20 Eliciting Emotions
Empathic Communication

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> Clinical empathy is universally lauded. This interpersonal skill is an acknowledged essential component of professional competence. Patients desire it. Physicians who are empathic are more satisfied and have less burnout. Sincere empathy is recognised as a major constituent in the practice styles of excellent 'healing' clinicians. However, despite all these attributes, empathy in medicine may be hard to find.
>
> Schattner 2012: 287

Abstract: Patients' emotions are seldom revealed on their own initiative, but often have to be laboriously "elicited" by the doctor in empathic communication. When in a further, now third step of the manual the patient's emotions are brought into the focus of the conversation (§ 20.1), this is by no means intended to suggest an order or even a ranking. Rather, according to the motto: "Emotions have priority!", the emotional topics are to be taken up and further dealt with where they are "offered" verbally or non-verbally by the patients in the conversation, even if their *cues* are only given indirectly.

The deficits in empathic competence must be identified in an inventory (§ 20.2), as they are to be deplored both for medical interview practice and already in medical studies, despite an ideal self-image of the medical profession. Special didactic measures must be taken in the current study programme to counteract a decline in empathy, especially

among students in the higher semesters, who have to adjust to the challenges to their empathic competence as (future) doctors in good time during their training.

Before the verbal interventions for empathic communication can be differentiated on the manual and explained using anchor examples, definitions and concepts of empathy will be presented and discussed as they have developed first in psychotherapy and then in medicine (§ 20.3). In doing so, the three-part empathy concept, which distinguishes between cognitive, affective, and interactive aspects, is to be elaborated within a staged model of empathic communication. This model allows for the consideration of both paired sequences (adjacent utterances) and longer-term conversational developments. Finally, the barriers and limits of empathic communication must be taken into account, requiring a specific competence in matching responses to ensure that a "tension arc" between doctor and patient can be "established" but not "overstretched."

Depending on the doctor's fitting competence, *opportunities for empathic communication* can be misjudged or taken, but also given away again (§ 20.4). Just as the problem of relevance has already arisen in the medical consultation in general (§ 7, 17), the alternative forms of upgrading and downgrading the relevance of emotions are to be summarised in a *typology* of empathic (non-)responsiveness, which is to guide the empirical conversation analyses (§ 20.4.3). As is to be differentiated in detail in anchor examples, the patient's specifically emotional topic offers can be downgraded in the relevance negotiation because, for example, the doctor seeks to *minimise* or *normalise* the emotions or simply to *ignore them* by reacting with a change of topic (§ 20.4.4-5). In the case of relevance upgrades, the types of which we briefly compare with the well-known, internationally used NURSE scheme (§ 20.4.6), the specific *empathic* interventions come into play, which, following our manual, are first differentiated as *acknowledging* stress and coping as well as *offering* help and comfort (§ 20.5) and then as *naming*, *addressing*, *clarifying* and *interpreting* emotions (§ 20.6), and are each explained using anchor examples.

As empirical anchor examples, both (shorter, neighbouring) pair sequences between patient and doctor and longer passages of conversation will be considered, in which complex forms of *empathy-in-interaction* become effective, which can develop right at the beginning of the conversation (§ 20.7) or in the further course of the conversation (§ 20.8). In a final example of a conversation (§ 20.9), various aspects of

empathic communication in *cooperative* storytelling will be considered, in which the promotion of an *associative* narrative flow is particularly important. The appropriate interactive implementation of the *association rule* (in the sense of Freud's *basic rule communication*) (§ 9.3) is a very first prerequisite for a *helping* conversation in which the patient's emotive-narrative (self-)exploration can succeed.

20.1 Manual: Step 3: Eliciting emotions

After the first personal relationship with the patient has been established (§ 18) and the main concerns and complaints are sufficiently known (§ 19), the associated emotions should be brought more into the focus of the conversation, if this has not already been done in advance. Emotions are usually already linked to the patients' narratives, in which the patients' personal perspectives of experience with their fears, hopes, wishes, etc. are more or less manifestly expressed.

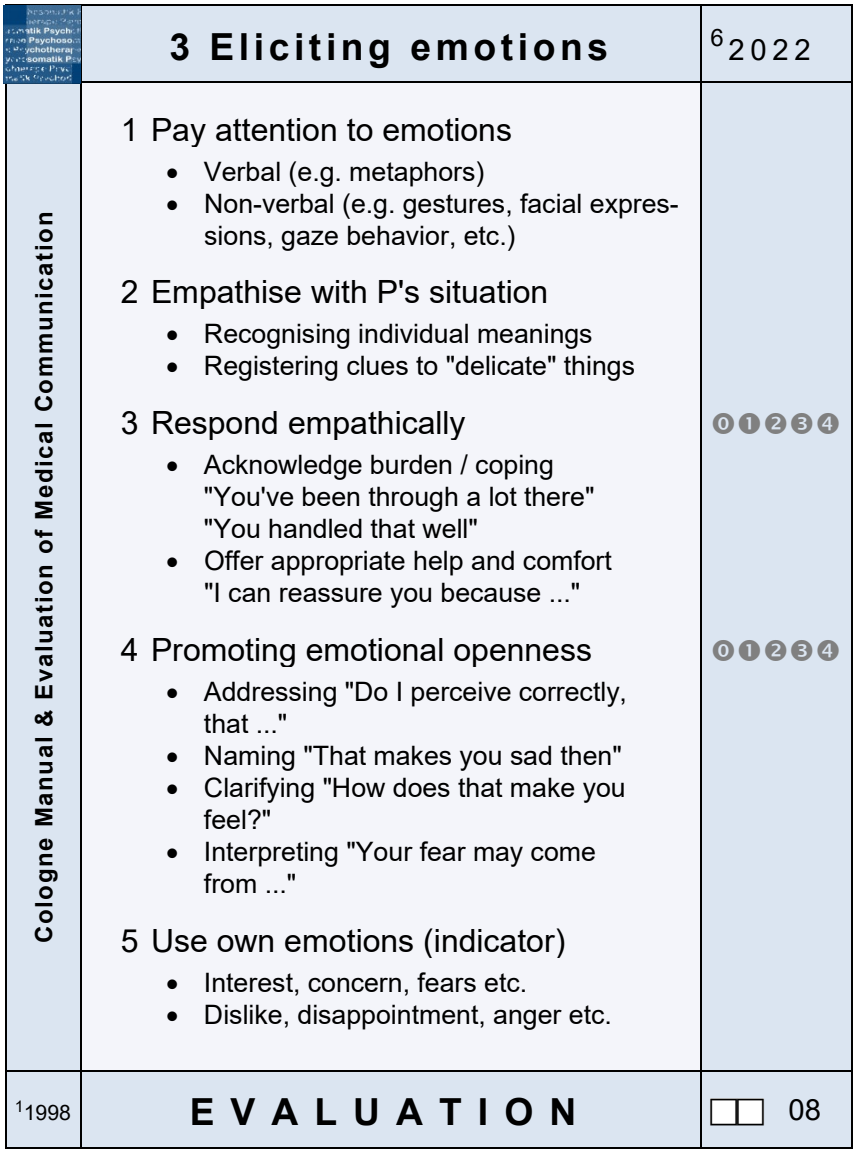
While some patients are able to bring their emotions into the conversation on their own initiative, other patients require certain "extra" invitations from the doctor, who must encourage his patients to engage in emotional self-exploration, and repeat this if necessary, before they can open up emotionally. In the third step of our manual, we will differentiate the typical interventions and illustrate them with exemplary anchor examples, in which the patients' emotions are not only passively "allowed" but actively "*elicited*" through the appropriate medical conversation.

Especially with regard to the emotions, a *flexible application* of the manual is required, as has already been justified in general for the *art of medical conversation* (§ 17). If the emotional opening of the patient is a focal point in the third step of the manual, this is by no means intended to establish an order. Rather, the super maxim is: "Emotions have priority!" Since emotions are a "fleeting" phenomenon, they must be "called up" and "processed" where they arise in the conversation, i.e. also become "visible" or "audible" to the doctor. Thus, it happens that patients "give free rein" to their feelings right at the beginning of the conversation, which from the doctor's point of view should not be "stopped", but "listened to" at least as seriously as physical complaints. The boundaries between "having pain" and "suffering pain" are in any case fluid when communicating "complaints about pain", especially

when the pain interferes with daily life (family, household, job, hobby, sleep, etc.). Accordingly, medical questions about the impairments in daily life, which we will deal with separately in step 4 of the manual (§ 21), can trigger the patients to express their corresponding feelings again or even for the first time.

As in the previous steps of the manual, in the third step we limit ourselves to observable interview behaviour (3.3-3.4), for which ideally a partial result of 8 points out of a total of 50 points of the evaluation form (C-EMC) can be achieved (see Fig. 20.6 and § 17.5). However, as we will see from the examples, there is always more going on in the conversation than is finally "brought up". Students and doctors know from their own experience that in conversations below the linguistic "surface" there can still be "subliminal" emotions that can be perceived as such by one or both participants, such as "suppressed anger". From a doctor's point of view, it is the patients who are "annoying", "frustrating", "irritating" or who are "stimulating", "delighting" or simply "sympathetic". As an example, let us recall the case analysis according to von Uexküll and Wesiack (2011) (§ 4), in which a patient initially appeared "unsympathetic" to the doctor, before a change in the doctor's attitude towards the patient took place as the conversation progressed.

Of course, processes of *transference* and *countertransference* take place continuously not only in psychotherapy, but also in the medical consultation (and elsewhere), which should not be brought up directly and certainly should not be acted out uncontrollably. However, the perceived emotions (of ego and alter) as part of what is happening can certainly serve the experienced doctor as indicators for *diagnosing the relationship* (§ 3). For self-awareness, we have therefore included the corresponding recommendations in the manual under points 3.1, 3.2, 3.5, which are also made a topic in examinations on the conduct of conversations (OSCE) (§ 13, 41).



3 Eliciting emotions — 6 2022

Cologne Manual & Evaluation of Medical Communication

1 Pay attention to emotions
- Verbal (e.g. metaphors)
- Non-verbal (e.g. gestures, facial expressions, gaze behavior, etc.)

2 Empathise with P's situation
- Recognising individual meanings
- Registering clues to "delicate" things

3 Respond empathically — 0 1 2 3 4
- Acknowledge burden / coping
  "You've been through a lot there"
  "You handled that well"
- Offer appropriate help and comfort
  "I can reassure you because ..."

4 Promoting emotional openness — 0 1 2 3 4
- Addressing "Do I perceive correctly, that ..."
- Naming "That makes you sad then"
- Clarifying "How does that make you feel?"
- Interpreting "Your fear may come from ..."

5 Use own emotions (indicator)
- Interest, concern, fears etc.
- Dislike, disappointment, anger etc.

1 1998 — **E V A L U A T I O N** — ☐☐ 08

Fig. 20.1: Excerpt (from: Manual & Evaluation): Step/Function 3: "Eliciting emotions" (The complete manual can be found at the end of the chapter, Fig. 20.6)

In this way, the atmosphere and mood in the conversation can be discussed between examiners, students and simulation patients (SP) in retrospect and alternating between self-observations and observations by others, and then joy, irritations, frustrations and suppressed anger can be brought up - the latter, for example, because the strongly demanding behaviour in the conversation, which was part of the role model of the SP, had probably also been played by the latter so authen-

tically that the empathy of the role-playing doctor was also considerably "strained".

Here, in an examination situation, what generally applies to later professional practice comes into play, namely that medical empathy towards "difficult" patients (§ 34) is particularly challenged. As we will see in detail in examples, patients can more or less accommodate their doctors in empathic communication.

20.2 Deficits of empathic competence

While the emotions of patients in psychotherapy are the excellent "reasons for consultation" that should be specifically brought to light, they are often seen as "disturbing factors" in medical consultations, which must be specifically avoided or suppressed if they are to be "brought up" against all odds. This "emotionally adverse" attitude to conversation does not only become established under the everyday stress of later professional medical practice, but is already adopted by students, in whom a decline in empathy can be observed even during their studies.

As has been widely documented in a long tradition of research, the deficits in medical empathy are already inherent in medical training and continue in professional practice, so that there, in turn, hardly any academic and medical teachers can be found as role models (Putnam et al. 1988, Butow et al. 2002, Hojat et al. 2004, 2009, Neumann et al. 2011, Seitz et al. 2017, Andersen et al. 2020, Childers et al. 2023). Apparently, the fixation on *biomedical* issues is so dominant in training and professional practice alike that empathic communication then remains rather a marginal phenomenon, which is at best considered in cases of particularly dramatic disease stress (such as in oncology, palliative medicine) (§ 16, 38). We begin with the presentation of the deficits in medical professional practice, from which the decline in empathy already in medical studies can also be explained.

20.2.1 Physician's defence against emotions

In everyday medical practice, the motto is often: "Diseases yes, emotions no!" According to the traditional biomedical understanding, taking an anamnesis often remains limited to further psychosocial "data" as mere

"facts" such as marital status, education, profession, etc. The change of attitude in interviewing associated with the paradigm shift to *biopsychosocial* medicine (§ 4) is still difficult for many doctors because they may remain focused on "purely" biomedically relevant patient offers due to traditional training.

The empathic handling of further patient offers that refer to patients' emotions is often perceived as a burden, as was already formulated early on by Zinn (1993): "empathy might seem like a burden for the busy clinician" (1993: 307). The patients' emotions, their worries, fears, sadness, hopes and anxieties associated with the disease, are just as little attributed to the original area of responsibility of medical action as the topics relevant to their lives (family, profession), insofar as the emotions associated with them (depression, aggression) can put a strain on the relationship with the doctor himself. Because emotions tend to be "delegated" by "referral" to a specialist for psychotherapy, they can apparently be warded off in one's own conversation practice for apparently "good reasons".

We were able to make such experiences regularly in the further training on *basic psychosomatic care* (§ 15), in which, especially at the beginning of the group participation, the group members repeatedly made spontaneous statements during the case discussions, which indicate a principled defensive attitude towards an "emotionalisation" of the medical consultation. Without claiming to be systematic, the following prototypical statements are listed here as examples (Box 20.1), which were spontaneously put forward in this or similar ways in numerous variants to justify a reductionist approach to the patient and dealing with his emotions in the case discussions.

Box 20.1 "Filtering out emotional issues"

1. First gather the facts, then address the emotional.
2. It's better to stay on the factual level, you're on safe ground there.
3. One is afraid to dig deeper with the patient. She wouldn’t be able to handle it, and neither would I.
4. Otherwise, you are stepping onto thin ice with the patient.
5. You have to filter out the emotional issues.
6. It's better to have both feet on the ground, everything else is often scary.

Koerfer et al. 2004: 244

These spontaneous, self-explorative statements of the group members on their own medical discussion practice illustrate first of all the spectrum of typical attitudes and their justifications for warding off emotions that trigger "fear" (3, 6) or at least "uncertainty" (2, 4) in the doctors concerned. Accordingly, if emotions cannot be *avoided* according to one's own preferences (2, 6), they should be *sorted out* again if possible (5) or given *lower priority* in a hierarchy of relevance (1). In view of the *risks* feared by doctors (2, 3, 4, 6), the few examples selected already make clear the difficulties of promoting an empathetic attitude to discussion in training and further training practice, with which emotions are not only *passively* accepted in the sense of toleration, but *actively elicited* from the patient and productively used in further discussion work for *diagnostic* and *therapeutic* purposes.

Such a more far-reaching objective, however, requires a change of attitude on the part of doctors, who apparently still try to justify their defence against emotions with a negative "cost-benefit balance", according to which giving in to patient feelings continues to be an incalculable risk. The mere orientation towards the ideal of a "good" doctor, who above all has empathic competence, is apparently not sufficient to overcome the prevailing attitudes in professional practice, which at best lead to compromise formations that guide action, as in the medical statement (1).

20.2.2 Ideal and practice of empathy

According to the ideal self-image of the medical profession, *empathic competence,* which will be described in detail according to term and concept (§ 20.3), is mostly attributed an outstanding function for medical action as a whole, also or especially in relation to other medical competences. This can be proven by content-analytical studies, which were based on interviews with academic professional representatives of various medical disciplines on the question "When is a doctor a good doctor" (§ 6). According to the content-analytical evaluation of the interviews, *empathic competence* ranks first, together with *professional competence,* far ahead of other competences or characteristics of a *good* doctor (*competence to act*, *reflexivity*, *cooperativeness*, *willingness to learn,* etc.) (Herzig et al. 2006). According to this, empathic competence is undoubtedly to be regarded as a *key competence* (§ 6) in medical practice.

Just as with the academic professional representatives, relatively uniform preference profiles initially emerge among patients as well as students and doctors, which point in the direction of an ideal of empathic communication, but whose implementation in practice leaves much to be desired. While empathic competence is generally prioritised, at the same time the barriers in training and conversation practice become clear, where empathy may even decline (Hojat et al. 2004, 2009, Pedersen 2010, Neumann et al. 2010, 2011, Derksen et al. 2015, 2016, Seitz et al. 2017, Andersen et al. 2020). As many intervention and evaluation studies show, teaching empathy as part of communicative competence remains a major challenge.

Already in an early intervention study, Putnam et al. (1988) convincingly report specific successes in improving the communication skills of the *residents* they trained. However, the authors then describe their difficulties in dealing with *emotions* in a communicative way (Box 20.2), which ultimately shows the limits of patient-centered medicine, because patients have to expect resistance from their doctors when disclosing their psychosocial problems.

Box 20.2 "Handling" emotionally charged issues

Most of the time, the residents expressed great discomfort at allowing patients to talk about their illness in their own words because they were afraid patients would bring up emotionally charged issues which they could not handle (...) it became clear that the real reason residents were reluctant to let patients reveal their psychosocial problems was that they felt that they should "do something" to solve them.

Putnam et al. 1988: 44f

As Putnam et al. (1988) further explain, the residents are under the misconception that the patients themselves expect them to provide a practical solution to the problems. In contrast, patients initially expect nothing more than an attentive listener, with whom, however, they can give free rein to their emotions without having to take into account the resilience of their medical interlocutor. Rather, doctors should not only be able to endure their patients' emotions "without resistance", but actively encourage their disclosure.

However, the problem of "handling" *emotionally charged* topics is not only encountered by novices, such as the residents in internal medicine here, but extends across all general and specialist medical fields to spe-

cialised care institutions where experts have many years of relevant professional experience, such as in oncological or palliative medicine fields. Particularly in these sensitive fields of action, specific competence in dealing with the emotions of patients in particular need of help is required (Buckman, Kason 1994, Kappauf 2001, Butow et al. 2002, Köhle et al. 2010, Philip, Kissane 2011, Köhle 2017, Obliers, Köhle 2017, Childers et al. 2023) (§ 16, 38). Despite these special requirements for an empathic physician, Butow et al. (2002) (Box 20.3) in their summary of the state of research as well as their own empirical studies on oncological care also state a considerable discrepancy in the communicative skills of physicians vis-à-vis different needs of patients to receive both *informative* and *emotional* support.

Box 20.3 Informative versus emotional support

In conclusion, this research supported earlier findings suggesting that oncologists may be effective in acknowledging and meeting the informational needs of their patients but are not recognising and/or dealing with emotional needs. If doctors do not recognise and acknowledge patients' cues for emotional support, patients will be discouraged from seeking that support during the consultation.

Butow et al. 2002: 56f.

This empirical imbalance in communicative competence regarding emotional needs, as opposed to informational needs of patients, is thus manifested not only in observable forms of medical communication behavior, where the corresponding patient *cues* are overlooked or ignored, but also results in a restrictive communicative behavior from the patients themselves. These patients, discouraged by their doctors, retract their need for emotional support.

As a result of the reciprocal "conditioning" (§ 9), in which the patients still learn in the ongoing conversation that emotions are not "announced", an institutionalisation of a communication with *little emotion* is to be expected. Apparently, from the doctor's point of view, the *ideal patient* turns out to be an "emotionless" patient who, in the above sense of Zinn (1993), spares the "busy" doctor from further impositions and burdens. Thus, the competent handling of patients' emotions seems to be the most difficult hurdle in the training and further education of medical conversation management, which is often not overcome in con-

versation practice - even if the ideal self-image of the medical profession speaks a different language.

The discrepancies between ideal and practice are also experienced in this way by the doctors acting. Neumann et al. (2010) quote an internist who, from his point of view, sums up the dilemma in a simple denominator: "Lack of time and stress are the worst empathy killers" (2010: 334). Despite all the priority in the ideal self-image of the actors, empathy is apparently at the same time the first "victim" when the "real" priorities have to be set under practical pressure. Medical students apparently set a similar relevance when a decline in empathy is observed in them during their studies, which apparently takes place in anticipation of their later professional practice.

20.2.3 Decline of empathy in studies

While the barriers to empathic communication in professional practice can still be explained by the pressure to act and the time pressure under which doctors, in case of doubt, decide to reduce themselves to biomedically oriented conversation, the decline in empathy already during studies may at first seem surprising, especially since students generally begin their studies with great *enthusiasm* and *idealism.*

Nevertheless, a change in attitude soon occurs in the course of studies, in which the *decline in empathy* is also seen in connection with the *increase in cynicism* (Hojat et al. 2004, 2009, Neumann et al. 2011, Seitz et. al. 2017, Andersen 2020). Many reasons are cited for this regrettable regression. In addition to the general reasons already given for later professional practice (stress, time pressure), Seitz et al. (2017) (Box 20.4) cite above all the lack of role models in training practice, in which teachers may teach empathy but hardly practice it themselves.

Box 20.4	Decline of empathy due to lack of role models

It is interesting to note that students indicated that teachers are the strongest advocates of empathic behaviour towards patients, but rarely show it themselves from the students' perspective. According to students, doctors are the least likely to advocate empathic behaviour and rarely demonstrate it. In addition, most students are not oriented towards doctors when it comes to empathic behaviour, but towards psychosocial professional groups. According to the authors, this is a serious problem,

since doctors and teachers have or should have a role model for the students (...) In order to improve the training of empathic conversation among students, psychosocial professions such as psychotherapists could be integrated.
The lack of integration of these and the negative or missing role modeling by doctors and teachers is a possible cause for the fact that there is a decline in the intention to show empathy in the course of studies.

Seitz et al. 2017: 29

From the students' point of view, the well-known dilemma that theory and practice can diverge widely is experienced here in the course of their studies. Apparently, the students orient themselves on the perceived conversational practice of their teachers, to which they still adapt during their studies. Thus, with their decline in empathy, they anticipate a conversational attitude that the residents mentioned above (Box 20.2) or the seasoned practitioners from our Cologne training groups (Box 20.1) have long since elevated to common conversational practice in everyday professional life - so that these practitioners would have already lost their role model function there if the students completed part of their practical training with them.

It remains to be seen to what extent the missing role model function of academic and medical teachers could be compensated for by the integration of psychosocial professional groups such as psychotherapists in practice, as proposed by Seitz et al. (2017). In the *Cologne Curriculum Communication* (§ 14), the so-called *psych subjects* are already heavily involved and therefore largely utilised, especially because the experienced clinicians, most of whom have psychotherapeutic training, are already continuously employed in teaching. Recourse to external "resources" would certainly have to overcome organisational and financial hurdles.

Here, the practical suggestion could be discussed that the students participate more in the care practice of psychotherapists, as it were, as hospitants: "This could lead, on the one hand, to a higher level of security and an increase in the feeling of competence and, on the other hand, to a relief of the student and a better understanding of one's own feelings and thus better processing competence" (Seitz et al. 2017: 30). To increase the feeling of competence and improve the relieving self-perception, it would also make sense to participate in (junior) Balint groups, in which one's own strengths and weaknesses could be critically compared with those of the other group members in self-observation

and observation of others. In our clinic in Cologne (for psychosomatics), *Balint group* and *small group work,* which is also proposed by Hojat et al. (2009) as a measure against the threatening "erosion of empathy in medical school", is already an integral part of training and further education.

In addition to the inadequate role model function, stress, interference from third parties, time pressure, etc. are also named as factors for the decline in empathy during studies (Neumann et al. 2011, Seitz et al. 2017). However, it will be just as difficult to remedy this directly during studies as it will be in later professional practice, where stress and time pressure are more likely to increase. Nevertheless, initial or further learning situations could be created in current education and training practice as "free spaces" for empathic *trial action* without sanctions, for example in communication with *simulation patients* (SP) (§ 13, 41). Although the SPs can largely react authentically qua training, they are nevertheless less "sensitive" to "mishaps" and "failures" of empathic communication than real patients, who could also always be "damaged" by a "failed" communication. In this respect, patient cases can be designed and trained with SP in such a way that special challenges can be posed to empathic competence without the students necessarily having to "master" them, whereby the more or less successful trial actions are to be evaluated in subsequent reflective case discussions together with the experienced clinicians.

20.2.4 Challenges of empathic competence

Overall, simulation patients are used in many ways in the *Cologne Curriculum Communication* (§ 14), not only in examinations but also in teaching, in which precisely the aforementioned scope for *trial action* without sanctions is to be created. For example, in the preparatory course for the *practical year,* exercises in conversation management are also offered, in which the students are confronted with patients (SP) who suffer from *mental comorbidity* (anxiety disorder, depression, etc.). In the process, problems of communicative handling of patients' emotions arise again and again, which is also repeatedly made a topic in the regular case discussions. Characteristic are, for example, the following statements (Box 20.5) made by students who had to hold conversations with a patient (SP) with *diabetes* (as an underlying disease) and a *depressive comorbidity.*

Box 20.5 Statements on dealing with depression

1. I have often noticed an "annoyance"/dislike among fellow students towards the depressed patient.
2. As a budding doctor, one always wants to get one's patients well as quickly as possible, indeed, preferably do something immediately. Unfortunately, there is no such treatment option for depression. Even medicines developed for depression take several weeks to have an effect, as do talk therapies and other psychotherapies.
3. As a doctor, I find this extremely unsatisfactory. For me, they are very "stressful" patients who nevertheless have to be taken seriously. Personally, however, I would always ask someone from psychosomatics to do this, as I am the wrong contact person myself.

Neumann, Obliers, Albus 2012: 66

These statements by students in the 10th semester tend to be similar to the problems and reservations already expressed by the *residents* in the intervention study by Putnam et al. (1988) (Box 20.2). All three statements of the students show how "exhausting" to "annoying" the handling of depressive patients is experienced, which in some way trigger *helplessness* or at least, as in statement (3), "dissatisfaction" in the trainee doctors. In statement (2), the need for immediate action is directly expressed ("preferably do something immediately"), which was already the core problem of the aforementioned residents (Box 20.2: "they felt that they 'should do something'"). Because the students do not feel up to the demands they have imposed on themselves, they follow the already described tendency of practising doctors to "delegate" patients with "difficult" emotions (Buckman, Kason 1994, Philip, Kissane 2011) to the specialists because, as in statement (3), one believes to be "the wrong contact person" for their problems.

Thus, patients with "difficult" emotions are often classified at the same time as "difficult" patients (§ 34) whose treatment should be "refused" for reasons of excessive demands. Here, too, a parallel to the described tendency of a *decrease in empathy* with a simultaneous *increase in cynicism* can be observed among the students. In a separate study, from which the above statements of the students originate, a tendency towards *social distance* towards mentally ill patients was also determined (Box 20.6), which was more pronounced at the end of the study

(10th semester) than in the comparison group at the beginning of the study.

Box 20.6 Changing attitudes towards mental illness

While the students' attitudes prove to be independent of the personality traits, significant differences between the two groups emerge, indicating that the distance towards mentally ill patients in the medical role and the uncertainty with regard to the causes of mental disorders are more pronounced at the end of the studies than at the beginning. These findings underline the need to better prepare medical students for dealing with mentally ill patients.

Neumann, Obliers, Albus 2012: 66

In order to be able to make these problems in dealing with mental illnesses sensually tangible and conscious in patient contact in the first place, the patient cases with SPs, which were based on real medical histories, had been constructed accordingly "emotionally" and the SPs had been trained that *mental comorbidity* ("anxiety", "depression") was part of the illness and role model.

