficiencies in emotional confirmation, changes between under and over stimulation, neglect and trauma during childbirth, hinder the development of empathy [16,17].

Empathy and attachment

Empathy development is also promoted by a trustworthy relationship and a secure emotional attachment [18]. All children attach to their caregiver, but depending on the quality of the emotional attachment, they develop different attachment pattern, secure pattern, insecure avoidance pattern, insecure ambivalent pattern, and disorganized pattern. Secure attachment pattern is characterized by trust where the child is looking for a caregiver as soon as the child feels insecure, experiencing anxiety or a threat, whereas in the disorganized attachment pattern, the relationship is characterized by fear and anxiety. The most devastating attachment pattern for empathy development is disorganized pattern, as when the child turns to the parent for help, a feeling of threat is evoked. Previously it was considered that the attachment pattern that a person developed during the first years could not be changed. Today, we do not have such a deterministic view. People who own the ability to reflect seem to be able to change their attachment patterns [19]. The attachment behavior and the need to attach is something we carry with us throughout our lives.

In 2002, there were three bombings in Bali, of which a suicide bomber detonated a bomb near a nightclub. In total, about 200 persons were killed, among them 6 Swedes. A group of Swedish young people on their way to Australia were there and witnessed the incident.

Instead of continuing their journey, many of them returned home to Sweden. At my clinic I met several of them and almost everyone said spontaneously "I could not get home soon enough". "I just had to go home and meet mom and dad but now I can go on travelling".

Empathy and mental development

What is relevant to mentalization and development of empathy is also the mental development [20]. Mental development can be described according to Stern's model [21] which is based on the following parts in self-development: 1) The emergent of self 0 - 2 months, 2) The core self 2 - 6 months, 3) The subjective self, 7 - 15 months, 4) The verbal self, 16 - 36 months and finally 5) The narrative self 3 1/2 years and beyond.

It is during the 3rd period that the child discovers that the other also has an inner life. That is the basis for intersubjectivity, as it makes it possible to share experiences and feelings which is the foundation of empathy. Stern emphasizes the importance of vitality affects for intersubjectivity [22]. These kind of affects are evoked largely by non-verbal emotional communication / expressions, and differ from what is called category affects such as joy, interest, surprise, disgust, distress, anger, sadness, fear and shame [5]. The vitality affects are of great importance during the early interaction of the mother-child interaction, but also in different forms of therapies.

Empathy and affect consciousness

Feelings are a motivating driving force which controls our behavior. Monsen [23] underlined the importance of affect consciousness for mental health. He proposes the following basic feelings; interest, eagerness, well-being/joy, fear/fear, anger/rage, shame/humiliation, sorrow/despair, sadness/jealousy, guilt and tenderness [24]. Experience of feelings and expressiveness are considered as the key psychological dimensions of what we call emotional consciousness (being able to identify, host, and communicate the feelings).

When our own emotional experiences come in the background and others' expectations and demands come to the fore, one can lose contact with their own feelings in, what Stern calls the subjective self. The social self dominates the subjective self and we lose the essence of ourselves, what Stern calls the core self [21]. This makes us feel empty.

The tool Empathic Communication illustrated by two cases

I have worked for more than 20 years as a clinical psychologist/psychotherapist in a pediatric department. Our goal was to provide the best possible care for children and their families, and we had organized a committed teamwork. The staff in general wants to do the best for the patients just as parents want for their children. However, for various reasons, this is sometimes not enough.

Already in the 1950s Sweden began, with the initiative of Ivonny Lindqvist [25], with play therapy in hospitals and preparing the children for medical examinations. The value of play therapy and preparing children for medical examinations and sampling was after 1950s spread throughout the country and became part of paediatric care. Our paediatric department was one of the first to introduce play therapy and preparations for sampling. Nevertheless, we encountered several children, who were traumatized from medical examinations and sampling at the hospital and even at our department which was not acceptable. We worked hard to prevent further traumatization and in the 1980's, we also started a project, which we called, an expanded model of play therapy [26], where we treated children traumatized in the hospital.

