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# Communication Skills in Clinical Practice

## (Doctor–Patient Communication)




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CHAPTER

# 4

# Non-verbal Behavior (NVB)

*What we are communicates far more eloquently than anything we Say or Do.*
—S Covey

## INTRODUCTION

Whenever two persons talk to each other directly, the meaning of a message is not merely derived from the spoken words but from an amalgamation of the following:

- Spoken word – Language
- Voice tone – Para-language
- Gesture and expression – Body-language
- Dress and grooming – Personal appearance, e.g. over-coat, hairstyle, etc.
- Possessions – Personal effects, e.g. pen, stethoscope, etc.
- Affiliation and activity – Context and intent of the behavior.

Ray Birdwhistell, an anthropologist, has estimated that during a typical dyad, only one-third of the message is conveyed by spoken words; the rest is conveyed by the other elements of communication. Albert Mehrabian, in 'Silent Messages', has said that spoken words carried only 7% of feelings, emotions and attitudes, para-language, 38%, and body language, the remaining 55%. Truly then, *action speaks louder than words.*

## DEFINITION

Body language includes any voluntary, involuntary or reflex movement of a part, or all of the body. This communicates emotional messages to the outside world. These signals are often missed or misread unless a person is trained in socio-cultural nuances of body language. In contrast, non-verbal behavior (NVB) includes body language and all the other non-verbal cues like appearance, possessions and affiliations.

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## LISTENING WITH THE EYES

The total message conveyed during any dyad includes facts, ideas, principles, feelings, attitudes, values, self-concept, needs, aspirations and motivation. A listener may not receive many of these if s/he is *blind* to the non-verbal signals and *deaf* to the verbal ones.

Non-verbal signals are subconscious, unless the person is an actor playing a role. Usually these gestures just precede the verbal output and one has to train oneself to look for these signs at that point of time. After taking ward rounds for years with students and residents, I am convinced that the most important difference between a senior clinician and a novice is the ability to perceive and interpret NVB.

There are about 5000 gestures using the hands and 20,000 using the face. One should look for the *big picture* and understand the main message than analyse gestures in isolation.

When verbal and non-verbal messages are contradictory, one instinctively tends to believe the latter. Research has proven this valid. It is easy for the conscious mind to utter falsehood by words. On the contrary, it is virtually impossible for the subconscious mind, which controls spontaneous gestures and expressions, to lie. Moreover, the involuntary non-verbal output always precedes the conscious verbal output. Physicians, who appear to have great insight into patients' minds, are generally adept at picking up these true non-verbal messages from them.

Clinicians assessing mental status interpret patients' non-verbal behavior in terms of its i) quantum of discharge, ii) expression, iii) interactional cues, and iv) neurological signs like Parkinsonism, Bell's palsy, etc. While decoding non-verbal expression for interactional cues, consider the three general aspects discussed below. These contribute to forming an initial impression. One should also look for the major NVB signals described later.

## READING AND RESPONDING TO MAJOR NON-VERBAL SIGNALS

Individual signs of body language, though important, may not convey the whole picture and at times, may even mislead. The 'big picture' has to be taken into account. The cumulative meaning of NVB may be classified into the following eight non-verbal signals. Once understood, it is easier for a physician to follow the signals emitted by a patient and respond appropriately.

### Closed versus Open Position

Fear, nervousness, scepticism, defensiveness, secretiveness, confusion, lack of rapport and similar negative emotions result in closed signs. Some of the universal signs of *closed position* are:

- A hand over the mouth
- The arms folded tightly across the chest
- Hugging an object (a book or a hand-bag) or clutching it with both hands
- Locked legs or interlocked big toes
- Lack of eye contact, tense or blank expression, and covering the face.

In *sari*-clad women, "*pallu sign*" (*pallu* is the extra length of sari, normally covering the chest and hanging free at the back is wrapped around to cover the whole upper torso) is a strong sign of closed position. In some communities, *pallu* is used to cover the head also. A common variation of this sign is tugging the right border of sari in front of the chest in an attempt to cover the front torso better. Less common are tugging the left border and tucking it

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in to the waist line. Similar signs can also be perceived with other dresses like skirt and *salwar-kameez* (tugging at the hem of a skirt and readjusting the *duppatta*).

