A Study of the Effectiveness of Narrative Patient-centered Counseling

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Abstract

This study aims to investigate the effects of narrative patient care on depression index, anxiety index and DT index of cancer patients. Through the experiment, patient education sessions were implemented for 100 cancer patients, practicing the three elements of narrative medicine — attention, reproduction and belonging, observing the psychological pain and anxiety and depression changes of infectious disease combined with tumor patients after narrative patient education sessions, and observing the changes of empathic ability and narrative ability of the participating healthcare personnel, so as to analyze the reality and generalizable significance of narrative patient education sessions practiced in the clinic, and to provide reference for the subsequent clinical work. The experimental group is planned to include a total of 100 cases in the experimental group. A total of 100 cases of the experimental group were planned to be included.

Key Words: Narrative Medicine; Narrative Patient-centered Counseling; Cancer; Depression

Introduction

In 1988, American scholar and international medical anthropologist Arthur Kleiman, realizing the dilemma of lack of humanity faced by the development of American medicine, the alienation between technology and humanity, and the self-disorientation of modern medicine in cold medical devices, proposed to integrate the narrative mode into medical activities as one of the ways for doctors to understand their patients. In January 2001, Rita Caron of New York-Presbyterian/Columbia University Medical Center published an article entitled "Narrative Medicine: Form, Function, and Ethics" in the Annals of Internal Medicine, after which more and more medical practitioners began to pay attention to the "narrative medicine" movement. In January 2001, Rita Cullen of New York-Presbyterian/Columbia University Medical Center published "Narrative Medicine: Forms, Functions, and Ethics" in the Annals of Internal Medicine, launching the "Narrative Medicine" movement, after which more and more medical practitioners began to pay attention to the value of the application of narrative methodology in clinical diagnosis and treatment. Patient education is an important means of implementing narrative medicine. The purpose of this paper is to document the process of implementing and observing the effects of patient education sessions with cancer patients, and to analyze the collected findings with repeated-observation analysis of variance (ANOVA) to quantify abstract emotions. This thesis will first review the development of narrative medicine both domestically and internationally, then describe the concept and format of the patient education narrative session, and finally present the experiment and results.

The History and Introduction of Narrative Medicine

With advances in medical technology, the average human lifespan has generally increased, yet the amount of meaningful time in their lives has greatly decreased. Identity problems have led to a crisis of loss of sense of meaning. Among other things, identity problem refers to the individual's identification with those who have a higher status or achievement than him or her, in order to eliminate the psychological problems such as frustration and anxiety caused by the individual's inability to achieve success or fulfillment in real life. As a result, an individual's sense of powerlessness leads to a vicious cycle of confusion and emotional indifference, which ultimately results in intergroup hostility and interpersonal alienation. Current medical research and medical institutions generally focus on the solution of "disease", but neglect the "human" problem, not to mention the nature of human beings. The process of humanizing knowledge has also been repeatedly put on hold. In terms of the working environment itself, medical workers themselves are not entirely healthy psychologically, and the high-pressure working conditions have led to widespread anxiety, so that the concept of "health first" has not been fully established in the course of practice, much less passed on to patients.

In addition to this, there is a general mentality problem in the physician community and the medical education model needs to be upgraded. Medical students need to go through a selection process to enter the medical profession, and are most concerned about their grades and scores. In university medical studies, the curriculum is very intensive and most of the subjects studied are medical sciences. As a result, medical students' focus on interpersonal interactions or dealing with people fades, and they are reluctant to put their spare time into technically irrelevant matters. Because of this, doctors develop inherent patterns and guidelines for seeing patients and slowly develop burnout.