The below examples illustrate when Empathic Communication contributed to general development of the child care and one when a seriously ill boy was understood and could receive better care.

A medical examination that may be traumatic for children is intestinal biopsy. It is often done on an outpatient basis and you do not know the child very well. If you passed such an examination room at the child clinic you could sometimes hear how the child cried heartbreaking. Most of us can differentiate between when a child is crying heartbreaking and screaming with protest and anger.

At a morning meeting when most doctors at the clinic were gathered, I addressed the problem with intestinal biopsy examination. I suggested that maybe the doctors who performed intestinal biopsy themselves might undergo the examination in order to more easily find a way to carry out the examination more gentle.

Initially, there was a general jocosity in the group and no one was prepared to undergo intestinal biopsy. I continued to ask them to tell a little about how they looked at this problem and how they experienced such a medical examination, what they felt and which consequences it had for them. Soon, one doctor began to tell how difficult it was at first to do this kind of examination and how badly he felt afterwards. Another doctor said "when I got my own children I felt even worse". Several doctors followed and told about their "empathy pain" [1], how they felt, what consequences it had had for them on a personal level and how they had managed to deal with their feelings. They tried to think "The parents will be satisfied if I do this examination", "I just want to do something good ", I want to be a good doctor ", "children forget soon", "I think I have become emotionally a little detached", etcetera.

Then we had a serious discussion about the various abuses of children in care and what we could do to prevent them. We discussed the necessity of sampling in relation to the costs for the individual child. We agreed on that many of the examinations and sampling were not urgent, that you often have time to prepare the child more. We talked about the benefits of conducting examinations and sampling in collaboration with children and parents.

Through telling their stories, much of the doctors´ suppressed empathy was awakened. After our meeting, more examinations and sampling took place in collaboration with children and parents. More often the doctors reflected on the necessity of an examination or sampling and asked whether the sampling and examination are really necessary or is it just due to own insecurity. By reflecting on the costs of examination and sampling for the individual child as well as conducting examinations and sampling in collaboration with children and their parents, it was possible for medical doctors to maintain their empathy and to better cope with the empathy pain it means when you sometimes have to expose children to something that hurts and is very unpleasant.

The second case is about a boy 14 years old, who suffered from cystic fibrosis and was treated in the hospital. He was very ill and it was clear that he would not live long. He was very anxious and the staff perceived him as depressed which they assumed was due to the great fear of death. They found it difficult to talk to him about death and he was referred to me. I had met him before and had some knowledge of him and his family.

I asked him to tell me a bit about his situation, how it was for him just now and what he was feeling and thinking about. He had a lot to tell. He was thinking a great deal about the future, when he got too sick that he could no longer "defend himself" and of losing control over all sampling. Furthermore, he was afraid of what they intended to do with him and with his body. He told of all the occasions he had been held by staff for sampling. "That's probably why I so easily feel trapped and get panic feelings". "You have to promise that they do not put me on a respirator". He also explained that one of his biggest fears was to be left alone. I knew he had 3 smaller siblings and that he was often staying in the hospital without his parents. After talking for a long while about what had been, clarified the meaning for him, we started to talk about how he wanted it to be in the future. First, we decided that together we would talk to the staff and tell them what worried him and how he wanted it if or when he get worse. We also decided that he would write down how he wanted the situation to be. He furthermore said, "I know I cannot get home, but I want it to be like a home". "The door to my room should be open and the staff should be able to come and stay for a little while, drink some coffee and talk. They can come even when I am asleep and just sit there for a while".

The next day we had a very good talk with the staff and in a small notebook he wrote about how he wanted the future and he continued to write about "important things" in this notebook. It was decided to try to avoid intensive care. He began to feel better, became more open and active and seemed to have been reconciled with his situation. The staff felt more secure and they thereafter talked more easily to him and could give him better care.

This boy died a day in November but during the last weeks, when he was weak and bound to bed, his door remained open and coffee, juice and biscuits were placed on a table. Sometimes the staff went in and out, drank some coffee and talked with him for a while if he was able. If unable to talk, they just sat and held his hand, when his parents were not there.