Outstretched arms, open relaxed limbs, loose smooth motion, legs standing at ease (comfortably apart), friendly face and comfortable eye contact are the hallmarks of *open position*. Undoing signs of closed position, e.g. unlocking the big toes or re-adjusting the sari also indicate open position.

***Caution***

These 'open signs' indicate a confidant, fearless, clear-headed state and imply trust in the attending physician. Young male doctors should not misread these signals in female patients as having sexual undertone. Such errors can lead to wrong responses, which are unprofessional misdemeanours and unethical acts.

### Possessions and Appearance

The way people dress and appear make statements on their lifestyle, beliefs and the state of health. Men from rural India shave only once in a few days and only if they feel well. Therefore, *the beard sign* often indicates ill health in them. One of my favourite quote is, "A beard—with fever and a heart lesion is infective endocarditis, with haemoptysis is pulmonary TB, with jaundice is viral hepatitis, with epigastric pain is active peptic ulcer and with pain in the right upper quadrant is amoebic liver abscess." New residents from other states are surprised until they realise that all these unrelated conditions are subacute problems and common in south India; these affect the sense of well being and then the rural men stop shaving.

Similarly, *mehndi* application on the fingertips or nail polish in rural women and men indicate festivities or celebrations. From the proximal length of new nail growth, one can even guess when the event took place. This is not a mere curiosity. Our studies on non-adherence to therapy have shown that among patients, who have chronic problems such as diabetes mellitus, hypertension or heart disease, festivities as well as grievances are major reasons for skipping therapy.

Some other *appearance signals* in India are new bangles, dress or footwear, and shaved head. The last sign, especially in females, indicates a religious pilgrimage and the hair growth can say when it took place. In males, it could also be due to death of a parent or a first degree relative. A newly married woman is often detected by her shiny new jewels, silver anklet with noisy bells and too ostentatious a dress for medical consultation. "Honeymoon cystitis" and early pregnancy are common reasons for such consultations.

### Distance and Direction

Turning towards and moving closer to the other person are open positive signs except when aggressive in intent. Turning around and moving away are signs of withdrawal. Turning at right angles could be a *warm* or *cold* sign depending on if the person was initially facing away or not. Instead of the whole person moving, only the upper torso or the face may reveal these signs.

### Language Proficiency and Hand Movement

Stammering and gesturing is often seen in our patients when they try to speak in English rather than their mother tongue. A study found that bilingual subjects speaking in their non-dominant language produced more groping hand movements and stammer more. In addition,



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in comparison with a high imagery (picturesque) topic, when the subjects spoke about a low imagery (non-picturesque) topic, they displayed more pointing movements. Clinicians listening to bilingual patients may wrongly interpret an increase in motor activity as a sign of psychopathology (Marcos, 1979).

### Touching and Self-Concept

Persons with low self-concept, who are unsure of themselves, touch their body more frequently than those with a high self-concept (Muller et al, 1980). If doctors want to project an image of confidence, they should avoid touching themselves while talking to the patients (or their examiners!).

The following paragraphs describe eight major non-verbal signals and suggest how to respond to them if you perceive them in your patients.

### Positive Signals

These indicate agreement, enthusiasm or co-operation. These are seen in those patients with whom you already have a good rapport or when the dyad is proceeding in a way that patients appreciate much.

- Nodding, smiling, alert and relaxed face
- *Sprinter's position* of sitting on the edge of the seat, leaning forwards with feet on tip toes and a slight tilt of the head (even pet dogs do this!)
- Fully attentive with riveting eye contact and without any hostility
- Rubbing the palms together
- Coat or vest unbuttoned, sleeves rolled up, *pallu* of *sari* gathered and tucked in to the waistline.
- Open body position
- Standing at ease—legs comfortably apart with hands on the hip

The following indicate inclination to further interaction:

- Changed voice-tone—gentler and conciliatory, or more animated and enthusiastic
- Body positioning—moving closer, tilting head towards, or aligning the shoulder towards you
- Hand gestures: rub, clap, pat, grab, touch or shake hands.

