SPECIAL REPORT

Nonverbal communication and the therapeutic relationship

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"**Interviewer:** *Do you feel Dr M. cares about you and your illness?*

Joan: *Yes, very much so. He's... uhhh... he's kept a very close eye on me. I've been coming back for 10-day checkups, follow ups on my medication... just to see how I'm progressing... I think he's very concerned and wants to see me get better, too.*

Interviewer: *How does he communicate that to you?... uhhh... How do you know that?*

Joan: *Uhhh... (long pause)... That's a hard one... Just in the tone of his voice; in the eye contact that we make I feel that he really does want me to get better... and the frequent visits...*"*

Nonverbal communication is integral to the effectiveness of the physician-patient relationship. It helps to establish a connection between the patient and the doctor necessary for a successful therapeutic relationship.[1]

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* *Transcript of an interview with a 25-year-old woman, a patient suffering from episodic depression, who was interviewed immediately following a routine consultation with her doctor.*

Communication between patient and physician needs to be viewed in its entirety. The distinction between verbal and nonverbal communication is somewhat arbitrary. The purpose of this article is to focus attention on the nonverbal component of communication, because awareness of this aspect of our communication will lead to a greater understanding of our patients and ourselves and the messages we exchange.

Nonverbal communication provides a way of communicating the emotional experience of illness that is often difficult, if not impossible, for the patient to verbalize. It allows health care providers to send messages of empathy and understanding and to communicate messages, such as "I care," clearly.

Arthur Kleinman,[2] in writing about healers, described Paul Samuels, a committed and caring clinician who seemed to have a compelling ability to connect with his patients. Kleinman interviewed one of Dr Samuel's patients, a 35-year-old contractor with diabetes, who spoke of this ability.

You mean Doc Samuels? What makes him so darn good? I don't know, but they ought to patent it. He is the genuine article. He listens. Doc Samuels knows what you're going through. I don't know, it feels like – well, you know, like he's there with you, right with you while you go through a bad spell, an emergency. He wants you to get better. Sometimes I think I feel like he needs you to get better.[2]

Background of nonverbal communication

"We communicate all the time. Even our silence speaks."[3] People communicate through the use of two channels: the verbal and nonverbal, and the process is both conscious and unconscious. Verbal communication refers to words and their meaning. Nonverbal communication is more complex and more difficult to define. It involves actions as distinct from words, both intentional and unintentional, as well as the context and manner of spoken interaction.[4,5] Specific behaviors and aspects of human interaction expressed nonverbally include facial expression, eyes, voice, touch, body posture and gestures, physical appearance and presence, use of space, and handling of time.[1,3,5]

Facial expression. A patient's emotive state, such as fear, distress, or sadness, is communicated to the health practitioner by facial expression.[1] The experience of observing a 12-month-old infant smiling and playing happily and then suddenly frightened, face crumpling in distress, provides a vivid example of the immediate communicative potential of facial expression. A facial grimace can reflect the subjective sensation of pain in spite of words to the contrary. It can be considered a request for comfort.[3]

The practitioner's emotions and expectations are often communicated clearly and forcefully through facial expression. For example, these expressions might be manifested as tight-lipped anger or stoical resignation with a patient's noncompliance, or caring and pleasure at a patient's understanding and response to treatment.

Eyes. Eye contact is one of the most important nonverbal cues. It can express fear, guilt, confidence, or support. The eyes help the physician decipher the truth.[3] For example, the

experience of establishing eye contact with an aggressive, paranoid patient can leave one searching for the examining room door, whatever the content of the spoken words.

Eyes can also indicate accurately a positive or negative relationship. People tend to look longer and more often at those whom they trust, respect, and care about than at those whom they doubt or dislike.[3] Normal pupil dilation is not controlled by the individual. When looking at something pleasing, an individual's pupils will dilate measurably; when viewing something displeasing, the pupils will constrict.[3]

Voice. Vocal intonation can convey meaning beyond the words, particularly information about a person's emotional state. Rhythm, pitch, and intensity are fundamental components of expressive oral communication. If vocal information contradicts verbal information, vocal information will dominate.[6] Feelings, such as fear, anger, sadness, joy, and pain, are transmitted strongly through vocal cues.

