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"All I could do was hand her another tissue" – Handling Emotions as a Challenge in Reflective Texts by Medical Students

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In some medical teaching institutions, students have to partake in compulsory training in communication skills. They are required to demonstrate good listening skills, to repeat, mirror and summarize information, structure an interview and use open and closed questions. They are also informed that they will be confronted with their own and their patients' emotions during a consultation and they are asked to develop methods of signaling empathy. This essay reports on data collected from medical students at a British university who wrote a reflective text in which they explore their communicative behavior in connection with a memorable encounter with a patient. While they are prompted to think about how they felt during their encounter and hence the mention of emotions is frequent in the texts, our thematic content analysis reveals that some of the students choose the topic of handling emotions during a patient encounter as particularly noteworthy. We observe that students are affected by the positive and negative emotional stance of the patients and draw on an impressive scope of emotion words. When creating an emotional stance in their text, students draw on verbal cues and they use language to describe vocal, body, physiological and facial cues. They also enact emotions in constructed dialogue.

1. Introduction

This essay presents results on how the topic of emotion emerges in a corpus of English texts written by medical students of the University of Nottingham, UK. These texts were written as part of a compulsory clini-

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cal communication skills module and belong to the genre of reflective writing. The students were asked to recall a memorable encounter with a patient and to discuss the communication skills that they employed, how they felt about the interaction, and what conclusions for future behavior they draw from the experience. Reflective writing – texts written to critically examine one's own practice, conduct or position – has been recognized as a valuable tool in teaching in the discipline of medicine for some time, but is still not widely used according to Branch and Paranjape (1185). Its purpose can be defined as follows: "In medical and health science courses you are required to produce reflective writing in order to learn from educational and practical experiences, and to develop the habit of critical reflection as a future health professional" (Monash University). Doctors are encouraged to engage in this kind of writing throughout their careers.

From a linguistic perspective, the texts offer ample research possibilities such as the discussion of linguistic identity construction or character positioning (cf. Gygax, Koenig and Locher), genre analysis or the study of metaphors. From an applied perspective, our analysis can feed back into the development of clinical communication skills teaching. In this essay, we discuss if and how the students talk about emotions. We first turn to positioning our study in its context and to describing the data in more detail (section 2). In section 3 we turn to the analysis of the texts by applying a mixed method. More specifically, this involves (i) a quantitative analysis of the vocabulary used in the corpus, (ii) a quantitative thematic content analysis of a sub-corpus and (iii) a close reading of how emotions surface in one particular text. Section 4 draws conclusions and offers an outlook for the research.

2. The Context of the Study and the Data

This essay draws on data that was collected in connection with the interdisciplinary project "Life (Beyond) Writing: Illness Narratives," funded by the Swiss National Science Foundation. The project brings together research interests in narrative in health contexts from different disciplines. Franziska Gygax ("On Being Ill"; "Theoretically Ill") explores autobiographies that deal with illness in the field of literary and cultural studies, while the linguistics team studies reflective writing texts that were written by medical students at the University of Basel and the University of Nottingham, as well as reflective texts by doctors published in medical journals. It is one of the aims of the project that the

results of these research efforts inform the further development of clinical communication skills teaching at the University of Nottingham (Victoria Tischler) and Basel (Alexander Kiss) (e.g. Gygax, Koenig and Locher).

The data for this study consists of 189 reflective writing texts that medical students from the University of Nottingham composed in connection with their communication skills course taught by Dr Victoria Tischler. The average length of the texts is about 1,500 words. When the students submitted their texts (a task that was optional), they were in their second year of medical training (of a five year degree; three years *Bachelor of Medical Sciences* BMedSci plus two years *Bachelor of Medicine, Bachelor of Surgery* BM BS). They have had clinical interaction through attachment to a general practitioner and during regular hospital visits. They have also completed a Clinical Communication Skills module in the first year of the course, in which the following topics are introduced: how to structure a clinical interview; use of different question types; signaling empathy and other verbal strategies; rapport building; non-verbal communication; and roles of doctor and patient. The texts were collected in 2010 and 2011. The task completed by the students can be summarized as follows:

> – The students write about a *memorable encounter with a patient* during their internship at a GP surgery or a clinical surgery.
> – They are invited to *introduce / describe* the situation and the characters of their narrative and to use constructed dialogue for key passages.
> – They are asked to *reflect* on their communication skills, on their emotional reactions and *to draw conclusions* about future behavior.

The instructions thus follow the classical set-up for a reflective writing task: description – reflection – conclusion (Hampton; for a more refined description see Watton, Collings and Moon). The actual information that the students received about the task was much more detailed and the image in Figure 1 shows that the information was structured with relevant questions given for the students to respond to. For our purposes here it is especially noteworthy that the students were explicitly invited to reflect on their emotions (*Describe what you felt after the encounter*, and *How did I feel during the conversation and afterwards?*) and that they were asked to use constructed dialogue.

Reflections on communication with a patient

Instructions:
Think about which conversation/encounter with a patient impressed you most. The questions listed below will help you to structure your thoughts about this encounter from memory. Those questions marked with an * **must** be addressed. The other questions can be chosen if relevant to the specific context of the described situation.

Before you start writing up your text, write down everything that you remember about the encounter. Then you can proceed according to the points listed below.