#### *How to Respond*

- Show appreciation by gestures or smiling; thank him/her when appropriate.
- Note the things you say or do ("*hot-buttons*") that elicit positive signals from the patient; continue in the same vein to build an even better rapport. For example, if mention of non-drug therapy elicits such a response from your patient, spend more time explaining it further.
- Show friendliness and an equal enthusiasm; listen intently.
- Respond to any interactive gesture in an appropriate way with out crossing the ethical norms.

### Thinking Signals

When a major decision has to be made by the patient and the options are many, a patient may show these signs:



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- Repetitive gestures like rubbing the chin or neck, twisting the hair, scratching with a finger tip, tapping on the head, smoothening the hair, beard or moustache, etc.
- Chin resting on the palm while the thumb and fingers touch and stroke either cheek
- Meditating expression, look of concentration, intense but blank stare *at* the wall, ceiling or floor or *through* you
- Hands clasped *behind* the back with the head bent down and downcast eyes, or *thinker statue* like posture (flexed sitting position with forehead resting on the hand)
- Pinching the nose-bridge with eyes closed, rubbing the eyes or lips, or stroking the corners of the mouth; simpletons and small children may elaborately pick the nose or ear while in deep thought
- Methodically and slowly wiping spectacles, putting objects like a pencil or an ear-piece of spectacles in the mouth; a smoker may inhale deeply and others may take deep breaths
- Repeatedly mumbles to self or asks reassuring questions; doodles (scribbles) letters or an object repeatedly.

***How to Respond***

- Do not interrupt while the patient thinks deeply; keep looking at the face and wait for eye contact
- Elicit reasons for deep thinking: Is it due to wavering, being unsure or fear?
- Summarise major benefits of following your advice
- Anticipate and respond to any further queries
- Reassure on how good the decision would be; use facts and figures, not jokes or frivolous remarks.

*Caution*

Some of these signs may be due to boredom and a patient may let his/her thoughts wander to other concerns. Beware! Double check by eliciting some responses from the patient.

## Signals of Disinterest and Restlessness

The following signals suggest boredom or disinterest. Patients show these when one tries to advise them an unacceptable treatment option like giving up smoking.

- Blank, *zombie* like expression that looks through you
- Avoidance of eye-contact or drooping eyelids
- Absent verbal or non-verbal response
- Repeated yawning
- Chin resting on hands, body slouched in seat with legs stretched out
- Body and head turned away
- In a group, talking among themselves, sharing jokes or passing notes around (diversion).

***Caution***

Remember that these signs may also indicate underlying fatigue or sleepiness. In that case, fix another appointment.



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The following signs indicate **restlessness**. These are more often seen in a doctor than a patient! So check yourself if you inadvertently reveal these signs!.

- Fidgeting in the seat or couch
- Restless gestures like tapping, drumming, looking at the wristwatch repeatedly, clicking a ball pen, etc.
- Crossed legs with one foot kicking or tapping
- Frequent nodding and hastening the dyad
- Doodling, bending clips, or tearing slips of paper.

#### *How to Respond*

- Ask relevant questions and force attention and interaction
- Skim over 'boring' topics and focus on areas of interest to the patient; alternately stress why the apparently boring information is of importance to the patient
- Create interest using humour, drama, anecdotes or facts in an enthusiastic, involved and interactive way
- Take a break and resume later.

### Confidence Signals

These are often seen in VIP cases and persons who have been in positions of authority. The *tough ones* (in my experience) are village headmen, elderly schoolteachers, head priests and heads of organisations. They may show the following signs:

- Stand or sit erect
- Lean back on the seat with hands on the back of the head
- Facial expression of inner calm and poise
- Lack of nervous mannerisms
- Frequent direct eye contact
- Joining the fingertips in front—the *steeple gesture*; higher the steeple gesture, more is the feeling of superiority; an extreme case may peer at you through the steeple hands!
- Speaking slowly, in a lower pitch and a relaxed manner.