The subtle quaver in the patient's voice, perhaps heard over the telephone, contradicts the patient's declaration that all is well. All is not well, and often the patient is only waiting for the physician to listen to unburden themselves of their suffering. "It is not what we say that counts, but how we say it."[3]

Touch. The "laying on of hands" is one of the more spiritual and symbolic aspects of the health practitioner's care. Historically it was viewed as a kind of blessing involving the transfer of healing powers.[1] This symbolic value might still exist to some extent and therefore could help create positive expectations in the patient for resolution of symptoms.

Healthy infant development depends on love and affection, transmitted in large part through tactile communication. The behavioral development of babies deprived of such experiences can be stunted and can result in a variety of health problems, such as allergies and eczema.[3,7]

Touch is also comforting. This is physiologically based, and such activities as patting, gentle massaging, and backscratching can reduce tension.[1]

Physical contact during a physician's examination will produce reactions on emotional and interpersonal levels. Issues of trust, intimacy, respect, and power will be raised and communicated, largely nonverbally.

Body posture and gestures. Humans express attitudes toward themselves and others vividly through body motions and posture. The degree of postural relaxation displayed indicates the liking of, and respect for, another individual. The postural orientation toward another person similarly reflects the respect and preference accorded the other person.[3] A physician whose posture is closed and head buried in the chart can undermine his or her goals before he or she begins.

Emotional state is reflected in how people walk, stand, and sit. Depression, for example, declares itself by the stooped posture, eyes on the floor, and shoulders carrying the weight of the world.

Body posture and movements are frequently indicators of self-confidence, energy, fatigue, or status and can invite or discourage communication.[3] Gestures and body movements need to be interpreted in context because no specific gesture has universal meaning.

Physical appearance and presence. State of cleanliness, dress, smell, and grooming all communicate. Clothing can reflect the personality, attitudes, mood, and values of the wearer and can identify sex, age, socio-economic class, and status.[7] The traditional white coat is no longer a necessary mantle of office for most physicians. Physicians' cleanliness, personal grooming, and appropriate attire can, however, continue to communicate respect for patients.

Use of space, proximity, and environmental cues. The use of space is a subtle but important component of nonverbal communication. It can indi-

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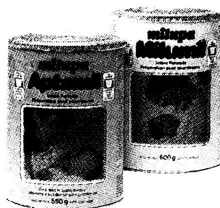

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cate territory to which access is allowed or denied to other people or objects.[3,8] How the furniture is arranged in the physician's office can set the tone for communication that will occur. For example, the physician who is seated in a splendid leather armchair behind a massive darkwood desk as the patient is ushered in communicates clearly a hierarchy and an agenda. This contrasts vividly with the physician who provides the more comfortable chair to the patient and sits within touching distance without interposed furniture.

Similarly, the design, lighting, comfort, and cleanliness of the office and waiting room communicate a respect and sense of importance to the patient.

Handling of time. The waiting room is an unfortunate but apt title for a place to sit and wait for someone whose time is clearly of greater importance and who will see you when he or she is ready. How a patient's time is respected will communicate a hierarchy between physician and patient and can establish the emotional tone of the meeting. The contrast between this and the housecall is forceful if one considers the implicit contextual communication. (The doctor will take the time and make the effort to see the patient in his or her home.)

Culture is an important determinant of the way people view time, and it needs to be considered in cross-cultural settings.[9] For example, in scheduling an appointment for Haida Native Indian elders, it is important to respect their sense of time. The interview must allow enough time for some general discussion before the reason for the visit is reviewed. A sense of hurry or overly directed questioning often results in loss of rapport and perhaps not getting to the real problem at all.