Situation: DESCRIPTION

* Describe the patient (age, relevant diagnosis, first impression – appearance, posture, language, anything else noticeable, etc.).
* Describe in which context the encounter took place (what was the reason for the encounter?).
* Describe what you talked about by using verbatim speech (the exact words) as much as possible. If you cannot remember the exact wording, reconstruct the dialogue for the crucial moments as well as possible.
* Describe how you felt after the encounter.

Reflection: REFLECTION

The following questions should help you to structure your reflections.

* 1. The uniqueness of the encounter

a) Why do I remember this particular encounter so well?
b) What was so special about the patient or my behaviour that I remember it so well?

* 2. Communicative aspects

a) Did I communicate with the patient as I intended to?
b) Did the conversation proceed as planned?
c) If yes, why and in what ways have I achieved this?
d) If no, what went wrong and what could I have done differently?

Aims: CONCLUSION

* What have I learnt from this encounter?
* What would have helped me to manage/shape the encounter in a better way?
* What aspects of my behaviour and language will I change in order to improve my next encounter with a patient with a similar problem?

Hints for writing the text
Please anonymize the names of all parties involved.
For crucial moments in the conversation, indicate reported speech in the following way:

Mrs. XY: *"and none of the doctors told me anything about a mistake; they wanted to simply not talk about it and I now have to suffer for it. That's outrageous, isn't it?"*
Student: *"You are very angry, aren't you?"*
Mrs. XY: *"Yes, of course I am! If they had properly told me and had apologized, it would have been only half as bad."*

Mrs. XY: *"... and then the surgeon said it will be all my fault if the operation won't succeed; as I didn't have the best conditions, and being so overweight, the situation is always difficult.*
Student: *"yes, a doctor shouldn't say anything like this."*

How did I feel during the conversation and afterwards?
For example: *I was absolutely crestfallen afterwards. During the conversation, I never knew what was okay to say. Am I allowed to criticize a surgeon? Did he really say what the patient reported, or is this only the patient's version? Was it wise to encourage the patient to speak more about her experience or should I have stopped it? I didn't dare put an end to it because I didn't want to appear like yet another 'bad doctor'.*

What would I change for the next interaction?
...

[Administrative pointers]

Figure 1: The instructions to the students (the designations *description*, *reflection* and *conclusion* have been added)

A questionnaire on the students' linguistic background handed in together with the consent form indicates that the Nottingham contributors are female in 63 per cent of all cases and 92 per cent are aged between 19 and 21 years. Eighty-eight per cent of the students indicate English as one of their first languages. The other first languages mentioned are of European origin, but, importantly, include also many languages spoken in Asia and some in Africa.

In what follows, the content analysis is based on a thematic reading of 50 texts, the analysis of emotional stance is illustrated on one text and the vocabulary analysis draws on the entire corpus of 249,708 words.

3. The Surfacing of Emotions in the Corpus

To study how emotions surface in the corpus, we have chosen a mixed methodology. In a first step, we use a quantitative vocabulary analysis that allows us to get a crude overview of the semantic fields that the students draw vocabulary from. In a second step, we establish what the students write about in their texts and whether they table emotions as a topic in its own right by conducting a quantitative thematic analysis of a sub-corpus. This quantitative overview is followed by a qualitative close reading of how a particular student writes about emotions. After presenting these analyses, their main results will then be briefly discussed against previous studies on emotion management in medicine/medical training.

3.1. The Vocabulary of the Corpus

In order to gain a first impression of the use of emotion words in the corpus, a quantitative vocabulary analysis is conducted. The aim is to detect the semantic fields that characterize the texts and to gain a rough understanding of the overall composition so as to better understand the role of emotions within the corpus. The analysis is based on the corpus of all 189 texts, which amounts to a total of 249,708 words, or 108,017 words when stop words (such as articles, conjunctions and prepositions) are excluded.

Figure 2 displays a frequency cloud of the first 100 most frequent words in the corpus (excluding stop words). The words are shown in alphabetical order and their respective size indicates their frequency. The chart nicely illustrates the semantic fields of the patient encounter

(e.g. *patient, GP, student, [patient] history, consultation, hospital*), the focus on communication skills (e.g. *communication, interview, question, rapport*), and the reflective part of the task (e.g. *feel, felt, think*).