In these teaching/learning units, *cognitive*, *affective* and *communicative* learning goals were pursued, in which a connection is also made between an *underlying disease* (e.g. diabetes) and a *psychological comorbidity* (depression). In this context, teaching can also tie in with the need for quick "curative" successes, which is not only widespread among students, as articulated in the statement above (2): "As a budding doctor, you always want to make your patients well again as quickly as possible" (Box 20.5). This problem does not only exist for the treatment of depression, but also for diabetes as an underlying disease, where the future general practitioner or internist is constantly confronted with questions as to why exactly this or that diabetes patient cannot be satisfactorily "adjusted" despite all the explanatory talks.

Although students in the 10th semester, who still indiscriminately seek quick "curative" success (Box 20.5), should have rudimentary prior knowledge of a possible connection between a "poorly controlled" diabetes patient and his or her depression, they should be able to combine this perhaps abstractly existing *knowledge* in the patient conversation (SP) with the sensory *experience* that patients who suffer severely from depressive symptoms often lack the necessary "self-care in matters of diabetes", etc. Such an *empathic understanding* of the doctor towards

the *depressed* diabetes patient could at the same time promote understanding for the *non-adherence* that is to be deplored, which could lead to a modified treatment concept for the underlying disease (diabetes) in *joint decision-making* (§10), etc.

Thus, in the course of such a teaching unit, it should be conveyed in a sufficiently sustainable manner that a *psychological comorbidity* must first of all be recognised in the anamnesis interview through appropriate exploration, which requires a special *empathic competence* towards the *depressed* or *anxiety-disturbed* patient, before, if necessary, a co-treatment of the comorbidity is started, if this is possible and sensible, for example, within the framework of *basic psychosomatic care* (§ 15). In particularly severe cases, however, which must first be recognised as such, further treatment by the "specialist" (*psychotherapist*) can then also be initiated. However the decision is made together with the patient, the treatment of the *underlying disease* diabetes may only be successful if the depression is also treated as a *comorbidity.*

The general learning objective at the end of such a learning unit should be that empathic competence means more than just passively showing tolerance towards patients' emotions. Rather, the patient's emotions should be actively addressed and taken up as challenges of empathic competence and finally worked on together so that they can be used productively in the diagnostic-therapeutic circle to the advantage of both interlocutors in a *win-win situation* (§ 10). The *rehearsal* with SP (§ 13, 41) also allows for "failures" of empathic communication, the simulation of which, as an anticipation of the risks, helps to better assess the later handling of emotions in real conversation practice.

Even if orientation towards more or less perfect *role models* is generally considered the ideal way, the specific possibilities of learning from the *negative model* should also be used (Koerfer et al. 1996, 1999, 2008) (§ 13). Thus, it is possible to *learn from mistakes* if they can be recognised as such and reflected upon in comparison with the better alternatives. As will become clear in the following *comparative* conversation analyses (§ 20.4ff), many "failures" of empathic communication must be expected in medical conversation practice, with which the differences to the so-called *best practice examples* (§ 13) can be worked out in contrast.

In order to gain a critical evaluation perspective for the later empirical conversation analyses, definitions, concepts and models of empathic communication will be discussed beforehand, as they were first developed in psychotherapy and then in medicine. Barriers and limits to em-

pathy will also have to be taken into account, which go beyond organisational problems (pressure to act, time and costs, etc.) and affect the therapeutic design of the doctor-patient relationship itself.

20.3 Definitions and concepts of empathy

The term *empathy* originated more than a hundred years ago and goes back to a translation of the word *insight* (i.e. feeling into) in the English-speaking world. From there, the term has not only been retranslated into German as "empathy", but has found a general, cross-cultural and cross-linguistic spread in everyday and scientific language (Black 2004, Breithaupt 2017). This long tradition is referred to again and again when different ways of using empathy in different (philosophical-hermeneutical, ethical, sociological or medical-therapeutic) disciplines are described in a basic understanding of empathy (Miller 1989, Coulehan et al. 2001, Mercer, Reynolds 2002, Black 2004, Pedersen 2008, 2009, Neumann et al. 2009, 2010, Derksen et al. 2013, Mayer 2013, Breithaupt 2017, Frankel 2017, Hall, Schwartz 2019, Rodat 2020, Guidi, Traversa 2021, Hall et al. 2021, Childers et al. 2023, Arshad et al. 2024, Tustonja et al. 2024). According to this, a basic understanding of empathy can still be adhered to, which is described as "*empathic understanding*", but in addition, certain *cognitive*, *affective* and *interactive* components of empathy are differentiated, the function of which is focused on with varying weight depending on the context.

Empathy is a *ubiquitous* phenomenon that can play a prominent role in everyday and many institutional contexts (Fiehler 1990, 2005, Peräkylä, Sorjonen (eds.) 2012, Breyer (ed.) 2013, Pfänder, Gülich 2013). What is true in everyday life or in other institutions is especially true for doctor-patient communication: Because of the often existential importance for patients, a particularly empathic understanding of therapists and doctors is indicated there. Accordingly, certain general concepts of empathy, such as those critically discussed in the context of a *Theory of Mind* (ToM) (Dullstein 2013, Breithaupt 2017), need to be specified for the empirical analysis of empathic communication between doctor and patient, as described by terms such as "mind reading", "shared mind", "meeting of minds" or "sharing emotions" (Branch, Malik 1993, Stivers, Heritage 2001/2013, Epstein, Street 2011, Epstein, Beach 2023). What in doctor-patient communication should finally lead

to shared decision making between the interlocutors requires shared knowledge about life problems (family, profession) and personal attitudes and emotions (hopes, wishes, fears, etc.) of patients, whose individual preferences must be taken into account in decision making (§ 10, 22, 26). From this aspect of patient participation alone, the empathic understanding of the other-psychic constitutes an essential function of medical action, in which the professional helpers have to adjust to the individuality of the patients and their more or less manifest emotions again and again with a high degree of *fitting accuracy* (§ 3, 17, 20.2.4).

20.3.1 Empathy in psychotherapy and medicine

The professional art of being able to "read thoughts and feelings" and "help to verbalise them" has a long tradition, in which a variety of theoretical and empirical studies on the forms and functions of empathic communication have emerged. The role of empathy was first recognised in psychotherapy before it became a topic in medical communication as well (Rogers 1942/1985, Miller 1989, Squier 1990, Zinn 1993, Finke 1994, Wellendorf 1999, Coulehan et al. 2001, Black 2004, Pedersen 2009, Lelorain et al. 2012, Neumann et al. 2009, 2012, Derksen et al. 2013, 2015, Sulzer et al. 2016, Childers et al. 2023, Zhang et al. 2023, Arshad et al. 2024). The therapeutic function of empathy has already been highlighted by Carl Rogers as one of three essential conditions for the development of a therapeutic relationship (Box 20.7). In addition to the therapist's congruence ("agreement with oneself") and *acceptance,* which requires unconditional *appreciation* and *positive attention* towards the patient, *empathy* ("empathetic understanding") is identified as the "second essential condition" for a "growth-promoting relationship".

Box 20.7	Empathy (empathetic understanding)

The second essential condition of the therapeutic relationship, in my view, is that the therapist develops a precise empathic understanding of the client's personal world and is therefore able to communicate some of the essentials of the fragments of what is thus understood. To feel the client's inner world with its very personal meanings as if it were one's own (but without losing the quality of 'as if'), that is empathy and that seems to me to be the essence of a growth-promoting relationship (...)

> When the world of the client has become clear to the therapist and he can move freely in it, then it is possible for him to convey his understanding to the client of what he is only vaguely aware of and he can also address meaning in the patient's experience of which he is hardly aware. This highly sensitive empathy is important to enable a person to come close to himself, to learn, to change and to develop.
>
> Rogers 1962/1990: 216

Rogers' concept of empathy already includes *cognitive* ("understanding") as well as *affective* ("empathising", "feeling") and finally *actional ("*communicating") aspects. Since in the cognitive and affective aspects of empathy, an *as-if attitude* must be maintained, according to which the therapist can only put himself into the "inner world of the client" in the subjunctive ("as if it were his own"), he must choose a correspondingly moderate mode of communication, especially if he wants to "address meaning in the patient's experience", "of which the patient is hardly aware". This form of communication has been described by Rogers as the *non-directive* method of conducting a conversation, in distinction from a *directive way* of conducting a conversation, which is characterised, for example, by more parts of speech and specific questions, with which the course of the conversation is more strongly directed.

It is a historical merit of Rogers (1942/1985) to have investigated the difference in conversational methods at an early stage on the empirical basis of tape recordings (Koerfer et al. 1996, 2010) (§ 19.3, 40). From today's perspective, the *non-direct conversational* method is characterised above all by forms of *active listening* (§ 19) and *empathic feedback,* which will be differentiated in detail below using empirical examples. However, forms of relevance downgrading of patient emotions will also have to be taken into account, which already indicate a lack of empathic competence on the part of doctors at the level of mere listening, where the cognitive and affective prerequisites for appropriate empathic interaction with the patient are already lacking.

The triad of *cognitive*, *affective* and *interactive* aspects of empathy has become established not only in psychotherapy but now also in medicine (Coulehan et al. 2001, Mercer, Reynolds 2002, Mercer et al. 2004, Derksen et al. 2013, Neumann et al. 2009, 2010, 2012, Sulzer et al. 2016, Guidi, Traversa 2021). In their recommendations on empathic communication, Coulehan et al. (2001) also assume a tripartite concept of empathy (Box 20.8), which furthermore already addresses the possible patient reactions to an empathic intervention by the physician.

Box 20.8 Cognitive, emotional and actional focus of empathy

The concept of empathy has three important implications.
First, empathy has a cognitive focus. The clinician "enters into" the perspective and experience of the other person by using verbal and nonverbal cues, but she neither loses her own perspective nor collapses clinical distance.
Second, empathy also has an affective or emotional focus. The clinician's ability to put herself in the patient's place - or walk a mile in his moccasins - requires the experience of surrogate or "resonant" feelings (...).
Finally, the definition requires that clinical empathy have an action component. One cannot know without feedback. The practitioner communicates understanding by checking back with the patient, using, for example, statements such as "Let me see if I have this right" or "I want to be sure I understand what you mean.
This gives the patient opportunities to correct or modulate the physician's formulation. At the same time it expresses the physician's desire to listen deeply, thereby reinforcing a bond or connection between clinician and patient.

Coulehan et al. 2001: 221

Following directly from the tripartite empathy concept, possible continuations of the conversation are discussed here, in which the therapeutic relationship can develop further. However, this further development is already based on a possible reaction of the patient, who could also react to the empathic response of the doctor with a modification or even negation, to which the doctor would in turn have to adjust again cognitively, affectively and interactively in a readjustment. In this way, *repetitive patterns of action* emerge, in which the action of one partner is also to be examined as a reaction to the action of the other partner. While the tripartite division of empathy into *cognitive*, *affective* and *actional* (or behavioural) components has also become widespread in medicine, theoretical concepts and empirical analyses of empathic communication often remain limited to activities in pair sequences. In this context, the focus is mostly on individual empathic doctor utterances as a reaction to a patient utterance, without sufficiently taking into account the interactive pre- and post-history, which should be examined with an expanded concept of verbal and non-verbal conditioning of utterance sequences (§ 9, 19). For the empirical conversation analyses, a stage mod-

el of empathic communication will be presented below, with which (longer) *interaction histories* between doctor and patient can also be taken into account.

20.3.2 Stage model of empathic communication

The long-term interactive processes of verbal and non-verbal exchange between doctor and patient remain mostly underexposed in theory and practice. Here, too, psychotherapy research, with recourse to conversation analysis (§ 2), has provided important impulses for the analysis of an *emotion/empathy-in-interaction* that often extends over a larger conversation development (Leudar et al. 2008, Heritage, Lindström 2012, Voutilainen 2012, Peräkylä 2012, Lindemann 2012, 2015, Weiste, Peräkylä 2014, Buchholz, Kächele 2016, 2017, Buchholz et al. 2016, Buchholz 2014, 2017, Peräkylä 2019, Buchholz 2022, Scarvaglieri et al. (eds.) (2022). For example, Buchholz et al. (2016) describe specific *repair activities* of the therapist that can extend over several conversational turns after the cooperation between the participants and thus the therapeutic relationship initially appeared to be at risk. Likewise, Peräkylä (2012) analyses a longer history of interaction between therapist and patient (§ 21.3.4), which begins with a therapeutic intervention in the sense of classical "interpretation", which initially seems to be placed "abruptly", i.e. abruptly, before both interlocutors gradually negotiate further possibilities of meaning, which they even take up again in follow-up conversations and further differentiate.

In order to mark the larger focus of the analysis of *empathy-in-interaction*, a recourse to an already early developed stage model by Miller (1989) on *therapeutic-empathic communication* seems suitable to us, which will be adopted and expanded here in its basic features. In doing so, his *five-stage model* will first be reproduced in Miller's words (Box. 20.9) and presented in a modified diagram (Fig. 20.2), which is to be extended at least by the patient's reaction, to which the therapist/doctor can in turn react, etc.

Box 20.9 Therapeutic empathic communication process model (TEC)

The five-stage model proceeds as follows:

1. The patient sends both verbal and non-verbal cues regarding his or her own inner experience.
2. The therapist receives the cues that have been sent by the patient.
3. The therapist processes the communication that includes:
   (a) becoming immersed in the patient's experience;
   (b) processing cognitions on multiple tracks as participant observer, transference figure, external observer, and therapeutic ally;
   (c) integrating this information with previous knowledge of the patient, the therapist's experience, and knowledge of the patient's defences, resistances, and potential.
4. The therapist sends a response to the patient that is partially accurate and is conveyed both verbally and nonverbally.
5. The patient receives the empathic message from the therapist and accepts the resulting feeling state.

In this model, *empathy alone* can be understood as the experiencing another's inner state and as such is complete at the end of the third stage. *Empathic responsiveness* is complete at the end of the fourth stage. However, *empathic communication* is only completed at the end of the fifth stage.

Miller 1989: 532

On the one hand, Miller's 5-stage model is very complex because it takes into account not only the knowledge already acquired and the shared experiences of both actors, but also possible *defensive processes* in the communication between them, which at least temporarily require a rather *tangential* conduct of the conversation before a change to more *confrontational* interventions becomes possible (§ 3, 17, 32). This is precisely why the model is incomplete on the other hand, because it does not sufficiently take into account the possible misunderstandings, corrections, modifications or even resistances of patients on the level of interaction, which the therapist or doctor in turn must have understood before reacting with another empathic intervention, which in turn results in a new patient reaction, etc.

In this way, dialogical action patterns can be triggered with chains of utterance pairs, in which changed or completely different, new meanings can be negotiated step by step, if necessary also with longer narra-

tive sequences. These negotiations of meaning can only be captured in a suprasegmental conversation analysis, in which, for example, narrative conversation developments with specific emotion content are to be reconstructed (Koerfer et al. 2000, 2004, 2010) (§ 9, 19, 25). In order to be able to capture these developments in a model of empathic communication, we have added further stages (6-9), which initially serve formally as placeholders that are to be filled differently in terms of content depending on the individual case (Fig. 20.2).

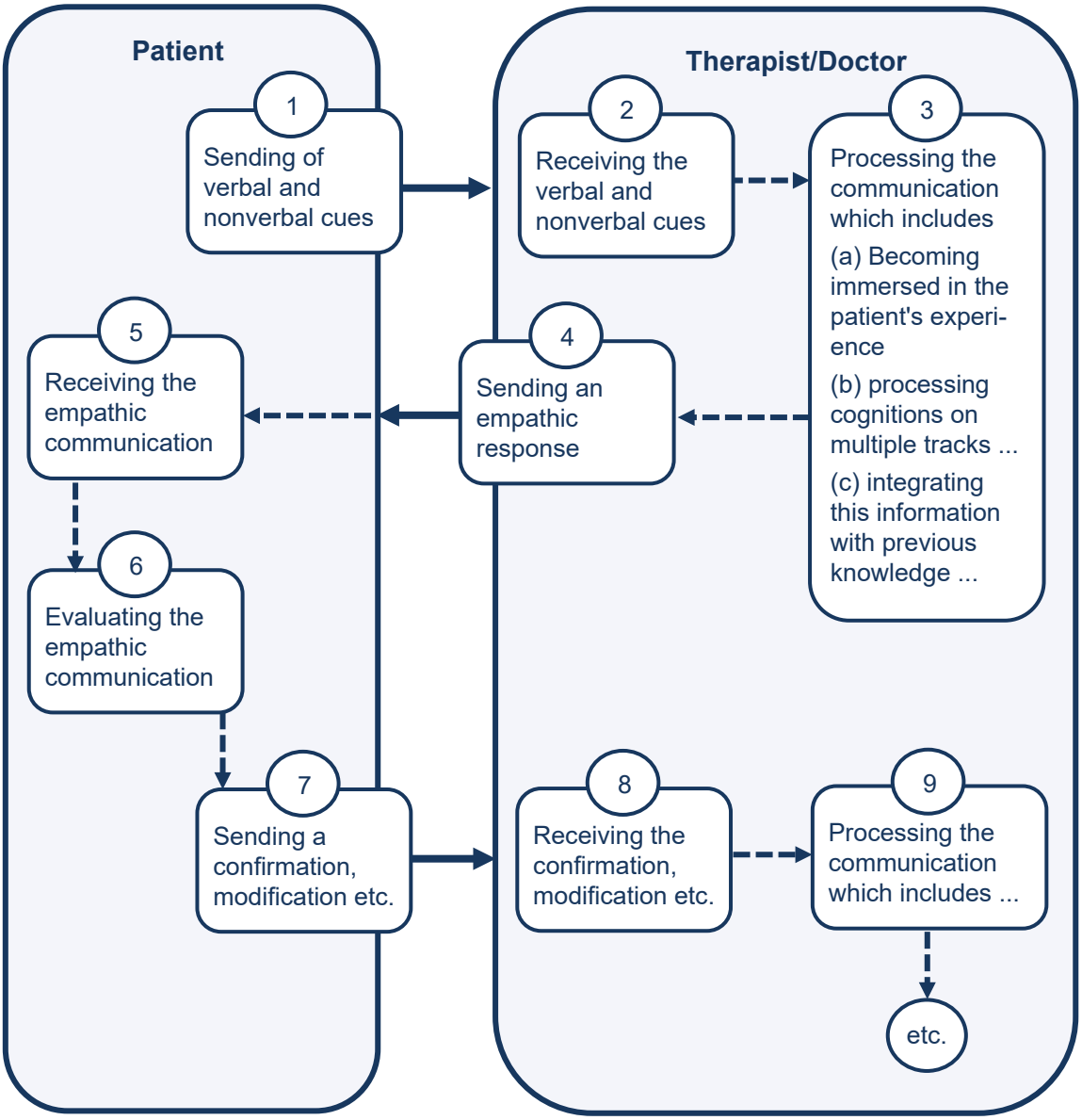


Fig. 20.2: Therapeutic empathic communication (TEC) process model (modified, shortened and extended on Miller 1989)

Thus, the patient can *accept* the empathic response of his professional interlocutor "ideally", as Miller obviously assumes (Box 20.9: Stage 5), but also *modify* or even completely *negate* it (7), which in turn will result in various professional reactions (9ff.), and so on.

In this extended model, too, the interactive processes are distinguished from the intrapsychic (cognitive-affective) processes of the interlocutors. With the solid arrows (in deviation from Miller) only the (observable) interactive processes are marked, while the dashed arrows refer to the intrapsychic processes of the interlocutors. In the extended version, the model takes into account specific patterns of action with a sequence of at least three speech contributions (P1→D4→P7). Accordingly, in the following empirical conversation analyses on empathic communication, multi-part interaction sequences should be used wherever possible, which take their starting point with a (potential) *emotional* cue from the patient (1), which the doctor takes up with an empathic response (4), to which the patient in turn can react with different forms (from silence to rejection) (7), and so on.

In exemplary cases, we will also draw on longer passages of conversation in order to reconstruct developmental processes of empathic communication in which the negotiation of meaning between the actors also leads to a change in meaning that is recognisable to the actors themselves. The repeated run through the positions of the action pattern in the model ideally leads to cooperation (of a higher order), in which the actors themselves perceive and ratify the progress they have achieved together, in order to build on it in further conversations if necessary.

The modifications and extensions to include further stages (6-9) are not intended to call Miller's basic model into question, but to further differentiate it for applications in empirical conversation analyses. According to Miller, conflicts in the cooperation between the interlocutors must be expected in all stages (already differentiated by him), which can develop and stabilise over longer periods of conversation, so that the therapeutic relationship itself is strained. Here, both partners are challenged to overcome barriers to empathy in order to reach the limits of empathy as late as possible, which in principle remain when understanding the external psychic.

20.3.3 Barriers and limits of empathy

The intended therapeutic success can fail to materialise for various reasons. As Miller argues in detail with reference to a number of classics of psychotherapy research (e.g. Greenson, Kernberg, Kohut, Rogers), problems and disruptions can occur at all stages of the model, from *empathy alone* (1-3) through *emphatic responsiveness* (4) to the (temporary) end (5) of *empathic communication*. A "breakdown" (Box 20.10) of empathic communication can be attributed to both the therapist and the patient as well as to their relationship.

Box 20.10 "Breakdowns" in empathic communication

A breakdown in the TEC [Therapeutic empathic communication] process may occur in any of the five stages. Therapy then becomes a joint effort of the therapist and the patient to discover where the communication broke down. Again the breakdown can be in the therapist, the patient or their relationship. The most source of difficulty in the TEC process is the interference from the patient's psychopathology.

Miller 1989: 537

Although the patient may have a significant ("psychopathological") share in possible "breakdowns" of empathic communication, both partners must make a joint effort to overcome them. Following Miller, a first overview of possible problems and disturbances of empathic communication will be given here, which already contains references to exemplary conversation analyses (also in other chapters of the handbook). Specific barriers to empathy can be distinguished from boundaries and degrees of empathy.

Barriers to empathy

The first problems arise when patients refuse to open up verbally for emotional self-exploration, for example by not wanting to accept certain invitations to talk (§ 9, 19). Thus, even in the early stages, the expected *emotional cues* from patients may fail to materialise - for whatever reason: "Blocking empathic communication may also be a way that some patients avoid feeling the vulnerability of dependency" (1989: 533).

Moreover, patients whose capacity for expressive self-exploration is limited anyway are to be expected: "Because of the limitations of language and communication skills, patients will, at best, only be able to express an approximation of their inner experiences" (534). This kind of "speechlessness" of patients has also been studied under the construct of *alexithymia* (Greek: *without words for feelings*) (Subic-Wrana 2017), which can also be used with critical reservations for *somatoform* disorders of patients (§ 32).

However, the *inhibitions* in *verbalising emotions* are often of a "banal" nature, for example with young patients who first have to overcome their "shyness" in unfamiliar dealings with the doctor. Here, the professional helper must first laboriously "draw the patients into a conversation" before they overcome their reservations (Koerfer et al. 2010). In this respect, dealing with an adolescent schoolgirl, for example, can prove more difficult than with a child of preschool age, who proves to be more "impartial" and "falls into the house" with specific *emotional* topics right at the beginning of the conversation. In a direct comparison of the two conversations from a GP practice with the same GP, the differences will be worked out in detail (§ 25).

Here, also under the aspect of "socialisation" into an "unfamiliar" type of conversation (Koerfer, Neumann 1982), the question should be pursued to what extent young patients in childhood are gradually "trained away" their initial readiness for emotional self-exploration with further visits to the doctor in their lives. Because they learn that emotions are not "called for" in the doctor's office, they may lose their "childlike impartiality" in communicating their feelings ("sadness", "fear", etc.) in case of illness. When talking to the doctor, they limit themselves to supposedly relevant topics that have been "conditioned" again and again by the now familiar medical questions ("where does it hurt?" etc.).

Furthermore, according to Miller, despite attentive listening and the best intentions in empathic understanding, specific barriers can of course remain due to *cultural* and *social* differences between the professional helper and his patient. In addition to the *linguistic-social* differences, where, depending on the level of education, problems of understanding must also be overcome in the relationship between everyday and professional communication (§ 10, 27), special problems arise, for example, in *intercultural communication* (§ 28), especially when third persons are involved as mediators.

There is a risk here that both lay people (relatives, neighbours, hospital staff) and professional interpreters are subject to the tendency, for

the sake of economy, to make a selection for seemingly medically relevant topics during the "fleeting" translation and then to more or less "consciously" "suppress" emotionally charged topics that the "real" patient may already have "brought up" openly and clearly. In this case, the professional helper would miss out on important emotional information because the communication would take place behind his or her back and the loss would not even be noticed. Here it makes sense to address appropriate instructions to the participants in advance and to renew them in between so that the relevance of empathic communication remains clearly marked.

Limits and degrees of empathy

For all the specific barriers to empathic communication, one must reckon with principle "limits of empathy" (Breyer (ed.) 2013), which are reached not only in everyday life, but also in psychotherapeutic-medical contexts, despite professional empathic competence. Thus, Wellendorf sums up for (psychoanalytic) psychotherapy: "In the discussion about the prerequisites and problems of empathic understanding, its *immanent* limits have been pointed out again and again" (1999: 15). Even in psychotherapy, according to Wellendorf, the "enigma of the other" (Laplanche) remains "beyond empathy" because the patient's "unconscious" also repeatedly eludes empathy.

Despite all the basic barriers, Wellendorf sees specific problems of empathic understanding in the person of the therapist or patient, but also in different life experiences, which can also be (inter)culturally conditioned. Special problems arise in the case of traumatic experiences of patients: "These patients are exposed to situations that mean the collapse of all empathy" (1999: 16). This includes not only kidnap victims or victims of the Holocaust (ibid.), but also other patient groups with post-traumatic disorders (after torture, abuse, domestic and criminal violence, accidents, etc.) (Filipp, Aymanns 2010, Maercker, Gurris 2017). Before these patients can be (further) treated in a specific psychotherapy, they usually present at the GP's office, where they are (co-)cared for by the GP, for example in *basic psychosomatic care* (§ 15, 25). Here, a special *empathic* competence in conversation is required for the anamnesis and diagnostics at the GP's, which we will come back to separately when dealing with "sensitive issues" (§ 21.6).

All in all, even beyond the limits of empathy, certain *degrees* of empathic understanding and response must be distinguished and accepted, which, according to Miller (1989), can depend on very individual or situational factors: "Most therapists know that the degree of accuracy in understanding patients' communications varies considerably from person to person, day to day, issue to issue, and moment to moment" (536). Overall, therefore, only an approximation to the optimal empathic intervention can be achieved: "While complete accuracy in understanding both the current and historical state of mind is impossible, the therapist strives towards this goal in the formulation of the empathic response" (ibid.). How this empathic response is received by the patient in each case depends strongly on the (problems and disorders of the) patient, who might react with a "yes, but" statement or quickly change the subject "in order to avoid the experience of having felt understood" (536). Nevertheless, according to Miller, it is always the patient who has the last word: "Only the patient can evaluate the fifth stage" (543). Although the patient should be given free leeway to react, Miller assumes that the patient agrees to the doctor's empathic response (Box 20.9: Stage 5), which can at best be an *ideal* case.

However, since *adversative*, *negating* or merely *modifying* patient responses ("yes, but maybe ...") are also possible in addition to the *affirmative one,* we have extended the model to include further positions of the action pattern (Fig. 20.2.: 6-9), in which the patient has to weigh up and decide after reception (5) how he or she finally wants to react to the preceding empathic response (4).

Whatever the outcome of the evaluation (6), the respective (affirmative, adversative, etc.) feedback from the patient (7) sets the course for the further development of the conversation, in which first of all the professional helper (8-9) and then alternately both conversation partners are challenged to further cooperation on further levels of empathic communication (higher order) *ad infinitum*. In a successful case, their contributions gradually lead to convergences in the negotiation of meaning, which does not have to exclude divergences in the meantime up to the limits of the therapeutic relationship.

Thus, in an interim conclusion, it can be summed up: Empathic competence does not only include immediate "goal-oriented" interventions, which patients can agree to without "ifs and buts", but also tentative interventions in the sense of an empathic *trial action,* in which the doctor/therapist can just as *competently deal* with gradual "failures", which the patient qualifies as such through his reaction. The empathic

interventions may appear "justified" according to the previous state of the conversation history, but the patient retains the last word with his evaluation (see above). The "failure" thus identified must first be processed intrapsychically (cognitively and affectively) before new (modifying, correcting) interventions are then interactively "put to the test" again with the patient. This testing procedure is kept going until a preliminary consensus is reached, which forms a basis for further negotiation processes with new topics and tasks or therapy goals.