#### *How to Respond*

- A good way to say that you are on the patient's side is to acknowledge his experience or expertise and that you are glad to be of service to him/her (see "superior personality")
- Do not get intimidated; the other person may be great in his/her own field but then you are a professional too and your help has been deemed necessary by the other person
- Act confident yourself but do not try to challenge; it is unprofessional and may also stir *the hornet's nest* and divert the attention from health care concerns
- Subtly reveal your knowledge, expertise and professionalism thereby establishing your credibility; after all you should know more than the patient on health care issues of your speciality.

### Signals of Scepticism

A patient who has doubts, disbelief, confusion or distrust may reveal these signs. It is commonly seen when there is a mismatch between *illness* and *disease*. Illness is what the patient perceives



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and disease is what the doctor perceives. Many 'severe illnesses' may just be 'trivial diseases' and *vice-versa*. If the doctor is not empathetic in such situations, a patient is bound to show the following signs.

- Raised eyebrows and a quick sideways glance (I find it more in female patients)
- Facial expressions of frown, smirk, sarcasm or amazement
- Open mouth with finger on the lower teeth or finger tapping on the chin; shaking of the head sideways
- Scratching the head or rubbing the nose
- Pushing back in a chair, stepping back or turning away on a couch with defensive crossing of arms
- (Patients wearing glasses) Lowering the spectacles and peering over them at the ceiling or the floor.

***How to Respond***

- Empathise with the patient; elicit reasons for doubt and clarify with ample proof from authoritative sources
- Fully explain any illness-disease paradoxes to promote understanding
- Use open, friendly position and positive gestures
- If the patient seems unconvinced, *agree to disagree* until the next dyad.

## Negative Signals

A patient with feelings of hostility, anger or frustration may show these signs:

- Increased eye contact with a challenging look, squinted glance, taut face and frowning expression
- Closed body-position with clenching of fists or clutching the edge of a table, chair or couch
- *The self-controlling gestures:* A palm on the back of the neck and locked ankles; arms across the chest with fingers tightly clutching the upper arms
- Restless signals (see above)
- Abrupt, jerky movements and aggressive body shifts, banging on a table or a cot
- *Aggressive gestures:* Destroying small objects like paper clips and rubber bands or crushing a paper violently.

***How to Respond***

- Use non-threatening body postures and calm voice
- Elicit reasons for restlessness or anger
- If anger is 'at something else', allow it to be let off. Studies have shown that giving time to vent anger and frustration helps soothe the person in a few minutes; the person may in fact smile at you at the end of it!
- Never inflame the patient by arguing or vehemently denying
- If the patient 'does not get it', blame it on your inability to get it across effectively.

*Caution*

With a psychiatric case, or a very hostile person, keep a good distance, maintain eye-contact at all times, keep the door and windows open; call for help if things seem to go out of hand.



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## Signals of Deception

Patients do not always say what they think or feel; they often say what they think you wish to hear from them. The following signals should caution one not to take the patient's words at face value.

- *The Hot-seat syndrome*: Squirming in the seat, especially if the patient feels nervous about lying to the doctor or suspects that lying has been detected.
- *Nervous mannerisms*: Picking nails, finger tapping, playing with jewellery or pen, repeatedly readjusting the specs on the nose, or *the pallu of a sari* or *duppatta*; frequent smacking or licking of the lips; repeatedly wiping the face with hand or a kerchief; wringing of hands, especially when pressed to answer
- *Voice changes*: High pitched rapid speech at high volume; short and rapid breathing; unnecessary repetition or stammering
- *Self-comforting gestures*: Palm on the head, handclasp, etc.
- Eye contact goes to either extremes of a) avoiding direct eye-contact, throwing furtive sideways glance or looking up and down, and b) over compensated prolonged eye-contact with nodding of the head and tapping on the furniture, (*the believe me* gesture).
- Sudden non-purposive movements, especially when telling a lie
- *The double cross sign:* Cross arms defensively, then uncross while lying, and then cross again in a defensive or defiant way.