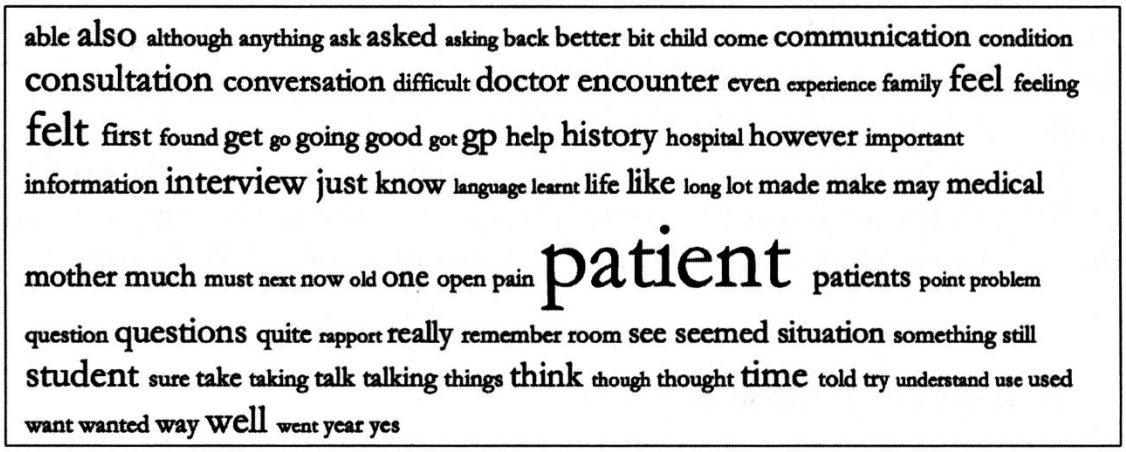

Figure 2: Frequency cloud Nottingham I and II (first 100 words, excluding stop words, ordered alphabetically)

The same topics emerge when we conduct a keyword analysis (Stubbs 129; Scott). Using AntConc (a free program for corpus linguistics), all words of the corpus (not lemmatized and including stop words) are compared to the reference corpus of the BNC (British National Corpus) in order to establish the set of words that are particularly characteristic of the reflective writing corpus. The following list shows the first twenty most typical words (ordered according to their log-likelihood values):

> *I*, 10245; *patient*, 3829; *felt*, 960; *student*, 736; *interview*, 656; *consultation*, 651; *feel*, 642; *gp*, 593; *doctor*, 580; *encounter*, 564; *history*, 543; *questions*, 541; *me*, 2159; *mrs*, 453; *seemed*, 432; *medical*, 388; *patients*, 387; *conversation*, 383; *communication*, 379; *asked*, 371

The importance of the pronoun *I*, which is in first position, can be explained with the focus on first person reflection in the corpus. The role of emotions is not visible within the 100 most frequent words (see the cloud) or the 20 most typical keywords (see the list above). While the verb *feel* is frequent and the noun *feeling* occurs as well, we cannot know from the list alone whether the words refer to semantic fields of reflection or to the field of emotion. While looking at word lists out of context constitutes an obvious disadvantage, we argue that exploring the

lists further will nevertheless result in giving us a crude understanding of the overall vocabulary composition of the texts. Our search for emotion words thus led us to look at the frequency list of the entire corpus (with the stop words excluded; N=108,017). The percentages reported below present an approximation due to the limitations of the word list analysis just mentioned.[1]

Our perusing of the lists confirmed the semantic fields of patient encounter, the focus on communication skills, and the reflective part of the task. In addition, we found that names of body parts, technical medical vocabulary and emotion words define the corpus. About 12.3 per cent of the words (N=13,755) pertain to either body parts (e.g. *ankle*, 7; *anus*, 4; *arm*, 24; *armpit*, 3; *arms*, 27; *bones*, 3; *brain*, 10) or medical jargon (referring to medication and conditions; e.g. *abdominal*, 20; *abdominous*, 1; *abortion*, 10; *ache*, 8; *aching*, 2; *adhd*, 2; *aeds*, 1; *aetiology*, 1; *aftercare*, 3; *agammaglobulinaemia*, 1; *aids*, 21). The low frequency of the words with many single occurrences is particularly noteworthy.

Turning to lexemes that indicate either emotions or reflection, the overall frequency of about 5 per cent (N=5,846) is lower than for medical jargon, but many of them occur quite frequently. The following list is ordered according to overall frequency:

felt, 960; feel, 642; think, 577; feeling, 248; empathy, 142; happy, 139; comfortable, 135; upset, 128; feelings, 119; believe, 112; worried, 98; sorry, 94; emotions, 81; emotional, 78; confidence, 60; confident, 59; thinking, 55; calm, 54; confused, 54; nervous, 54; concerned, 53; involved, 50; worry, 50; anxious, 48; embarrassed, 47; sympathy, 43; angry, 41; frustrated, 40; sad, 40; pleased, 38; sensitive, 37; feels, 36; empathetic, 35; fear, 32; emotionally, 31; mood, 28; satisfied, 25; empathise, 24; glad, 24; shy, 24; worrying, 24; annoyed, 23; frustrating, 23; love, 23; believed, 22; comfort, 22; emotion, 21; frustration, 21; guilty, 21; judge, 21; brave, 19; grateful, 19; afraid, 18; loved, 18; sympathetic, 18; stress, 17; empathize, 15; anger, 14; disappointed, 14; happier, 14; satisfaction, 14; comforting, 13; polite, 13; upsetting, 13; worries, 13; apprehensive, 12; unhappy, 12; upbeat, 12; ashamed, 11; distressing, 11; fears, 11; lonely, 11; pleasure, 11; sympathise, 11; annoying, 10; desperately, 10; judgmental, 10; pleasant, 10; saddened, 10; stressed, 10

[1] The word lists were gone through manually by two raters, who might have missed some lexemes. As mentioned before, word lists do not allow the rater to make decisions as to whether, for example, *back* is used as a noun or a preposition. These comments are valid for all subsequent presentations of frequencies in this sub-section. In other words, the reported percentages are to be taken as a rough indication of the overall corpus composition and not as precise numbers.