20.3.4 Empathy and fitting

Even if the limits of empathy in other-psychic understanding cannot be overcome in principle, the chances of empathic communication can be improved. In this sense, not everything has to be tried out first, but serious failures can be avoided preventively. The discussion of the other person's emotions is often a "delicate" matter, not only in everyday life, but also in medical consultations. Even there, the tension of an explosive topic, which always challenges the relationship between the interlocutors, must not be "overstretched".

Communicative access to the patient's feelings often has to be found via intricate paths that can sometimes turn out to be detours or even wrong paths. The empathic understanding of the psychic of others is already an art in everyday life, which has experienced a special, namely professional, development in the medical consultation. Language does not have to be reinvented. The communicative means that the doctor uses originate from everyday communication, but are specialised in the medical consultation. What we would forbid ourselves in everyday life is usually allowed to the doctor who, because of his professional role, is allowed to "listen in" on us with traditional medical questions, enquiries and questioning.

Compared to everyday life, communication in the consultation is characterised by greater *intimacy* (§ 9), which is associated with more *personal impositions* on the patient. In order for the doctor to be able to help him, the patient must be more or less willing to "turn his innermost self inside out". This is seldom successful at first go, but requires special *empathic* interventions that first aim at recognising the patient as a person who must be able to trust the doctor's support and help. In order to avoid "going too far" in the further emotional work, for example by "breaking" resistance, the impositions in the conversation must be

placed "in good time" and "in good doses" or else withdrawn or merely suspended.

In order to find the right measure for the resilience of the current therapeutic relationship also between doctor and patient, a specific *fitting competence* is needed, which was already described in advance with von Uexküll and Wesiack (1991) as the *self-reflective meta-competence* of a critical *meta-physician* (§ 3.3). This meta-physician should be more or less able to observe himself and the patient self-critically during communication. The critical self-observation of the meta-physician may be an *ideal* construct because it is only approximately possible to observe and reflect on one's own actions and those of the other while still interacting. However, this high art of reflexive self-observation can certainly be learned in communicative action and optimised in long professional experience up to *mastery* (§ 1, 40).

In this professional perspective, serious failures in empathic communication can only be recognised as "failures" in the first place, which can also be gradually avoided in communicative action. To illustrate it in extremes: Where a "novice" uses invasive ("probing") enquiry techniques to "pour oil on the fire", as it were, and tries to "overcome" the patient's increased resistance argumentatively, if he notices it at all, the "master" has long since been on the retreat due to his fitting competence by not delving further into the "delicate" topic for the time being, but instead making a change from a rather *confrontational* to a *tangential* conversational approach (§ 3, 17, 32). However, putting a "dicey" topic "on ice" for the time being does not preclude its later resumption, as Morgan and Engel have already pointed out.

Morgan and Engel (1977) describe specific communication patterns in which conflicts between doctor and patient manifest themselves, which can develop in one or the other, more or less (un)productive direction. This also applies to the communicative handling of open or concealed emotions of patients or their forms of defence, which may temporarily stand in the way of the intended "clarification work" in the conversation. Clinical experience teaches that the patient's forms of defence should not be "broken through", but should be tolerated to a certain extent, especially at the beginning of a still unstable doctor-patient relationship, so that even "dicey" topics can only be gradually taken up again in the subsequent conversation (Box 20.11), whereby "detours" must also be taken:

Box 20.11 Dealing with emotions and defence

Some patients downplay or deny their symptoms. By doing so, they try to cope with their anxiety and are not aware of how much they are distorting their complaints. Other patients deliberately conceal facts of which they are ashamed or which they fear. The doctor recognises such patients by the fact that their description and their condition do not match. Thus, a patient in hospital may insist with a smile that he is well or that he has no complaints at all (...) The patient who deliberately conceals information betrays to the doctor by repeated blushing, hesitation and gestures or by an inappropriate laugh that he is touching on a dicey subject. Since the doctor does not want to break through the patient's defences, which would frighten the patient, he drops the sensitive topic for the time being and tries to return to it later in a roundabout way.

Morgan, Engel 1969/1977: 68f

All in all, the doctor is guided by his perceptions of verbal and non-verbal communication with the patient, who obviously more or less "indicates" the extent and limits of what is *reasonable* himself or "betrays" them through his behaviour (*blushing*, *hesitation, gestures,* etc.); but in any case behaves in such a way that the doctor should be able to draw the necessary conclusions. From the last recommendation of Morgan and Engel for further interaction, a *sub-maximum* for dealing with emotions can be derived according to the motto: "*Postponed* is not *abandoned"*. Dealing with emotions or forms of defence requires a clinical-communicative double competence (§ 3, 17), on the basis of which the doctor must first come to a perception of what the limits of what is individually "reasonable" are vis-à-vis this individual patient in the "here and now" of the conversation situation, for which it is then necessary to find the "right" words with a corresponding *fitting competence.*

As will become clear when dealing with patients with somatoform disorders, a *tangential* approach is always appropriate when emotions cannot be openly addressed and expressed, let alone clarified in detail or questioned in an interpretive way, but rather when multiple forms of defence are to be expected (§ 3, 17, 32). The sense and purpose of a rather cautious approach to conversation, which in the above sense of Morgan and Engel (Box 20.11) "drops" some "delicate topics for the time being" and "comes back" to them "in a roundabout way", consists precisely in testing with *tact* what is "just about possible" at a certain stage

of development of the conversation and the relationship and what is "to be avoided at all costs" because it would "overshoot the mark". Analogous to *instrumental* action (e.g. medication), the *problem of dosage* has already been referred to in *communicative* action. Insisting on verbalising and interpreting emotions "overcharges" can also mean *too much of a good thing*, however desirable it may be to clarify patient emotions in the "here and now".

With the necessary *fitting competence*, medical action moves on the tightrope between *over- and under-stimulation* (§ 17). Intervening with an *overbearing* attitude ("at the drop of a hat") can be just as unproductive as the exaggerated fear of the risk that the patient might regress and start crying. To merely provoke this would be unethical, but to prevent it at all costs would be to underchallenge the patient out of sheer gentleness. We will also come back to dealing with crying patients with Morgan and Engel (1977) and an empirical example (§ 20.8), which is about a longer *empathy-in-interaction*.

With reference to the previously expanded stage model of empathic communication (according to Miller 1989), empirical conversation analyses should go beyond the *local* train-by-train sequences (of neighbouring pairs of utterances) and also take into account exemplary *global* conversation developments in which, for example, a change of topic is carried out because either a topic saturation has already been reached or it is obviously "indicated" under psychodynamic aspects of conversation development that, for example, a crying patient is to be temporarily relieved of the strong affect (§ 20.8) so that the therapeutic relationship itself does not threaten to reach its limits.

All in all, the perception, evaluation, promotion and processing of emotions are part of the *empathic* competence of the doctor, of which he has to make active use in many ways in the conversation. As in the preceding conversation analyses, exemplary cases will be differentiated according to the categories of the manual, which can serve as anchor examples for research and teaching. In addition to the positive examples, the sources of "failures" in empathic communication, which point to a lack of empathic competence, should also be revealed. In doing so, it is also possible to learn from "failures", which make the so-called *best-practice examples* appear all the more plausible in direct comparison.

20.4 Relevance negotiations of emotions

The lack of empathy described above (§ 20.2) can also be seen in empirical analyses of conversations. In medical conversation practice, emotional patient *cues* are often neglected or even ignored because (reactions to) emotions are not considered part of the core area of medical care. This becomes particularly clear in cases where the doctor meets an emotional topic offer from the patient with a radical change to a biomedical topic, which is tantamount to downgrading the relevance of the patient's initiative. In contrast, a doctor who is oriented towards a biopsychosocial medicine will upgrade the relevance towards an emotional patient offer until the patient feels sufficiently accepted and understood. In a dialogue feedback model, we had presented the processes of relevance negotiation between doctor and patient in general (§ 17.4), which are now to be specified in dealing with emotions. In doing so, we will first describe the problem of topic development of conversations in the metaphor of the "window", which can be opened, closed or kept in the background at the same time, among many other windows, before being brought to the foreground again, and so on.

20.4.1 Thematic opportunities of empathic communication

We had already pointed out at the beginning (§ 20.1) that emotions are very "fleeting" phenomena, which should ideally be given a medical relevance upgrade immediately where they appear in the conversation, according to the motto: "Emotions have priority!" If they are "suppressed" by other topics, they quickly disappear from the surface of the conversation, so that it is difficult to "bring them back out of obscurity". That is why the empathic doctor should react directly to the emotions of patients who have problems disclosing them anyway. Thus, the doctor often has to be "all ears" in order to perceive the "discrete" patient *cues* at all. Pollak et al. (2007) (Box 20.12) describe that this is not always possible even for doctors who should have the necessary sensitivity in their specific field of action, even for oncologists who should be used to dealing with emotions professionally and yet often miss "empathic opportunities".

Box 20.12 Patient cues and medical (non-)responsiveness

Patients may not want to burden oncologists with their concerns and instead may provide indirect cues or clues about their concerns. For example, rather than ask about prognosis, patients may simply say, "I'm not sure what there is to look forward to." These indirect cues are often missed by oncologists (...) Such cues or clues often create empathic opportunities, or moments that beg empathic responses from clinicians. Empathic responses directly address patients' emotions, validate their feelings, and invite further disclosure. Such responses are considered empathic continuers. Unfortunately, clinicians often do not respond to cues with expressions of empathy. They may avoid the emotion or may change the topic with empathic terminators that can negatively affect the patient-physician relationship.

Pollak et al. 2007: 5748

Depending on the doctor's (non-)responsiveness, conversations can develop into very different topics, with corresponding effects on the relationship. As we will see in detail with examples, doctors miss not only *indirect* but also *direct* patient *cues,* which they obviously do not just overhear in the reception, but may well have heard, but nevertheless ignored, for example when they make a "*change of topic".*

For our empirical conversation analyses, we adopt the terminology that has now become established in research on empathic communication, namely the term "hint" (of the patient), which is used in the variants *cue* or *clue,* as well as the term "empathic *chance*" or "opportunity", which is variously applied to capture the "potential" for empathic communication (Branch, Malik 1993, Suchman et al. 1997, Levinson et al. 2000, Coulehan et al. 2001, Bylund, Makoul 2002, Salmon et al. 2004, Pollak et al. 2007, Hsu et al. 2012, Childers et al. 2023). In an early work, Branch and Malik (1993) already introduced the term "windows of opportunity", which is intended to capture the fact that, for example, with open questions such as "What else?", the doctor opens up specific "opportunities" in the conversation for the patients to be able to speak up on completely different topics than those that have previously determined the course of the conversation.

With an example from the GP's practice we will see that with a medical question of a similar type ("What else is going on") in a conversation in which the patient initially complains exclusively about "heart com-

plaints", a turn is brought about to a completely different conversation in which the patient brings up his "hopelessness" with regard to his wife's illness. This emotional topic is then taken up again and continued in a joint follow-up conversation with the couple (§ 25). If a conversation takes on a completely new conversational quality here, even smaller episodes, which Branch and Malik (1993: 1668) call "mini-windows", can lead to an enrichment of the conversation with new topics and concerns ("to explore patient's psychological and social concerns") without jeopardising the "time efficiency".

Rather, beyond the topic of Branch and Malik (1993), it can be assumed that such "mini-windows" can "pay off" because of their long-term effects. Once an emotional topic has been established through verbalisation, it can "continue to have an effect" even if it seems to have temporarily "disappeared" from the surface of the conversation. The temporary "disappearance" of topic windows can be compared to our creative use of computers, where we can keep many windows open on the screen, close them temporarily or move them into the background, only to bring them back into the foreground again, etc.

Here we are also *more creative* in conversation than in dealing with the computer, where we also always have to reckon with an overload of the "working memory". If not in every respect, but in many, the human "memory" is superior to that of the computer. Without the risk of a "crash" that would require a "restart", doctor and patient can reactivate and reconnect many topics together after many "sessions" have already been completed, which had in the meantime faded into the "background". Here, the two interlocutors can communicate solely by means of "keyword" communication when, for example, weeks later it is a question of updating the anamnesis ("How is the retraining, dismissal, divorce, eating disorder of the daughter", etc.). Of course, due to the volume, we cannot trace the creative resumption, linking and further development of topics in consultation processes here, but at best illustrate them in excerpts that illustrate an *empathy-in-interaction* (§ 20.4.2) over longer conversation processes. The conversation analysed in detail above (§ 19.8), which lasted eight minutes, will serve as an example of the course of the conversation and will be recapitulated here in its development of interaction and topics.

20.4.2 Empathy-in-interaction: Formulations

First, let us recall the conversation with the patient with chronic stomach complaints, which has already been analysed in detail from a narrative perspective (§ 19.8). The patient had been forced to make an "alternative" career choice as a civil servant after failing his exams at university, which he has suffered from to this day (§ 19.8). In addition to our presentation of the *dialogue role structure* of the conversation (Fig. 19.7), the *biopsychosocial* theme structure will be presented here in broad outline (Fig. 20.3), which extends over the entire length of the conversation (approx. 8 minutes). The entire course of the conversation had been documented and described in detail beforehand and will be recapitulated here under the specific aspect that interlocutors can effortlessly "switch" back and forth between the *cascades of thematic windows* they have created themselves without losing the red thread that they themselves spin.

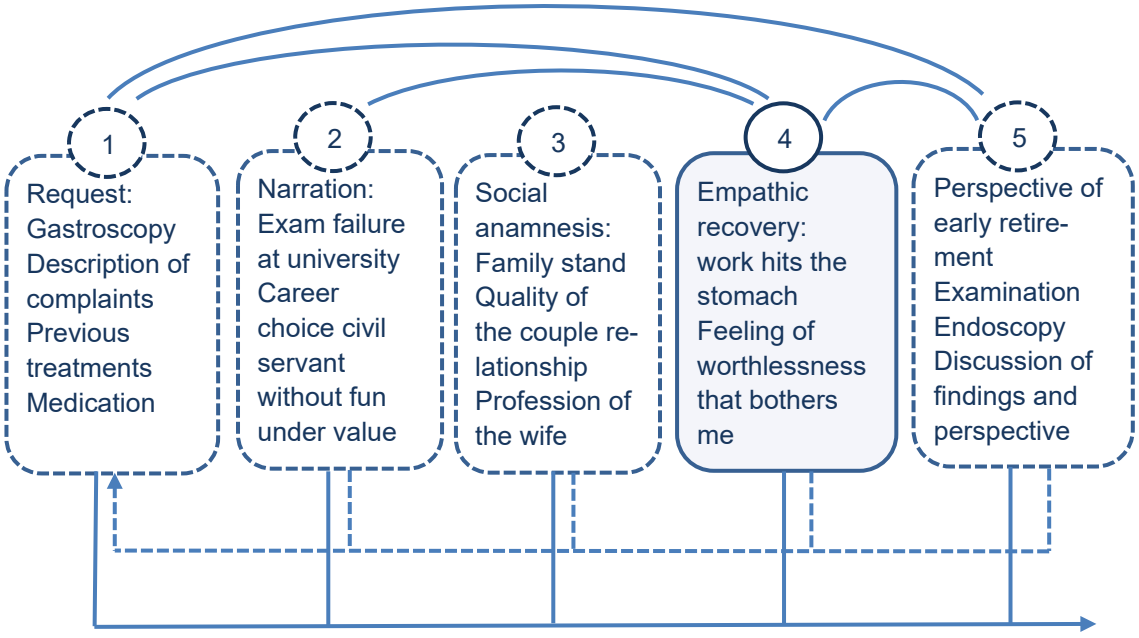


Fig. 20.3: Cascades of theme windows in a developed interaction story

In the rough representation of the *biopsychosocial* theme progression (Fig. 20.3), the essential interactions between theme windows are represented by the arcs, which at the same time mark *bundles* of long-term effective interventions by the doctor that unfold their *global* effect as *key*

interventions to all sides of the conversation (Koerfer et al. 2010). In this context, effective interventions are directed both backwards and forwards by taking up "old" topics in such a way that "new" (aspects of) topics are generated, which at the same time can open up further *opportunities* for empathic communication (*empathic opportunity).* Thus, the doctor's central intervention (E 20.2: "well, but work really does seem to be hitting on your stomach") takes on a constitutive function for the conversation in that the doctor, in summing up, establishes a connection between the stomach complaints (1) and the work (2) in a simple metaphorical way that apparently hits the core of the patient's emotional problematic with pinpoint accuracy, as can be seen from his reactions, with which a new thematic direction of conversation (4) is taken after the topic window (3) has been closed for the time being.

This development of the conversation up to a new time and topic window will first be considered under the general aspect of the *cooperation* between doctor and patient in their *negotiation of meaning,* before we return to the linguistic-communicative details. The now currently opened window (4), which is documented again below as an extended transcript (E 20.2), stands in a developed *interaction history* (Fig. 20.3), in which the interlocutors also continuously reflect and communicate on a *local* level from speech turn to speech turn in their intermediate balances both *retrospectively* (dotted arrow line) and *prospectively* (solid arrow line), which is expressed, for example, under tacitly accompanying or explicitly formulated questions, such as: "What have we considered, discussed, done, etc. so far?" and: "What should/must we still consider, discuss, do, etc.?" Such *formulations* (Box 20.13) are an integral part of any communication in which the interlocutors have to orient each other about their actions.

Box 20.13 Formulations of the participants
We refer to the procedures of conversation participants when they say what they do in many words as *formulations*.

Garfinkel, Sacks 1976: 147

Even though participants can reach their limits in their *formulations* in conversational practice because, as is well known, one cannot formulate everything that is relevant at the same time, the repertoire of their formulations is very diverse and extensive. Thus they formulate not only

what they do, but also "what they talk about, or who talks, or who we are, or where we are" (ibid.) (cf. § 8.4). Particularly in institutional communication, one must reckon with special formulations that are indebted to the various institutional purposes of action (Koerfer 1994/2013: 150ff). In their orientation towards these purposes of action, the participants must constantly communicate about the currently achieved status and the perspective of their actions through appropriate formulations.[1]

This is particularly true in medical communication, since here the ends and means of joint action must be negotiated among existential concerns (the patient's recovery, improvement, etc.). In order to reach this "end point" of action, a series of intermediate steps are necessary (§ 8), which the doctor routinely carries out from a professional perspective and which the (adult) patient also expects qua "socialisation" when dealing with doctors. This is the only way to explain the willingness of patients to allow questions and enquiries about *intimate topics* in the consultation (§ 9, 21), which would be frowned upon in everyday life and rejected there as "unseemly".

However, such questions cannot be asked abruptly in the consultation, but only in a developed context of conversation in which a basic trust in the doctor has already grown sufficiently. In the present case (Fig. 20.3), the patient had initially formulated the request for a gastroscopy in the topic window (1), which the doctor had formally agreed to after a later repetition ("yes, okay, yes we can do it"), to which reference is made again at the end of the conversation with the preparation of the endoscopy (5). However, the doctor had at the same time clearly marked his interest in further topics ("I only have a few more questions"), which then led to the dramatic, emotional *story* (§ 19.8) about failing the exam and choosing a profession that was "not fun" (2). The doctor had already pre-formulated precisely this topic with an empathic intervention ("that's no fun?"), which was confirmed by the patient at the end of his narrative by re-stating it (after 1 minute!) (§ 19.8), as will

1 The particular types of "therapeutic" interventions, ranging from *active listening* to *(re)formulation* and *interpretation*, as described somewhat in psychotherapy research, will only be referred to here by way of example (Antaki 2008, Vehviläinen et al. 2008, Bercelli et al. 2008, Pawelczyk 2011, Peräkylä 2008, 2012, Deppermann 2011, Scarvaglieri 2013, Peräkylä 2019, Guxholli et al. 2021, Scarvaglieri, Graf, Spranz-Fogasy (eds.) 2022) and discussed below (§ 21); cf. esp. § 8.4, 20.4, 21.6.

be documented again in the abridged version of topic window (2) (E 20.1).

E 20.1		Topic window (2): "that's no fun?"
01	D	(hm) . what do you do for a living? .
02	P	I am a civil servant in the city of A .
03	D	and what field of activity? .
04	P	I sit around in the office.
05	D	(yes) . that's no fun? .
06	P	well ... let's put it this way ... [smiles] uh ... I'm actually not the type of civil servant .
07	D	hm . hm . but rather what/what (would you say what) [quieter to silence] .
08	P	[Abridged version of the long 1-minute narrative from § 19.8] I had planned something completely different (...) somewhere it got the first crack .... (4) .... I wanted to study natural sciences, had/have started, but then dropped out in the preliminary exam [-] (...) and then briefly did a bit of administrative things, had myself trained as a civil servant, without making any particular effort at [-] ... and then do it [+] more or less like that now, because I don't enjoy it, unfortunately.
09	D	Yes, so that you always have the feeling that you're selling yourself short, right?
10	P	definitely. I would say ... I would /let's put it this way ... I can financially afford, let's say, not to work, let's put it that way. (D: hm) ... I would prefer to stop ... and maybe start studying again, just as a hobby, somehow.

In these conversation sequences, the *empathic topic opportunities* are directly perceived by the doctor and passed on as offers for the patient to narratively (self-)explore emotions. The patient initially gives only *indirect* hints ("I am a civil servant", "I sit around in the office") with his indeterminate response behaviour, with which, however, he already verbally "shows through" his attitudes to his profession, especially since he speaks audibly "resignedly" non-verbally in the consultation when talking about his profession and visibly sits there similarly "disgruntled" and "listless" as apparently in the office. It should be remembered that the patient did not stretch and straighten up completely until the beginning of his narration, to the point where his voice threatened to fail him even while telling about his oral exam failure. As the preceding as

well as the following interventions of the doctor make clear, the doctor is obviously able to integrate his perceptions in the verbal and non-verbal mode of communication (§ 12, 18) into his overall "scenic understanding" (§ 9.2) and also to "bring his understanding to the point" (*no fun*, *selling himself short*) for the patient so well that he is sufficiently stimulated in each case for further emotional self-exploration.

Since we have already worked out this development of the conversation in detail, at this point we will only hypothetically assume the possible alternative development (by omission test) in order to contrast the function of the doctor's interventions in setting the course in comparison with alternative interventions. It would also be considered a "normal" development of the conversation (in an internal medicine or gastroenterology practice) if the doctor, after learning about the patient's profession (02P: "I am a civil servant in the city of A"), had immediately moved on to the topics in window (3) to complete the social anamnesis and asked about the partnership and the wife's profession. Here, however, it must be anticipated with Morgan and Engel (1977) (§ 21.5) that the mere collection of facts and events is of little use if the patient's personal experience and the individual meanings he associates with the facts and events are not also collected.

After the topic of the patient's personal professional experience has reached a certain saturation with dramatic narrative and emotional self-explorations (§ 19.8), the doctor also first continues the psychosocial anamnesis (3) (marital status, quality of the couple relationship, wife's profession, etc.) before returning to the "actual" topic from (2), which he reactivates without further ado with a summary (4), in which the patient's *biopsychosocial* problem is reduced to a short *metaphorical* denominator (E 20.2), with which the doctor formulates the "topic of the hour", as it were, in his *key intervention* (03D: "Work hits the stomach").

E 20.2		Topic window (4): "Work seems to hit on the stomach".
01	D	but not in the same- .
02	P	No, the [wife] works for another authority.
03	D	hm . hm ... well, but it seems that work really does hit on your stomach, doesn't it? .
04	P	[audibly agrees] yes . somewhere this sss feeling [smiles] of not being really needed, I find .
05	D	hm .
06	P	That's what bothers me.

07	D	hm .
08	P	to be underutilised .
09	D	don't have the feeling that the work you do is valuable for any purpose? .
10	P	[shakes head, smiles] no I think the work is unnecessary . [laughs] . I think (...) [longer continuation].

Obviously, the doctor touches the patient's emotional situation again with a high *accuracy of fit* (§ 3, 17, 19) of his interventions, which are obviously understood and accepted and can be actively spun further by the patient as part of the red thread. The doctor was previously able to switch back from the topic of the wife's professional situation to the patient's own professional problem without any difficulty, who in turn was able to switch fully to his individual emotional situation after a slight delay (04P), in which one can also perceive the effect of the doctor's key intervention non-verbally at the beginning in the sense of "scenic understanding" (§ 9.2) (P04). This verbalisation of the patient is then taken up again by the doctor and continued (09D), so that the patient is given another empathic "*opportunity*" to deepen the verbalisation of his feelings (10P), etc. To put it in the familiar image of the two people who, after possible "disagreements", finally find themselves in "harmony": Doctor and patient are now on the same wavelength on which they seek to fine-tune (*attunement*) their negotiation of meaning.

The development of the conversation as a whole makes it clear how the interlocutors can flexibly "switch" back and forth between different topic windows in their *cooperative negotiation of meaning* once certain emotional topic symbols have been introduced. These can then be called up again and again from the symbol field with the associated emotions and further elaborated in their individual meanings (§ 21.5).

The *emotional vocabulary* already worked out together in topic window (2) ("no fun", "selling yourself short"), then serves as the *basis* for further thematic differentiations (4) (03D: "work hits on the stomach", 04P: "feeling not needed", 09D: "not feeling that your work is valuable?"). In view of the dispensability (10P: "unnecessary"), these mutual differentiations of the individual significance of the work for the patient finally already refer to the *experience* of the patient as a *person* who, according to his or her own self-assessment, suffers from the *underdemand* experienced in this way (08P: "underutilised"), even if this *suffering* is still vaguely formulated (06P: "that bothers me so much"). In this way, doctor and patient jointly develop possibilities for a "dialogue

screw without end" (§ 7.2) in their cooperative negotiation of meaning, which once set in motion can be kept going even if it should be interrupted in the meantime by other topic windows such as (3). In this way, emotions are permanently *bound verbally* in the conversation, which are then also no longer "fleeting" after they have become recognisably manifest for both conversation partners through verbalisation, so that they remain *close to consciousness* and *can be thematised* at any time.

In contrast, emotions can be "lost" again if they have not been immediately recorded and verbalised as such in a way that is recognisable to both interlocutors. As we will see in the following examples of empathy-in-interaction, a premature downgrading of relevance can virtually "undo" the emotional patient offer. If patients are frustrated with their often tentative emotional *cues*, they rarely muster the energy to try again. As a reaction to the doctor, possible windows for emotional patient offers then remain unopened or they are specially locked by the patient - possibly even with the result that the doctor, if he fails to recognise the connection between cause and effect, later complains in a training session about how "closed" his patient is.

The extent to which patients are able to "open up" is always also a consequence of the (type of) way in which the doctor conducts the conversation. After the further typological distinctions on the relevance of emotions, empirical evidence is then given in the form of *positive* and *negative anchor examples* on the conduct of conversations in which empathic communication is promoted or hindered or prevented. The differences are shown both in shorter (mostly neighbouring) (pair) sequences of doctor-patient expressions and in longer developments of an *empathy-in-interaction*, which can already refer to the beginning of the conversation (§ 20.7), but also to the further course of the conversation in the middle (§ 20.8) and at the end of conversations (§ 20.9).

20.4.3 Typology of empathic (non-)responsiveness

All in all, "empathic opportunities" for an emotional opening of the patient do not arise by themselves, but must be "created" by the actors in the ongoing conversation, i.e. initiated, received, accepted and interactively continued as such. It is obvious that the possible development of topics largely depends on the doctor, who in his professional role essentially decides on the course to be set at the sensitive points in the con-

versation where the emotional patient offers are upgraded or downgraded in relevance.

Previously, the processes of relevance negotiation were presented in general terms in a *dialogue feedback model* (§ 17.4), which now needs to be specified for the communicative handling of emotions. In a backward and forward summary, the essential types of empathic (non-) responsiveness to emotional patient offers are to be distinguished in advance and the alternative developments presented in a flow chart (Fig. 20.4), which will then be illustrated with the corresponding anchor examples in the empirical conversation analysis of empathic communication.

