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Nonviolent (empathic) communication for health care providers

M. ROSENBERG* and P. MOLHO†

**The Center for Nonviolent Communication, Reigolsdwil, Switzerland and †Centre de Traitement de l'Hémophilie, Hôpital Cochin, Paris, France*

Summary. The purpose of Nonviolent or Empathic Communication Training is to facilitate the flow of information necessary for people to work cooperatively and resolve differences effectively. Such training is widely used in medical communities where the communication with patients and the cooperation between team members are of critical importance for the effectiveness of the treatment. Communication skills are of particular importance for health care providers dealing with patients having chronic diseases such as haemophilia. In addition to the difficulties inherent to the chronicity of the disease, the HIV contamination has dramatically impaired the relationships between patients and health care providers, creating a lot of pain, still alive in both parties. The purpose of this presentation is to offer to health care providers and patients some tools to deal with their feelings and restore effective, compassionate and fulfilling communication.

Keywords: Nonviolent communication, empathic communication, empathy, cooperation, conflict solving.

Communication is the core part of the work of a physician or other health care providers, and very little or no specific training is offered during the medical or paramedical course. Communication skills are of particular importance in chronic diseases such as hemophilia, where the relationship between the patients and the medical team is usually a life-long story. In such chronic diseases, there is a very subtle equilibrium to be found between very close and personal relationships, which can get in the way of therapy, and an exaggerated distance.

The blood contamination with HIV has dramatically impaired the patient-doctor relationship. Among the numerous feelings stimulated by this drama, anger is the most frequent on a patient's side, and guilt on the doctor's side. These feelings are often unexpressed, which makes the situation worse, and more than 10 years after the contamination, healing is still not complete, neither with patient nor doctor. The situation is worse in countries where there are still ongoing trials, some physicians beings sued for "complicity of poisoning". Such words are harsh, and contribute to stimulate a lot of anger and fear for doctors. In addition, the fear of unknown risks such as the transmission of infectious agents, not yet identified, or any other complication related to the treatments, adds significant pressure on the physicians and a lot of fear and distrust for the patients. On top of that, conflict within the team is a common feature of any large institution, often leading to burn-out.

How, under such conditions, can a trusting relationship be restored between patients and the medical staff in order to provide the best medical treatment to patients?

The conclusion of a recent editorial in the *Lancet* [1] entitled "Physician empathy — should we care?" is that we cannot afford not to. It has been demonstrated that physician empathy increases patients' satisfaction [2], improves their compliance [3], and enhances physicians' ability to diagnose and treat their patients [4]. In our experience, it also increases the physicians' satisfaction, sense of meaning, and enjoyment of their work. In addition, Levinson [5] and Beckman [6] have demonstrated that physicians who demonstrate empathic behaviours have a significantly reduced risk of litigation. However, a recent study based on transcripts and videotapes of primary care office visits showed that physicians seldom demonstrate an empathic behavior [7], leaving patients not feeling understood. Therefore, there is a need for efficient training to help physicians and other health care providers become competent and fluent in the use of empathy.

The purpose of Nonviolent (Empathic) Communication [8] is to facilitate the flow of information necessary for health care providers to demonstrate their care and treat effectively their patients, as well as to work cooperatively and resolve differences effectively. It also helps identifying when a patient needs empathy, and what might be

Correspondence: Dr Pascale Molho, Centre de Traitement de l'Hémophilie, Hôpital Cochin, 27 Rue du Faubourg St Jacques, 75014 Paris, France. Tel. and fax +33 (1) 42 34 10 87; email: yvette.sultan@cch.ap-hp-paris.fr

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interfering with our ability to respond to another person's needs for caring at a given moment (our own emotions, preoccupations for diagnostics or treatment, etc.).

This paper includes a general description of the process and some concrete examples of its application within health care settings, since it is widely used in many countries.

General description of the process (Fig. 1)

Nonviolent (empathic) communication outlines a process for expressing:

- clear observations without mixing in evaluations
- one's own feelings and needs without making critical judgments of others
- clear requests and presenting them in a respectful, non-coercive manner

The ability to separate evaluation from observation (Fig. 2) represents a major step in the process. Exercises using daily situations help people realize that as soon as we mix evaluation, judgements, and criticism, it stimulates defensiveness on the part of others, thus decreasing the likelihood to get our needs met.