Emotion and reflection vocabulary is here presented together as – on the basis of the word list alone – there can be made no meaningful decision whether words such as *felt/feel/think/feeling*, etc. refer to emotions or the process of reflection. Nevertheless, we can glean from the list a surprising scope of emotion words, ranging from those with negative connotations (22 per cent, N=1,278) and positive connotations (23 per cent, N=1,312) to those that have either neutral or unclear connotations out of context (56 per cent, N=3,238).

In the list of emotion words with negative connotations, we can make out clusters of word fields that are notable because of their comparative high frequencies: *WORRY* (N=185), *BEING UPSET* (N=143), *FRUSTRATION* (N=87), *NERVOUSNESS* (N=67), *SADNESS* (N=62), *EMBARRASSMENT* (N=60), *ANXIOUSNESS* (N=55), *CONFUSION* (N=54), *FEAR* (N=52), *ANGER* (N=41) and *STRESS* (N=40). While the list itself does not yield any insights as to whether these emotions are assigned to the patient or the student, the mere scope of them is noteworthy.

The emotion words with positive connotations are equally varied in scope. The most frequent clusters are around *EMPATHY* (N=240), *COMFORT* (N=181), *HAPPINESS* (N=165), *CONFIDENCE* (N=120), *SYMPATHY* (N=83), *CALMNESS* (N=69), *PLEASANTNESS* (N=64), and *SATISFACTION* (N=43). The frequent mention of *empathy* can be explained with the fact that this concept does not only refer to genuinely felt emotions but also to a strategy taught in the communication skills module and recommended for the purpose of enhancing rapport with patients (see, for example, l. 40-42 in the Appendix).

To illustrate the use of positive emotion words in context we present extracts from a text written by a 20 year old, female medical student, who indicates English and Thai as her first languages (N-088). The memorable encounter is about a patient who impressed the student with her positive attitude. The patient is a dancer with diabetes whose legs were amputated. The student starts the text by setting a dark scene (the extracts are quoted without any corrections; italics added):

> 1 It was a dark, rainy morning when my colleague and I visited the patient
> 2 during our first hospital visit of the year.
>
> [371 words: Description of the history taking, the feeling of shock and being at a loss at learning that the patient had been a dancer whose legs had been amputated ("I felt shocked"; "I was lost as to how to react")]

36 I was really *sad* to hear that, a dancer who no longer had legs! That
37 must've felt *awful.* My colleague and I *failed to find appropriate*
38 *consoling words* for the patient. *We stayed silent. I was at lost.* [sic.]
39
40 But we did try to [b]e *empathetic*, offering kind words of support
41 and understanding as the interview went on. I *nodded and mirrored the*
42 *patient's slight gestures and frowns, hoping to convey my empathies.*

The student explicitly states that the tragic fate of the dancer was *not why [she] remembered the encounter so vividly* (l. 16). Instead, the student is affected by the positive and optimistic outlook of the patient. An extract that is positioned after several passages with constructed dialogue illustrates this nicely (note the repeated use of metaphors):

57 I felt a *revitalizing energy* from the patient. She was *strong.* I saw her
58 as *powerful and hopeful.* She would never let something like this
59 *"drag [her] down."* I was *taken aback, surprised, and proud of the*
60 *optimism* all at the same time.
61 She was *marvelous.*
62 The patient herself must've felt *proud* as well. She was *smiling*
63 *brightly, laughing,* and her speech and language was *uplifting.* She
64 must've felt that she could not give up, even with this condition, and so

65 she *refused to feel down.*
(N-088)

In this extract we witness how the emotions of the patient directly affect the student. In addition, and from a stylistic point of view, the description of the student's emotions as a reaction to the patient's fate are the leitmotif for the composition of the text. The patient's worldview is so uplifting that the student's emotions also change as a consequence.

Finally, there is a set of words that have to do with reflection and emotion, which have neutral or ambiguous connotations out of context (as mentioned above, an analysis of word frequency out of context defies easy assigning of these lexical items to either emotions or reflections only). Particularly striking are the clusters around FEEL/ FEELINGS (N=2,005), THINK (N=641), and BELIEVE (N=146). *Think* and *feel* also belong to the 100 most frequent words in the corpus overall (excluding stop words).

3.2. Thematic Analysis of 50 Reflective Writing Texts

After having established that the students draw on the semantic fields of emotions as an important aspect of their vocabulary use, we now turn to a quantitative analysis of the topics the students choose to write about in a sub-corpus of 50 texts. The first 25 texts from the two cohorts were analyzed with respect to the main themes that students raised in their texts (N=50; 27 per cent of the entire corpus).[2] A team of three raters achieved consensus by discussing the question *What is this text about?*[3] The results are presented in Table 1. Up to three categories could be chosen in order to understand why the students had chosen the particular memorable encounter they wrote about. Table 1 shows that the students make the explicit discussion of communication skills a central aspect in 37 of the 50 texts (74 per cent). This means that the students do not only reflect on communication skills in the reflective part, but they also choose a memorable encounter in which (successful or unsuccessful) communication skills present a central point. This thematic preference is then followed by singling out special medical conditions (28 per cent; e.g. depression) and talking about (lack of) professional experience on the part of the medical student (20 per cent).