This case shows that by listening to the boy´s story you could capture what really worried, frightened and even depressed him. He was understood and together, something could be done about it.

Empathic communication as an approach in the work of neonatal care

As a psychologist and psychotherapist with anchoring in theories of emotional and cognitive development, I believe in development and change in both children and adults with mental illness, with psychiatric problems and different disabilities. On many occasions I have seen children who have had a very bad start in life, with severe illnesses and despite poor prognosis have been cured and children with serious disability have developed more than expected.

I have had the privilege of following children's development from birth to adulthood and seen how a "competent child" has helped the mother to become a good enough mother and a "competent mother" managed to "seduce" a fragile, sick child to life. As one mother said about her little girl, who was born very premature, "we have given her the name Victoria, because we feel and think she goes from victory to victory".

Sometimes, I have also experienced that both mother and child have had limited resources for interaction and therefore need a lot of support to achieve an acceptable level of interaction, but also the opposite when the interaction between mother and child is like "an elegant and perfect dance".

In order to support an optimal mother – infant interactional development, one has to know the mother´s experiences, feelings, thoughts about herself and the baby and what that means for her and the interaction. One also has to know who the baby is, how the baby feel and what does that mean for the interaction. The obstacles for interaction must be identified, but also the resources and more often than not there are great openings for development.

You can draw parallels with Empathic Communication that also focuses on who the person is, affect consciousness, clarification of the meaning. what the obstacles and the resources are for development and change.

Discussion

The aim with this article was to describe a tool of empathic communication, its background and usefulness in paediatric care.

Medical care today has made major medical achievements. This is welcome development but at the same time staff increasingly talks of major problems and difficulties in health care. Within the healthcare in Sweden following problems are expressed: lack of resources (mostly time), lack of job satisfaction, an increased sick leave and difficulties in recruiting young people to care professions etc. The list can be made much longer.

The development of medical technology has created increasing distance from the human, the person behind the disease. This means that we cannot always practice the care and treatment intended and wished for. Staff who have worked for a long time in health care has increasingly begun to reflect on, what has been lost, what has gone wrong in the health care and where we are heading.

There is little discussion about the importance of good quality in care or what should be included to ascertain good quality of care for the individual patient. What is sometimes talked about is how to respond to the patient, how to give the patient adequate and enough information, which is something different from meeting the patient "where the patient is". Sometimes this is formulated as a compliance problem; patients do not do as professionals say.

For about 400 years BC, Hippocrates formulated 4 theses regarding medical art [27]. One was about the importance of knowing the person behind the disease. There might be a reason "to dust off this thesis" and give it increased topicality. Furthermore, current research shows that the quality of a meeting between therapist and the patient may be crucial to the outcome of the medical treatment and absolutely crucial for psychotherapeutic treatment [28].

The two cases described above showed that by using the tool Empathic Communication in paediatric care you increased the quality of care. In turn this may have an impact on both diagnosis and treatment. Many of us who chose to work in health care for children did it because we were interested in children and their parents and we wanted to work on something that felt meaningful. Because health care today is less holistic, and distant from the human person, we need to create conditions which make it possible for understanding the person´s experiences, feelings needs and what that mean to them. By the use of Empathic Communication these conditions can be improved. To work with Empathic Communication also leads to an opportunity to develop oneself on a personal level. The work offers self-observation and reflection [2], which benefits both work and private life. By referring to our own feelings, we learn the way to work with Empathic Communication on a more solid and well-integrated level. Empathic Communication should not only be a tool or model but an approach in the meeting of the children and the parents in paediatric care as described above in the work of the neonate department.

As far as I know there are no studies about this tool of empathic communication besides Moe´s et al. study, which showed that nurses benefited from using the tool Empathic Communication in the meeting of parents of a sick child [29]. More studies are thus warranted.

Conclusion

In conclusion, one can say that by using the tool Empathic Communication you may increase the quality of care, develop us as helpers, reduce feelings of inadequacy and awaken the staff´s sense of meaningfulness at work.