### *How to Respond*

- Never imply that you know that the patient is lying and never directly challenge veracity, except in rare instances of a chronic defaulter, etc.
- Elicit response in different ways to check for veracity; it is difficult to lie consistently
- Correct their mistakes authoritatively with facts, figures and evidences; speak in a non-judgemental manner
- If you can not make the patient tell the truth, agree to disagree until the next dyad.

## Signals of Hurry

These are more commonly seen among doctors than patients. If a patient is in a hurry to catch a bus or empty the bladder or bowel, or if s/he wants an unpleasant dyad to end, the following signals may be present:

- Signs of restlessness (see above *)
- Looking at the time frequently
- Answering even before the question is fully asked
- Short and curt responses even to open-ended queries
- Repeated attempts to get up from the chair
- If the meeting is accidental while crossing paths, not stopping but continuing to continue to walk, drive, etc.

### *How to Respond*

- Confirm if the patient is in a hurry to attend to some thing else
- Fix up another convenient time to meet; if the message is urgent, ask for a minute and tell the gist.

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## SPECIFIC NON-VERBAL SIGNS IN PRACTICE

Many NVB signs have been described and are formally taught in the schools of drama and dance. These form the *words* and *phrases of the non-verbal language*. More relevant to us are the NVB signs studied in health care settings by various researchers. Some of the major findings are summarised in this section. These form the vocabulary of the body language.

### The Eyes and The Face

#### *Eye Contact*

A physician should consider a variety of factors in evaluating the patient's eye contact including cultural background, emotional state, personality characteristics, and gender.

In a Japanese study (Bond and Komai, 1976), when the interviewer gazed at subjects' eyes, their response latencies were shortened and body movements were reduced, reflecting greater subject involvement in the interaction. When the subjects gazed at the interviewer's eyes, the subjects increased self-manipulation using their hands, reflecting the upsetting effects of monitoring the interviewer's face during interaction. The consequences of *gazing at another's eyes* thus appear to be different from *having one's eyes gazed at* by another.

If your patient seems to go rigid or answers questions with nervous rapidity, it indicates the intensity of patient's involvement in the dyad. You may gaze at the person less and even move away a little bit to give her more space. If the patient shows excessive self-manipulation while making eye contact with you, you may reduce the duration of eye contact to reduce upsetting her.

#### *White of the Eye and Emotion*

Exposed eye area (EEA) was measured in Indian adults who modelled six emotions, viz., happiness, sadness, fear, anger, surprise, disgust and a neutral expression. EEA for fear and surprise were significantly larger, and the EEA for disgust was significantly smaller than that for other emotions (Mandal, 1992). Beware of the narrowed palpabral fissure—it may indicate disgust.

#### *Gazing and Personality*

The duration of eye contact gives us an indication of the extraverted nature of the patient. A study of 20 extraverted and 20 introverted women found that the *extraverted women made longer eye contact while listening*. Gazing at the interviewer while speaking was similar in both groups. The women gazed longer at a female interviewer than at a male interviewer (Iizuka, 1992).

#### *Facial Expression and Rapport-Building*

Nonverbal interactions may contribute to development of a "visual holding environment" in its broadest sense. This may be based on mutual needs of the patient and the clinician to *hold and to be held*. It may be as difficult for a clinician as a patient to feel warm towards the other person who is blind to the non-verbal facial signals. The development of therapeutic



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relationship involves active and mutual eye contact, the *language of silence*. Facial expressions form a bridge to personal relatedness between the therapist and the patient (Weil, 1984-5).

The clinician's face therefore, has a crucial role in the development of therapeutic relationship. A patient can read and respond to the facial expressions of the clinician and build a therapeutically symbiotic relationship. During this phase, *either player's facial expressions "belong" as much to the other as to oneself* (Searles, 1984-5).

This study explains how some physicians can put off their patients forever by their unfriendly facial expressions and blindness to non-verbal signals of the patients.