1. **Relevance upgrading of emotions**
   Ideally, the doctor responds to an *emotional* patient offer with an appropriate *relevance upgrade* until the patient feels sufficiently *understood* and *accepted.* When upgrading relevance, the doctor can use different forms, such as *active listening* (§ 19) or *empathic responses.* Here, the spectrum of *upgrading* interventions ranges from simple listening signals ("yes", "oh well", "oh dear!", etc.) to verbal interventions with which the doctor supportively *acknowledges* the patient's stresses and coping capacities ("Great!", "Good!", "Golly!") and *offers* his medical *help*, i.e. also seeks to *comfort* or *reassure,* if this is appropriate to the situation. In order to *stimulate* the patient sufficiently for further emotional self-exploration (§ 17.3), the doctor primarily uses verbal interventions with which he *addresses, names*, *clarifies* and *interprets* the (non)verbal patient cues. Ideally, the dominant pattern of empathic communication consists of cascades of relevance upgrades that can lead to a further development and deepening of emotionally charged topics and thus to a new quality of conversation and relationship (§ 3, 17, 25).

2. **Relevance downgrading of emotions**
   In the *case of conflict,* the doctor fails to hear or ignores the emotional patient offers, for whatever reason this happens (inattention, disinterest, lack of time, etc.). The "inaudible" is counterfactually "overheard", as if it had not been said in the first place or as if what was said was not meant to be so relevant that the doctor would have to respond to it.

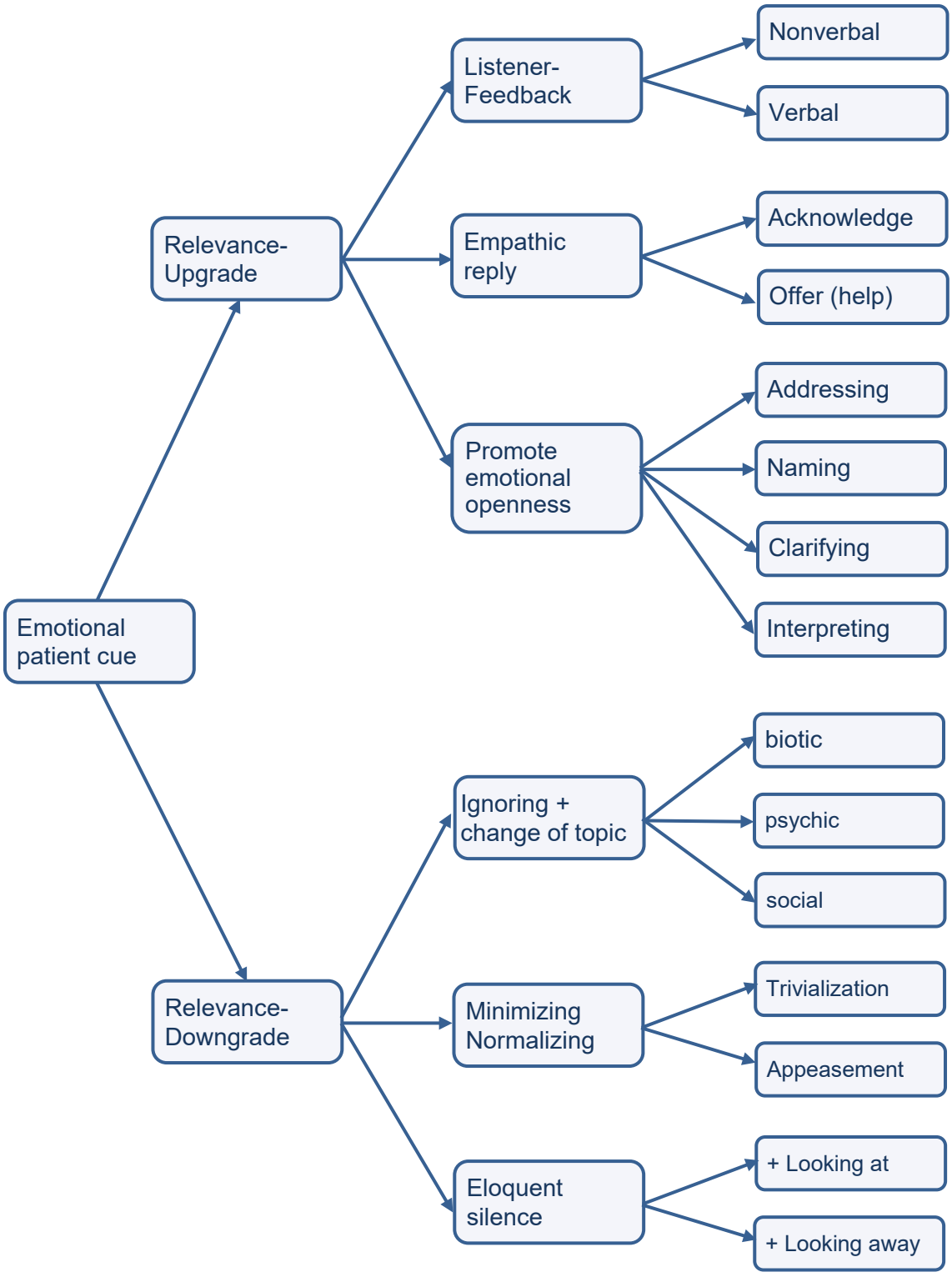


Fig. 20.4: Typology of empathic (non-)responsiveness

Thus, the doctor can elegantly bypass the "inaudible" by, for example, silently waiting for the end of the emotional patient offer or by setting a *communication stopper* ("truncator") with "good" or "okay" and then making a radical *change of topic* (usually to a biomedical topic), with which, in the sense of a *change of relevance,* a final downgrading of the previously made emotional patient offer is to be achieved. In the further course of the conversation, this often leads to *resignation on the part of the* patient, who finally "falls silent". In repeated cases, the willingness to open up emotionally is likely to dry up completely. These forms of *ignoring* emotional patient offers can be distinguished from forms of minimalisation or *normalisation,* with which an apparently moderate downgrading of relevance is undertaken, in which the doctor denies the legitimacy of emotions to his patients by seeking to trivialise or appease them.

It remains to be seen in individual cases which types of relevance downgrading are experienced by patients as *cynicism* and to what extent. *Not* getting a word of feedback can be just as offensive as the *wrong* word if patients have already turned to the medical assistant with their emotions in a trusting manner. As a rule, however, loosely based on Watzlawick et al. (1967) (§ 7.4), the maxim can be formulated that the *rejection* of the other person's self-presentation is experienced as less "hurtful" than the permanent *ignoring* (according to the motto: "Some feedback is better than none at all"). On the other hand, in individual cases it depends on the type and extent of rejection, compared to which tacit ignoring sometimes allows for more protection, because here there is greater room for interpretation for (self-)deception. However, before speculating further about the extent to which interlocutors may be offended, not only in theory but also in conversational practice, all types of *injury* to the patient should be preemptively avoided through empathic communication if possible.

3. Relevance upgrades of emotions after downgrading

In a complex *problem case,* the patient, whose initiative was initially downgraded by the doctor, may renew his rejected emotional offer several times until it is finally heard despite previous downgradings by the doctor. In this way, a series of circular in-

teraction loops may develop in which, in a roundabout way and with a mixture of downgrading and upgrading, an empathic understanding of the patient can be achieved in the end. However, in comparison to the *ideal case,* considerable additional communicative effort must be expected on both sides, which can result from delays and time-consuming attempts to repair misunderstandings.

It must be taken into account that time-consuming corrections in emotional conversation work can also contribute to "injuries" of feelings, just as they were already possible when emotional patient offers were *rejected* and *ignored.* The patient's permanent struggle for understanding and recognition can be just as "costly" as the timely resignation at the first relevance downgrading by the doctor. In any case, the doctor should also draw a (psycho-)economic balance, according to which his defence against patient emotions (§ 20.2.1) may well have negative consequences for the development of the relationship and thus also for himself, if emotions should later "break out" in an uncontrolled way, which could reveal itself as resistance to the "treatment regime" and be reflected in *non-adherence* (§ 10, 26) on the part of the patient. Under the aspect of participation, we had not only referred to the possibility but also the necessity of developing a sustainable relationship to the advantage of both only in a *win-win situation.*

As already explained above (§ 17.4), the ideal case in which the doctor achieves an empathic understanding of the patient with a high degree of accuracy of verbal interventions, i.e. with maximum efficiency through corresponding relevance upgrading of emotional patient offers, is not the rule in everyday clinical practice, but empirical cases of empathic communication should ultimately be measured against such a *normative* feedback model of relevance upgrading. From this critical evaluation perspective, the following conversation analyses will first start with negative examples of relevance downgrading of emotions before we continue with the positive examples of relevance upgrading, which also follow the steps in our manual.

It should be emphasised once again that the linear sequence of steps in the manual, which is necessary in the presentation, must be flexibly implemented in the practice of the conversation in steps which must

always be adapted to the current state of development of the conversation with its individual course (§ 17). When negative and positive anchor examples are contrasted in the following, this is done with the didactic intention that it is also possible to learn from mistakes, with which the *best-practice examples* as such can also be understood comparatively. For such a comparison, didactic tips for teaching will also be given below.

20.4.4 Relevance downgrading: Minimising and Normalising

In many examples of relevance downgrading, it is not possible to decide, even in the broader context, whether a doctor did not perceive the emotional patient offers or whether he deliberately overheard and passed them over. The relationships between *saying*, *meaning* and *understanding* can be highly complex. Sometimes we experience in everyday life that we are misunderstood, even though we think we have expressed ourselves clearly enough. If we feel misunderstood, we react with questions or, in repeated cases, with accusations such as "Are you deaf?" or "You only listen with half an ear!" or even with "You don't want to understand me!", which can already indicate serious disturbances in the cooperation between interlocutors.

In the latter case in particular, we assume that the interlocutor is pursuing *strategic* communication in the sense of Habermas (1981) (§ 7.3), in which he or she does not cooperate in a communication-oriented manner, but rather adopts a more or less success-oriented strategy of "playing dumb" (Kallmeyer 1978, Koerfer 1994/2013). Unfortunately, strategic communication is not a special case in extreme situations, but is also common in medical communication, as has been shown in empirical analyses of the medical ward round (§ 24), in which the *factual asymmetry* (§ 7, 10) of communication between doctor and patient contradicts all the rules of the *art* of medical conversation (§ 17).

Strategic forms of communication can also prevail in medical consultations, for example when patients do not have their say or their word remains "unheard" - for whatever reason. While inattention may still be excusable, ignorance of the patient's word is a lack of cooperation which, in contrast to the *emotional* word, proves to be a lack of *empathy,* as already described above (§ 20.2) for training practice and medical professional practice.

Even though it may not be possible to prove in individual cases what the reasons are for the lack of empathic communication, it can be stated as a result what Salmon et al. (2004) have already brought to a general denominator in the title of their empirical analyses, especially for the psychosocial *cues of* patients with "unexplained symptoms": "Voiced but unheard agendas" (2004). In this context, what is said can remain "unheard" in various ways. Beyond the strict *ignoring* of emotional patient cues, which will be differentiated in a moment, different variants of *partial responsiveness* can be distinguished, which often appear no less "cynical".

These include forms of *minimisation* or *normalisation* with which the legitimacy of their emotions is more or less questioned vis-à-vis the patients (Salmon et al 2004, Hsu et al 2012). Because it is drastic and short enough, an (English-language) example (E 20.3) from the Salmon et al. (2004) corpus of conversations is given here.

E 20.3		Minimise or normalise
01	P	oh dear. Have I got to have any more, any more? After me wife died I had both my knees, done. My second knee was done in February '97, in February '98 I had that appendix and December '99 I had this flu. I shouldn't have had it after I had the injection should I?
02	D	It's bad luck, isn't it?

Salmon et al. 2004: 175

It remains to be seen whether this kind of "cynicism" can be surpassed by strict ignorance when doctors let their patients talk, perhaps even listen sufficiently, but "pass over" what is *said* and *meant* and also what is *understood* in the further interaction as if it had not been said or was not meant in this way, etc. In the preceding case, the emotional cues are not completely ignored, but they are answered with the "wrong" words. The downgrading of relevance consists in a degradation of the emotional experience of the patient, who has "gone through a lot" in the sense of critical life events.

Instead of adequately acknowledging these burdens (§ 20.5), the doctor takes refuge in an everyday phrase ("bad luck"), which can already be used in everyday life to "shut down" the emotions of our interlocutors if we (want to) lack empathy. Certain types of *trivialisation* and *appeasement* ("it's not that bad", "we'll get over it"), which are also bor-

rowed from everyday communication, go in the same direction. As we will see with examples, the medical consultation is also full of everyday communication, such as praise and blame, but it should be free of manners that at best serve to "dissipate" the speaker's affect, which he or she affords at the expense of the listener.

An "open" word need not be a "hurtful" word, to which mere "silence" is also not always a suitable alternative. Even more or less "eloquent" silence can be experienced by the listener as "deathly silence". In the case of *ignoring* by silence, the patient's *emotional cue* is not acknowledged with a *wrong* word, but with *no* word at all.[2] The necessary relevance is then denied to the patient in such a way that it apparently no longer deserves another word, at least not on the subject of the person concerned. The emotional topic can then also be "tacitly" ignored because of its "irrelevance", which is then often also more or less "obviously" expressed in a radical change of topic. Without claiming to be exhaustive, the following examples are intended to illustrate the spectrum of *ignoring* emotional patient offers by changing the topic.

20.4.5 Relevance downgrading: Change of topic

A very frequent form of relevance downgrading is the more or less radical change of topic. In this case, the doctor can switch back and forth within the biopsychosocial spectrum of topics, even without establishing connections or considering other aspects of the topic that has been broached. Thus, he can jump from one topic ("What do you do for a living?") after a short answer from the patient ("I am a haulage contractor") to the next topic ("Are you married?"), in order to "call up" the next topic with the further question ("Do you have children?"), without connecting other aspects in each case. Should "unpleasant" topics nevertheless "break through", they are often "shut down" again by switching to a biotic topic. Thus, in the "interrogation interview" (§ 19.6), the doctor had already changed the subject as soon as he had found out about his patient's profession ("doctor's assistant") with an immediate question about the accompanying signs of her heart complaints ("Do you have

2 Silence can have both negative and positive effects, for example when it is used for reflection. On specific forms and functions of silence in psychotherapy, see Koerfer, Neumann (1982), Knol et al. (2020), Dimitrijević A, Buchholz (eds.) (2021) and Buchholz et al. (2022).

shortness of breath?"). This was an extreme example from the extensive spectrum of (types of) relevance downgrading, only a selection of which can be illustrated here by way of example.

We start with a clear case of *ignoring* through a doctor's *change of topic*, where the patient had already explicitly introduced a specifically psychosocial topic ("trouble in the family") once, which she now seeks to renew because the doctor apparently gives her a good chance to do so.

E 20.4		"other trouble in the family"	Comment
01	D	(...) so you say yourself that there is stress behind it ... or are there other things that cause you problems? I mean other difficult things.	Opening of a psychosocial thematic opportunity (PS)
02	P	well I had other/other trouble in the family within .	Psychosocial patient offer
03	D	hm .	
04	P	which is actually still ongoing, which was only there recently, where a lot of things got mixed up ... but ... that's also the only thing then .	Psychosocial patient offer
05	D	hm . yes Mrs S . I think I will examine you now .	Downgrading ↓ through subject change PS→Bio
06	P	hm .	Listener signal

As is already known from the history of the conversation shared by the doctor, the "other trouble within the family" coincided with a miscarriage and the patient's "anxiety" and heart-related complaints described at the beginning of the conversation (§ 21.5). The patient had already mentioned the "trouble in the family" beforehand, without coming directly to the point with it, because the topic of the miscarriage had first been given a relevance upgrade, and now tries it again at a point in the conversation where the doctor opens an opportunity for it (01D: "Stress (...) problems (...) other difficult things?"). The patient takes up this thematically broad offer of conversation and again places her offer of a topic explicitly and unmistakably (02P: "other trouble in the family (...) where a lot of things got mixed up"), so that the doctor is put under pressure to react to the patient's current offer.

Instead of pursuing this patient's offer further, however, the doctor prefers a completely different continuation of the conversation by using a routine procedure of relevance downgrading, namely (in the sense of Labov, Fanshel 1977) to switch directly from *patient's events* ("trouble in the family") to *doctor's events*: he not only cuts off the topic initiated again by the patient by setting a communication stopper (*truncator*) ("hm . yes Mrs. S, I think ..."), but at the same time ends the conversation by changing from communicative to instrumental action ("then I will examine you now"). The patient can only "acknowledge" this radical change resignedly with a quiet listening signal (*hm*), without getting any opportunity for agreement or contradiction, for example, to assert herself once again with her topic, which is now finally "shut down" for the time being in this consultation. However, since psychosocial topics of this type are not arbitrarily retrievable, but should also be perceived "on the spot" as conversational opportunities once they have been developed interactively, the doctor runs a high risk here of leaving unused information that may be important for understanding the medical history to complete the biopsychosocial anamnesis by downgrading relevance through his radical *change of topic.*

Such "problem cases" can be used in teaching without identifying them as such beforehand (§ 13.4). Depending on the level of learning achieved, the deficits in the doctor's conduct of the conversation are often worked out independently by the course participants and summed up, for example, in such a way that the doctor here "takes refuge in the examination instead of pursuing the anger further". With such a critical evaluation of the case study, an intermediate stage of learning is reached, which can be further developed. In the learning group, further reflections on appropriate verbal or non-verbal follow-up interventions by the doctor can then be stimulated through practical exercises.

As already described in detail (13.4), the group members should put themselves in the role of the doctor and intervene "in his place" ("it's your turn") to get the patient - despite her own downgrading of relevance ("but that's also the only thing then") - to tell about her "trouble in the family". Here, the suggestions of the group members can range from forms of *active listening* (§ 19) (such as literal repetition: "Trouble in the family?") to explicit invitations to tell (such as: "What got mixed up? Tell me!"). In this way, learning processes that are conducive to discussion can be initiated in learning groups with "competitions" among group members to find the best possible intervention ("best choice") at a

critical point in the conversation - a procedure that we also seek to use in multimedia teaching (§ 13.5).

In another example, which can also be used well for teaching purposes because of its brevity, the doctor, when completing the social anamnesis, passes over the patient's more or less direct emotional reference to the topic of "childlessness".

E 20.5		"unfortunately no children"	Comment
01	D	are you married? .	Social history
02	P	yes .	
03	D	children? .	
04	P	unfortunately no children .	Psychosocial patient services
05	D	hm . marriage good? .	Downgrading ↓ through subject change PS1→PS2
06	P	have been married for 20 years now (...)	

Here, an emotional topic offer is made by the patient and, at the same time, the conversation opportunity thus opened for further clarification of the individual meaning is given away by the doctor. The doctor apparently "overhears" or ignores the brief expression of *regret* ("unfortunately") and levels the topic potential with a suggestive, elliptical questioning technique ("marriage good?") to the normative expectation format of a "good marriage". With the content and form of this type of suggestive questioning, to which we will return separately (§ 21.2), the topic of "childlessness" has "disappeared" from the conversation without a sound. The doctor switches from one psychosocial topic (1) to another psychosocial topic (2) (quality of the couple relationship) without establishing a connection between these topics by asking or enquiring.

However, in order to find out the subjective significance of childlessness for the patient and the couple relationship, the doctor would have had to upgrade the relevance, which he could have achieved by the simple technique of *active listening* (§ 19), for example by simply repeating words with question intonation ("unfortunately?"), or also in explicit form by "You say unfortunately?" or "You seem to regret that", etc. Depending on the answer, follow-up questions would suggest themselves, with which "biological" causes or "psychosocial" reasons for childlessness could be made the subject of conversation, which may have been

wanted at one time, but could be regretted today in retrospect, which may also have become a burden on the couple relationship, which would then not have been unreservedly judged as simply "good" throughout, etc.

In the following example (E 20.6), which we had already mentioned before (§ 19.4) under the general aspect of relevance downgrading, it is about the current experience of the patient (02P: "yes, that happened earlier"), which had also motivated him to visit the doctor immediately, which alone "proves" the relevance of the patient's concern.

E 20.6		"a little more serious, no?"	Comment
01	D	and you saw stars, did you say? .	2.3: Literal reprise "starlets ..."
02	P	yes, that's what happened earlier, I was ... (...) I was driving up the mountain... really cold, blew, and then into the warm room, then all of a sudden ... Stars	
03	D	Dizziness? .	4.1: Accompanying signs
04	P	yes .	
05	D	hm .	2.2 LS (reconfirmation)
06	P	I thought to myself, this is a bit more serious, no? .	Concern ("being more serious")
07	D	are you otherwise in treatment?	Change of topic 4.3: Pre-treatment
08	P	yes .	
09	D	why?	4.3: Pre-treatment

After this current experience that something "happened", the patient now expresses his concern by repeating his previous thoughts (06P: "I thought to myself") in the consultation ("this is a bit more serious"). This kind of self-quotation is obviously linked to the expectation of a statement from the doctor, as is also reinforced by the attached short confirmation question ("no?") (*tag question*), which here in short form takes over the "consent-getting" function of the long form ("isn't it?").

But the doctor reacts to the patient as ignorantly as if the patient had not addressed him with his concern as a specific contact person. Not only does he not lose a "word", but not even a listening signal (*yeah, hm*) to indicate his understanding. Rather, he makes an unceremonious radical change of subject by asking the patient about "other" (pre)treatment). The patient's affect is here "shut down" with a question on a topic that could have been clarified later without loss of information. In contrast, opportunities to further clarify the patient's *concern* should be taken "on the spot", also to learn something about his "subjective theories of illness" (§ 21.5), if necessary.

In the next example (E 20.7), the patient also appeals to the understanding of the doctor, to whom he expresses the wish to be able to continue his old life, which seems to be endangered after a stay in hospital (among other things because of heart problems).

E 20.7		"it depresses me"	Comment
01	D	hm .	
02	P	I want this to go away, I want to go back to the way I was, don't I? .	Psychosocial patient services
03	D	yes, yes, yes .	
04	P	because it depresses me, doesn't it? . maybe you can understand that? .	Emotional expression + appeal
05	D	hm . um . how/when was that ... about, the hospital stay I mean	4.3. Pre-treatments
06	P	the stay was three/four weeks ago.	
07	D	four weeks . hm . and didn't you get any medication or something .	4.3: Medication

Here too, the patient tries in vain to get the doctor to comment on his emotions, which are explicitly expressed ("I want ..."; "it depresses me"). In both cases, the expectation is again "consent-seeking" reinforced by a confirmation question (*tag question*) ("doesn't it") before the patient makes an explicit appeal to the doctor's understanding ("maybe you can understand that?"). In the face of this appeal to his understanding, which is strongly marked several times, the doctor reacts extremely sparingly to "poorly" with mere listening signals (*yes, hm*), before abruptly changing the subject to *biomedicine,* which leads to medication

via hospitalisation. Because these questions could have been clarified later, further promotion of the patient's emotional self-exploration would have been the better alternative, not only to mark the doctor's understanding of the patient's situation more clearly, but also to learn more about his subjective fears, which would have to be explored in detail (§ 21) according to the type and extent of the feared life impairments.

In the example that concludes for the time being (E 20.8), the relevance downgrading of the patient's direct request for help, who would like to see a specific treatment option perceived precisely by this doctor ("with you"), is "undermined" by doctors' information questions about details, the clarification of which proves to be dominant for the time being.

E 20.8		"I preferred to have it done here"	Comment
01	D	hm .	
02	P	and the doctors said . that it had gone well . and they said . you might have to have another chemotherapy, that that would be better. and that's why I [puts her purse in her bag] /I preferred to have it done here . if I needed chemotherapy . because I was here before . with you .	Description of the course of treatment and possible options Requesting help directly from the doctor + Reason
03	D	you were in Hamburg in Professor Schulze's department? .	Relevance downgrading: Details
04	P	no . that was Professor Dr. Müller ...	Correction
05	D	Müller . yes . a liver specialist .	Reconfirmation
06	P	yes .	
07	D	and that was now in February . at the beginning of the year .	4.3: Clarify details
08	P	yes, and I was there for two days and they removed it . and they also did another CT (...)	Description of the course of treatment (continued)

Here, the patient's request for help is addressed directly to the attending physician, who, because of her apparently good experience with the previous treatment, seems to have become the physician she trusts at the same time, when she explicitly prefers further treatment by him ("I would rather have it done here (...) with you"). Instead of responding to

this direct request for help just as directly empathetically as a helper (§ 20.5), the doctor seeks to gain certain further information, the clarification of which thematically "displaces" the patient's current request for help.

As this example also shows, psychosocial topics offered by patients also represent specific offers of relationships, which is why the alternatives of downgrading or upgrading relevance under both aspects must also be continuously considered in the *self-reflective* observation of the course of the lesson. If in everyday life we often experience radical changes of topic by our interlocutor - especially in repeated cases - as a "snub", the repeated ignoring of psychosocial topics in the consultation can develop into a "slight" to the patient, which endangers the relationship itself. In contrast, the upgrading of relevance of emotional patient offers in particular can contribute to the development and stabilisation of the doctor-patient relationship, in which *intimacy* and *trust* (§ 7, 9, 10) can grow together in the ongoing interaction.

20.4.6 Relevance upgrading and NURSE concept

As already emphasised above, it is equally true for communication in everyday life as in medical consultations that not everything can be upgraded to a higher level of relevance at the same time. Rather, a *suitable* choice must be made, in which it makes sense to deselect topics that are sufficiently saturated. Before topics are downgraded in relevance again, they must first be given corresponding opportunities for development, at least if they are already recognisably "close to the heart" of one of the interlocutors. In this sense, the motto: "Emotions have priority" should also be understood as a plea for patient-centered conversation, in which the patient is granted the privilege of choosing his or her own topic without having to "fight" for it.

However, as the preceding examples have made clear, psychosocial or even strongly emotionally charged topics (such as "fear", "anger", etc.) are often "nipped in the bud" by doctors even before they can come to fruition. *Emotions* as well as *narratives* often share the same fate in the medical consultation, where they are both "unwelcome", which manifests itself especially in an *interrogative* style of conversation (§ 19.6). In contrast, a *narrative* style of conversation is also more conducive to patients' emotions, because the invitations to tell stories explicitly grant the right to speak freely and at the same time to explore topics for one-

self (§ 19.7-9, 20.7-9). In the following, anchor examples of shorter conversation sequences are compiled, in which psychosocial topics of patients are given a higher relevance.

Before we come to the "positive" examples of relevance upgrading of psychosocial topics, a historical excursus on terminology will differentiate the (names of the) categories in doctors' dealings with patient emotions, as they have more or less established themselves in research on empathic communication under the *acronym* NURS(E): *Naming*, *Understanding*, *Respecting*, *Supporting* and (often complementary) *Exploring* (Table 20.1). This concept, which is now internationally widespread, is often attributed to more recent work, for example by Back et al. (2005) or (2007).

However, the basic concept of the NURS(E) scheme goes back at least to the early work of Smith and Hoppe (1991) and has been further used from there, for example in the (new) editions of Smith's textbook on "patient-centered interviewing" (Smith 2002 and (new edition) Fortin et al. 2012: "Smith's patient-centered interviewing"). The NURSE scheme has often been illustrated with fictitious, more rarely with real examples, as they will be compiled shortly after our Cologne interview manual. Since these examples can also be used for the NURS(E) scheme, the similarities and differences will be briefly presented and explained.

Without claiming to be representative, the overview of the NURSE scheme by Pollak et al. (2007), which also contains examples (Tab. 20.1), will be reproduced here for orientation. It remains to be seen to what extent the examples were ultimately fictitiously constructed or borrowed from empirical conversations and subsequently "sterilised" for the sake of better "readability", i.e. freed from specific characteristics of oral communication.

Reference should first be made to the not unproblematic distinction between *direct* and *indirect empathic* opportunities (*empathic opportunity)* (§ 20.4.1) or *explicit* and *implicit* verbalisations of emotions by patients, which can certainly not always be applied as strict dichotomies in conversation practice. Here one must even critically question the numerical relationships when Pollak et al. obtain the following result: "Of the 292 empathic opportunities, 68% were direct and 33% were indirect" (2007: 5750). Despite the relatively good interreliability (κ = 0.71), it would be interesting to know not only the result, but in detail how the coders were trained and what was coded for what reasons in

which context, especially how the contentious cases of coding (§ 40) were decided.