Importantly, two topic categories have to do with either the patient's emotions (18 per cent) or the student's emotions (16 per cent). In one text both emotion topics are raised, so that there are 16 texts in total, in which emotions play an important thematic role (32 per cent). This finding shows that rather than just mentioning emotions in the reflective parts of the texts (the instructions require reflections on emotional reactions), the students raise the topic of emotions and how to cope with them in its own right. This high percentage of emotion topics confirms that it is challenging for medical students to deal with emotional patients as well as to deal with their own emotional reactions to patients. This problem will be discussed more thoroughly against previous research below.

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[2] Since there is no underlying ordered principle (other than the name of the student before anonymization) for the sequence of texts in the corpus, this choice amounts to a random selection.

[3] The core researcher Regula Koenig developed a catalogue of bottom-up thematic categories, and then trained two raters in recognizing them. Since a text could raise many issues in passing and the question was about the "main themes" raised, the team decided to reach a consensus about one to three important themes per text by discussion rather than independent coding (see MacQueen, Mclellan-Lemal, Bartholow and Milstein; Namey, Guest, Thairu and Johnson).

Table 1: Thematic analysis (only categories of more than 10 per cent are displayed)

	No. of texts	% of N=50
Communication skills explicitly present	37	74
Special conditions	14	28
(Lack of) Experience	10	20
Emotions patient	*9*	*18*
Impact of illness on patient's life	9	18
Emotions student	*8*	*16*
Setting (several participants/people)	6	12
Successful encounter	5	10

Furthermore, taking a closer look at the 37 texts in which communication skills are explicitly focused on as a topic, it transpires that the use of *empathy* is mentioned in a third of all texts (N=16, 32 per cent), preceded only by mention of the use of *questions* (N=21, 42 per cent) and *structuring an interview* (N=18, 36 per cent), and followed by the mention of *rapport* (N=15, 30 per cent). Once again we therefore see the importance of dealing with emotions for the medical students as a critical part of their professional training.

Medical educators including our collaborator Victoria Tischler have recognized the need for giving guidance to medical students by introducing lectures on communication with patients who are distressed. This issue is a legitimate concern for young people on their way to becoming doctors since they are on the one hand encouraged to find ways of expressing empathy with patients (see, e.g., Maguire and Pitceathly) and on the other they are warned against *compassion fatigue* in order to prevent burn-out (see, e.g., Pfifferling and Gilley). It is striking that these young students, who are reporting on their first experiences in the field, already single out this topic as problematic and thus put their finger on an important aspect of their profession, which has been termed *emotional labor* (Hochschild *The Managed Heart*, "Emotion Work"; Erickson and Grove), a term to which we will return at the end of the next section.

3.3. Illustration: Dealing with a Distressed Patient

Having established in the previous sections that students highlight emotions as an important topic and that they use a wide range of emotion words, we now turn to illustrating how an emotional stance (cf. Matoesian) is created in the text of a particular student, which combines writing about the patient's emotions and the student's emotions in the same text.

The theoretical framework for our analysis is inspired by Planalp's work on emotional cues in face-to-face interaction. Table 2 shows that these cues are multimodal, ranging from vocal, verbal, body, and physiological to facial cues. When taken together, they constitute a *composite signal* which is created *online* and designed for the identification by the recipient (Clark 178-179; for overviews on emotional cues, cf. Ochs and Schieffelin; Langlotz and Locher). In our data, we have to rely entirely on the linguistic power of evoking emotional stance. In other words, the writers use language for the emotional *verbal cues* listed in Table 2, but they can also choose to use language to report on and describe the other cues (vocal, body, physiological, facial) in retrospect.

Table 2: Planalp's overview of emotional cues (see also Langlotz and Locher)

Class of cues	Forms of realization
Vocal	voice quality: low, loud, slow, fast, trembling, high-pitched, monotonous, animate voice
Verbal cues	language-specific emotion vocabularies metaphors speech acts emotional discourse practices, e.g. therapeutic discourse
Body cues	animated, energetic movement physical actions: throwing things, making threatening movements, kissing, caressing gait: walking heavily, lightly, arm swing, length/speed of stride body posture: stiff/rigid, droopy, upright hands/arms gestures: hand emblems, clenching hands or fists
Physiological cues	blushing, pupil dilation, heart rate, breathing, skin temperature
Facial cues	facial expressions of emotions through forehead and eyebrows, eyes and eyelids, and the lower face (mouth, lips, labionasal folds)

The chosen text (N-85, see Appendix for the entire text) was written by a 20 year old female student with English as a first language. The main issue described in the chosen encounter is the role and impact of the patient's and the student's emotions on how the encounter develops. In addition, the student also focuses in particular on empathy as a communication skill in the reflective parts of the text. The chosen encounter is about a patient who becomes very distressed during the consultation due to her condition (a persistent viral infection and pregnancy) and starts crying. The student recounts that she does not know how to handle this outburst. The patient becomes even more upset when a blood test is required because of her severe phobias about needles and blood. At this point the patient starts to scream and hyperventilate. After the encounter the student feels emotionally drained and is not satisfied with how she dealt with the situation.

