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Is non-directive communication in genetic counseling possible?

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Abstract

In 2007, over 560,000 genetic tests were performed in Italy. However, only 70,154 genetic counseling sessions were conducted. Some say that non-directive counseling is necessary so that the patient understands the test results and the different options available and that the physician should not influence the patient's free choice. We need to clarify the meaning of non-directive consultation and if it is in fact possible. Each doctor has his own values and, in order to achieve the intended purpose, he will give information that, with his verbal, para-verbal and body language will guide the patient to one decision or another.

Taking into account the axiom of effective communication "You can't NOT communicate", non-directive counseling is very difficult or even impossible. In genetic counseling, the knowledge that the patient receives of the correct diagnosis and related medical facts and of the applicable genetic considerations is basic to the entire process. Nonetheless, such knowledge in itself is not sufficient if it cannot be appropriately imparted to the interested person or persons.

We think "persuasion" is not the right method, but instead "convince" meaning "co-win", "win together" may be the best approach to a problem of such great importance.

The counselor will have achieved the desired goal with his patient if he is able to channel the emotion towards a mutually beneficial objective. The primary goal is not to persuade but to win-together (convince) with the patient and the unborn child. ***Clin Ter 2011; 162(5):e141-144***

Key words: *convincing, ethics of communication, epistemology, genetic test, persuasion, NLP, philosophy of medicine*

Introduction

In 2009, the UK *Human Genetic Commission,* the Government's advisory body on new developments in human genetics once again defined the genetic test as "a test to detect the presence or absence of, or a change in, a particular gene or chromosome or a gene product or other specific metabolite that is primarily indicative of a specific genetic change"(1). In 2007, over 560,000 genetic tests were performed in Italy, including 311,069 cytogenetic analyses (148,380 postnatal and 162,689 prenatal), molecular genetic analyses of 227,878 (215,551 postnatal and 12,327 prenatal), and 20,813 immunogenetic analyses but the genetic counseling sessions performed were only 70,154 (2).

In Italy, genetic counseling is conducted by a doctor who can benefit from the input of other pertinent professionals, such as a specially trained psychologist (3).

Genetic counseling is a demanding communication process for everyone involved (4). It is difficult for the patient (5), since he/she has to understand and to decide whether or not to a undergo test, and he/she has to understand both the meaning of the results of the test and the possible choices arising therefrom. It is also a difficult communication process for the doctor. If a defect is found in the unborn child, the physician can only advise the parents to accept their unborn child with the defect or to terminate the pregnancy, due to the discrepancy between the increase of the diagnostic knowledge and limited ability of therapeutic intervention on the diseases diagnosed. The physician is in a difficult situation: he can mediate between directive counseling (i.e. what he believes to be the right choice) and non-directive counseling (6). The aim of the latter is to ensure that the patient understands the test results and the different options available (7); the physician should not influence the patient's free choice (8).

From persuasion to convincing in genetic counseling

We define "communication" as a transmission of information related to facts, thoughts, moods, instructions, codes, values and empowering or limiting beliefs, accompanied by a feedback process (9).

"Genetic counseling is a communication process which deals with the human problems associated with the occurrence, or the risk of occurrence, of a genetic disorder in a family. This process involves an attempt by one or more appropriately trained persons to help the individual or the

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family to: 1. comprehend the medical facts, including the diagnosis, probable course of the disorder, and the available management; 2. appreciate the way heredity contributes to the disorder, and the risk of recurrence in specified relatives; 3. understand the alternatives for dealing with the risk of recurrence; 4. choose the course of action which seems to them appropriate in view of their risk, their family goals, and their ethical and religious standards, and to act in accordance with that decision; and 5. to make the best possible adjustment to the disorder in an affected family member and/or to the risk of recurrence of that disorder (10)".

The emphasis in this definition is on the process of communication. Implicit in it, however, is the concept that knowledge of the correct diagnosis and related medical facts and of the applicable genetic considerations is basic to the entire process. But such knowledge in itself is not sufficient if it cannot be appropriately imparted to the interested person(s). In addition, knowledge alone will only be of partial benefit to the recipient(s) if assistance is not provided in applying it to their specific concerns.