### *Facial Expression of Type A Personality*

In a study, facial expressions of 24 type A and 24 type B men were examined. Two expressions viz., *glare* and *disgust* significantly differentiated type A from type B. The Glare and Disgust scores in turn correlated most notably with hostility, which is associated with coronary artery disease (Chesney, 1990).

### *Omega Sign of Depression*

The corrugator muscle region of the forehead has special significance in producing facial expressions associated with depression. Darwin observed in 1872 that contractions in the corrugator region produce peculiarly formed wrinkles on the forehead, referred to as *"Omega Melancholium."* In a study, 61 women with major depressive disorder showed a significant positive correlation between facial corrugator electromyographic values and psychomotor agitation. These data indicate that excessive corrugator muscle activity causes the *Omega sign* of melancholia and depression (Greden, 1985).

### *Facial Expression in Pain*

Facial expressions contribute substantially to the judgement of sufferer's pain. In a study, volunteers' facial reactions to pain were analysed. The common facial actions were:

- Narrowing of the palpebral fissure from below,
- Raising the upper lip, pulling the lip corners, parting of the lips, or dropping the jaw, and
- Eyes closing or frequently blinking.

These reactions were most salient at the onset, expressing blends of startle, adaptive reaction and emotional reaction to pain. The relation between subjective distress and facial expression was greatest at the beginning of noxious stimulation; they declined in vigour over time, although self-report of pain continued to mount. The social models had a potent impact on verbal report and pain tolerance but not on facial expression, indicating relative independence of component reactions of painful experience (Craig, 1985).

This study corroborates with our every day hospital experience. When we judge pain merely by their facial expression, our patients 'seem to get used to the pain after some time'. This is not true; the pain continues to mount but as time passes by, their faces do not reflect it as well. We have to elicit verbal description to know how they feel. The exceptions are illiterate women of low economic status, whose social model permits them to continue to cry loudly, often using colourful phrases to describe their pain. This is most prominently seen and heard in our labour rooms.



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### *Faking and Suppressing Pain*

In a study of patients with chronic low back pain, the facial display of pain reflected differences between *sources* of pain, *social context* in which pain is induced and *individual differences* among patients. Considerable voluntary control over the facial expression of pain was observed (Prkachin, 1992). However, attempts to suppress the facial grimace of pain were not entirely successful.

The faked expression was more an intensified caricature of the genuine expression (Craig, 1991). In another study, assessors attributed more pain to those who faked pain than to those who suppressed their facial expression of pain (Poole, 1992). It is indeed difficult to guess if a grimace is faked caricature of pain or a true indicator of severe pain. It is safer to give the benefit of doubt to the patients until one learns more about their background.

### *Lie Detection*

In a study, truth and falsehood were classified thus: sincere agreement or sincere disagreement (*truthful*), pretending to agree (*ingratiating lie*), and pretending to disagree (*non-ingratiating lie*). Observers then rated the sincerity of each message based on information available from one of four different channels: *verbal* (written words only), *audio* (audiotape only), *visual* (videotape without sound), and *audio-visual* (videotape with sound). Results showed that—

a. Lies told by women were more readily detected than lies told by men.
b. Lies told to the opposite sex were more easily detected than lies to same sex targets.
c. Ingratiating lies were more successfully detected than were non-ingratiating lies, particularly when told to attractive targets.
d. For ingratiating lies, detectability was greatest with videotapes (visual non-verbal cues).
e. Persons addressing an attractive listener were perceived as being less sincere, when lying or telling the truth; the attractive appearance of the listener perhaps distorted the non-verbal behavior of the speaker (DePaulo, 1985).

Implications of this study are:

i. A very attractive doctor may make a patient appear insincere (and *vice versa*).
ii. Written history, even through a computer, can mask all the non-verbal cues of truth, sincerity or deception.

To explain how people judge that others are lying, an *expectancy-violation model* has been proposed. According to the model, deception is perceived from non-verbal behavior that violates normative expectation. In studies conducted in USA and in India, people exhibited weird non-verbal behaviors (arm raising, head-tilting, staring, etc.) while speaking. American undergraduates as well as Indian illiterates inferred deception from these weird behaviors. This was consistent with the expectancy-violation model (Bond, 1992). In hospital setting too, this model seems to be operational.

