WHAT ARE THE SPECIFIC SKILLS OF ATTENTIVE LISTENING?

Listening is often equated with "sitting and doing nothing", a passive rather than active approach. Yet as **Egan (1990)** says in "The Skilled Helper":

> How many times have you heard someone exclaim, "You're not listening to what I'm saying!". When the person accused of not listening answers, "I am too; I can repeat everything you've said", the accuser is not comforted. What people look for in attending and listening is not the other person's ability to repeat their words. A tape recorder would do that perfectly. People want more than physical presence in human communication; they want the other person to be present psychologically, socially and emotionally.

In fact attentive listening is both active and highly skilled. There are four specific skill areas that can help us to develop our ability to listen attentively:

- wait-time
- facilitative response
- nonverbal skills
- picking up verbal and non-verbal cues

Wait-time

Making the shift from speaking to listening at appropriate moments in the consultation is not easy. Inadvertently, we often find ourselves preparing our next question rather than focusing attention on what the patient is saying. We may become so involved in formulating our next question that we divert our own attention from hearing their message and, by interrupting, fail to give the patient adequate time to respond. Evidence from the world of education rather than medicine helps to illuminate the value to both doctor and patient of allowing the patient more space to think before answering or to go on after pausing.

Over 20 years, **Rowe (1986)** studied non-medical teachers in a wide variety of classroom settings. She found that when teachers asked questions, they waited one second or less for a reply. Similarly, they only waited one second after a student stopped speaking before they responded. However, if the teachers were trained to increase their pauses at each of these key points to three seconds, remarkable changes occurred in the student's behaviour in class. The students contributed more often, spoke for longer, asked more questions, provided more evidence for their thinking and failed to respond less often. Difficult or "invisible" students started to contribute successfully. In turn, teachers asked their students less questions but of a more flexible nature and they increased their expectations of their students.

In the medical interview, using wait time effectively allows the patient time to think and to contribute more without interruption and the doctor to have time to listen, think and respond more flexibly.

Facilitative response

Some doctors clearly have a greater ability than others to encourage their patients to say more about a topic, to indicate to patients that they are interested in what they are saying and that they would like them to continue. This is often achieved very efficiently with minimal or no interruption and it is worth considering exactly what these minimal clues are that seem to be such powerful indicators to the patient that we are listening and wish to hear. Along with nonverbal head nods and the use of facial expression, doctors practising attentive listening use innumerable verbal encouragers which signal the patient to continue their story. This is often achieved very efficiently with minimal or no interruption and yet provides the patient

with the necessary confidence to keep going. Such neutral facilitative comments include "uh-huh", "go on", "yes", "um", "I see" - we all have our own particular favourites.

Nonverbal skills

Much of our willingness to listen is signalled through our nonverbal behaviour which immediately gives the patient strong clues as to our level of interest in them and in their problems. Many individual components are involved in nonverbal communication including posture, movement, proximity, direction of gaze, eye contact, gestures, affect, vocal cues (tone, rate, volume of speech), facial expression, touch, physical appearance, and environmental cues (placement of furniture, lighting, warmth). All these skills can assist in demonstrating attentiveness to patients and facilitate the formation of a supportive relationship; ineffective attending behaviour in contrast both closes off the interaction and prohibits relationship building **(Gazda 1977).**

Among the most important of all the non-verbal skills is eye contact. It is so easy to be distracted from providing this by the notes or the computer as we grapple to comprehend our patient's problem: yet, poor eye contact can be readily misinterpreted by the patient as lack of interest and can inhibit open communication. First impressions are very important here.

Communication research has shown that non-verbal messages tend to override verbal messages when the two are inconsistent or contradictory **(Koch 1971, McCroskey et al 1971).** If you provide the verbal message that you want the patient to tell you all about their problem while at the same time you speak quickly, look harassed and avoid eye contact, your non-verbal message will win out and the patient will correctly construe that time is at a premium today.

The importance of both verbal and nonverbal facilitation skills lies in the message that they impart to the patient. Facilitation skills are effective in encouraging patients to tell us their story because they directly signal to our patients something about our attitude to them, our interest in them and their story, and our helpful intentions. Without these skills, the patient remains uncertain about our interest in what they are saying and our need for them to continue with their account: it might be clear to us in our minds that we wish the interview to proceed in a certain way but is our verbal and nonverbal behaviour skilful enough for the patient to share that understanding?

Picking up verbal and non-verbal cues

Another important listening skill is that of picking up patients' verbal and non-verbal cues. This requires both listening and observation. Often patients' ideas, concerns and expectations are provided in nonverbal cues and indirect comments rather than overt statements **(Tuckett et al 1985)**. These cues often feature very early in the patient's exposition of their problems and the doctor needs to look out specifically for them from the very beginning of the interview. The danger lies in either missing these messages altogether or assuming we know what they mean without checking them out with the patient. Patients' cues and the assumptions we make about them need to be checked out and acknowledged in the interview.