It also requires the ability to empathically receive the following information regardless of how others are communicating:

- what others are observing
- what others are feeling and needing
- what others are requesting

Nonviolent (empathic) communication also identifies language and communication that interferes with our ability to work cooperatively and resolve differences effectively. Such communication is referred to as "life-alienated communication". In life-alienated communication, our thoughts are disconnected from our feelings, and nonviolent communication helps us to integrate the mental and the emotional (Fig. 3). It allows us to realize that all forms of judgements, whether towards ourselves or others, as well as feelings such as anger or depression, are tragic expressions of unmet needs.

In addition, life-alienated communication includes:

1. Criticism — Criticism implying errors or something bad; e.g., "The problem with Dr. Smith is that he is too impulsive in making diagnoses". This kind of criticism contains a quality of "should-ness", that is, it implies that people should not behave this way.

Many people do not know how to evaluate the performance of others without criticizing. For example,

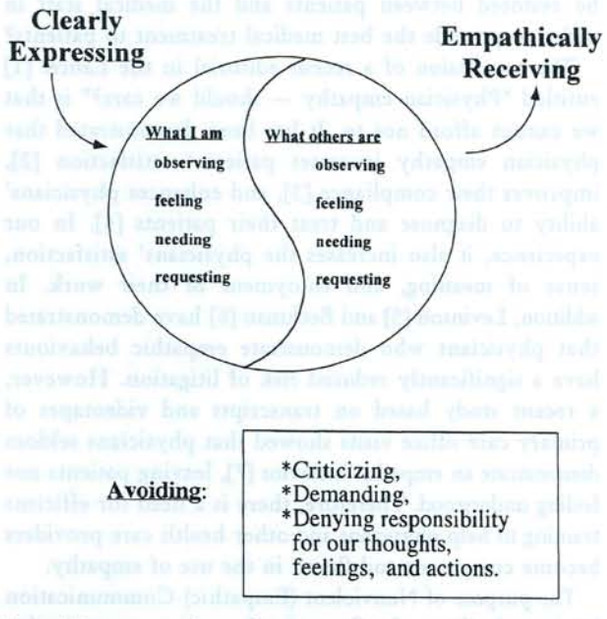

Fig. 1. The process of empathic (nonviolent) communication. The diagram shows the two parts of nonviolent communication — honesty (expressing how I am) and empathy (hearing how the other person is) — and the four basic components of the process: observations, feelings, needs and requests.

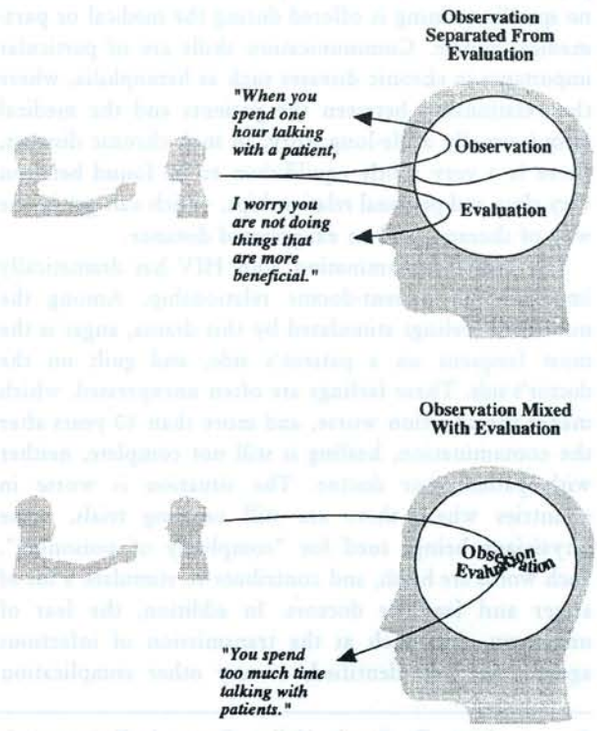

Fig. 2. Separating evaluation from observation. Two ways of communicating with another person about the same fact are presented in order to illustrate the difference between a pure observation and an evaluation mixed with an observation.