	Definition	Examples
Empathic Opportunity		
Direct	Explicit verbal expression of emotion	"I have been really depressed lately."
Indirect	Implicit verbal expression of emotion	"Does this mean I am going to die?"
Continuers (NURSE)		
Name	State patient emotion	"I wonder if you're feeling sad about the test result." "I can see this is making you angry."
Understand	Empathizing with and legitimizing patient emotion	"I can imagine how scary this must be for you. "Many of my patients feel discouraged when they aren't seeing the response they want, so it makes sense that you feel this way".
Respect	Praise patient for strength	"You've done a great job at keeping everything in perspective" "I applaud you for your courage in all of this".
Support	Show support	"I will be with you until the end." "No matter what happens, I will always be your doctor."
Explore	Ask patient to elaborate on emotion	"Tell me more about what is upsetting you." "What do you mean when you say this is not going to happen to me?"

Tab. 20.1: Codes for Empathic Opportunities and for NURSE (mod. after Pollak et al. 2007) (cf. Smith, Hoppe 1992, Smith 2002, Back et al. 2005, 2007, Fortin et al. 2012, Childers et al. 2023).

The problem of differentiating between *direct* and *indirect* or *explicit* and *implicit* communication has already been pointed out several times, for example in the context of speech action and communication theories (§ 7). It often makes sense, especially in oral communication, to emphasise the self-evident, for example in: "I am afraid/scared of the risks of the operation, its consequences, the anesthetic, of death, etc." But the *explicit verbalisation* of a (cognitive, preferential, emotive, etc.) attitude is often dispensable, because what we believe, expect, hope, wish, fear, etc. can also be revealed in other ways.

Thus, even in everyday life, it is sufficiently clear what we *mean* (and want) when we *say*: "Can you pass me the salt?" Such an utterance will hardly be misunderstood as an exploration of the capabilities of the addressee, who will also do more than merely say "yes". As a rule, we are handed the salt without also having to make many more wordy additions, such as "I would like it too" etc.

The example of an utterance given by Pollak et al. 2007, which they classify as *indirect* or *implicit,* would be similarly *unambiguous*: "Does this mean I am going to die? (Table 20.1). Should the patient (have to) become similarly explicit on this topic as in the explicit contrast example ("I have been really depressed lately"), he would have to express himself in a strangely "stilted" way, like this: "Does this mean I must have the *fear* (or *anxiety*) of dying soon?". Such an explicit form, however, contradicts all the rules of cooperation (§ 7.3) which, according to Grice (1975), we also follow in our everyday communication, in which, among other things, we proceed economically and avoid redundancies, unless we want to use them in exceptional cases as just meaningful.

The problem of strict dichotomies often remains vis-à-vis the practice of conversation. As has already become clear in the preceding empirical examples, one can often only speak of *more or less explicit* patient offers. Although the term *cue* (or *clue*) is also problematic, it seems sensible to continue to speak of more or less clear *indications* from patients, which, however, in the current case require specific interpretations from the doctor (as well as from external observers) that are sufficiently context-sensitive.

According to this, not only the meaning of sentences (such as "Does this mean I am going to die?") is the object of interpretation, but the meaning of utterances in context (Wunderlich 1976, Koerfer 1994/2013). In this context, our everyday knowledge of language and the *world* is also always bound up, which includes, for example, the general knowledge of our attitudes towards death and illness. However,

the empathic understanding of the other-psychic is also complicated in the medical consultation by the fact that doctors cannot rely on "normal meanings" in principle, but must work out the *individual* meanings of events as experiences with their patients, which we will come back to separately in the *detailed exploration* (§ 21.5).

This brings us to another problem (not only) of the NURSE scheme, which is related to the specific focus on emotions. General problems of selectivity arise here, because certain procedures such as "*naming*" or "*understanding" or "exploring*" can of course also be carried out relatively independently of emotions. Overall, certain duplications cannot be avoided, such as when forms of *active listening* (listener feedback, repetition, paraphrase) are also related to dealing with emotions, but cannot be limited to this.

The later addition of the category "Exploring" to the NURS scheme also points to problems of selectivity, especially when certain standard interventions are cited for this (such as "Tell me more about ..."), which are already relevant for variants of narrative (self-)exploration with which the patient's narratives are to be encouraged. *Exploration* is on a different level of analysis, where the relations of super- and subcategories would have to be determined more precisely.

What certainly remains a problem for research can be tolerated under the aspect of a meaningful didactic reduction. In the first edition of the *Cologne Conversation Manual* (1998), which was only marginally changed until the current version (Köhle et al. 2010, Koerfer, Albus (eds.) 2018) (cf. Fig. 20.6), we already drafted a similar typology for empathic interventions, as it was already rudimentarily laid out with the initial NURS(E) scheme by Smith and Hoppe (1991), which was then later adopted many times and used for purposes of research and didactics (Smith 2002, Back et al. 2005, 2007, Pollak et al. 2007, Fortin et al. 2012, NKLM 2015/2021, Langewitz 2017, Walczak et al. 2018, Childers et al. 2023). However, Smith (2002) and Fortin et al. (2012), for example, have stuck to their original NURS version (without "E"), but without further justifying this.

While the NURS(E) scheme exclusively records positive reactions to emotional patient cues, we had previously distinguished relevance upgradings from relevance down-gradings in a typology on *(non-) responsiveness* (Fig. 20.4), for which empirical examples from conversation practice were first given.

In the third step of the *Cologne Manual of Medical Communication* (C-MMC) (§ 20.1), we now follow a division into (3.3) "Respond empathical-

ly" and (3.4) "Promote emotional openness", which was also adopted in our typology (Fig. 20.4) and supplemented by the listener feedback, provided that this proves to be specifically *empathic* according to the following anchor examples (e.g. "Great!", "Wow!"). Under sub-step (3.3) ("Responding empathically") of the manual, the further subtypes "Acknowledging stresses and coping" and "Offering help and comfort appropriately" are distinguished, which roughly correspond to the types *Respecting* and *Supporting* from the NURS(E) scheme.

Furthermore, under sub-step (3.4) ("Promoting emotional openness") of the manual, the subtypes *Addressing, Naming*, *Clarifying* and *Interpreting* are differentiated, whose (dis)congruencies with the NURSE scheme will emerge on the basis of empirical anchor examples.

Those who prefer to work with the NURSE scheme in view of its international distribution,[3] can nevertheless get practical suggestions for their research and teaching purposes with other or related categories of analysis in the following collection of anchor examples for the *Cologne Manual of Medical Communication* (C-MMC) (§ 20.1. and Fig. 20.6).

20.5 Responding empathetically

With an *empathic response* (= Manual 3.3) (§ 20.1) the doctor reacts to the patient's distress and need for help. He shows his willingness to understand and help and makes himself available to the patient in a supportive manner with his professional competence. If this is *appropriate* in each individual case, he will acknowledge the patient's stress and attempts to cope (§ 20.5.1) and offer the patient help and comfort (§ 20.5.2). If this is justified, it is equally part of the relational offer of help and comfort to express confidence appropriately and to give the patient hope for a solution to his problem. A solution to a problem that is satisfactory for the time being is not necessarily identical with "healing", since medical action also extends to other (preventive, palliative, etc.) functions in addition to the curative function.

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3 In order to counter a possibly exaggerated impression regarding the international dissemination of the NURSE scheme, it should be pointed out that many (text) books on doctor-patient communication on the topic of "empathy and emotions" also manage without the scheme altogether (e.g. Platt, Gordon 2004, Roter, Hall 2006, Hugman 2009, Parrott, Crook 2011, Cole, Bird 2014, Brown et al. 2016). Childers et al. (2023) refer to the well-known scheme, but explicitly argue "Beyond the NURSE Acronym".

20.5.1 Acknowledgement of stress and coping

If doctors encourage them to do so, patients also tell their life stories about the stresses to which they have been exposed singularly or iteratively or are still currently exposed. These stresses can be triggered by *critical life events* (Filipp, Aymanns 2010, Maercker, Gurris 2017), which include not only extreme experiences (violence, accident, abuse, etc.) but also relatively common experiences that are quite common in our society (unemployment, debt, divorce, etc.). Likewise, the illnesses themselves can lead to life impairments (e.g. in the case of diabetes mellitus), which demand special coping skills from the patients (§ 22, 29). In all these cases, special *empathic recognition* by the doctor is required if the patients are to feel sufficiently understood in their suffering and appropriately supported in their attempts to cope.

In the first example (E 20.9), the patient continues her biographical narrative, which she had already begun, after another narrative invitation from the doctor, with the essential content that already as a girl and young woman she had to constantly take on the role of a "substitute mother" in the family, who also had to take care of the problem and nursing cases in the family. The following, abridged excerpts are not only about the patient's burdens, but also about her *subjective ideas* (§ 21.5) that she could meet the same threatening fate as her relatives.

E 20.9		"You've been through a lot too, yes."	Comment
01	D	(...) and what happens to you .	
02	P	yes - it all came down to me, I always had to go, I was always the stupid one who had to go, my mother called me at night, every time, whether the children were freshly born, whether they were old and grown up, I always had to come, he didn't want anyone from the neighbourhood to help, no (...) but then the mother, then the brother died of a heart attack at the age of 42, how long ago was that now? .... Yes ... ten, fifteen years ... and the mother a few years before that...	Abridged narrative about helper role as daughter Early care and death in the family
03	D	you've been through a lot too, yes.	3.3: Acknowledge burdens
04	P	yes, he came in the morning and said, come	Continuation of

		on, I can’t wake up your mother, I said, you're crazy, I was still there last night, yes, we still had the doctor ... she never went to the doctor, she had more than 200 in both arms and the upper pressure must also have been ... over, completely over ... there ... she always had the pain ... up here ...	the narrative Death of the mother
05	D	hm ... when you feel something like that in your body, you think, now I feel like the others?	4.2: Subjective ideas
06	P	now it's the same for me as for the others, that's that. and that's what makes my nerves all shot.	Literal resumption and expansion
07	D	that's what it's like, it shots your nerves.	2.3: Literal repetition
08	P	yes, that that that . then you are - .	
09	D	then you ca . that is also hard to bear ...	3.3: Acknowledge burdens
10	P	that's ... and that's what I've got now ... pfhh ... with the ... dizziness and everything (...)	Continuation of symptoms

Doctor and patient cooperate in this narrative in a way that not only retrospectively stressful events and experiences of the patient are brought up, but also their current meanings for the patient in the "here and now", who sees herself similarly endangered in her subjective ideas as her relatives in the "there and then". The narrative already begun in advance is promoted here and kept going by ongoing upgrades of relevance, to which, in addition to *active listening* ("verbatim repetition") (D07) (§ 19), the *acknowledgements of the stresses* contribute here in particular (D03, D09). That the doctor is correct in his exploration of the subjective ideas (D05) is shown by the patient's reaction, who in turn makes use of the means of verbal repetition in the sense of confirmation (P06). In this interplay of past and present perspectives, the patient herself then associates the current stresses with her current symptoms (10P: "dizziness"), so that both interlocutors are back in the "here and now" of the consultation.

In the following example (E 20.10), the focus is first on the patient's current stresses, which include a visit from relatives abroad, before long-term stresses in the marriage are also discussed.

E 20.10		"You can't stand it any more".	Comment
01	D	hm ...	
02	P	every excitement ... now the sister has grandchildren from America, and now we don't speak English and he doesn't understand us ... and he's so wild and ... and then the brother-in-law ... all the physical stuff around it ... I never had that before...	Subjective explanation of the (reasons for the) current agitations Topicality
03	D	You can't stand it any more ...	3.3: Acknowledge burdens
04	P	no ... I ... and now I have to say that my husband doesn't give me much support either, since the pension ... I would have imagined my pension life to be better ... like this ... (3) ...	Permanent load since the start of the partner's pension
05	D	you have to do everything on your own, you don't get any support, do you? .	3.3: Acknowledge burdens
06	P	oh ... God, he does, but everything, everything with "must" then and before it was different how he worked hard . I said (...)	Permanent load since the start of the partner's pension

In this case, it is about the empathic recognition of both current stresses (D03), which will also be temporary from the patient's point of view, and permanent stresses (D05), which can arise and persist as typical stresses due to social life changes such as one's own retirement or that of one's partner. Here, life development can be directed against expectations, which we will come back to with this example in a moment when *naming* emotions. Later (§ 20.8), typically stressful events such as divorce and the resulting role stress as a single parent will also be discussed, which require an *empathetic recognition* of the life achievement of the person concerned beyond the mere *acknowledgement by* the doctor.

These types of stresses caused by life events must be distinguished from the specific stresses caused by diseases themselves, which must be honoured just as much as their attempts to cope. This will be shown by two examples of diabetes patients who have to "fight" for their personal "values" every day. As can be seen from the two examples (E

20.11 and E 20.12), doctors as professionals are not too "shy" to express their appreciation of their patients' efforts in an everyday language that can be understood by all.

E 20.11		"good! . yes, you have found that out well"	Comment
01	D	what was the sugar like now?	4.1+4.3: Exploring details
02	P	my sugar is 170 this morning.	Info
03	D	that's good...	3.3: Acknowledge Coping
04	P	yes, and yesterday too - I have to tell you, doctor. I injected 3 times a day and when I got up in the morning my sugar was always at 250, 260 ... and now I did that before I went to bed, and I go to bed quite late, about half past eleven every night, so I injected another 20 units . I injected 20 units and, lo and behold, in the morning I was under 200 again and again.	More info on the patient's individual treatment procedure
05	D	good! . yes, you have found that out well ...	3.3: Acknowledge Coping
06	P	yes . and i believe that . i'll keep doing it ... i'll have 170, 160, 170 in the morning . and that's fine yes . for me anyway....	Confirmation and perspectivation

E 20.12		"gosh!, gosh!"	Comment
01	D	(...)but then you kind of feel your way into it.	4.1+4.3: Exploring details
02	P	yes, I have also done that so far . the last HbA1 value was ... which is perhaps quite good .	Info
03	D	yes .	LH
04	P	because it was still quite high before . with Dr. Z and also with my GP . it looked like . that at some point I was at 12.1 or something .	Communication current value
05	D	hm .	
06	P	I started in January ... and am now at 5.8 on	Comparative

		26.4 (=April) ...	values
07	D	wow . Gosh! . gosh! that's a very very good value then . when were you diagnosed .	3.3: Acknowledge + 4.1: (time)
08	P	uh . [reaches for pocket] 7.10. last year (...)	

Both doctors (in E 20.11+12) pay their respect to their diabetes patients' coping skills in direct empathic feedback, which they both formulate in everyday language that their patients can understand. In the first example (E 20.11), the patient sees himself confirmed to continue the way he "found out well" from the doctor's point of view (D05). In the second example (E 20.12), the short interjection ("Gosh!") would already suffice as listener feedback, but it is then verbally reinforced again ("very, very good value") (D05), before the doctor then follows up with another question for detailed exploration.

This is a brief exchange of information in a conversation, the course of which should still interest us under the special aspect of participatory *decision-making* (§ 10), under which the current treatment concept is subjected to a probationary test that goes beyond the purely *biomedical* aspect of the "well-adjusted diabetic". Regardless of his current "good" values, the patient nevertheless prefers a different treatment concept ("change to pump") with which he can better adjust to his living and working conditions. This example then shows in detail how the two interlocutors weigh the advantages and disadvantages of the alternative treatment procedures ("injections" versus "pump") in order to be able to reduce the degree of impairment caused by a chronic disease or to improve the patient's quality of life (§ 22.5, 29.2). In order to achieve such further goals, a developed relationship between doctor and patient is needed, which can already be experienced as sufficiently *helpful* in the initial consultation.

20.5.2 Offering help and comfort

In the development of a *helpful relationship* (§ 1, 3, 8), (primary) care physicians' actions do not differ significantly from psychotherapeutic actions, but possibly only to the extent that psychosocial problems are made the subject of exploration and therapy. In principle, primary care physicians also make use of specific supportive interventions to promote a helpful relationship, as the following examples make clear. However, problems of a special kind often arise here at the beginning of the

conversation if patients cannot accept the offered medical help or cannot accept it immediately.

Offering help and comfort is often difficult because these supportive offers can also be experienced by patients as inappropriate and rejected accordingly. We have already referred (§ 20.3) to the barriers and limits of empathy, which can already begin where patients have fundamental difficulties in seeking medical help. In *the initial stage of seeking help* (§ 18.2), some patients are also unsure whether their complaints and concerns can justify a visit to the doctor at all.

In the following example (E 20.13), the patient is plagued by a "guilty conscience", as she says herself. Apparently, she doubts her entitlement to seek medical help because of the current improvement in her complaints, which she tries to dissuade the doctor from doing by repeatedly *encouraging her* to seek help even if her complaints improve. This is a problem that certainly occurs more frequently in the doctor's office: the patient had made an appointment when she was feeling "bad" and now keeps it even though she is feeling "better" in the meantime.

E 20.13		" yes, no, but that's actually right like that"	Comment
01	D	(...) quite a different impression .	4.3
02	P	and today I have a guilty conscience because I thought to myself, actually, I feel much better today than I did yesterday.	Patient note "bad conscience“
03	D	yes, no, but that's actually right like that .	3.3: Offering help 1
04	P	but then I thought, oh who knows what the point is, you have the appointment now when you weren't feeling well yesterday and then you just go-	Patient note (uncertainty)
05	D	also go there .	3.3: Offering help 2
06	P	yes	Confirmation

The patient's perception of the consultation is now reinforced twice by the doctor: the first time, the use of the helping relationship is already confirmed (03D: "that's actually right") in such a way that the patient seems to overcome her doubts about the justification of the visit to the doctor in the self-citation. The second time, the doctor precedes the patient's thought with the special construction of a so-called "joint sen-

tence production", which testifies to a high degree of empathetic perspective-taking.

By intervening in the patient's ongoing sentence construction and completing it on her behalf (04P: "and then you just go ..." – 05D: "... also go there"), the doctor indicates her *anticipatory understanding* of what *the* patient is about to say in a collaborative form of communication. The meta-communicative function of such sentence completions through speaker changes can be paraphrased as follows: "You don't need to bother any further, I understood you already". In this way, we give ourselves a "we-understand-each-other" feeling in everyday life as well as in the consultation, on the basis of which we can also better clarify "contentious issues". It should also be noted that collaborative forms of communication of this kind ("sentence completers") are by no means to be regarded as "*interruptions"* (§ 19.3). Even if one formally "interrupts" the current speaker, sentence completers serve to liquefy communication in the sense of an abbreviated procedure, which is usually accepted by both interlocutors as a special sign of mutual understanding.

The mutually achieved level of shared understanding is often affirmed by a reconfirmation from the completed speaker, as here by the patient ("yes"), who in turn indicates retrospectively that she was well understood by the doctor in advance. If, from whatever perspective, the perception of the consultation appointment was ever something "contentious", the communication at this point can undoubtedly be continued in agreement.

What is marked as understood in advance turns out to be an emphasis on the self-understanding in the sense of an abbreviated procedure (precisely because of the interruption). The patient can continue to communicate in the certainty that she has behaved appropriately and has been encouraged in this by her interlocutor as a helper in the current consultation. With this affirmative offer from the doctor, a current feeling of insecurity on the part of the patient during the establishment of the relationship is eliminated and the relationship can be continued with a new feeling of security, which will probably also come into play when seeking medical help in the future.

As already explained in the preceding examples of the typology of the opening of the conversation, doctors often offer themselves to their patients as *helpers* at the beginning of the conversation (§ 19.2). If doubts arise during the conversation that relate less to willingness than to the ability or possibility to help, the helping relationship may have to be

"proven" again, provided this is justified according to medical evidence. According to this restriction, distinctions must be made, for example, between permissible and impermissible *reassurances* of patients who, for their part, must be prepared to give sufficient credence to the doctor they trust when he says: "I can reassure you because ...". However, the doctor must follow patients' further need for justification without reservation, without interpreting this kind of need for information as mistrust, which it can be in individual cases.

The relationship becomes problematic when patients believe themselves to be a "hopeless" case that "cannot be helped" or when they "fear" to be the "victim" of a "wrong treatment" because important diagnostic or therapeutic measures were "missed". In the following example (E 20.14), which has been greatly abridged here, the doctor must first dispel such a patient's "suspicion" of prior treatment by a third party, in order to then reinforce trust in the medical profession by emphasising the relevance of "giving the right help".

E 20.14		"there I can reassure you a bit"
01	D	yes .
02	P	and they only did an ultrasound at the time . who knows . maybe they would have found out then that there was a small tumour .
03	D	hm .
04	P	and it could grow in the two years, ne .
05	D	hm . hm . yes but that is/there I can reassure you a bit . Mrs. Müller . so that you don't get the impression that something has been missed. (...) that is also a part of the incalculable nature of this disease . of course it doesn't get any better if you are constantly examined .
06	P	yes, yes .
07	D	it's like this . it happens or it doesn't happen . and when it's there . and it's noticed . then you can't undo it . yes .
08	P	yes .
09	D	so our experience is that it is very important to give the right help, but that it really doesn't matter that much whether you find out sooner or a few weeks later.
10	P	hm .
11	D	that makes no difference for what needs to be done.
12	P	hm .
13	D	so it's a bit different from the way it's always said elsewhere .

		Early detection is important.
14	P	I already know . maybe . sometimes I blame myself a bit . back then like I did (...) [new topic: tablets not taken = non-adherence].

Although the patient does not use any relevant expressions (such as: *worry*, *concern*, *omission*, etc.), her "fears" are nevertheless "unmistakable" when she plays through her lay hypotheses in her words ("only did", "who knows, maybe ..." etc.). Her "words" are also "heard" as "fears" by the doctor, who expresses his *empathetic understanding* of her statements to the patient: Before he begins a longer (here abbreviated) explanation, the patient's "fears", which he understands in this way, are reformulated (D05). He tries to "reassure" her by countering the "impression" that "something has been missed" - thereby expressing the content of what the patient has already suggested ("omission").

The doctor tries to convey reassurance in a weakened form by "*diminution*" ("a bit"), which is often used as a stylistic device in these contexts: "I can reassure you a bit" (D05). Obviously, with this stylistic device, the doctor at the same time admits to residual doubts whose justification is not to be "completely" denied, but rather *emotionally* acknowledged, even if they may not seem *rational* for factual reasons. Attempts at "reassurance" are always subject to failure, which doctors also take into account linguistically. Especially with the emphasis on the relevance of "giving the right help" (D09), possibilities of mistreatment are also acknowledged in principle, even if they are ruled out in the present case.

It remains to be seen to what extent the patient could be sustainably reassured, which is apparent for the time being (P14) and does not reveal itself differently in the further course of the conversation, in which the next helpful steps in the current treatment are discussed. In order to be able to take these further steps, an intermediate step had apparently become necessary, in which there was a need for clarification on the part of the patient with regard to pre-treatment by third parties. In view of the patient's "apprehension", then initially contributing to "reassurance" through medical clarification work was a prerequisite for the further development of one's own relationship with the patient, which could be continued with sufficient confidence in the medical art of helping.

However, a distinction must be made between objectively justified reassurances and "pseudo-reassurances" which are undertaken "for their own sake" in order to achieve the *perlocutionary effect* (§ 7.3) that a

patient is ultimately "reassured". If "lies have short legs" in everyday life, then even more so in medical practice. The proverbial "truth at the bedside" requires communication that should not be *covert-strategic* but *communication-oriented* (§ 7). However, open information does not mean informing patients "ruthlessly" about facts, but rather proceeding as "cautiously" as possible when communicating "*bad*" *news* (§ 10, 16, 38). In doing so, patient emotions should not be "silenced" but "disclosed".

20.6 Promoting emotional openness

In order to promote the emotional openness of patients, certain types of verbal interventions can be used at different levels, which are described below as *addressing*, *naming*, *clarifying* and *interpreting* emotions and will be illustrated by means of anchor examples. The risks involved in dealing with emotions must also be taken into account, but they are usually a better alternative than *ignoring them*, which was described earlier (§ 20.4) under forms of relevance downgrading of emotions. For the forms of relevance upgrading, we follow the linear presentation in the Conversation Manual (§ 20.1), but would like to emphasise again that this is not intended to suggest any order or even ranking. Emotions are to be taken up in the conversation and "treated" appropriately as they are "offered" more or less clearly by the patients through "*cues*", however discrete.

20.6.1 Addressing

It had already become clear in the preceding examples that doctors cannot always assume that their patients "wear their hearts on their sleeves". Rather, the emotions are often laborious to "elicit". In the process of disclosing emotions, doctors cannot base their perception solely on the "surface" of the conversation, but must read or listen "between the lines" in order to be able to arrive at an overall impression.

Non-verbal phenomena must also be taken into account in the perception and interpretation of communication, which can be determined by "aggressive" or "depressive" gestures, facial expressions, posture, tone of voice, etc. (§ 12, 18). The holistic perception of communication also includes the so-called "scenic understanding" (§ 9.2), for which we

had already given examples in the case of narration (§ 19). For example, a patient in his story about his exam failure ("so I couldn't get anything out of myself") had similar articulation problems in the narration during the consultation, in which his voice threatened to fail again as it had in the exam situation.

However, the holistic perception of communication is not limited to individual utterance sequences and particular verbal and non-verbal phenomena, but also extends over longer passages of conversation in which impressions can be more or less collected and added up. Although there seems to be no local "patient reference", doctors nevertheless formulate their personal "impression", which they seem to have gained supersummatively. There are similarities and differences here in comparison with everyday communication. Although we are also guided by supersummed impressions in everyday life, we are usually careful not to "address" more or less strangers directly. *Addressing* perceived emotions is obviously a medical privilege that is used in the consultation for good reasons.

In the following example (E 20.15), the doctor first marks the change to "addressing" the perceived emotion with a caesura ("now something completely different") before he also brings up with the patient the "very worried impression" that he obviously "makes".

E 20.15		" you make a very... worried impression"	Comment
01	D	(...) for a while now, too, ne?	
02	P	yes that I ... I was working the night shift and ... Yes, I got up and ...	Complaints
03	D	hm .	
04	P	poured a cup of coffee ...	
05	D	hm .	
06	P	I have this feeling. It's like someone is taking my breath away.	
07	D	hm ... uh ... now something completely different ... you make a very... worried impression, huh? .. since you read [that the something-	3.4: Addressing ("worried impression")
08	P	[well, do I ... I don't know what it is...	Confirmation of concern
09	D	because right . we want to see what it is .	3.3: Offer help

After the caesura, the doctor formulates his impression and thus gives manifest verbal expression ("worried") to a patient emotion that had remained latent until then. What had previously been unspoken is now spoken and made an issue. The patient confirms the impression ("well I do") and justifies it with his *not-knowing* ("I don't know what it is"), which is in turn directly taken up by the doctor. In his reaction, the doctor performs a typical *supportive* function of medical action, namely the elimination of "not-knowing" that makes the patient "worried". Here the doctor holds out the prospect of a joint clarification (09D: "we want to see what it is"), which the patient then immediately takes up and in the further course of the conversation extends to the clarification of his further concern about a risk of infection towards his partner ("that she won't get the same crap"). The communication of this further concern can only be seamlessly connected by the fact that the concern previously perceived by the doctor has already been made an issue by him.

Excursus on the use of WE

In this example, a short excursus on the use of "WE" is also appropriate, which can be generalised for the further conversation analyses. The doctor had formulated his offer of help and spoke of "we" (09D: "we want to see what it is"). It should be noted that the frequent *use of "we"* in the linguistic realisation variants of supportive interventions is not the frowned-upon *pluralis majestatis*, which is sometimes wrongly assumed in research, but rather a genuine "we" that refers to common problem solutions in the sense of a temporary community of solidarity or purpose. This commonality is often specifically marked linguistically with "we" in the sense of "we (both) will (jointly) see/find out whether ...". In addition, there is also an impersonal expression (“one can, should do ...”), in which the agent is assumed to be *anonymous*. In these cases, however, the doctor often means "you and I".