In Italy, the purpose of genetic counseling (11) is: 1. to clarify the meaning, the limits, reliability, specificity of genetic testing, 2. to acquire and/or add to the family tree data, when this is not already provided, and 3. to obtain consent to the test (12).

The counselor has a big responsibility, he/she must have the ability to fully apply his/her values (13). The patient can then make an independent decision after hearing the comments by the counselor on the data.

Too many times we forget that, even if the data were "only" scientific, their understanding, their remarks and their descriptions will never be "only" scientific. Therefore, the communication and interpretation of results and the advice on its possible implications should be considered integral parts of a genetic test.

Counselors should strive to use language suited to the patient's culture and level of understanding. The language is appropriate if the counselor uses the same predicates and "hot words (14)" (very important words) used by patients. In spite of this, the statement issued by the Italian Privacy Authority (15) in order to protect the patient, does not address the problem of communication in counseling, nor does it specify the criteria for "clear" and understandable communication. A study by Ley clearly indicates that physicians overestimate their ability to relate and 36% of patients do not recall the information given by their doctor about the prognosis and therapy (16).

A counselor's possible solution to this problem is to bring the language from the "technical level" to the "patient level" using the multi-sensory language (VAK). The multisensory language (typical of the Neuro Linguistic Programming) explains the words that may not be understood by patients through images (V), audio (A) and feelings (K). The clinical use of multisensory language may not be easy, more so because we are used to describing our reality through generalizations, deletions and distortions (17) that make communication with the patient very difficult and ineffective.

The doctor's way of speaking and relating with patients is constantly accompanied by verbal and non-verbal signals that largely depend on his unconscious. The counselor's way of expressing his thoughts is the result of a careful selection from a range of information, which he has developed on the basis of his values, beliefs and filters and that the brain uses in order not go into overload (18).

This accurate selection of information is then explained during the consultation in different ways and, above all, for different purposes.

Since ancient times, human beings have understood that the response to the request for the satisfaction of their needs could be guided and directed. They sought those elements that could produce "that influence", "that persuasion". Thus was born the art of persuasion, aimed at influencing, if not controlling, the reply from the sender of the message.

More recently, experts have realized that most of the communication can be traced back to a persuasion game. The researchers focused their interest on the message itself, analyzing the type of transmission, reception, decoding and assimilation.

Palmarini (19) argues that persuasion is an act which always involves a choice and a form of behavior aimed at inducing a change in the opinions of others, by the mere transfer of ideas, of mental contents, which the other party may be unaware of.

Cialdini (20) shows that the various persuasion techniques can be grouped into six categories: consistency and commitment, reciprocity, social proof (or imitation), authority, liking, scarcity (or fear of being deprived of something), each of which corresponds to a basic psychological principle, that guides and directs human behavior and therefore empowers the tactics used.

This does not mean that in order to be persuasive you are obliged to learn and use "techniques", because the art of persuasion came from unconscious attitudes and behaviors, which were studied retrospectively (21). The study of charismatic speakers has allowed us to understand and to model the techniques that arise from the "spontaneous behaviour of individuals".

The patient's attitude, his gestures, the intonation of his voice, and other factors that are difficult to control, give the Counselor a clearer picture of the emotional involvement contained in the patient's messages. These para-verbal and non-verbal messages help the Counselor to confirm or contradict what the patient has said in words, revealing an unconscious coherency, or else the existence of an incoherent message.

Furthermore, the structure of the message also has a persuasive impact, i.e. the order in which the physician presents his arguments affects the patient's memory. When faced with a series of contiguous information, people tend to remember best the first (*primacy effect*) and last (*recency effect*), while those in the central part of the presentation are hardly recorded in the memory (22). The persuasion model used in the world of business states that communication only works at the level of *"understanding"*, and *"persuasion"* at the *"emotional* (23)" level.

In the business model *"to persuade"* means *"to act at the emotional level"*, in order to effect a change, particularly an emotional one, aimed at arriving at the final decision to purchase. This form is based on the following principle of persuasion: *"In order to change someone's opinion it is important to act at the emotional level. Logic is only effective 5% of the time. Emotion is effective 95% of the time"* (24).