Since the topic of this text is how an encounter with a distressed patient did not go smoothly, the text is brimming with emotion cues. Lexical emotion cues are indicated in italics in the extracts below and in the appendix. The student is assigning emotional mental states to the patient and to herself during the encounter by employing verbal cues of language-specific emotion vocabularies. A selection of examples is given here in italics:

- She smiled but it struck me that she looked *unhappy.* (l. 8-9)
- I was left alone with the patient who was becoming more and more *upset* (l. 18-19)
- *I felt awful* that I couldn't do anything to help her. [. . .] (l. 29)
- I tried to adopt a *soothing tone of voice* when speaking and *felt desperate* to say something to *make her feel better.* (l. 54-56)
- This made the patient even more *upset,* I felt utterly *helpless.* (l. 59-60)
- The *fear in her eyes* made me *feel even worse* – I knew how *scared and upset* she was but I couldn't make it better. (l. 62-64)

The student uses emotion adjectives and collocations as verbal cues of emotional stance (*unhappy, upset, scared, feeling awful/ desperate/ helpless*), describes a vocal cue (*soothing tone of voice*) and a facial/physiological cue (*fear in her eyes*).

The student does not only assign mental states by means of emotion vocabulary to herself and the patient, but also stresses how the patient's distress affects her own emotional state. As a consequence of the patient's distress, she herself feels *awful, desperate* and *helpless.* This is primarily the case because the student feels that she cannot adequately help the patient. Indirectly the student thus highlights her expectations that a

doctor should be able to improve the patient's situation (*I couldn't do anything to help her*, l. 29; *make her feel better*, l. 56; *couldn't make it better*, l. 64). The fact that doctors often in fact cannot help patients (medically or emotionally) is rarely talked about as doctors are usually trained to intervene. In contrast, Johansen, Holtedahl, Davidsen and Rudebeck, in a study on GPs treating terminally ill cancer patients in Norway, point out that acknowledging a shared humanness can enable a doctor to simply "be" with a terminally ill patient where medical intervention is no longer effective. This requires understanding of both physiological and existential suffering, which is often absent in biomedical training.

The student also uses the description of actions to signal the patient's and her own emotions (italics added):

- She *smiled* but it struck me that she looked unhappy. (l. 8-9)
- The patient began to *cry*. (l. 24)
- I reached into my bag and *leaned towards* the patient *asking if she needed a tissue*. (l. 28-29)
- Later, Dr Name began to prepare the patient for blood to be taken, when she realised what was happening *she screamed and began to hyperventi late*. (l. 60-62)
- Between *her sobs* she explained that she had severe phobias of both nee dles and blood. *All I could do was hand her another tissue*. (l. 64-66)

The emotion cues in these examples once again represent lexical items that have emotional connotations (*smile, cry, scream, hyperventilate, sobs*). However, there are also a number of actions that are indexical of showing concern and empathy in the context of such an encounter (*lean towards the patient, offer a tissue*). The student recalls these actions (body cues and speech acts) that indexed emotional stance at the time and reports them by means of language.

In other instances, the student describes a situation in words that only become emotionally charged when interpreted in context:

- I found it *difficult* to know what to say: I had *no idea of how someone in this situation would feel and I didn't want to sound insincere or make matters even worse*. (l. 24-26; see also l. 34-35)

The sentences in lines 24 to 26 describe an emotional situation in which the student could be described as feeling helpless and worried about doing the right thing, but the words in themselves are not strongly emotionally indexical.

In addition, the student employs a more indirect means of evoking the emotional state of the patient in that she uses *constructed dialogue* (cf. Tannen).[4] By presenting the patient as using her own words to signal emotional distress, the emotions are *enacted* rather than assigned (italics added):

- Patient: *"I'm sorry about all this."* (l. 20)
- Patient: "It's just . . . this has been going on for so long and *I can't cope anymore.*" (l. 22)

The literature on oral narratives of personal experience reports that constructed dialogue can be used to create involvement in the listeners, create immediacy and can move the narrative plot forward (Tannen). Rather than summarizing or paraphrasing a dialogue, the listeners are invited to draw their own conclusions. However, the student who creates the story world of her memorable encounter does not use the passage with constructed dialogue to advance the story much. Instead, she uses it as an illustration to give her own assessment of the patient's unhappiness more credibility since it is the patient herself who implies that she is desperate (*I can't cope anymore*, l. 22).

In the reflective passages, the student explicitly highlights that she was surprised about the force of the emotional contagion (also note the use of the container metaphor in the first example):

- I know that this encounter was *emotionally draining for me* and *I can only imagine that it was ten times worse for the patient.* (l. 38-40)
- I wasn't aware of how much of an effect the patient's upset would have on me; (l. 80-81).

She explicitly refers to the use of *empathy* as a strategy that she tried to employ in order to counteract the distressing situation:

- *I hope that by at least offering her a tissue and showing some empathy towards her this made her feel slightly better.* (l. 40-42)

Students are introduced to the use of empathy in the communication skills course as a strategy that can be signaled verbally and non-verbally. Empathy is encouraged in clinical communication as a powerful tool for

[4] The students are explicitly invited to use constructed dialogue in the instructions for the reflective writing task. The presence of constructed dialogue is thus not surprising but how it is used is of interest for our study.

enhancing rapport and therefore relationship building with patients. Empathy is a type of emotional resonance that students and clinicians are advised to develop as it has therapeutic benefits such as encouraging disclosure and reducing anxiety (Halpern). Students are advised to try to imagine the patient's experience by emotionally attuning to verbal and non-verbal cues that they can express for example in their tone of voice or use of emotive language.