In the ward round, additional staff may be included in the space of action (§ 24), so that a specific (partial) quantity problem arises here in the sense of "he/she + I + you", which can be resolved accordingly by patients as recipients in each case or also left as it is in its ambiguity. Compared to "one", however, "we" has the additional function that not only the *helper* perspective of the doctor is taken personally, but with the linguistically marked commonality of action ("let's see what it is")

the necessary cooperation of the patient in the further clarification is addressed at the same time. The frequent use of *"we"*, which can also be analysed as a relationship indicator, emphasises the joint work in the conversation (Koerfer et al. 2010), which we will return to in subsequent analyses, for example in the case of GP communication (§ 25).

Corrections for "failures"

When communicating impressions of the patient's communication behaviour, the doctor briefly changes from the *we-perspective* of the general *participant role* to the specific *observer role* without, however, leaving the common field of action. Accordingly, as in the previous example, the impressions gained are often communicated after a clearly marked caesura, which already points to the special nature of addressing emotions. Its chances and risks for empathic communication can be weighed carefully or decided spontaneously, without the "consequences" for the further course of the conversation always being foreseeable. Addressing the patient's emotions can sometimes lead to "failures", which is illustrated here by a short example (E 20.16), in which the conversation first deals with the detailed exploration of the patient's acute "cough" before the doctor pauses and makes his perception known to the patient.

E 20.16		"You make a worried impression somehow"	Comment
01	D	what does it look like? .	4.1: Quality.
02	P	oh . what do you mean, how does it look? . eh ... the cough? .	
03	D	yes .	
04	P	if I spit this out? .... pfhh ... a bit greenish...	
05	D	greenish, yes... um... You make a worried impression somehow.	3.1: Addressing
06	P	no, I'm just exhausted, I've had two ... exhausting days.	Correction 1
07	D	what happened? .	
08	P	[laughs] I had a birthday party ...	
09	D	congratulations! .	
10	P	... yes... [laughs] ... no, and I'm not worried, not at all! ...	Correction 2

According to her own statement, the patient is "exhausted", which the doctor obviously perceived differently (namely as "worried"). The patient's correction follows on its heels and can be well integrated into the relationship. However, these very rare cases of "error" should by no means be used as a reason or excuse to avoid the risk of failure in attributing emotions in the first place. As in almost all the cases we observed, the doctors were "spot on" in communicating their impressions, as the further course of communication showed in each case. The "addressing" of emotions that had previously remained "unspoken" is often gratefully received by the patients because they not only recognise the empathic understanding of the doctor, but can also experience emotional relief themselves.

20.6.2 Naming

Before marking the differences, the similarities in *addressing* and *naming* emotions should be emphasised. In both cases, the doctor takes the explicit topic initiative for an emotional content that had not been explicitly addressed before. What was previously "unspoken" is now spoken. The doctor's intervention is based on specific *inferences* ("conclusions") that the doctor can draw qua everyday and professional knowledge on the basis of the patient's verbal and non-verbal *cues*.

The distinction between *addressing* and *naming* brings into play the problem that has already been characterised (§ 20.4) with the gradual gradation that patient indications move more or less in one direction or the other in certain *dimensions* (*implicit-explicit, indirect-direct, latent-manifest*). Without misjudging the problem of demarcation, it should be assumed here in the case of *addressing* that the emotion in question was currently less "close to consciousness" for the patient before it was "addressed" by the doctor. In contrast, in the case of "naming", the emotions in question have already been "pre-formulated", as it were, by the patient when they are finally "brought to mind" by the doctor. The essential differences between the two types thus lie in the interactive prehistory in which the verbalisation is more or less "initiated". As already noticed in the previous examples of *addressing*, it is often preceded by an interaction caesura because the change of topic is obvious, which is essentially based on a non-verbal perception. In contrast, *naming represents* an intermediate result in a continuous process of "progressive

verbalisation" of emotions, for which the patients do essential preparatory work.

For all the differences between *addressing* and *naming* emotions, what they have in common is the conceptual awareness that is stimulated by the doctor's intervention. The more or less "clear" indications that patients may have given more or less consciously in previous verbal and non-verbal communication are "brought to the concept" by the doctor introducing a thematic *key symbol* from an *emotive* word field (e.g. fear, anger, sadness) that is constitutive for the further course of the conversation. The constitutive function of the thematic key symbol often proves itself through affirmative feedback from the patient (e.g. "yes exactly", "yes, right", etc.), who thus indicates that he has been well understood by the doctor in the sense of the accuracy of fit (§ 3, 17) of interventions. Through a later resumption of the thematic key symbol, both partners signal to each other their now interactively shared understanding of meanings they have negotiated together.

The following examples (E 20.17) and (E 20.18) come from the same conversation in which the patient had already begun to complain about her husband who, since his retirement, has been behaving completely against her expectations, which is now being continued in the empathic cooperation with the doctor, which is reproduced here in two excerpts.

E 20.17		"then you get annoyed"	Comment
01	D	you have to do everything on your own, you don't get any support, do you?	3.3: Acknowledge burdens
02	P	oh ... God, he does, but everything, everything with "must" then and before it was different when he worked hard. (...) and then when he does, he goes to the garage, where he puzzles around ... he probably always has something to do ... but then the bottle of beer is already there and then, for me, the day is already over ...	Permanent load since the start of the partner's pension
03	D	then you get annoyed? .	3.4: Naming emotions
04	P	yes . and ... he doesn't admit anything . he counts the first and the last thing and not what was in the middle, and that's the (...)	Confirmation + Expansion

E 20.18		"a huge disappointment"	Comment
01	D	(...)	
02	P	(...) because he, as I said, when I'm a pensioner, we do so many things... and it's just the opposite.	Complaining about being "retired
03	D	a huge disappointment.	3.4: Naming emotions
04	P	yes . re:al . real disappointment! I have to say, he's doing his job, but . he's already doing everything, no . but then there's always the drinking and then (...)	Strong confirmation through repetition + Theme expansion

In both cases, when *naming* the emotions, the *term* "anger" or "disappointment" is used to describe what was already "in the air", as it were, because the patient had already "pre-formulated" it in other words. Thus the doctor's naming of "disappointment" is already suggested by the patient with her relation of opposites, when she compares her husband's promise ("then we'll do so many things") with his real behaviour ("and it's just the opposite"). In naming, the doctor's utterance stands in a specific hierarchical paraphrase relation to the patient's previous utterances in the sense that the doctor carries out a *conceptual abstraction* of the more concrete patient utterances.

The *accuracy of the fitting* is usually proven by the reaction of patients, from which the doctors can "read" how much they have "hit the mark". The reactions range from minimal feedback through simple, affirmative listening signals (*yes, hm*) to stronger feedback (*exactly, right*) to multi-part affirmations. The fact that the doctor in the second case has accurately *named* the patient's emotion with his term "huge disappointment" is manifested by her feedback, in which she repeats the doctor's term with a slight modification, which is at the same time emphasised as ("re:al, real disappointment"). In both examples, the emotional patient offers are upgraded in relevance through the naming, which the patient can use to further expand the topic she has started.

Naming can be related not only to problems relevant to life in the broader sense, but also to bodily experiences that are explicitly associated with symptoms of illness that can trigger insecurity, worry, anxiety, etc. These emotions are also often implicitly brought into the conversation before they are brought to the term by the doctor. In the follow-

ing example (E 20.19), first the worries about the sugar levels and then the fear about a feared heart attack are named.

E 20.19		"You are then always afraid (of heart attacks)".	Comment
01	D	and then there's the sugar, no... and that makes you all worried, no...	3.4: Naming emotions
02	P	yes ... yes ... and I can do what I want . I can eat what I want and it won't go down . and now, when you were on holiday, I think, now the doctor isn't here . it doesn't help that we go there (...) but the pain goes from here to there [points around the chest] . from there to there . really bad, I mean, when I lift my arm, it breaks off . uh, quite strange the stitches, no	Description of complaints and symptoms Sugar levels Pain Pointing gesture Stiches
03	D	and you're always afraid that it's a heart attack or something like that.	3.4: Naming emotions
04	P	yes . or that it ... yes yes: ... because (...)	Theme expansion

The emotional offers of the patient are twice upgraded in relevance, which stimulates the patient in her own way to further thematic expansion. The patient tries to convey to her doctor the dramatic nature of her experience, which has been heightened by his absence as a helper. She makes it unmistakably clear to him that her complaints or symptoms were so severe that she would have consulted him earlier if he had not been on holiday (02P: "I think, now the doctor is not here, it doesn't help that we go there"). The patient then describes the heart-related complaints non-verbally (by pointing at her chest) and verbally ("pain", "stiches") and characterises them as "quite strange", before the doctor then explicitly expresses her emotion with the appropriate term "fear" (of a heart attack).

20.6.3 Clearing

Whereas in the case of *naming*, the emotions in question seem to have been clarified for the time being because they have been brought to a concept, however provisional, in other cases *clarification* is still pending. Therefore, the possible emotions are also conceptualised, but are put up for conversation in questioning actions. The following example (E 20.20) is about clarifying the emotions of the patient who has already been treated for kidney stones and now wants another examination ("another ultrasound").

E 20.20		"are you worried that something is wrong"	Comment
01	D	(...)	
02	P	(...) and ultrasound again to see if there is anything from the kidney stone, uh ...	
03	D	whether there is anything left .	2.3: Sentence completion
04	P	yes, whether again . yes, as a precaution ...	Confirmation
05	D	do you have any complaints? .	4.1: Complaints?
06	P	no .... no, I noticed a bit here, but actually nothing, maybe (unintelligible) or something.	
07	D	and eh . are you worried that something is wrong or something?...	3.4: Clarifying emotions
08	P	yes . just as a precaution .	Confirmation
09	D	yes ... yes . you are a little anxious, yes? .	3.4: Clarifying emotions
10	P	yes, I'd rather have it checked, no, because it's also my disposition (...)	

Right at the beginning, the doctor shows his understanding of the patient's concerns by anticipating her further formulations through *joint sentence production*, which is a special form of *active listening* (§ 19). After the short speech delay and pause ("kidney stone uh ..."), the doctor rushes to the patient's aid by "standing in" for her. The verbal support here is not by paraphrase, but by completing the patient's speech, towards which an *anticipatory* understanding is indicated. After the patient's request has already been formulated cooperatively, the doctor tries to find out about her motivation in three steps. First, he asks

about possible complaints, which the patient denies, in order to then inquire in two variants about possible emotions ("worry" - " anxious") that could be connected with her concern. Both questions are confirmed by the patient ("yes"), but the confirmations are each modified with further information.

After the first answer to the decision question (07D: "are you worried that something is wrong or something?") the "hurdle" for the formulation of a weaker emotion is reduced again. Through the specific type of further questioning (§ 21.2), with which the doctor already indicates his expectation of the answer (09D: "you are a little anxious, yes?"), and through the specific "weakening" or "reduction" (*diminution*) ("a little") the doctor further accommodates the patient, who not only answers with a simple "yes", but additionally justifies her preference ("rather have it checked") ("because it is also my disposition"). This seems to sufficiently clarify the degree of "concern" or "anxiety" as a "subjective" prerequisite for a possible examination, which then also took place.

While the previous example dealt with the clarification of body- or disease-related emotions, the next example is an attempt to clarify emotions in the relationship of a patient who encounters her partner with great ambivalence. The doctor and the patient have already begun a joint conceptual work on emotions (E 20.21), which will be reproduced here in short excerpts for better understanding, before the clarification of the patient's ambivalent emotions is then (E 20.22) brought into the focus of attention.

E 20.21		"there is a lot of worry and fear"	Comment
01	D	ah yes! (...) try to remind me a bit what it's all about...	2.3: Active listening
02	P	yes, it's about his alcoholism . which has also flared up again . for a few years now, and . it has now taken on forms again, so I say, so uh . there absolutely has to be ( ) .	Psychosocial theme expansion
03	D	something done .	2.3: Sentence completion
04	P	yes, something has to be done, I have spoken to him several times (...) uh, you have to be very careful with him . and then treat him like a raw egg ... because then ... he flees directly . always, yes, so . he avoids and uh	Psychosocial theme expansion
05	D	that is, life with him has become very difficult	3.3: Acknowledge

		for you .	burdens
06	P	er... yes, it was difficult from the beginning, but I had maybe, I was once told, it's always this helper syndrome that women have in them, yes, um, or mother instincts, but (...) (...) (...) at some point in life the boy starts to idealise his father and does the same ... these are my fears.	Psychosocial theme expansion Current emotions (fears for the development of the child together)
07	D	there is a lot of worry and fear in you.	3.4: Naming emotions
08	P	but ... yes ... very much ... so I think through so many things and um . (...)	Confimation

E 20.22		"what do you still feel for him?"	Comment
01	D	(...)	
02	P	(...) I also have, you know, I'm also to blame for everything ... no matter what, he's looking for me to blame, and I'm hysterical and... a witch, so there are mean things that come up, you ask yourself why you even bother with a guy like that (...) I mean, you still have feelings, yes.	Topic expansion Emotional (self-) exploration Current Sensations
03	D	what . what do you still feel for him? .	3.4: Clarifying emotions
04	P	oh, well, how should I put it? . so at the moment when I'm angry, I could shoot him to the moon. I could knock him down, murder him, everything . but when he's gone for a few days, then I miss the same person again. I find that unusual, so...	Topic expansion current emotions of the patient towards her partner

The excerpts make clear how *empathy-in-interaction* develops not only turn-by-turn, but as a process of emergence of negotiated meanings through a series of conversational steps that build on each other in a dialogical feedback system (§ 20.3-4). Despite the abridgements, it becomes readily apparent how both interlocutors cooperate in empathic communication, gradually developing a shared conversational history based on a shared *basic vocabulary* that serves the patient's further

emotional self-exploration. This brings to light the ambivalences towards her partner, whom she could "murder" on the one hand, before she then "misses him again", which she herself finds "unusual".

In this process of the patient's progressive self-exploration, the doctor with his interventions performs a *midwifery function* in the *verbalisation of emotions* (§ 9). As already indicated in the comment columns to the examples, the types of empathic interventions are first used, which have already been differentiated as *recognition* of burdens and *naming* of emotions, before the doctor now makes use of the further type of *open clarification* of emotions (E 20.22: 03D: "what do you still feel for him?"). This is an "open clarification" in the literal sense of the word, because the possible answer does not yet seem to be sufficiently "clear" to either interlocutor. This *not-knowing*, which can only apply to the intervening doctor, but also to both interlocutors, is an essential characteristic of the *open clarification* of emotions.

The fact that in this case not only the questioning doctor is "in the dark", but also the answering patient herself cannot give a clear self-disclosure about her current emotional situation, manifests itself in her ambivalent answer, according to which the patient moves in extreme alternatives with her emotions in the relationship with her partner. In order to grasp the consequences of this emotional conflict situation for the patient's health, both interlocutors turn the "dialogue screw" (§ 7.2) one more time, reaching a higher level of conceptual abstraction at a level where the doctor's type of *interpretation* of emotions is also located.

20.6.4 Interpreting

While the types of empathic relevance upgrading differentiated above can mostly be determined relatively context-free or in narrow contexts, the function of interpretations often only proves itself in larger contexts. If *naming* emotions already required a history of interaction in which the emotion in question was "conditioned" by the patient's preliminary work, an interpretation requires longer cooperation between doctor and patient.

The meaning of an interpretation can only unfold in the context of a meaningful prehistory, which is a developed conceptual history, in the context of which the participants know sufficiently well what they are talking about when they initiate, modify, complete, substitute this or that vocabulary, etc. In the process, "objective" meanings remain, but

they are supplemented by a *subjective meaning* that the participants have worked out in advance and which they can retrieve and readjust at any time.

Although longer excerpts from the preceding conversation had already been reproduced, they only rudimentarily illustrate the developed conceptual emotional work of the conversation partners. The following excerpts (E 20.23) and (E 20.24) can also at best illustrate the meaning-giving function of the doctor's interventions for the further development of the conversation.

E 20.23		"that's a huge tension"	Comment
01	D	(...)	
02	P	(...) that's why it's probably also very difficult to make an abrupt, um ... termination ...	Self-reflection
03	D	hm .	
04	P	I've had these thoughts very often, so...	
05	D	that is, it's a huge tension, on the one hand you want to kill him and on the other hand you long for him back (...)	3.4: Interpreting
06	P	yes ... yes ... you could get along with him, um... if he probably sees a shore for himself again... a shore, I suppose.	Strong confirmation

E 20.24		"which means you're in a tight spot"	Comment
01	D	(...)	
02	P	(...) if I were sitting there alone, now with a child, and um . well, I can already imagine in advance what it would look like, yes . the work would totally go over my head . um .	Self-reflection
03	D	which means . you are in a tight spot .	3.4: Interpreting
04	P	you bet! . you bet! . (...)	Strong confirmation

While the patient, as in the previous case, once again focuses on one side of the ambivalence conflict, the doctor now places the conflict itself at the center of attention, which is raised to a *higher level of abstraction* with the terms "tension" and "tight spot". In both cases, the doctor's interventions are typically introduced with a *standard formula* ("that is ...,

which means ..."), the linking function of which establishes an inferential relationship to the preceding patient utterances (§ 21.2.3). The metaphorical intensification of the doctor's interventions can also be fully understood by the patient in terms of content and well integrated into her own point of view, which had already been described in a similarly metaphorical way. While the patient, in view of the "tension" between "murdering" and "longing", immediately looks again for the one alternative side of (conciliatory) conflict resolution, her current distress is obviously made so clear to her in view of the "tight spot" that she initially emphatically agrees ("you bet, you bet!"). Thus, towards the end of the consultation, the patient's conflict situation has at least been *verbalised* to such an extent that the interlocutors can effortlessly continue and deepen their conversational work in the next conversation by resuming the terms in question, which is what then happened. Preliminarily consented terms such as "tension" and "tight spot" then function as *cues* with which interpretive stories can be remembered, recalled and further developed.

This type of interpretive talk in a GP consultation is generally still below the level of "interpretations" characteristic of psychotherapies (Thomä, Kächele 1989/2012, Ehlich 1990, Vehviläinen et al. 2008, Peräkylä et al. (eds.) 2008, Peräkylä 2012, Scarvaglieri 2013, Buchholz 2014, Buchholz, Kächele 2016, Guxholli et al. 2021, Scarvaglieri et al. (eds.) 2022). Regardless of the type of conversation, more or less strong interpretations up to interpretation can be distinguished. Further anchor examples of *empathy-in-interaction* will be discussed below and in the following chapter (§ 21).

Classical "interpretation" can also only unfold its meaning-giving function by connecting to an already consented meaning that is sufficiently *close* to the patient's *consciousness.* In the process of emotional (self-)exploration by patients, the types of *addressing*, *naming* and *clarifying* emotions differentiated above can prove to be preliminary stages (of types) of *interpretations,* which for their part can be located at ever higher levels of meaning, as long as they remain easily integrable by patients for further self-understanding.

20.7 The empathic conversation starter

In presenting and justifying the *stage model of empathic communication* (§ 20.3), it was already assumed that conversation analysis can rarely be limited to a simple sequential exchange in the sense of isolated pair sequences, but must be extended to interrelated sequences of utterance pairs. In order to capture the interplay of emotional patient *cues* and types of empathic interventions, larger conversational units need to be considered in which *local* and *global* conversational developments can be taken into account. As has already become clear from several examples, *empathy-in-interaction* often extends over longer passages of conversation in which the two conversation partners were each involved in their own way in the emotional (self-)exploration of the patient in the short and long term. Further examples will be given below, which are located in certain initial, middle and final phases of conversations (§ 20.7-9). The first conversation that follows is already opened by the doctor with a particularly empathetic invitation to talk, which the patient can immediately use to present his or her concerns in detail.

20.7.1 Formulating the concern as a service

Conversations can be opened in very different ways, which can be more or less strictly classified under a typology of conversation openings (§ 19.2). Some conversation openings are so original that they can hardly be assigned to a type. We have already mentioned the following example (E 20.25) as a special case, the further development of which will now be considered in detail. It is possible that the doctor was previously still absorbed in her attention when she now makes herself available to the patient without restriction ("completely") in her "exclusive" listening role with an apt *metaphor* ("I am all ears").

E 20.25		"so . now I'm all ears"
01	D	so . now I'm all ears .
02	P	yes . so . I do go to the gym now and then . but I've noticed lately . I don't feel well at all . I always have such pressure here [pointing gesture] . I haven't talked to my wife about it . but now I've told her the truth . now I have to see a doctor after all . I want to

		have a complete check-up .
03	D	hm . aha .
04	P	that's why i'm here .
05	D	hm .
06	P	I am now (...)

With the doctor's opening of the conversation, the patient is given the full attention of his listener, who is initially granted a special *listening privilege* (§ 18, 19). The doctor gets to hear something that the patient initially concealed even from his wife before he "told her the truth", which he thus repeats to the doctor. Apparently the self-help system described by Siegrist (2003) has failed (§ 18.2), so that the patient has to seek professional help ("now I have to see a doctor after all"). As a request, the "total" examination is then presented, which is answered by the doctor not only by a simple signal of understanding ("hm") but by an empathic feedback ("aha") expressing a certain surprise. The previous and further minimal feedback from the doctor represents an *upgrading of relevance* (§ 20.4), which, without interrupting the content, at the same time encourages the patient to continue talking fluently, which he uses to justify and specify his request.

The justifications and specifications of the patient's concern are characterised by very emphatic formulations which emphasise the urgency of the "total" examination, which is "appropriate" as a "proper" examination and should be carried out ("co-treated") by the doctor herself, but also by a urological specialist (06P). After the doctor has so far proved to be an attentive but "sparing" *listener* with short feedbacks, the first longer verbal intervention by the doctor (E 20.26: 09) comes after these very direct formulations of the *patient*'s concerns, after which the doctor-patient *relationship* initially seems to be determined by *services* (§ 10), which signals an agreement with the specific concern that the patient has conspicuously paraphrased as "pressing" (instead of "palpating").

E 20.26		"I'll take a look at it right away"
05	D	hm .
06	P	I'm 59 years old now . I'm approaching 60 . and a proper examination would be a good idea . and maybe a visit to the urologist . that this is also treated there, yes .
07	D	hm .

08	P	that's why I'm here now . maybe you press this [pointing gesture to stomach] .
09	D	I'll take a look at that right away .
10	P	I don't know what's going on either.
11	D	aha .
12	P	I always feel a bit- [exhales air, facial expression and gestures of helplessness].

By agreeing to the examination, the doctor first takes the "pressure" out of the conversation, which the patient builds up with the multiple justification of his request, which is now taken into account. At the same time, the doctor signals the continuation of the conversation by announcing that the examination will take place "right away", i.e. later, after the conversation has been concluded. At the same time, the patient is given another opportunity to talk about the topic, the use of which then also leads to a change in the relationship model in the conversation, which was previously essentially determined by the patient's biomedical service claim (02P: "complete checkup", etc.).

20.7.2 Changing the relationship model: "Fear and worry"

The patient uses this new opportunity to express his *ignorance*, which can be typical for unclear descriptions of complaints (10P: "I don't know what's going on either"). After the doctor's empathic feedback ("aha"), which again represents an upgrading of relevance with the expression of surprise, the patient's helplessness and lack of advice again becomes visible and audible when he does not finish the sentence he has started (12P: "I always feel a bit-"). Instead of completing how he "feels", he only exhales air, combined with facial expressions and gestures of helplessness. This initiates a change in the relationship model between the patient and his doctor at the latest, in which the patient can no longer be "helped" with the mere services that he so vehemently demanded at the beginning.

The last two patient utterances (10P, 12P) represent, as it were, a cry for help that manifested itself on a verbal and non-verbal conversational mode. Thus, enough patient *cues* have accumulated on both conversation levels to favour or require a doctor's relevance feedback that goes beyond the previous listening pressure messages and the announcement of the physical examination. The doctor now reacts with an

empathic intervention (E 20.27: 13: "do you have a little fear . and worry?"), with which she seeks a conceptual *clarification* of the patient's emotions, to which the patient initially responds vaguely.

E 20.27		"Do you have a little fear and worry?"
12	P	I always feel a bit- [exhales air, facial expression and gestures of helplessness].
13	D	do you have a little fear . and worry? .
14	P	yes also . [smiles sheepishly]
15	D	hm .

We cannot, of course, as external observers, "see into the doctor's head", but we can nevertheless reflect on her motivation for the empathic intervention (13D), which may be *multi-conditioned* (§ 9). First, it may be an immediate reaction in the local context of the patient's previous utterances (10P, 12P), whose attempt to represent his not knowing and his sense of self resulted in a helpless self-abortion. However, the doctor's attention can also go back further in terms of content to the patient's reasons for his request. During reflections in training and further education, participants had already become "alert" to an initial implicit patient reference (*cue*) when the patient mentioned his age in the context of the justification for his request. If the patient emphasises the upcoming change of years (06P: "I am 59 years old now, approaching 60"), this can have a special meaning.

A distinction can be made between *logical* and *psychological* understanding (§ 9, 19.5). Someone who is 59 years old should not "logically" have to emphasise that he is "approaching 60". If we normally avoid over-information in order not to violate a corresponding *conversational maxim* of quantity, in the deviant case we can use redundancy precisely to *mark relevance* (§ 7.3). The fact that the patient here emphasises his impending age of 60 in this way can have several reasons that can become the antithesis of *psychological understanding.* For example, this age represents a special caesura for all of us, which also applies relatively to the preceding and following series of round year numbers (30, 40 ... 70, etc.), whereby these are increasingly associated with ageing processes, impairments, illnesses or even death, and so on.

At the age of 60, certain health or illness expectations are added, which are not least related to preventive examinations, etc., the relevance of which is precisely supposed to enter the consciousness of pa-

tients so that they also make use of the preventive services. In addition, patients may have had specific, age-related life experiences that take on an *individual significance*, as this then also turns out to be the case in the present case.

20.7.3 Negotiating of individual meanings

After his initially vague answer (14P: "yes also"), to which the doctor skillfully reacts in a waiting manner with minimal feedback ("hm"), the patient reveals specific emotions for which the doctor had previously provided the conceptual placeholders (*fear - worry*) hypothetically for clarification. The provision of the terms in question was very "low-threshold" here, since the doctor also chooses a form of "weakening" or "*diminution*" (in a broad sense), which are typical of empathic interventions, as this has already become clear in previous examples. The change from "fear" to "worry" alone represents a *gradual gradation* that has already been reinforced ("a little") for both emotions. Thus, through the doctor's formulation as a whole (13D: " do you have a little fear . and worry?"), the corresponding emotions (downgraded as "weaker") can be more easily conceded, which the patient then confirms in turn with the relativisation (14P: "yes also"), which he repeats (smiling) (16P: "also") before continuing with a series of dramatic events and experiences from his family environment (E 20.28) to make his own emotion ("funny feeling") understandable.

E 20.28		"when you are now at that age"
15	D	hm .
16	P	also . [smiles] my father/my grandfather died of cancer . my grandmother died of stomach cancer . my father had a heart attack . he was 62 when he died . in our family, everyone died at an early age . and that also plays a role, I have a weird feeling . in the back of my mind . [smiles] at least that's how I feel .
17	D	well, of course ... when you are now at that age.

Although the terms offered by the doctor are not taken over directly by the patient, but only implicitly in the relative confirmations ("yes, also" - "also"), the subsequent series of threatening deaths in the family environment are, as it were, "illustrators" of the patient's own "fear" and

"worry" of suffering the same fate as his close relatives. Again, the analogy is put into perspective ("that also plays a role") and the emotion involved is vaguely described ("I have a weird feeling in the back of my mind"), only to make a firm commitment to this "weird feeling" ("at least that's how I feel"). Without the corresponding concept of "fear of death" being explicitly introduced here, it is sufficiently clear to both interlocutors what the analogies are about, which is also formulated by the doctor as self-evident ("of course"): "of course, now that you are at that age", whereby the implicature can easily be "thought along" ("... are at that age", >when your relatives died<) (E 20.29: 17). At this intermediate stage of the communicative exchange between the patient and his doctor, a degree of dialogical understanding has already been reached in a short time, in which both interlocutors only "blow by blow" by confirming and reconfirming what they have worked out together as a *consensus.*

E 20.29		"when you think, 'I hope nothing's wrong with me now'."
17	D	well, of course ... now that you're at that age.
18	P	just like that .
19	D	when you think . hopefully nothing is wrong with me now .
20	P	right .
21	D	I can imagine.
22	P	exactly .