Implications of this study are that weird behavior by a doctor may be inferred as signs of deception by the patients, both literate and illiterate. Sticking to expectant model of behavior in one's dress, appearance and communication enhances his/her credibility. "In Rome, do as Romans do" sums it up well.

### *True and Deceptive Smiles*

Subtle differences among forms of smiling could be distinguished. Muscular activity around the eyes ('smiling with the eyes') along with the smiling lips occurred more often when people



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were actually enjoying themselves. When a smile was feigned to conceal negative emotions, it included traces of disgust, fear, contempt, or sadness (Ekman, 1988). The message is, "The eyes smile truly while the lips may deceive." So, observe the patients' eyes when they smile.

### *Chronic Blushing*

Severe chronic blushing is associated with social anxiety, anxiety state and depression (Edelmann, 1991). It is common in our young unsophisticated womenfolk, especially teenage girls and unmarried women from rural areas. One should be more tactful and gentle in communicating with them.

### *Laughter*

Laughter is a unique and ubiquitous human phenomenon. Until recently, medical research has neglected laughter and relegated it to philosophers and naturalists, particularly Darwin.

Laughter, as a behavior, has many causes, including humour, incongruity, relief, and a sense of well being. *Laughter may have developed for its cathartic effects and adaptive value.* As an evolutionary device, laughter may have served to thwart aggression, spread information, and preserve social unity. Laughter has a great potential for a variety of clinical uses that awaits further research (Black, 1984).

### *Laughter and Pain Threshold*

Two experiments have been conducted to test the proposal that laughter is a pain antagonist. Discomfort thresholds were higher for subjects in the laughter and the relaxation inducing conditions provide by audiotapes or narratives. Laughter, and not simply distraction, reduces discomfort sensitivity, suggesting that laughter has potential as an intervention strategy for the reduction of clinical discomfort (Cogan, 1987).

### *Laughter and Stress Hormones*

Positive emotional activities have been suggested as modifiers of neuro-endocrine hormones involved in the classical stress response. The mirthful laughter experience of watching a comedy for 60 minutes appears to reduce serum levels of cortisol, dopac, epinephrine, and growth hormone. These biochemical changes indicate reversal of the classical neuro-endocrine and hormone response to stress (Berk, 1989).

### *Humour as Therapy*

Laughter is an effective placebo while fear is a potent *nocebo*. The main effects of therapeutic humour are symptom relief and increased cohesion between a doctor and a patient. Humour may have a therapeutic value when it is associated with the following principles:

i. A positive doctor-patient relationship that includes the *freedom to be humorous*;
ii. The humour used is life affirming and is not cynical or negative;
iii. The humour increases social cohesion;
iv. The humour is interactive;
v. The humour reduces stress.

These principles are not to be applied in an isolated manner. One should combine it with other principles of doctor-patient dyad. One should also be aware when humour is or is



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# Communication Skills in Clinical Practice

*Communication Skills in Clinical Practice (Doctor–Patient Communication)* is an exhaustive book that goes beyond mere communication to reveal the expertise (know-how and show-how) required to cultivate successful doctor–patient relationships. Based on amalgamation of three sources of knowledge, viz. clinical, managerial and social sciences, this book attempts to forge together a holistic approach in dealing with patients and their relatives in a variety of settings.

The book is aimed at Practitioners, Students and Educators of Medicine, Dentistry and Allied Health Sciences like Nursing and other Paramedical disciplines. Its objectives are:

(1) To describe the core skills involved in successful doctor–patient communication,

(2) To discuss how to apply the core skills in clinical practice and

(3) To indicate how to use communication skills to succeed in clinical practice and avoid litigation.

Every chapter has been referenced for further reading and practical exercises to help the readers acquire the various component skills of successful communication.

Young professionals and students of clinical disciplines will derive maximum benefit from this book.



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