In addition, the student proposes that showing (more) empathy and being *more confident, less anxious* and *embarrassed* could be a solution for handling future situations in a more satisfying way:

- As I gain more experience talking to patients and relatives who are distressed *I will become more confident and less anxious.* I realise that *my anxiety wasn't helpful* in this situation and could have *made the patient feel worse. In the future I think I will be better equipped for this type of situation where hopefully I will be able to reassure the patient by saying something like "I understand that you are upset".* (l. 43-48)
- On reflection I think that *I should have felt less embarrassed about saying the wrong thing. I should have just used more empathic statements and provided more of an opportunity for the patient to discuss how she felt. I think that as long as I was sincere the patient would not have been offended by my discussing her distress. Al though afterwards I have consoled myself with the fact that at least the patient felt comfortable enough in the consultation to remain there, continue talking to us and show her emotions.* (l. 71-78)
- Hopefully I will be *less anxious and more confident* in talking to patients about why they are upset [. . .] (l. 91-92)

In developing these future scenarios, the student discusses the potential emotional consequences that a change in her communicative behavior might have. Finally, the student also points out that showing too much empathy might be negative:

- I wasn't aware of how much of an effect the patient's upset would have on me; in the future I will try to remain empathic *but I must also be aware of maintaining a professional amount of distance.* (l. 80-83)

Finding the balance between empathizing and not being drawn into an emotional situation at the expense of the medical practitioner's own health is indeed a difficult task. The student uses the phrase *maintaining a professional amount of distance* to refer to this challenge. However, students also often use this or similar phrases not only to express concern for their own health, but also because they are worried that they cannot re-

main professional if they get too drawn into the emotional world of the patient.

So how can these insights be related to the more general topic of reflective writing in medical training and corresponding challenges of emotion management? Erickson and Grove convincingly argue that all interaction between people involves the need to manage emotions (707). Drawing on Hochschild's work (*The Managed Heart*), they propose to make a distinction within emotion management between "emotion work" "to refer to the management of emotion in personal interactions (e.g., with family and friends)" and "emotion labor," which "should be used only in occupational contexts where one is managing emotions because it is part of what the job requires" (Erickson and Grove 707). In healthcare and therapy contexts, the need to address the patient's emotions is particularly prominent as the latter are given help in coping and managing their emotions (Erickson and Grove 707). Learning how to manage the professional's emotions, however, is also part of learning about the practice. In their review of work about nursing, Erickson and Grove show that there are conflicting norms at play. On the one hand, "we generally expect that our doctors and nurses approach our health care with a certain level of empathic concern," and on the other hand, "emotional detachment, neutrality, and/or emotional control" are taught as "fundamental to providing quality care and to preserving their own health and well-being" (712). It is exactly this dilemma that is described by the student in her description of neutrality and empathy above, which points to the importance of making emotional labor a topic in medical teaching.

The quantitative thematic analysis of the fifty texts and the qualitative discussion of a sample text have illustrated that very early on in their training students are aware of the emotional challenges of their profession. The role of emotions transpires as an important issue in the descriptive/narrative part of the texts as well as in the reflective parts. As illustrated with an exemplary analysis of one text, when creating an emotional stance in their text, students can draw on verbal cues and they use language to describe vocal (*soothing tone of voice*), body (*lean towards somebody, offer a tissue*), and physiological/facial cues (*fear in her eyes*).

4. Conclusions and Outlook

Our thematic content analysis of reflective writing texts of medical students shows that handling emotions in doctor-patient interaction tran-

spires as a challenge early in the training of medical students. The students report that they are affected by the patients' positive or negative emotions and that their own reaction is especially difficult to handle in the case of distressed patients. It is therefore important to offer tailored input on dealing with distressed patients and also dealing with one's own emotions and psychological welfare.[5]

The students use language to create emotional cues. The most straightforward ones are verbal cues, such as the use of language-specific emotion vocabularies, metaphors or speech acts. The students also use language to describe vocal, body, physiological and facial cues. Finally, they use constructed dialogue to give the patient a voice in expressing emotions themselves. The lexicon analysis shows that a wide variety of emotions are discussed and that positive and negative connotations are equally present.

Future research on these texts can explore a number of linguistic and applied issues in connection with emotions. It would be worthwhile to pursue the question of metaphors more, to understand better what exactly students mean when they write about "empathy," to see whether they propose solutions of their own to deal with their own or their patients' emotions. Finally, the use of such texts as a vehicle for catharsis could be examined as a potential way of combating stress and burnout.

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[5] Other challenging situations for doctor-patient communication are dealing with patients who are impaired in their capacities as communicators (physically or mentally, children), and situations in which the patient is accompanied by a caretaker or interpreter. In Nottingham specific lectures deal with these issues in addition to how to deal with distressed patients.