In genetic counseling "Persuasion" evolves into "Convince" meaning "Co-Win, Winning With You. Winning together". Counseling is not a meeting between different attitudes, options or figures, but rather between people. The value of the results the counsellor wants to achieve comes from that which the people involved attribute to them (and often from their own perspective). Genetic counseling is nothing more than an interaction between people.

In many situations, the technical ability to communicate a fact is not the only factor to take into account. It is important to know that doctors' and patients' basic attitudes weigh heavily on the outcome of consultation, which is why it is important to change with time: from antagonism to cooperation, from positions to objectives, from power balance to strong relationships (Win-Win relationship).

Each doctor has his own values and, in order to achieve a common goal, he will give information or advice that will have a greater impact if shared by the patient as well.

The counselor will have achieved his goal with his patient if he is able to channel the emotion towards a mutually beneficial objective.

The Counsellor's Influence

From the school of Palo Alto, the axiom of effective communication is widely known thanks to the research done by Watzlawick (25), "You can't not communicate".

Those people who decided not to communicate are sending a clear message, and are in fact communicating. We communicate by the mere fact of being alive, and we cannot do without it.

In the art of communication both the sender and the recipient of the message are important, whereas "to inform" is only to transmit news (regardless of the effect and the reaction provoked), communication requires "communion" and participation. The more the doctor can establish a relationship of communion with his patients (an empathetic relationship) the greater the patient's compliance will be.

The core function of any communication is to exert some form of influence (26). This is explicit in some situations and less explicit in others, although each person is capable of limiting the pervasive effect of the situation.

During the consultation we have to consider the two concepts described above: 1. we can't NOT communicate; 2. in interpersonal communication there is always some form of influence.When the consultation begins there is immediately a meeting of two different worlds, the one of the physician and that of the patient, each of which consists of values (which may or may not coincide) and is built on different beliefs defined in the course of their lives. The patient will emphasize with the tone of voice or gestures, his "hot words" i.e. those that are the most important to him, which in turn the counselor may use to his advantage to copy the language (echo his words). Moreover the patient may make *mini-movements* of appreciation like moving his lips or cheeks towards a smile, or discharging tension by scratching a body part, fiddling with his fingers or clearing his voice, making gestures of refusal such as removing objects, dusting crumbs from the table, moving his body backwards, and so on. Knowing how to identify these signals will be of great help to lead the conversation to a sound understanding of ethical and moral choices to be taken. In fact, as demonstrated by Mehrabian of the Mental Research Institute in Palo Alto: the voice (para-verbal) counts for 38% of the effectiveness of the message, while 55% comes from the non-verbal form (body language), and the remaining 7% is the effectiveness from the verbal content of communication (27).

The verbal part refers to "what" is said, the content, the words used. Non-verbal or body communication is "how" the content is presented, body-hand-feet-eye movements. Voice (para-verbal) is included in the definition of "how"; we cannot express words without the right support of the voice.

The idea of attributing to "what" a score of 7% leads us to believe that it is not so important "what" they say, but "how" they say (28).

Therefore, a counselor must learn to establish a good empathetic relationship on all possible levels, from the non-verbal (posture, gestures) to the para-verbal (tone, volume, flow and rhythm of the voice), and above all at the level of values in order to be able to obtain the best information.

On the basis of what we have said above we wonder whether is it really possible for a counselor to do a non-directive consultation.

Conclusion

The documents on genetic counseling still leave several issues concerning the relationship between the counselor and patient unresolved (29). We need to clarify the meaning of non-directive consultation and if it is in fact possible. We need to specify the cases in which the genetic counselor must take a decisive position.

In fact, the goal of communication in genetic counseling is not to persuade, but to convince (win together) using all the tools that lead the patient towards an informed choice.

The proclaimed non-directive approach could lead to manipulation of patients who rely on the doctor with his powers.

The ethical novelty is in bringing to the surface the complex interaction between different fields of values, thus arriving at a synthesis that does not exclude any of the parties involved. The problem that arises is not whether one position is more legitimate than another, but the real problem is if doctors holding a certain bioethical position are skilled communicators or not, whether they are aware of their communication skills, that "how" they say has a strong impact on the patient and lastly, if they are aware that the primary goal is not to persuade but to win-together (convince) with the patient and the unborn child.

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