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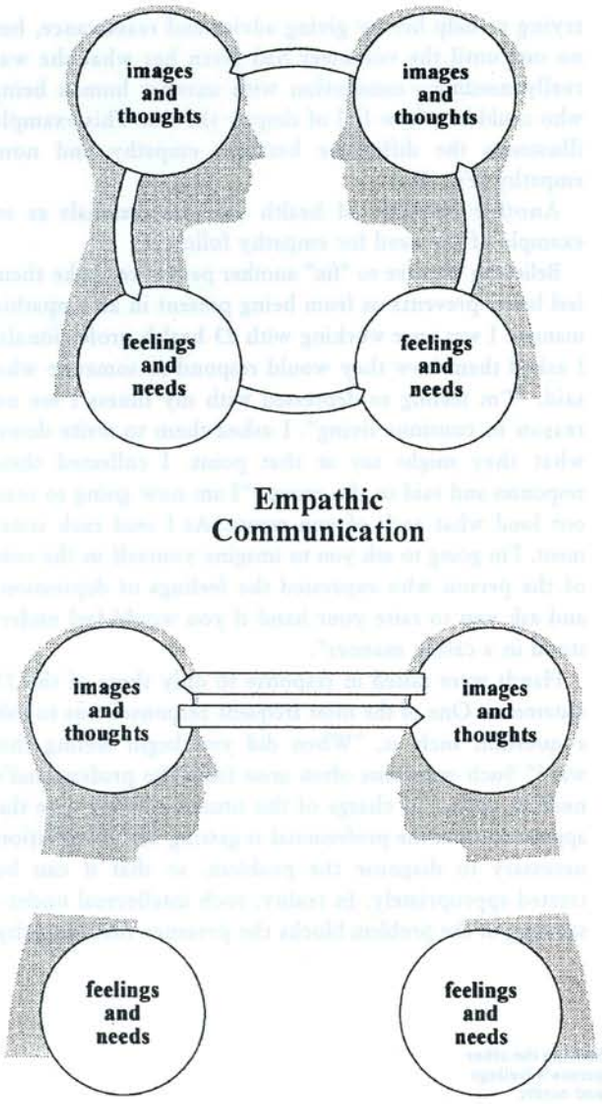

Fig. 3. Integrating the mental and the emotional. The lower diagram shows the disconnection between the mental (images and thoughts) and the emotional (feelings and needs), which is a characteristic of life-alienated communication. The upper diagram shows the goal of empathic communication, which is to help us to integrate the mental and the emotional.

when others are behaving in ways that conflict with their values, they communicate in terms of what is wrong with the other person. They may do this moralistically using words like "lazy" or "bad". They may use scientific jargon such as "sick" and "neurotic". It is a basic tenet of nonviolent communication that evaluating with such criticism is a tragic expression of one's values and standards.

2. Denial of responsibility for actions — A second characteristic of life-alienated communication is failure to accept responsibility for one's thoughts, feelings, and actions. An example is the words such as "have to" in the phrase, "There are some things that you have to do, whether you like to do them or not".

Responsibility for one's actions is denied when the cause of the actions is attributed to:

- the actions of others (*I criticized the nurse because she came late.*)
- vague, impersonal forces (*I cancelled the meeting because it was necessary to do so.*)
- one's psychological history, condition, diagnosis, or personal history (*I sometimes shout at the administration because I have a bad temper.*)
- to the dictates of authority (*I lied to the patient because my chief of service told me to do so.*)
- to group pressure (*I started administering the medication because everyone else on the staff was administering it.*)
- to institutional policies, rules, and regulations (*I dismissed the patient because it is the hospital's policy to do so in such circumstances.*)
- to sex roles, social roles, or age roles (*I had to do it because I am a nurse.*)
- to uncontrollable impulses (*I was overcome by my urge to say what I did even though I knew it would upset everyone.*)

I was once discussing the danger of a language that implies we have no choice with a group of head nurses in a hospital in the United States. One of the head nurses said, "But there are some things nurses have to do and it is our job as head nurses to tell them that they have no choice but to do it". I asked her for an example of a situation where people had no choice. She mentioned certain procedures that nurses have to carry out. It was interesting that she chose the examples she did because my reason for being invited to work in this hospital was that the very procedures she was saying "had to be done" were not being done.

When I later met with her nursing staff and asked them why these procedures were not being carried out, one of the nurses replied, "We forget". However, our subsequent discussion revealed that they harbored much resentment toward the head nurse for the dictatorial way they heard her expressing requests. It became clear that the nurses had a conflict between their mentally understanding the purpose of the procedures and their emotionally resenting how they were being told to carry out the procedures. Forgetting often occurs when this conflict between head and heart is present. I subsequently showed the head nurses how expressing requests differently could reduce forgetting of important procedures.

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Various applications of nonviolent (empathic) communication

Responding empathically to ill people with life-threatening illness

The following is a story of a volunteer demonstrating an example of empathy with ill people.