In this dense sequence of (re)confirmations, the doctor once again expresses the ambivalence conflict between "fear and hope" by emphasising the side of hope ("when you think . hopefully nothing is wrong with me now"). This resonates with the relation of opposites, according to which the patient's hopes can only be "thought" in the context of his fears. After the patient's confirmation ("right"), the doctor again follows up with an *empathetic assumption of perspective* ("I can imagine"), which is tantamount to *normalising* and *respecting* the patient's fears.

The doctor had repeatedly accommodated the patient through empathic relevance upgrades, so that he can already feel sufficiently understood and acknowledged towards the end of this short introductory phase of the conversation, which he expresses just as clearly in his feedback. As was already worked out in the previous examples, the *accuracy of fitting* (§ 3, 17) of interventions can mostly be "read off" from the positive reactions of the patients. The extent to which the doctor has

met the patient's emotional situation in each case becomes clear in terms of content from the corresponding topic offers with which the patient reveals his "fear" and "worries" through concrete comparisons with his family environment, and formally-dialogically from the strong (re)confirmation signals that the patient gives just at the end ("just like that" - "right" - "exactly") to mark the maximum level of understanding.

Finally, it should not go unmentioned that this was merely the brief beginning of a conversation which was then continued to complete the anamnesis and to explore the details of the complaints. Still following the conversation, physical examinations were then carried out and further examination steps were initiated with the result that the patient could be freed from his current "fear" and "worry" - however temporarily.

In order to verbalise these emotions, the doctor in her *midwifery function* (§ 9) had provided the necessary terms as thematic *key symbols* to clarify the patient's biographical-lifeworld "background" ("fear and worry"). The two interlocutors can come back to this without further ado if the patient once again - as in the beginning of this conversation (02P) - has to "tell the truth" and "see a doctor" in order to "have a total check-up". This now already known *concern* and its "motives" can then ideally be followed up with reductions of both conversations and examinations, if only the specific "fear" or "concern" of this patient is again empathically taken up and "treated further" with respect.

20.8 The empathic conversation development

In the following example of the development of *empathy-in-interaction,* the initial interview is already at an advanced stage, in which the current situation of the patient, who had previously been treated for a hypertensive crisis in the emergency room and then as an inpatient, has already been discussed.

20.8.1 Empathetic acknowledgement of stress

In the course of the conversation, which has already been mentioned briefly as an anchor example elsewhere (Koerfer et al. 2004) and will now be analysed in more detail here, the doctor completes the individual and social anamnesis, in which the topic of the patient's *burden* as a *single parent* comes up, which is reproduced here in abbreviated form (E 20.30), before the development of empathic communication is shown in several steps, but unabridged.

E 20.30		"that must not have been easy for you either"
01	D	(...)
02	P	(...) sometimes, of course, everything is a lot ... I'm a single parent . [briefly talks about her two children] (...) .
03	D	how long have you been alone? .
04	P	for 8 years . hm .
05	D	for 8 years .
06	P	hm .
07	D	. was it a divorce or .
08	P	yes .
09	D	I'm sure it wasn't easy for you either.
10	P	no . definitely not, no . we were married for 16 years . that was already a long time .
11	D	so long? . you are still young! .
12	P	yes . i got married when i was 18 . [smiles] . yes, yes [laughs] .
13	D	you've already been through a lot.
14	P	yes . quite .

First, the topic of *single parenthood*, which was initiated by the patient (02P: "I am a single parent"), is taken up by the doctor and developed further by specific questions (about duration and development) and by active listening (literal repetition: "for 8 years"), before an empathic upgrading of relevance through *recognition of the burdens* (§ 20.5) takes place in two steps (09D, 13D). In both cases of recognition, the doctor takes up the topic of the burden, which had already been "preformulated", as it were, by the patient (02P: "sometimes, of course, everything is a lot"). When the patient now reacts to the doctor's last summing-up intervention of recognition (13D: "you've already been through

a lot") with a brief answer that is tantamount to a downgrading of relevance ("yes, go"), the topic seems to be saturated. Nevertheless, the doctor continues it by first focusing again on the patient's stress (E 20.31) and then asking about the reason for and significance of the divorce.

E 20.31		"very hurtful?"
13	D	you've already been through a lot. .
14	P	yes . quite .
15	D	that was probably a difficult time too.
16	P	that was certainly a difficult time .
17	D	what was the reason for the divorce? .
18	P	he met another woman . yes .
19	D	very hurtful? .
20	P	yes [smiles] . but now it can't be changed . by now it's not so bad anymore .

As the patient's confirmations make clear, the doctor is able to create a conceptual fit with the patient's feelings ("difficult time", "hurtful"), as manifested in the reinforcing repetition (16P: "that was certainly a difficult time") and affirmation (20P: "yes"). Nevertheless, the patient seems to "refuse" any further deepening of the topic at first. Her reservation, which she introduces with a typical "yes but" formula (Koerfer 1979), is then also substantiated (20P: "yes (smiles) . but now it can't be changed ..."). It remains to be seen to what extent her justification is understood by the doctor as a pretext (for whatever topic taboo). In any case, the patient's last reaction suggests a downgrading of the relevance of the emotionally charged topic, because the admitted "injury" is no longer considered "so bad" (20P), i.e. its current relevance is downgraded.

The doctor is thus faced with the difficult decision situation of an alternative course of action, either to accept the relevance downgrading of a *dissimulating* patient who seeks to "trivialise" her current experience of a "hurtful" divorce, or to actively promote the patient's further (self-) exploration, which can remain a challenge with all the dangers of *decompensation*. Without being able to discuss this here in principle, attention should be drawn to the problem that *dissimulating patients* can easily be "disadvantaged" in comparison to *aggravating patients* if doctors are guided in their reactive conversation primarily by criteria of patient *loudness* and verbal *dramatisation*.

Here, an *asymmetrical* upgrading or downgrading of relevance in relation to different types of "*display"* of patients would lead to an "unequal treatment" in medical care - an essential aspect under which the following factual continuation of the conversation would also have to be evaluated. Insofar as the "correct" diagnosis and therapy depend essentially on a "good" anamnesis, it is precisely in the conversation with the patient that the essential course is set for the future "treatment". These decisions have to be readjusted from conversation to conversation and within a conversation from moment to moment and evaluated under the aspect that the specific communicative "treatment" of alternatives in the medical conversation can ultimately lead to alternatives in the medical "treatment" of medical care (in the narrow sense) itself.

20.8.2 Spontaneous affect: crying

With the preceding downgrading of relevance by the patient, according to which the "injury" caused by the divorce is classified as "now not so bad" compared to before, the topic seems to be sufficiently saturated and a change of topic seems opportune. Nevertheless, the conclusion can of course be drawn that the "injury" - precisely because it is "no longer so bad" - is still having a "bad" effect today, although less so, which is also what the doctor may think. In any case, with his further *insistent* intervention, the doctor makes precisely this comparative perspective of the patient between past and present his own (E 20.32) when he first makes the (manifestation of the) injury in the past the topic.

E 20.32		"it is still close to you now"
19	D	very hurtful? .
20	P	yes [smiles] . but now it can't be changed . in the meantime it's not so bad .
21	D	but it was bad.
22	P	yes it was very bad, yes .
23	D	it still gets to you now .
24	P	ye:s [smiles] ... [begins to cry] ..... [15 sec.]..... . well . [takes out handkerchief, regains composure] ..... [15 sec.] .....

What happened in the distant past is once again presented by the patient in her memory as "very bad", thus achieving a further upgrading of relevance by reinforcing ("very") the doctor's preceding conceptual offer (21A, 22P). The current after-effects when the patient talks about her emotions in the past are apparently also perceived by the doctor as part of the *scenic understanding* (§ 9.2), which is correspondingly reflected conceptually to the patient in his empathic intervention: "it still gets to you now" (23D). In his intervention, the doctor may be guided not only by his perception of the patient's last statement, but also by previous sequences of conversations in which the verbalisation of emotional topics was repeatedly accompanied by the patient's ("embarrassed" to "tortured") *smile* or *laughter (*P12, 14, 20, 24). Apparently, the patient has been trying to "smile away" her emerging emotions for some time, as was the case most recently with her emphasised affirmation (24P: "ye:s"), during which a "tipping over" of the initial smile into crying can be observed.

With the doctor's repeatedly *insistent* interventions, the patient is obviously confronted with her feelings of *there and then* in such a way that she is so overwhelmed by her spontaneous affect when remembering and reliving them in the *here and now* of the consultation that she begins to cry. "Outbursts of emotion" of this kind must always be expected in the medical consultation as soon as certain emotional topics are dealt with, which are often unavoidable anyway, such as when "bad *news*" is conveyed, no matter how gently (§ 16, 38, 43). It should be possible to integrate patients' crying as a "normal" behaviour in the conversation, especially since, according to Morgan and Engel (1977), it can be a "useful clinical symptom". Nevertheless, crying is often frowned upon, especially by newcomers to the profession who try to avoid dealing with crying patients because they fear it because of the threat of their own helplessness (§ 20.2). It is precisely because of this critical reservation towards crying that the assessments and recommendations of Morgen and Engel (1977) (Box 20.14) should be reproduced in detail. What the "classics" recommend here, especially towards students, naturally also applies towards (prospective) doctors, which we have added here in the quotation (in square brackets).

Box 20.14 Crying

When the patient starts crying during the anamnesis, the student [doctor] feels uncomfortable the first few times. Crying is not only a useful clinical symptom, but it often gives the patient relief. Patients often cry when they think of something that is troubling them, whether it is the illness or death of someone close to them, an impending loss, or a disappointment in their life. Perhaps the patient is also worried about their illness and its consequences. In any case, the patient's crying shows the student [doctor] that he has touched on an important point for the patient in the conversation. He therefore waits calmly, lets the patient cry and, if necessary, hands him a handkerchief. By a sympathetic nod or a friendly remark: "I understand how you feel", he lets the patient know that he understands his crying. In this way, he allows the patient to tell him his worries, which he may have wanted to discuss with someone for a long time. The student [doctor] must not then change the subject until the patient has fully expressed himself and is composed again (...) The student [doctor] need not fear that this will cause the patient to burst into stunned weeping and not stop. Usually he calms down after a few minutes and relieved, often also grateful, he is ready to answer the student [doctor] further questions.

Morgan, Engel 1969/1977: 64f (additions by us)

Contrary to all fears that patients could "lose their composure" when crying, clinical experience teaches that they soon find their way back into verbal conversation mode. That patients do not manage this return to conversation is often a catastrophising fantasy of interviewers who have little experience with crying patients and therefore try to avoid the corresponding risk by taking countermeasures in good time when topics in general threaten to become "sensitive" (§ 21.6). The return to the often experienced "normality" of the primarily verbal exchange should, however, according to the recommendation of Morgan and Engel, not be achieved by changing the topic "before the patient has fully expressed himself", but rather by continuing the topic in question until the conversation has reached a certain saturation, which then justifies the corresponding change of topic.

20.8.3 Conflict of maxims and conversation topic: "No easy life"

In the present case, it may come as a surprise that after about 30 seconds of (shared) silence, during which the patient merely says "well" and visibly regains her composure after using a handkerchief, the doctor nevertheless makes a radical change of subject. He changes from the patient's "burden" of divorce and single parenthood to an apparently less "explosive", biomedical topic ("blood pressure") (E 20.33), which had already been the initial and basic topic of this first interview.

E 20.33		"your blood pressure was very high"
23	D	it is still close to you now .
24	P	ye:s [smiles] ... [begins to cry] ..... [15 sec.]..... . well . [takes out handkerchief, regains composure] ..... [15 sec.] .....
25	D	was your blood pressure very high? .
26	P	yes .
27	D	when did it begin with the blood pressure?
28	P	I don't know . I've always had slightly high blood pressure . but it never caused any problems. (...)

It is obvious that the doctor wants to take the emotional "pressure" out of the conversation with the radical change of topic in order to relieve the patient and perhaps also himself. It remains to be seen to what extent the continuation of the original, emotional topic would have been the better alternative, in which the doctor would have acted according to the motto often cited in this Handbook: "Emotions have priority" and would have continued to address the patient offensively about her spontaneous affect. However, the formulation of conversational maxims, as most recently exemplified by the recommendations of Morgen and Engel (1977) in dealing with crying patients (Box 20.14), is one thing, their observance in conversational practice is another.

Maxims are not to be equated with principles, which are often to apply without restriction. In the conduct of medical conversations, the proverbial "riding on principles" would be just as misguided as "pure arbitrariness". As was also repeatedly emphasised in advance (§ 3, 17), *conflicts of maxims* can arise in the practice of conversation, in which one or the other direction of problem-solving can be taken. For example,

in the *art of medical communication* we had already pointed out the difficult *balancing act* between under- and *over-stimulation* of patients (§ 17.3), who can also be overtaxed in a certain situation with excessive "impositions". If one can always be slightly "wiser" in retrospect when reflecting on the conversation, second-best solutions are not generally frowned upon, especially if the difference to the better alternative does not seem to be so serious. In the case of a relevant difference, the notion of a (real) conflict of maxims would be obsolete anyway.

In the present case, the doctor may have had good reasons for trying to relieve the patient (and himself) of the emotional "pressure" for the time being. In this case, too, it is worth remembering the motto "Postponed is not abandoned" (§ 20.3.4), which was also justified by Morgan and Engel (1977) in dealing with "dicey" topics, which can be left for the time being in order to take them up again later because, for example, defensive processes appear less strong in the course of the conversation. Correspondingly, this doctor also takes up the topic of threatening *burdens* again later on at a "suitable opportunity" in the further course of the conversation, which deals with the patient's persistent *insults* and *fears* after her divorce, the persistent "encroaching" demands by relatives (parents, sister, etc.) as well as persistent unemployment, before he then brings her biography to the following conceptual denominator in an (elliptical) interim balance: "not an easy life" (E 20.34). Here too, as so often with medical interventions, agreement is facilitated by "mitigation" or "understatement" (*litotes*), although in the context it is clear to both interlocutors that the patient has just had to lead "a particularly difficult life".[4] We come back to alternative formulations when it comes to the question of (in)permissible "understatement" (litotes) or "exaggeration" (hyperbole) in medical *wording.*

E 20.34		"not an easy life"
01	P	(...) I have been unemployed (...) since (...) .
02	D	not an easy life .
03	P	no, that wasn't always so easy . that is right".

[4] Bergmann (2013) provides detailed analyses of the rhetorical figure of the *litotes* on the basis of psychiatric admission interviews. We can only return to his critical view of the use of this figure later (§ 21.3) in passing. To Bergmann's critical overall assessment of the type of conversation, which is summarised under the heading "Psychiatric Discretion: Uptight between Medicine and Morality", we can only refer here.

In any case, the patient can fully agree with the doctor's view of her life when, following the doctor's choice of words ("not an easy life"), she immediately and also relativisingly answers: "no, that wasn't always so easy . that is right" (P03). This is a sufficient *verbalisation* of the patient's past and present life, which can be regarded as a formulation of the theme of the hour ("not an easy life"), under which a series of further critical events and experiences from her family and professional environment can be arranged.

Despite the interim "caesura" in the interaction, which may have been perceived as a relief for both sides, the patient was able to "learn" in the ongoing conversation that the doctor had repeatedly expressed his marked interest in her emotions, which had motivated her to open up further emotionally, to recount further *episodes* from her "not always so easy life" that went back to childhood. For example, she had to take over the role of mother for her siblings as a substitute for the sick mother at an early age, while the father had even "not cared at all", which was interpreted by both interlocutors as a lack of "tenderness" in childhood and adolescence. As becomes clear in the joint conversation, the early marriage - as in the case reported by Uexküll and Wesiack (2011) (§ 4.3) - is presented as an "escape" because the patient "wanted to get away from home". In the further course of the conversation, both interlocutors correspond on the same interactive and thematic wavelength, on which the patient's more or less (un)pronouncedly "heavy" burdens in the past and present are conveyed so *close to her consciousness* that she finally declares her willingness in principle ("yes, that would be good") towards the doctor's suggestion of arranging psychotherapy (elsewhere) at the end of the conversation.

Along the way, emotional (self-)exploration had been promoted by the doctor through a series of *insistent* interventions (07D – 23D) with *cumulative* effect (Koerfer et al. 2010). When, from the doctor's point of view, the *tension* in the crying patient threatened to overstretch, he acted (with Morgan and Engel 1977) according to the motto: "Postponed is not abandoned!" and by changing the topic, he made a break for emotional relief (25D), in order to then take up the thread of emotional topics again later and to continue spinning it together under the hourly topic ("Not an easy life") with further biographically relevant events and experiences.

Overall, the example makes it clear that there are no "patent remedies" for "solving" conflicts of maxims, but that practical decisions often have to be made in a short time between approximately equivalent al-

ternatives for continuing the conversation, about which one might judge differently than the acting doctor as an external observer in retrospect, if there is enough time for reflection. The doctor did temporarily "shut down" an emerging spontaneous affect of the crying patient, but without permanently blocking it, so that the underlying emotions associated with the social event of divorce (*separation*) and the ongoing experience (*insult, fear*) from her professional and family environment could continue to "come up" extensively.

20.9 Empathy in cooperative storytelling

In the following example, too, the development of *empathic communication* is to be shown by means of longer passages of conversation, which at the same time involve forms of *cooperative narration*. It should be emphasised once again in advance that the general *rule of association* is not only to be practised in relevant psychotherapies, but that a moderate form should also be used in general practitioners' and specialists' consultations or ward rounds in order to promote the emotional (self-) exploration of patients (§ 9, 17, 19, 24, 25). In practice, however, one must always reckon with resistance from patients, whose willingness to tell stories often has to be awakened laboriously in several attempts before they finally get into a more or less *associative narrative flow* "under the doctor's direction".

20.9.1 Freud's basic rule in conversational practice

For a better understanding of the example, in which we refer to a number of theoretical and empirical previous works (Koerfer, Neumann 1982, Koerfer 1994/2013, Koerfer et al. 2000, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017), the following contextual information should be given beforehand: In two preceding phases of the initial interview, the current complaints ("stomach pain") as well as the history of the development, course and treatment of the patient's illness had been discussed in detail, before a current social event in its individual significance for the patient was then brought into the focus of the conversation and dealt with in detail: The patient had not fundamentally lost his formal (continued) employment, but he had lost his specific job (“job

canceled") which he had helped to build up himself for many years as a "programmer". He had finally tried to "make the best of" this situation, in which he continued to be employed as the "girl for everything", by applying for "semi-retirement". After this professional topic, which is taken up again several times later, has reached a certain saturation for the time being, the doctor now initiates a change of topic to complete the biopsychosocial anamnesis interview (E 20.35) by asking about "other changes".

E 20.35		"are there any other changes?"
01	D	so now we've talked about a change . are there any other changes? .
02	P	no .
03	D	not, yes . with your wife, was there somehow a disease? .
04	P	no .
05	D	your parents, in-laws and so on . has someone died maybe . or? .
06	P	yes . my mother died, but that was ten years ago, yes .
07	D	it was ten years ago with your mother ... and what was that like for you? ... I mean, it was a long time ago, but just because it comes to your mind now .

After a provisional conclusion of the professional topic, the doctor puts the further development of the conversation into perspective by means of a series of potential topic complexes ("other changes"), which he repeatedly concretises and combines by means of various formal placeholders (*family*, *illness*, *death*), so that a large selection spectrum of topics is made available to the patient. The use of *insistent* interventions of this type derives its justification from the medical experience that patients often do not accept the first invitation to talk about a topic, but need repeated, modifying encouragement.

If the topic invitation is still not accepted, doctor and patient often have to enter into a longer process of relevance negotiation, which involves clarifying the more or less explicit question: "What is worth telling here and now in the consultation or ward round anyway?" (Koerfer, Köhle 2009). In their practice of negotiating relevance, doctor and patient often form divergent hypotheses that manifest themselves in the interaction as marked (dis)preferences. Instead of actively using the doctor's offers of topics, patients can just as passively lapse into monosyllables or even silence - for whatever reasons, which in addition to the

apparent mental marginalisation of topics can also include emotions such as feelings of shame and guilt, etc., which make open communication difficult.

For these complex reasons, doctors should not be "fobbed off" with the first sparse patient reaction, but should make complex enquiries to ensure that nothing is "concealed" that is relevant for the medical history. These may be "minor" incidents such as temporary nausea or "major" changes in the patient's social environment (§ 21), which also includes partners, relatives, friends, neighbours, colleagues, etc.

In this example of a conversation, it takes several insistent interventions before the patient, after a short relevance negotiation, is finally willing to follow the doctor's relevance upgrading. In this context, acts of relevance can often be recognised by the repeated occurrence of reciprocal "yes-but" constructions by both interlocutors (06P, 07D), with which (partial) concessions can be made in terms of content and at the same time presuppositions can be rejected (Koerfer 1979). Such relevance negotiations can lead to turbulence in the conversation if the partners arrive at opposing reasons when deciding on the relevance of topic continuations, which can lead to very different developments in the conversation (§ 17.3). For example, the patient apparently downgrades the relevance of his answer by informing the doctor minimally about the death of his mother (as an *event*) (06P: "yes, my mother died ..."), but tries to reject a possible relevance of the topic (as an *experience*) with the argument of a lack of topicality (06P: "... but that was 10 years ago"). If the doctor does not want to follow this spontaneous downgrading of relevance by the patient, he has to counteract with an ad hoc upgrading of relevance before the emotionally sensitive topic opportunity has "evaporated" again.

What happens interactively in this small conversation sequence, i.e. in a narrow time window, has its mental equivalent in both conversation partners, which the doctor in turn must *mirror* appropriately qua *professional competence* towards the patient (Fig. 20.5) if he wants to enforce the *association rule* against the patient's resistance - or more concretely in terms of the result: if he wants to find out something about the patient's emotional experience of his mother's death.

Within seconds, the doctor must decide whether to accept the patient's relevance downgrading or to insist with a further intervention on the topic in question ("death of the mother"). In order to "elicit" the patient's possible *associations* to this topic, the doctor must be prepared for patients to initially behave in the consultation as in psychotherapy

in the same way as in "an ordinary conversation" (Freud 1913/1970: 194), i.e. to follow the *relevance maxim* as in everyday life (§ 7.3, 9.3). Freud anticipated the reservations of everyday knowledge and everyday action towards the psychoanalytical basic rule and therefore proposed a prototypical formulation for its mediation by the treating doctor (§ 9.3), the core of which is to be repeated here (Fig. 20.5, right-hand column) and placed in a cognitive and interactive context of conversational practice

Relevance	S	Interaction	Association rule (Freud 1913)
↓	P	Yes, my mother died, but that was ten years ago, yes	*You will be tempted to say to yourself, this or that does not belong here, or it is quite unimportant, or it is nonsensical, therefore it need not be said:*
Downgrading	P	Action a	b Diagnosis
Upgrading	D	Reaction d	c Maxime
↑	D	and what was that like for you? . I mean, it was a long time ago, but just because it comes to your mind .	*Never give in to this criticism and say it anyway (...) So say everything that crosses your mind.*

Fig. 20.5: Sample application of the association rule
(mod. on Koerfer, Köhle 2007: 634; explanations in the text)

In the interaction with patients, who in conversational practice in the sense of Freud can demonstrably still remain completely attached to "ordinary conversation" (Koerfer, Neumann 1982), *reflexive* and *communicative* competences must work together (§ 3, 17) in order to draw the right conclusions from the current development of the conversation and to implement them in action. In doing so, the *actional* pattern positions (a, d) can be differentiated from the *mental* positions (b, c) of the insistent action pattern of the relevance action, which have to be matched appropriately in the run through the action pattern.

In position (b) ("You will be tempted ..."), with Freud, the "diagnosis", as it were, is made for the patient's behaviour in position (a), while in

position (c) ("So say everything that crosses your mind") the corresponding "maxim" is preformulated for the patient, which the attending physician must implement with his insistent intervention (d) in reaction to the patient's expression (a) in a manner appropriate to the situation. For the purpose of an overall diagnosis of the patient's behaviour, which is identified *locally* as an attempt to downgrade relevance, the previous psychodynamic conversational and relational developments in the *global* history of interaction with the patient should also be taken into account, in the context of which the patient's conversational behaviour in question can be interpreted to different degrees ("denial" - "defence"). Depending on previous experience, the doctor will either be cautious with further "impositions" in order not to "overstretch" the arc of tension between the two interlocutors, or force it because the *limits* of empathic communication (§ 20.3) have not yet been reached.

In the present case, the patient had already been so open about his medical history and the sensitive topic of "job loss" during an initial interview that insistent interventions on the new topic ("death of the mother") still seem appropriate and promising. In any case, despite the clear downgrading of relevance by the patient (06P), the doctor decides to make an insistent intervention (07D), by which he recognisably increases the pressure on his interlocutor to answer and talk about the topic, whom he now puts under pressure.

To overcome the resistance or mere inhibition of the patient's willingness to tell stories, the doctor here chooses an ad hoc free translation of the Freudian basic rule message, which proves to be appropriate vis-à-vis the patient's expression: The maxim "So say everything that crosses your mind" (see above) is reformulated into the context-sensitive intervention: "and what was that like for you? (...) but (sic) just because it comes to your mind" (07D). The "idea" attributed to the patient, which had already been conditioned several times by the preceding interventions (01, 03, 05D), is now to be carried out further by the patient, who can hardly escape the compulsion of a forced topic invitation.

It is now up to the patient to (re)act (a') on the doctor's insistent intervention, which can result in multi-layered variants in the renewed run through the action pattern of the relevance negotiaton (a' - d'). Although the patient now seems to accept the invitation to talk (08ffP), his willingness to talk remains noticeably in abeyance (pauses, self-corrections, delays), so that further insistent interventions are needed before the patient gets into a narrative flow of his own, in which the

emotional experience in the relationship with the mother can gradually be "brought up".

20.9.2 Biographical-narrative anamnesis: "Unwanted"

If one follows the further course of the conversation, the insistent intervention (07D) proves to be a *key intervention* with which an essential function of setting the course for the development of the topic is performed. The doctor's thematization of his patient's *experience* of his mother's death (07D: "and what was that like for you?") triggers a series of biographical narratives in the same and subsequent consultations, in which the patient's emotive-narrative self-interpretation succeeds, ranging from early childhood through adolescence to adulthood. We can only focus here on the first narrative sequence (on childhood), the complexity of which can only be grasped from a few aspects. First, the patient gives an answer with an expression of *regret* (E 20.36: 08P: "unfortunately I have to say so for me") that is surprisingly direct and open.

E 20.36		"did you not feel well cared for as a child?"
07	D	It was ten years ago with your mother ... and what was that like for you? ... I mean, it was a long time ago, but just because it comes to your mind now .
08	P	that was also eh, unfortunately I have to say so for me eh ... not so bad . I didn't grieve so much .
09	D	hm, hm .
10	P	I didn't have such a good relationship with my mother .
11	D	not such a good relationship? .... (4) .... how was it, [quieter] the relationship? .... (4) ....
12	P	yes, it was always some kind of tension with my mother ....
13	D	did you not feel well cared for as a child? .... (4) ....
14	P	maybe that's the way to put it, yes .
15	D	hm, hm ..... (6) ..... in what [quieter] respect? ...