Appendix

Lexical patient emotion cues (<EP . . .>) and student emotion cues (<ES . . .>) are indicated in diamond brackets and italics:

1 As the patient stood up and walked towards the consultation room I
2 guessed that she was around 35 years old. Her face was slightly flushed
3 and she was holding a tissue[6] – I assumed that she was coming to the
4 surgery about a cold or flu. She entered the room and sat down; under the
5 bright lights of the consultation room I noticed how much the patient
6 reminded me of my neighbour. As "Dr Name" looked for her notes I saw
7 that the patient was sat towards the front of her chair with her legs crossed
8 looking towards the floor. <*EP She smiled*> but it struck me that <*EP she looked*
9 *unhappy*>.

10-17 [Summary of information on the patient's condition provided by Dr Name]

18 Dr Name left the room to get a syringe for some blood tests. I was left
19 alone with the patient who was becoming <*EP more and more upset*>:

20 Patient: <*EP "I'm sorry about all this."*>
21 Student: "It's OK"
22 Patient: "It's just . . . this has been going on for so long and <*EP I can't cope anymore.*>
And things I would normally take, you know like Echinacea, I can't with being pregnant."
23 Student: "It must be really difficult."

24 <*EP The patient began to cry.*> <*ES I found it difficult to know what to*
25 *say: I had no idea of how someone in this situation would feel and I*
26 *didn't want to sound insincere or make matters even worse.*> I wanted to
27 break the silence but couldn't think of anything to say to make her feel
28 better. I reached into my bag and leaned towards the patient <*EP asking*
29 *if she needed a tissue.*> She smiled as I handed her a tissue. <*ES I felt*
30 *awful*> that I couldn't do anything to help her. After the patient had left
31 Dr Name asked me if I was OK. <*ES I explained that I found it difficult*
32 *knowing what to say when the patient started to cry.*> It was easier in
33 hindsight to think I should have said "I understand why you are upset"
34 but I wasn't sure that I did understand. At the time I was concerned with
35 <*ES sounding insincere or even patronising*>; but in reflection, the
36 patient probably wouldn't have been that critical of the exact phrasing I
37 used and <*EP might have been comforted and felt more able to discuss*
38 *her feelings with me*>. I know that this encounter was <ES emotionally
39 *draining for me*> and <*ES I can only imagine that it was ten times worse*
40 *for the patient*> *I hope that by at least offering her a tissue and*
41 <*ES showing some empathy towards her*> <*EP this made her feel*
42 *slightly better.*>

43 As I gain more experience talking to patients and relatives who are
44 distressed <*EP I will become more confident & less anxious. I realise*
45 *that my anxiety wasn't helpful in this situation and could have made the*

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[6] The mention of the tissue is a foreshadowing that the patient is in distress, but the student is careful to point out that she first interpreted this sign as indexing a cold rather than distress.

patient feel worse. In the future I think I will be better equipped for this type of situation where hopefully I will be able to reassure the patient by saying something like "I understand that you are upset".> After speaking to Dr Name and consulting relevant literature I have also learned the value of a brief silence. This can give the patient an opportunity to discuss their feelings or simply for everyone concerned to reflect.

I feel that this encounter was memorable because it was the first time that was alone with *<EP a patient who was so obviously upset>*. I tried to adopt a *<ES soothing tone of voice* when speaking and *felt desperate to say something to make her feel better.>* As the consultation progressed The patient revealed that she was *<EP fearful of losing her job>* as she had had to take time off due to her illness and would then be going on maternity leave. *<EP This made the patient even more upset,> <ES I felt utterly helpless.>* Later, Dr Name began to prepare the patient for blood to be taken, when she realised what was happening *<EP she screamed and began to hyperventilate. The fear in her eyes> <ES made me feel even worse>* – I knew how *<EP scared and upset she was>* but I couldn't make it better. Between *<EP her sobs>* she explained that she had severe phobias of both needles and blood. *<EP All I could do was hand her another tissue.>*

I didn't communicate with the patient as I had intended. I didn't anticipate how difficult it would be for me to remain calm and say something comforting to the patient. As the conversation between the patient, Dr Name and myself continued the *<EP patient became increasingly upset;>* I had been hoping that it would have been the opposite to this. On reflection I think that *<ES I should have felt less embarrassed about saying the wrong thing. I should have just used more empathic statements and provided more of an opportunity for the patient to discuss how she felt. I think that as long as I was sincere the patient would not have been offended by my discussing her distress. Although afterwards I have consoled myself with the fact that at least the patient felt comfortable enough in the consultation to remain there, continue talking to us and show her emotions.>*

<EP I have learnt how difficult and how emotionally demanding some consultations can be. I wasn't aware of how much of an effect the patient's upset would have on me; in the future I will try to remain empathic but I must also be aware of maintaining a professional amount of distance.> As I have mentioned previously, this encounter has also taught me that sometimes a silence can be helpful in getting the patient to discuss their emotions and concerns with you. I don't think I could have been any more prepared for this encounter. Learning about the theory behind communication in these situations was useful but seemed to go completely out of the window when I was actually presented with a *<EP patient who was so distressed.>* I think now that I have been in this situation I will be more capable of shaping such an encounter in the future. Hopefully I will be *<ES less anxious and more confident>* in talking to patients about why they are upset although I appreciate that not all patients will react in the same way in these types of encounters therefore I must be flexible in my approach to them.
(Corpus: Nottingham, Text 85)

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