Contrast between nonverbal and verbal communication

Nonverbal behaviors and interactions provide a rich foundation upon which the more evident verbal content will rest. A comparison of the respective attributes of these two channels of communication will clarify our understanding.[5]

- Verbal communication is discrete. It begins and ends with the words or sounds produced. Nonverbal communication is continuous for as long as the communicators are in each other's presence.
- Verbal communication relies on a single mode at any one time; the auditory or visual mode for the spoken or written word, respectively. Nonverbal communication is multimodal in that all of our senses can be receiving signals at once. Furthermore, we can send and receive a variety of nonverbal cues simultaneously.
- Verbal communication is largely under voluntary control. We send and receive relatively explicit messages. Nonverbal communication is much less controlled and often beyond our conscious awareness. The content is usually implicit and more contextually bound.[5]

While almost any idea can be communicated verbally, nonverbal communication is largely concerned with imparting feelings and attitudes. It provides us with considerable information concerning the state of a given relationship with respect to liking, responsiveness, or dominance.[3] Nonverbal communication, focused on affect, is powerful and also difficult to control.[3] Oliver Sacks,[10] a neurologist, provides us with an understanding of this in his writings on aphasic patients.

It was often said of these patients, who though intelligent had the severest receptive or global aphasia, rendering them incapable of understanding words as such, that they none the less understood most of what was said to them. Their friends, their relatives, the nurses who knew them well, could hardly believe, sometimes, that they were aphasic.

...To demonstrate their aphasia, one had to go to extraordinary lengths, as a neurologist, to speak and behave unnaturally, to remove all the extraverbal cues – tone of voice, intonation, suggestive emphasis or inflection, as well as all visual cues (one's expressions, one's gestures, one's entire, largely unconscious, personal repertoire and posture): one had to remove all of this (which might involve total concealment of one's person, and total depersonalisation of one's voice, even to using a computerized voice synthesizer) in order to reduce speech to pure words...

...Something has gone, has been devastated, but something has come, in its stead, has been immensely enhanced, so that – at least with emotionally-laden utterance – the meaning may be fully grasped even when every word is missed.[10]

These damaged individuals, suffering from strokes or other neurological calamities, provide insight into the communicative potential that is within all of us – abilities that we all use to a greater or lesser degree and often without conscious awareness.

Generally, verbal and nonverbal communication channels work together to reinforce a message. When nonverbal and verbal messages do not match, the message believed is the nonverbal, and the impression is of insincerity.[1,11] A nonverbal clue might be picked up by the attentive observer and then be made explicit through the verbal channel.

Successful communication between physicians and patients involves arriving at some mutually acceptable understanding.[12] This might be difficult, particularly if the physician is unable or unwilling to acknowledge the underlying concerns of the patient, concerns that might be only subtly expressed nonverbally. As McWhinney[12] reminds us: "It is a universal experience that words are inadequate to express feeling."[12]

Emotions, particularly fear, can be a vital part of the experience of illness for a patient. Nonverbal cues may provide the means for the sensitive physician to understand the patient's struggle.

The experience of illness

Physicians have been trained to view illness in a way that is quite different from the existential experience of the patient. "Physicians see illness in terms of a disturbance of bodily function. Patients see it as a disruption of their 'being in the world.'"[12] Viewed through the eyes of the patient, illness is about losses. As Kay Toombs[13] wrote: *"The body can no longer be taken for granted or ignored. It has seemingly assumed an opposing will of its own, beyond the control of the self."*[13] Illness disrupts the fundamental unity between the body and self. It is experienced as a loss of wholeness.

Cassell[14] has proposed that four phenomena are central to the experience of being ill: loss of connection, loss of a sense of omnipotence, the failure of reason, and loss of control.[14] He defines connectedness as our sensory appreciation and interaction with the world. *As illness deepens, connections are increasingly cut off by the symptoms of sickness and by the forced withdrawal from society caused by sickness. The patient is alternately frightened by the perception of his withdrawal and disinterested in the loss as his horizon shrinks.*[14]

Fear is an important emotive response to this threatened loss of connectedness. "Fear and anxiety, are ever present in illness, even minor illness."[12] The ill patient thus burdened with fears and anxieties, struggling with the threat of lost connectedness, often presents to the physician in a search for explanation and meaning.[15,16] Tolstoy[17] graphically portrayed this in *The Death of Ivan Ilyich and Other Stories.*[17]

There was no deceiving himself: something terrible, new and significant, more significant than anything that had ever happened in his life, was taking place within him of which he alone was aware. Those about him did not understand, or refused to understand, and believed that everything in the world was going on as usual. This thought tormented Ivan Ilyich more than anything.[17]

A patient sees a physician with a compelling need to communicate concerns that often transcend symptoms and signs. These concerns are about fears, losses, and meaning – issues that are difficult, if not impossible to articulate explicitly. These issues strike to the very heart of our humanness.