Due to the doctor's insistent intervention, the patient's "not so good relationship" with his mother now becomes another topic of conversation, which through *active listening* (§ 19) (11D: repetition: "not so good relationship") and the doctor's open *question* ("how was it, the relationship?") experiences an immediate increase in relevance, which the pa-

tient uses for further topic expansion by first introducing the abstract concept of "tension" for the initial characterisation of the relationship with the mother. Although the doctor's subsequent (decision-making) question only makes further *conceptual clarification* available (§ 20.6), his verbal intervention (13D: "did you not feel well cared for as a child?") certainly remains risky at this early stage of the development of the theme, especially since the patient had previously only spoken vaguely of "tension", which had left a relatively large scope for interpretation. The fact that the (psychoanalytically trained) doctor nevertheless hits the patient's feelings with his intuition is evident both from the patient's immediate reaction (14P: "maybe you could put it that way, yes") and from the further development of the topic (E 20.37), which, after the doctor's simple but open (elliptical) question ("in what respect?"), is finally focused by both interlocutors on the patient's problematic *experience* in the *mother-child relationship.*

E 20.37		"and were you always disadvantaged there?"
15	D	hm, hm ..... (6) ..... in what [quieter] respect? ...
16	P	I can tell you that .... (4) .... that eh . what I believe and assume ... I ... eh am an illegitimate child of my mother ... (3) ...
17	D	hm, hm...
18	P	and eh ... I subsequently got two more sons from my eh foster father, who adopted me, my mother, so my two younger brothers ....
19	D	and were you always disadvantaged there [quieter] ( ) .
20	P	and somehow I had the feeling, sometimes my mother also told me indirectly, that I was not wanted, that I was, so to speak, I'll put it bluntly, that I ruined her life, right? . my mother sometimes said that to me and made me feel it . that's why I had an ambivalent relationship with my mother anyway ... in my opinion she sometimes put me at a disadvantage compared to my other brothers .
21	D	yes .... (4) .... one can imagine, it's hard for a child when you're told that, huh? .

After a number of hurdles have been overcome in advance of the patient's emotional (self-)exploration, a relatively open topic invitation (15D: 'in what respect?') is issued to an already established topic focus previously ratified by both interlocutors (13A-14P). The full paraphrase

from the (elliptical) doctor and patient statements can now be formulated as follows: 'In what respect can it be said that you did not feel sufficiently cared for as a child?' The patient now takes up this current guiding theme with a longer speech in which he tells the doctor his dramatic childhood story in a most vivid way as the story of an 'unwanted' child who not only had to passively experience the rejection by his mother, but was actively 'told' and 'felt' it in a drastic way. We will come back to this double mode of experience ("saying" or "hearing", and "feeling" or "letting feel") with further differentiations of the interlocutors themselves, who seek to further concretise the individual meaning of the rejection by the mother for the patient.

At the outset, from the many details of this very dense excerpt of conversation (E 20.37), attention should be drawn here, from the aspect of the theory and technique of interventions, to the specific phenomenon that medical interventions can have very different effects with different *ranges* of impact.

20.9.3 Impact of interventions

We have already addressed the problem of the scope of interventions (§ 9, 19.8) with examples and discussed it elsewhere (Koerfer, Köhle 2007, 2009, Koerfer et al. 2000, 2010). A distinction can be made between the aspects of *sustainability* and *after-effects* of interventions. On the one hand, there are verbal interventions with locally very limited effects. If questions such as: 'Do you smoke?' are answered in the negative, the topic is closed. On the other hand, interventions (also *cumulative* with others) can show long-term (also *synergetic*) effects, with which the conversation as a whole takes on a new topic shape. For example, a new thematic complex ("mother-child relationship") had developed in the wake of the insistent interventions (01-07), to which the specific key intervention (07D) had contributed considerably with its function of setting the course. As was already clear from previous conversations (e.g. § 19.8), global effects can be achieved with such key interventions, with which a new *quality of conversation* emerges under the content and relationship aspect.

Relatively independent of the (local to global) extent of effects, interventions with *immediate effects* can be distinguished from those with *delayed* effects under the aspect of after-effects. Thus, interventions may already have a latent effect, but their effects only become manifest

afterwards. In the preceding pair sequence (19D-20P), the delayed resumption (of the propositional content) of the doctor's verbal intervention (19D: "were you always disadvantaged?") is impressive, which can serve as empirical evidence for the effects of interventions, although these effects only become manifest later in the further interaction.

At first, one would like to assume an "ineffectiveness" of the doctor's intervention in the patient's immediate connection (20P), because the patient continues in his speech so "unmoved" as if he had not heard the doctor or had not understood him or even wanted to "overhear" him on purpose. Nevertheless, he later takes up the idea of a possible "disadvantage" suggested by the doctor, but in such a way that he specifically emphasises his personal "authorship" at the end of his longer contribution: "in my opinion (sic) she sometimes put me at a disadvantage compared to my other brothers" (20P). Thus the thematic gestalt that was opened with the doctor's question was closed again at the end of the patient's longer speech. Such cases of *postponed effects*, as already expressed in a biographical narration ("thrown off track") by another patient (§ 19.8), possibly illustrate the effectiveness of interventions beyond the conscious perception of patients, which should not be a problem for the doctor: If patients pass off their doctor's ideas as their own, this can, with the corresponding "evaluation" also "in the doctor's mind" ("all the better"), just be chalked up as a therapeutic gain without having to "teach" the patient about it.[5]

It is precisely a characteristic of cooperative conversation work that the common vocabulary is developed and first stabilised and then differentiated through literal and paraphrased reuptake without having to claim "copyrights". Although memories of the genesis of a shared vocabulary can be useful, the *context* of the emergence of supporting thematic *key symbols* (§ 20.9.5) is sufficient, in which at least the coauthorship of the doctor is allowed to "fade away". Although the stimulating cooperation of the doctor in the *emotive-narrative* conversation work is constitutive for achieving diagnostic-therapeutic progress, this medical *midwife role* in a *helpful relationship* (§ 3, 8, 9) may and should at some point become dispensable again.

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5 However, such cases of a mere supposed "dispensability" of medical interventions can also be used as a systematic *detection procedure, for* example for forms of *cooperative narration,* which we have already described and applied in advance (§ 19.3) and elsewhere (Koerfer et al. 1994, 1996, 2005, 2010, Koerfer, Köhle 2007). We will return to this method separately (§ 40) in the evaluation of doctor-patient communication.

20.9.4 Empathic feedback as (non-)verbal resonance

In the present case, the topic of the patient's (early) "disadvantage" is differentiated in a variety of ways in this and the following conversation up to the (professional) present. On the way there, however, the *biographical-narrative* anamnesis is first continued with the topic of the mother-child relationship (E 20.38), which both interlocutors seek to deepen reciprocally.

E 20.38		"ah, that's bad ..."
21	D	yes .... (4) .... one can imagine, it's hard for a child when you're told that, huh? .
22	P	yes .
23	D	ah .
24	P	that's the hardest thing that ever happened to me in my life, that my mother told me that, no .
25	D	I think so, yes ... that you are unwanted ... [quieter] ah, that's bad ...
26	P	yes, that was bad, when I think about it today, I still get so easily un-, I always tried .
27	D	what do you get? . when you think about it? .
28	P	such a slight- . no pain, but in in eh the soul it hurts then, no? .
29	D	yes, yes .
30	P	just thinking about it, no .
31	D	yes ... yes . exactly . yes ... (...)

Once set in motion, the flow of associations to the (after)experience of early childhood remains. After "the spell has been broken" and the dramatic experience of having been "unwanted" as a child has been brought up, the associated vocabulary of emotion and evaluation, to which we will return separately (§ 20.9.5), can be further differentiated. The doctor and the patient can continue to exchange ideas amicably, which becomes clear, for example, in the reinforcing adoption of the doctor's expression ("hard") by the patient (in the superlative) (24P: "the hardest thing that ever happened to me in my life"). As in the previous example with the patient who suffered from her divorce until the present (§ 20.7.2), it is often the *trivial,* everyday expression (25D: "bad") that can serve as an appropriate verbalisation of "unheard-of" events

and is usually well accepted by patients, as here (26P: "yes, that was bad"), i.e. can also be actively adopted.

The congruence between doctor and patient is expressed not only in the common vocabulary, but also in the non-verbal mode of conversation. Even as an external observer, one thinks one can "listen in" to how the doctor tries to process his own "consternation" about the patient's "hard" fate and yet, or precisely because of this, is able to give the patient sufficient *resonance* for his emotions. Thus, the emphatically empathic listener feedback (23D: "ah") can be regarded as an authentic sign of his *emotional resonance*, as can the lowering of the volume, which already decreases with the further empathic listener feedback (25D: "ah") before the verbal feedback ("that's bad"). Although empathy can also be expressed more or less "loudly" on appropriate occasions ("Oh my goodness!", "Golly!"), in cases like these "quieter" tones are certainly appropriate.

Despite or because of his consternation, the doctor is not only the *empathic* listener, but he also remains the *attentive* listener who does not miss the patient's self-termination of speech (26P: "I still get so easily un-"). The doctor does not simply let the self-breakdown "pass", but insists with an enquiry (27D: "what do you get?"), so that the patient paraphrases his suffering with two verbal attempts, which receives a repeatedly (29D, 31D) emphasised approval from the doctor and is later - despite the patient's subtle self-correction - taken up repeatedly in summary as "soul pain" (see Tab. 20.2 below). In this case, the patient is the "author" of a *thematic key symbol* whose individual meaning is varied in further courses of conversation in this and the next consultation, for example, when later there is talk of "soul scars" left behind by the "injuries" in early childhood, which can come under "tension" again in later life, and so on.

20.9.5 Interpretations based on thematic key symbols

The *basic vocabulary* developed jointly by doctor and patient, which has proven sufficient for the time being as a conversation-specific repertoire of *thematic key symbols* for dialogical understanding, is an essential prerequisite of *interpretations* that are not possible at some point or somewhere, but must "fall on fertile ground". To remain in this agrarian image: Only what has been "sown" before can be "harvested" (Koerfer et al. 2010). This brings us back to the problem of placing interpretations,

which can only unfold their meaning-giving function in the context of a developed interaction and thematic history (§ 20.6.4). We can only briefly reflect this extensive history of conversation here through a tabular compilation of *key thematic symbols* that have proven to be specific *emotion and evaluation vocabulary* (Tab. 20.2), which was jointly developed and differentiated in the cooperative conversation work of doctor and patient. Even this abbreviated overview of the common basic vocabulary represents a considerable reduction that can at best illustrate the previous thematic course, which here also only begins after the detailed complaint exploration (on the thematic key symbol "stomach pain") with the social anamnesis.

The interactive flow of topics and emotions in a conversation

The transition from the *topic of the profession* to the topic of the *mother-child relationship*, which appears abrupt in the tabular overview (Tab. 20.2: 11-12), had already been documented and analysed in detail in its history of development, also with regard to the further development of the basic vocabulary that was used jointly by the interlocutors in this phase. The more the conversation-specific basic vocabulary is developed and differentiated as the conversation progresses, the more specifically the two "co-constructors" can fall back on it. These opportunities for recourse apply to the thematic as well as interactive shaping of the course of the conversation.

After the narrative and emotional flow of the childhood experience had already started, it was easier to keep it going and also to resume it without any problems, even if it should have been interrupted in the meantime and overlaid or even replaced by other topics. Themes remain "virulent" even if they seem to have been put aside. As already explained above with the analogy to computer work (§ 20.3), "theme windows" can temporarily fade into the "background", only to be moved back into the "foreground" with little effort (thematic "quotation" recursions as "clicks"), so that they are fully "present" again in the current "window" as on the "screen".

	Development of thematic key symbols as basic vocabulary	
	Doctor	Patient
01		my job has been cancelled
02		I have done programming
03		I am now the girl for everything
04	is that still fun?	
05		oh, not particularly
06	your feelings (about it)?	
07		that disappoints me
08	anger swallowed (...) anger in the belly	
09		yes (...) possibly
10	hurt or offend in any way	
11		of course it does
12	What was the relationship like? [mother]	
13		always tensions with my mother
14	did you not feel well cared for?	
15		perhaps you could put it this way
16		I am an illegitimate child
16		not been wanted
17	were you always disadvantaged there?	
18		disadvantaged in my opinion
19	that's hard for a kid	
20		the hardest thing in my life
21	oh, that's bad	
22		yes, that was bad
23		in eh the soul it hurts then, no
24	yes yes (...) soul pain	
25	that remains like a scar in one	
26		that can be
27	when you had such a soul ache	
28	Injuries and insults remain	
29		I have never been so offended again
30	could be that these old scars	
31	get into tension	
33	so insults, injustices done	
34	this is something to think about	
35		sure (...) I have thought about it
36	to do with your early programming	
37		maybe you feel it as an infant
38		transfers to the child
38	(For continuation see below E 20.39)	(For continuation see below E 20.39)

Tab. 20.2: Development and repertoire (excerpts)
of the basic vocabulary shared by doctor and patient

In most cases, the vocabulary in question can be reactivated without having to document this, for example, in the form of an *explicit quotation* ("As you said earlier ..."). As a rule, "references" do not have to be specifically shown because the participants can easily make the necessary additions to the question of *who said what and when from* memory. Nevertheless, an explicit introduction can be useful - for various reasons, for example, because doubts may arise about the memory of a topic from a long time ago (also from previous consultations) or the specific attribution to the speaker should be *marked* as *relevant* in the context ("As you *yourself* said ...") etc.

Three-part interpretation

In this conversation, too, doctor and patient repeatedly refer to each other without and with "quotation" in order to clarify their individual and shared perspectives. First, the conversation partners cooperate on a series of further narratives ranging from childhood to adolescence to adulthood, and then bridge back to the patient's very early childhood experiences (Koerfer, Köhle 2007, Köhle, Koerfer 2017). This bridge is built by the doctor by introducing the linguistic image of "early programming" with a lengthy, three-part interpretation, not by chance in allusion to the patient's professional language, before he then additionally chooses the established term of "imprinting" (D 09) .

E 20.39		"it has something to do with your early programming ..."
01	D	so, if you've done programming, then you actually have a good understanding of it . then you actually have a good understanding for it . because with you it has something to do with your early programming ... the way you grew up with not being wanted and so on . you didn't realize that until your mother mentioned it or somehow there eh . so from the (unintelligible) . of course you still feel that as a child, yes . and . ehm- .
02	P	maybe you can even feel it as an infant, because my mother always claimed that she had never seen a child who cried as much as I did when I was a baby . maybe it was the mother's fault, who unconsciously, when she only gives the breast .

03	D	yes .
04	P	this is transferred to the child ... I don't know how to put it.
05	D	you are absolutely right.
06	P	that the child, that I felt that as a child eh . somehow . without her even saying anything, ne .
07	D	yes .
08	P	right? .
09	D	yes . you express it wonderfully ... there's no better way to put it ... that's how it is ...(6)... it's only on the level of feeling, not talking or anything like that, yes ... and that's where it gets imprinted . (...) you would perhaps say: is then programmed .
10	P	hm . hm .
11	D	and when something like that comes up, we can still work on it with reason, but this old programme gets started again, so that it hurts (...)

Although both the occupational topic, after which the patient had to endure the descent from "programmer" to "girl for everything", and the story about the "illegitimate" child who had "not been wanted", date back a long time, both interlocutors can seamlessly tie in with it like "old acquaintances", even to the point of remembering that the patient had already conveyed his experience in verbal as well as non-verbal modes of experience (E 20.37: 20P: "my mother sometimes told me so and made me feel it"). While there the verbal reproduction in the form of indirect speech (with *verbum dicendi*) still seemed to dominate (E 20.37: 20P: "told (...), that I was not wanted (...) that I ruined her life"), the patient now places the non-verbal mode of experience at the center of his observation (E 20.39: 02P: "maybe you even feel it as an infant ... (...) ... when she only gives the breast"). Apparently, the doctor had already hit the patient's emotional state with great *accuracy of fitting* (§ 3, 17) with his multi-part intervention.

In the first step, the doctor's intervention was already constructed in such a way that the non-verbal mode was brought into focus: "you didn't notice it until your mother mentioned it (...) of course you still feel it as a child, yes . and ehm-" (01D). The extent to which the patient feels directly "addressed" emotionally by this intervention becomes clear from his quick reaction, with which the patient's *spontaneous associations* with the mother-infant relationship "break through" in such a way that he more or less "jumps into the doctor's word" (02P: "maybe ..."). The patient's need to communicate is obviously so great at this point in the

conversation that he "takes the floor" as soon as an opportunity to speak arises, because the doctor pauses briefly with a delay (01D: "and ehm-" as a *hesitation phenomenon*), whereby he clearly wants to continue his speech.

The extent to which the patient can adopt the doctor's view of his childhood is not only formally apparent from the spontaneous speech connection, but also from the content, which the patient takes over from the doctor in a reinforcing manner by elaborating on it and concretising it in detail (02P: "when she only gives the breast", 04P: "transferred to the child", 06P: "that I felt that as a child"). The congruence of content between the two interlocutors is then also marked several times both by short dialogue feedback, which is carried out in an alternation of "interrogation of agreement" (*tag-question*: "no?") and confirmation ("yes"), as well as by longer content feedback, with which the doctor particularly emphatically *honours* the patient's elaborations (05D: "you are absolutely right" and 09D: "you express that wonderfully"). After this reciprocal upgrading of the relevance of the topic, a (reflection) pause (of about six seconds) occurs, which the doctor then uses to continue his interpretive interventions in terms of content, aiming at the after-effects of the child's experience up to the present.

The last, three-part interventions (01, 09, 11) lie on a line of interpretation that amounts to an overall interpretation of the doctor. In doing so, the doctor can refer, right up to the image of "programming", to diverse "preparatory work" in which both interlocutors have contributed in their own way to the *co-construction* of *key thematic symbols* that now prove to be conceptually sufficiently viable for a *dialogical understanding* to be able to advance the development of a "shared reality" between doctor and patient on this basis (Uexküll 1987, Uxküll, Wesiack 1991, 2011) (§ 3, 7).

This joint preliminary work between doctor and patient had been presented in rudimentary form in the overview of the development of the *basic vocabulary* (Tab. 20.2), the further development of which was documented and analysed in detail in the selected conversation excerpts (E 20.35-39) (Koerfer, Köhle 2007, Köhle, Koerfer 2017). Already the *iterative* narrative structure, which was introduced with the dramatic childhood narrative (E 20.36-38: *always*, *sometimes* 12P, 19A, 20P, 26P), suggests a *supplementary series* of critical events in the sense of Freud (1917), which is repeatedly extended by the doctor to the "injuries and mortifications" in the present, in which the patient had to

suffer a loss of job, which is tantamount to a loss of meaning and identity through the change from "programmer" to "girl for everything".

While the patient tried to "solve" the ambivalence conflict in his own way (more or less *rationally*) by initially "swallowing" the "anger" and going into "semi-retirement" without "particularly enjoying" his work in order to "make the best of it" in his situation, the doctor now contrasts this with the limits of "reason" (11D: "then you can still work it out so well with reason, but this old programme gets going again, so that it hurts ..."). Thus, towards the end, a kind of "interim balance sheet" is drawn up in an initial conversation, which already "shows its specific effect" in the bridging time until the next appointment, as this became clear in the follow-up conversation.

Openness in a helping conversation

At the beginning and at the end of the next consultation, the conversation with the doctor is subjected to an *evaluation* by the patient himself, whose symptoms had apparently already improved (E 20.40), by asking the question about the *helping* conversation in the sense of "thinking aloud", which he also answers positively himself at the end:

E 20.40		"did that help after all?" - "I have to be open with you"
Start	P	the next day, after our conversation, I think, didn't that help after all? (...)
End	P	I have to be open with you, otherwise you can't help me at all .
	D	that's right, yes .

This consensus at the end of the second conversation, at which a long series of individual narratives has joined together in their entirety to form a life narrative, refers to the patient's insight into the mode of action of such conversations, which depend on sufficient "openness" on the part of patients if they are to prove "helpful" (§ 3.1). The *self-censorship* formulated in advance with Freud (Fig. 20.5: "this or that does not belong here, it is quite unimportant ...") already seems to be overcome in the course of the short conversation practice. The association flow of the patient, who reveals his emotions in his narratives, is no longer curtailed by "scissors in the head", with which, for example, a *narrative taboo* or even a mere *narrative inhibition* is maintained.

Once the "spell is broken", patients can achieve a level of *emotive narrative self-interpretation* under their doctor's professional constructive participation, where the initial credit to be given for deviating "from an ordinary conversation" (in the sense of Freud) (§ 9) can pay off in a short time.

20.10 Further information

Previously, a large number of theoretical, didactic and empirical works on the complex topic of *empathic communication* in medicine and psychotherapy were cited, of which a few are to be cited again here under certain thematic aspects.

Those interested in the historical development of the concept of empathy will find further references in Black (2004), Breithaupt (2017), Guidi, Traversa (2021), Gil Deza (2024), Jami et al. (2024). For the role of empathy in psychotherapy, we refer to Rogers (1962/1990), Miller (1989), Thomä, Kächele 1989/2012 and Wellendorf (1999). For empirical studies on psychotherapeutic practice, we refer to relevant (conversation-analytic) works in Peräkylä et al. (eds.) (2008) as well as the current (also conversation-analytically oriented) studies by Buchholz (2014), Buchholz et al. (2016), Buchholz (2017) and in Scarvaglieri, Graf, Spranz-Fogasy (eds.) (2022).

For various (tripartite) conceptual developments of empathy in medicine, exemplary (partly as overviews) are mentioned: Coulehan et al. (2001), Mercer, Reynolds (2002), Derksen et al. (2013), Neumann et al. (2009, 2010, 2012), Heritage, Lindström 2012, Sulzer et al. (2016), Andersen et al. (2020), Zhang et al. (2023). For a description of the deficits in training as well as didactic suggestions for improving empathic competence, reference should be made to Hojat et al. (2004, 2009), M Neumann et al. (2011), E Neumann et al. (2012), Seitz et al. (2017) and Andersen et al. 2020 as examples.

Those who would like to work with the internationally used NURSE scheme, which we had critically compared with our Cologne Communication Manual (§ 20.4.6), will find suggestions in Smith (2002), Back et al. (2005, 2007), Pollak et al. (2007), Fortin et al. (2012), NKLM (2015), Langewitz et al. (2010), Langewitz (2017), Walczak et al. (2018), Childers et al. (2023). However, it should again be noted that the original version by Smith and Hoppe (1991) and later revivals in Smith (2002) and

Fortin et al. (2012) continue to adhere to the NURS conceptualisation without E(xploration). Likewise, reference should again be made by way of example to other (teaching) books that do without the NURS(E) scheme altogether on the topic of "empathy and emotion": Platt, Gordon (2004), Roter, Hall (2006), Hugman (2009), Parrott, Crook (2011), Cole, Bird (2014), Brown et al. (2016), Kondo (2022). Childers et al. (2023) explicitly argue “Beyond the NURSE Acronym”. A systemic review of Empathy in Doctor-Patient Communication (between 2017-2021) is provided by Zhang et al. (2023). An overview of definitions and the interaction of empathy and culture is provided by Jami et al. (2024).

Although the topic of communicative handling of patient emotions was the main focus of this chapter (§ 20), there are of course overlaps with other chapters, for example under aspects of *storytelling* and the associated *intimacy* of the topics, which require a special *empathic* (also "scenic") *understanding* of the doctor in his *midwifery function* (§ 9.2, 9.5, 19.7-8). On the specific connection between *narrative* and *empathic* communication, reference is made to the following examples: Angus et al. (2017), Habermas (1919), Habermas, Fensel (2022), Guidi, Traversa (2021) (cf. § 9, 19). For an overview of specific relationships between *active* and *empathic* listening, please refer to Rodat (2020), Collins (2022), Kishton et al. (2023), Epstein, Beach (2023), Tustonja et al. (2024) (cf. § 19).

For the specific handling of emotions in the communication of "bad news" (*BBN),* reference should be made back to the relevant chapter (§ 16) and to relevant chapters on dealing with patients with *depression* (§ 30) and *anxiety disorders* (§ 31) as well as to the chapter (§ 34) on dealing with "difficult" patients. Regarding the specific relationship between forms of questioning and interpretations, please refer to the following chapter (§ 21.3), where further anchor examples of *empathy-in-interaction* are discussed.

In advance, attention was repeatedly drawn to special *empathic* forms of *listener feedback* (*oh, great*), which are treated throughout the handbook as part of *active listening* (§ 19). In the subsequent chapters, the communicative handling of emotions will repeatedly play a special role when, among other things, the exploration of *individual meanings* (§ 21.5) and the deepening of "sensitive topics" (§ 21.6: *sexuality*, *alcohol,* etc.) will be at stake when completing the anamnesis.

Emotions also come into play again during the explanation and negotiation of therapeutic measures (§ 22) simply because patients have to develop trust not only towards the art of medicine, but also towards

their doctor as a person to whom they ultimately "entrust" themselves in many ways. This is essentially about fears and hopes for the future, which, however, are to be "dealt with" appropriately in the *here and now* of the consultation.

The complete *Cologne Manual & Evaluation of Medical Communication* (C-M+EMC) can be found at the end of this chapter. Further empirical anchor examples are analyzed and discussed in the other practical chapters (Part IV) of the handbook.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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Cologne Manual & Evaluation of Medical Communication see next page.

	Cologne Manual & Evaluation of Medical Communication					C-M+EMC
	OSCE Checklist for Medical Interviewing					[1]1998
	© Department of Psychosomatics and Psychotherapy at the University of Cologne					[6]2022
No.	Course	Interviewer	Date	Patient (SP)	Rater	Sum:
						☐☐ 50

1 Building a relationship	☐4	4 Exploring details	☐☐ 12
1 Framing • Enable confidentiality • Avoid disturbances		1 Inquire about complaint dimensions • Localisation and radiation • Quality, intensity *(scale 0-10)* • Dysfunction/disability • Accompanying symptoms • Time (beginning, course, duration) • Condition "In what situation ...?"	0❶2❸4
2 Greeting • Make eye contact • Verbal greetings, shaking hands • Address by name	0❶	2 Exploring subjective ideas • Concepts *"What do you imagine?"* • Explanations *"Do you see causes?"*	0❶2❸4
3 Introducing yourself • Introduce yourself by name • Communicate function ("ward doctor")	0❶	3 Complete anamnesis • Systems ("From head to toe") • General health, sleep, etc. • Previous illness, pre-treatment • Family risk factors • Family, friends, job, finances, etc. • Addressing gaps (sensitive issues)	0❶2❸4
4 Situating • Speak sitting down (chair to bed) • Ensure convenience • Coordinate proximity/distance	0❶		
5 Orientation • Structure conversation • Goals, time frame	0❶		

2 Listening to concerns	☐10	5 Negotiating procedures	☐☐ 12
1 Start the conversation openly • Offer "What can I do for you?" • Occasion *"What brings you to me?"*	0❶	1 Plan an evidence-based approach • What is secured? • Do diagnostics have consequences?	
2 Encouraging storytelling - feedback • Listener signals *hm, yes,* nod, etc. • Avoid interruptions • Allow pauses, free choice of topics	0❶2❸4	2 Clarify expectations • Ideas, wishes, hopes *"What did you have in mind?"* • Control beliefs *"What could you change yourself?"*	0❶2❸4
3 Active listening - verbal support • Encourage speaking up • Repeating statements verbatim • Paraphrase statements • Openly ask further: *"How did that come about?"*	0❶2❸4	3 Explaining previous findings • Communicate diagnosis • Communicate problems	0❶2❸4
4 Ensure understanding • Ask "Do I understand correctly ...?" • Summarise	0❶	4 Examination or therapy plan • Explore decision model (SDM) • Discuss proposals and risks • Consider reactions • Strive for consensus	0❶2❸4

3 Eliciting emotions	☐8	6 Drawing conclusions	☐☐ 4
1 Pay attention to emotions • Verbal (e.g. metaphors) • Non-verbal (e.g. gestures, facial expressions, gaze behaviour, etc.)		1 Summarise the conversation • Reason for consultation, complaints, • Diagnosis, therapy agreement	0❶
2 Empathise with patient's situation		2 Offer clarification of outstanding issues • Information *"Do you still have questions?"* • Satisfaction "Can you handle it? "	0❶
3 Respond empathically • Offer appropriate help and comfort • Acknowledge burdens, coping	0❶2❸4	3 Arrange follow-up appointments • Examination appointments • Set a meeting date	0❶
4 Promote emotional openness • Addressing *"I perceive that ...?"* • Naming *"You are sad then?"* • Clarify *"What do you feel then?"* • Interpret *"Your fear may come from..."*	0❶2❸4	4 Say goodbye to the patient 5 Complete documentation • Coding & conversation impressions • Topics for follow-up talks	0❶

0❶ [0 = not met; ❶ = met] 0❶2❸4 [0 = not met ...❹ = fully met]

Fig. 20.6: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)