Bibliography

1. Brudal Holter L. "Empatisk Kommunikasjon". Gyldendal Akademisk (2014).
2. Brudal Holter L. "Empathic Communication". The Missing Link. Createspace (2015).
3. Happé F and Frith U. "Annual research review: Towards a developmental neuroscience of atypical social cognition". *Journal of Child Psychology and Psychiatry* 55.6 (2014): 553-577.
4. Bruner J. "The narrative construction of reality". *Critical Inquiry* 18.1 (1991): 1-21.
5. Tomkins SS. "Affect theory. Approaches to emotion" (1984): 163, 195.
6. Monsen JT. "Vitalitet, psykiske forstyrrelser psykoterapi: Utdrag fra klinisk psykologi Tano Forlag" (1990).
7. Antonovsky A. "The salutogenic model as a theory to guide health promotion". *Health Promotion International* 11.1 (1996): 11-18.
8. Brudal L. "Positiv Psykologi". Fagbokforlaget (2006).
9. Brudal L. "Kunsten å være foreldre". Fagbokforlaget (2003).
10. Fonagy P. "Attachment and theory of mind: Overlapping constructs?". Association for Child Psychology and Psychiatry Occasional Papers 14 (1997): 31-40.
11. Schafer R. "Generative empathy in the treatment situation". *The Psychoanalytic Quarterly* 28 (1959): 342-373.
12. Kohut H. "On Empathy 1". *International Journal of Psychoanalytic Self Psychology* 5.2 (2010): 122-131.
13. Schore AN. "Affect regulation and the origin of the self: The neurobiology of emotional development". Routledge (1994).

14. Fabbri-Destro M and Rizzolatti G. "Mirror neurons and mirror systems in monkeys and humans". *Physiology* 23.3 (2008): 171-179.

15. Gallese V. "The 'shared manifold' hypothesis. From mirror neurons to empathy". *Journal of Consciousness Studies* 8.5-6 (2001): 33-50.

16. Stolorow RD. "Trauma and human existence: Autobiographical, psychoanalytic, and philosophical reflections". Taylor and Francis (2011).

17. Sroufe LA. "Attachment and development: A prospective, longitudinal study from birth to adulthood". *Attachment and Human Development* 7.4 (2005): 349-367.

18. Ainsworth MDS., *et al*. "Patterns of attachment: A psychological study of the strange situation". Psychology Press (2015).

19. Main M., *et al*. "Predictability of attachment behavior and representational processes at 1, 6, and 19 years of age". *Attachment from Infancy to Adulthood: The Major Longitudinal Studies* (2005): 245-304.

20. Fonagy P., *et al*. "Jurist, and Mary Target. Affect Regulation, Mentalization, and the Development of the Self" (2004).

21. Stern DN. "The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology". New York (Basic Books) (1985).

22. Stern DN. "Forms of vitality: Exploring dynamic experience in psychology, the arts, psychotherapy, and development". Oxford University Press (2010).

23. Monsen JT. "Vitalitet, psykiske forstyrrelser og psykoterapi: Utdrag fra klinisk psykologi". Tano Forlag (1990).

24. Monsen JT and Monsen K. "Affects and Affect Consciousness: A Psychotherapy Model Integrating Silvan Tomkins's Affect-and Script Theory Within". *Progress in Self Psychology* 15 (1999): 287-306.

25. Lindquist I. "Therapy through play". Arlington Books (1977).

26. Lundqvist Persson., *et al*. "Behandling av barn med spruträdsla". En utvidgad form av lekterapi. Report (1992).

27. Pinault JR. "Hippocratic lives and legends". Brill volume 4 (1992).

28. Falkenström F., *et al*. "Working alliance predicts psychotherapy outcome even while controlling for prior symptom improvement". *Psychotherapy Research* 24.2 (2014): 146-159.

29. Moe K., *et al*. "Encountering parents of a sick newborn child". Sykepleien Forskning (2017).

Volume 6 Issue 1 October 2017