A woman receiving nonviolent communication training in Sweden volunteered in a hospital one day a week. Shortly after participating in the nonviolent communication training she went to the hospital and was given the assignment to talk with an elderly woman who sat in her room all day repeating over and over again, "I want to die". The nurses said, "We have told this woman that she isn't that sick and that she would get better if she took her medicine, but all she does is sit in the room and say that she wants to die". The volunteer went into the elderly woman's room and, as the nurses predicted, the woman sat whispering over and over, "I want to die". The volunteer remembered from her training how reassuring it can sometimes be to hear our very words reflected back to us and she said to the woman, "So you would like to die". The volunteer in recounting this story told how surprised and relieved the woman was to have this response. She then began to talk about how no one understood how bad she felt. The volunteer continued to reflect back the woman's feelings. Soon the woman and the volunteer were holding one another. Later that day the nurses asked the volunteer what magic she had applied. The woman had started to eat, take her medicine, and seemed in much better spirits. The nurses had been trying to help her by giving advice and reassurance, but no one until the volunteer had given her what she was really needing — connection with another human being who could hear how full of despair she was This example illustrates the difference between empathy and non-empathy (Fig. 4).

Another anecdote of health care professionals as an example of the need for empathy follows:

Believing we have to "fix" another person to make them feel better prevents us from being present in an empathic manner. I was once working with 23 health professionals. I asked them how they would respond to someone who said, "I'm feeling so depressed with my illness I see no reason to continue living". I asked them to write down what they might say at that point. I collected their responses and said to the group, "I am now going to read out loud what each of you wrote. As I read each statement, I'm going to ask you to imagine yourself in the role of the person who expressed the feelings of depression, and ask you to raise your hand if you would feel understood in a caring manner".

Hands were raised in response to only three of the 23 statements. One of the most frequent responses was to ask a question such as, "When did you begin feeling this way?" Such questions often arise from the professional's need to appear in charge of the situation. They give the appearance that the professional is getting the information necessary to diagnose the problem, so that it can be treated appropriately. In reality, such intellectual understanding of the problem blocks the presence that empathy

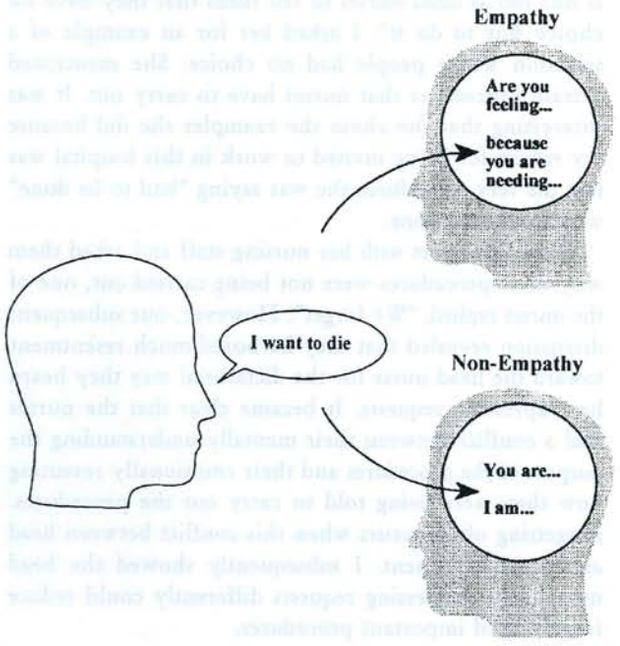

Fig. 4. Empathy – non-empathy. The difference between empathy and non-empathy is illustrated by two different answers to the same message from a patient, "I want to die."

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requires. When we are *thinking* about what the person is saying and looking for connections that tie into our theory, we are not *with* them, we are looking *at* them. The key ingredient in the process of empathy is presence, meaning we are neither feeling the feelings of the person (which would be sympathy) nor are we intellectually understanding: *we are being wholly there with the person and what he or she is experiencing.*

Remaining human when communicating with others communicating through life-alienated language — recognizing the need for empathy behind anger or aggressiveness

Here is a story of a patient who has been contaminated with HIV.

It is often when we need empathy the most that we express ourselves in an agressive or demanding way. A 23-year-old patient contaminated with HIV came to a haemophilia center to ask for a prescription for anti-haemophilic factor; after the prescription was written, he asked the physician to add a sleeping pill. The physician, knowing that he was a drug addict, already using several sleeping pills, refused, and the patient got extremely angry. He said, "anyway, all the prescriptions that you write are shit", to which the physician responded by tearing up the prescription. The patient started then to call the doctor names, and this almost ended with physical violence.

In such a case, a physician using NVC would have answered to the patient's initial request for sleeping pills, "I am feeling worried about writing this prescription, and, as for any medication, I would like to better understand what is leading you to ask for it; are you having trouble sleeping?" The doctor thereby expresses his feelings and needs that keep him from agreeing to writing the prescription, rather than saying "no" abruptly. Then, when the patient says "anyway all your prescriptions are shit", an empathic response using NVC would sound like: "Are you still feeling angry about the HIV contamination and needing more understanding of how it has impaired your life?"