By listening, caring, and guiding, a physician can help a patient reestablish a connectedness to self and to the world. Much of this communication will take place through nonverbal channels. "Therapeutic contact takes place within a connexional, or transpersonal, dimension of human experience, within which basic human needs for connection and meaning are met."[16]

Connecting: the physician's role

The physician's primary goal in helping a patient deal with the experience of illness is to reestablish a patient's connectedness to self and to others. As Suchman and Matthews[16] write, "The connexional dimension of human experience is basic to medical care yet seldom recognized or made explicit."[16] In describing such moments of connectedness, they wrote the following.

Such moments may be distinguished by a particularly intense awareness of another's feelings, of mutual closeness, which is accompanied often by a peculiar physical sensation, such as a chill, gooseflesh, or flushing. This moment may be followed by a lingering feeling of love, a sense of privilege at having been allowed into the patient's life so vividly, and a humble feeling that one is part of something bigger than oneself... The patient, too may be moved and awed by the feeling of being so profoundly understood, no longer all alone in his or her suffering.[16]

Enid Balint,[18] writing about psychotherapy, described the "flash" technique: an intense intimate contact that is sometimes made between the physician and the patient. This flash of understanding can occur in an interview when the patient is allowed to use the physician in his or her own way, and the physician adopts a role of attentive observation. She described three working principles that would facilitate the occurrence of these therapeutic moments.

1. The physician should not be too preoccupied with either theories or preconceived questions arising from these theories, but rather adopt a discipline of careful and attentive observation. Coupled with this the physician differentiates how much of what is observed originates from the patient and how much is contributed by the physician.
2. The physician reflects silently about his or her observations and their meanings, identifies with the patient, develops ideas about him or her, and intervenes with a comment or interpretation only with great care lest the intervention divert the patient from his or her train of thought.
3. The physician needs to respect a patient's defences and not attempt to run after "secrets," thus blunting his or her ability to observe what is there before his or her eyes. Balint wrote:

Our experience shows that if these working principles are more or less adhered to, an intense, intimate contact is sometimes made between the doctor and the patient. This contact does not lead to a dependant clinging relationship, or to a strong transference neurosis. But the flash of understanding, if meaningful, may expose the tip of an iceberg, or the heat of a fiery cauldron, which perhaps can gradually be explored either

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by the patient and doctor together or by the patient alone. The patient's independence and human dignity are not endangered. The patient is in control of the pace and content of the therapy. The therapy, we think, lies in the peculiar intense flash of understanding between the doctor and patient in a setting where an ongoing contact is possible, where neither the doctor nor the patient gives up his self-esteem.[18]

These powerful and somewhat spectacular moments of connectedness are uncommon. They depend on a respect for the patient's agenda and involve a deep understanding that can be reached through practising attentive silence; in other words, focusing the communication into nonverbal channels and communicating messages of empathy, positive regard, and caring.[19]

The daily routine of a practitioner rarely includes such wonderful moments, at least at a conscious level. Yet physicians are often surprised by patients who are unexpectedly grateful for the service rendered. Perhaps some of these patients, through the genuine support of their physician, were helped to reestablish a sense of connectedness with themselves and their world.

While recovering from an injury to his leg, Oliver Sacks[20] wrote about his visit to a surgeon.

He listened, with perfect concentration and courtesy, and then he examined me, swiftly but authoritatively, in detail. This is a master, I said to myself: I will listen to him as he has listened to me.[20]

Listening attentively is a complex nonverbal behavior that can lead to a therapeutic connectedness. What seems to characterize the effectiveness of the clinician in these relationships is a respect for the patient. This respect involves attending to cues offered by the patient that allow the physician to enter the patient's world, to see the illness through the patient's eyes.[21]

Conclusion

We constantly communicate nonverbal messages that are genuine, powerful, and immediate. Focusing attention on the nonverbal content of communication between a patient and physician can lead to a better understanding of how we can heal. ■

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