However, in order to be able to give such empathy to a patient, the doctor himself needs to receive first enough empathy for how painful and scary it is to deal with such patients. This leads us to another important issue, which is how to create support teams in health care systems.

Building cohesive work teams

The following is a story of a medical doctor needing empathy from another staff member.

A doctor who had put a lot of energy into building a trusting relationship with a patient once answers him on the phone, "this is not my job" when the patient had called for a health insurance problem. The patient said "you are not any better than any other doctor, I will not come back to your center", and he hung up. The doctor, who was very discouraged, went to a colleague for some comfort, and the answer she received was, "this is not your fault, this patient is just impossible, too resistant". This is what we call in NVC "the fix-it attitude", which is that, when we see someone in pain, we immediately want to relieve the person from that pain. In that case, real relief would have been brought by an empathic answer such as, "it seems like you are feeling very discouraged after all the time and energy you have invested in the relationship with this patient, and would have needed at least some understanding from his part". This quality of understanding is one of the strongest needs we all have. Building a cohesive work team means developing this capacity of empathically listening to each other rather than criticizing, giving advice, or trying to fix or to find solutions immediately. Learning to create an empathic connection rather than thinking about solutions is a very important part of this communication process.

Transforming resistance to innovation into cooperation

Another example is my work with the administrators at a hospital when introducing innovations. They were expressing anxiety about a forthcoming encounter with the physicians at their hospital, preparing to again ask them to support a project these physicians had already recently voted against — 17 to 1. The administrators were very interested in having me demonstrate how they might use nonviolent communication when approaching the physicians.

I assumed the role of administrator, and began by saying, "I'm feeling frightened to be talking about this issue." I chose to start that way because I sensed how frightened they actually were about confronting the physicians again. Before I could continue, one of the administrators stopped me, saying, "You're being unrealistic. We could never tell the physicians that we were feeling frightened."

I was curious about why the fellow believed this, and asked him how an admission of fear seemed so impossible. Without hesitation, he responded, "If we said that we were frightened, then they would just pick us to pieces." His answer didn't surprise me — I have heard similar reactions from others in talking about people at their workplace. Many have not been able to imagine themselves ever expressing feelings at their work environment. However, one of the administrators did decide to risk expressing his vulnerability at the dreaded meeting. Afterwards, he told me that he had stated his feelings along with his reasons for wanting the physicians to

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change their position. He noticed how differently they responded than when he expressed himself in his usual manner — a logical, rational, unrevealing way of communicating. And he told me how relieved and amazed he was when, instead of being "picked to pieces" by the physicians, he actually received the support he was seeking. In fact, the physicians reversed their previous position and voted 17 to 1 to support the project. This dramatic turnaround helped these administrators realize and appreciate the value of expressing one's vulnerability — even in the workplace.

Other applications of NVC

- Resolving conflicts within and between work teams
- Preventing "burn-out"
- Providing threatening technical information in a compassionate manner
- Improving customer relations
- Requesting the support necessary to serve others
- Increasing productivity of meetings
- Providing opportunities for family members of people with life-threatening illness to compassionately support them
- Evaluating performance in ways that maximize learning and morale
- Remaining human when institutional forces encourage competition, coercion, and dehumanization
- Staying connected to the human being behind titles
- Remembering what is important under time pressure

Training in nonviolent (empathic) communication

This provides opportunities to apply the process within oneself, in work relationships as well as in intimate or family relationships. It is available in 25 countries including most European countries, the US, and Israel. It consists of workshops and usually has two 3-day courses (a 3-day introductory course and a 3-day deepening). This provides enough training to allow participants to use it and benefit from it in their practices. Specialized courses for health care providers are also available. Contact the Center for Nonviolent Communication in Switzerland (Postfach 232, Reigolsdwil, Switzerland; tel. +41 (61) 941-2440; fax +41 (61) 941-2079; email: 74721.1121@compuserve.com) or the US (POB 2662, Shermann, TX 75091; tel. +1 (903) 893-3886; fax +1 (903) 893-2935; website: www.cnvc.org) for information regarding the training available in your country.

Conclusions

We would like to emphasize that the very power of this process resides in its simplicity, and the fact that the clarity of the intention is even more important than the words. And the intention of this process is to connect compassionately to other human beings before blaming, correcting, or educating. To sum up, we often say "empathic connection before education".

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