Because of this, a group of pioneers realized the existing problems in the medical field, and as mentioned in the introduction, Arthur Kleiman was the first to propose the incorporation of the narrative model into medical practice as one of the ways in which doctors could understand their patients. This paved the way for Rita Cullen's introduction of narrative medicine in 2001. Over the past 20 years, narrative medicine has been widely developed in the fields of clinical medicine, clinical nursing, and medical education in the U.S. In 2009, the American Medical Association released statistics that 106 out of 125 medical schools offered courses in humanistic medicine, and 59 offered narrative medicine as a required course. According to the statistics of the Joint Steering Committee for the American Medical Curriculum, American medical colleges and universities have offered courses related to "narrative medicine" education since 1994, and by 2015, more than 90% of medical schools and colleges have offered this course. King's College London launched a Master of Science in Medical Humanities program in 2010, with mandatory core modules "Medical Humanities Themes" and "Medical Humanities Skills", and in 2011, Sweden's Western University created the "Narrative Medicine" program. In 2011, Western University in Sweden created a program called "Narrative Medicine", which has been incorporated into undergraduate, graduate, and continuing medical education. A large number of foreign studies have promoted the construction of a three-stage teaching system of "narrative medicine" in early community practice, disease diagnosis and treatment practice, and preventive medicine practice; the ability to listen, communicate, feedback, reflection, and literary writing are taken as the teaching requirements for the practice of "narrative medicine", and the teaching requirements are progressively developed to meet the requirements of "narrative medicine". The teaching requirements of "Narrative Medicine" include listening, communication, feedback, reflection, and literary writing as the requirements for the practice of "Narrative Medicine", which are gradually implanted into the genes of medical students' professional quality, cultivate medical students to face diseases, pains, and lives with humility and reverence, train their empathy, guide them to reflect on medical behaviors and patient-physician relationship, and improve their understanding of and empathy with patients, so as to ultimately increase the effectiveness of disease prevention and treatment.

Narrative medicine is medicine practiced by healthcare professionals with narrative competence, where "narrative competence" refers to the ability to recognize, assimilate, interpret, and be moved by the story of an illness, i.e., the ability to empathize. Narrative medicine is essentially a kind of relational medicine, which enriches the humanistic part of the medical process by paying attention to, absorbing, reproducing, and reflecting on the patient and his/her story, and enhances the ability of the healthcare provider to "listen thoroughly" and "empathize appropriately," thus enabling him/her to understand the patient's story in a more in-depth and detailed way. Enhance the ability of doctors and nurses to "listen thoroughly" and "moderate empathy", so that they can more deeply and exhaustively understand the patients' disease conditions, family background, treatment wishes, etc., to ensure the joint decision-making of doctors and patients, to improve the patients' medical experience and satisfaction, and to enhance the doctor-patient relationship. "Patient-centered medical practice replaces the traditional "disease-centered" model of diagnosis and treatment, and builds a bridge of trust between doctors and patients.

The mission of narrative medicine is to promote the organic combination of "evidence-seeking" and "story-telling", and to construct a body-mind-spirit integrated medicine. From the perspective of humanistic management in hospitals, narrative medicine has the attribute of "instrumentality", and as a "humanistic science", narrative medicine plays an active role in humanistic construction in hospitals. Many patients in hospitals not only endure the physical pain brought by diseases, but also suffer from the discrimination of others against infectious diseases as well as being marginalized, so they need more support and understanding from medical and social personnel. Patients and their families are faced with not only physical symptoms, but also changes in social identity, psychological upheaval, and even life and death decisions, etc. For this reason, hospitals need to explore a new way to provide health care to patients, and to find a way to interpret the disease, otherwise the clinical symptoms will pale in comparison.

Parallel medical records refer to the non-technical language used by healthcare professionals to write about the patient's afflictions and experiences in addition to the standard clinical medical record. The parallel medical record has an important place in narrative medicine. It is a textual form of listening; it is the basis for reproducing the patient's suffering and thinking; it is a record of doctor-patient co-decision, interaction, and inter-subjectivity in the process of diagnosis and treatment; it is a catalyst for the harmonious relationship between the doctor and the patient; and it is also a condensate for the doctor's reflection on the process of medical treatment, especially on the combination of evidence-based medical treatment and narrative medical treatment. Parallel medical records can promote the formation of empathy between doctors and patients; provide first-hand original information for patients to participate in decision-making; provide a platform for the psychological, social, and situational healing of the disease; and provide a link for patient participation and doctor-patient collaboration. The parallel medical record is a condensation of the patient's voice and the collaborative efforts of doctors and patients to overcome the disease. The emergence of the parallel medical record has spawned another line of medical care alongside the science of evidence-based medicine (an approach to medicine that emphasizes the application of well-designed and executed research to optimize decision-making). The parallel medical record is the key to the success of narrative medicine. Without parallel medical records, it is difficult to accomplish anything in narrative medicine.

As a certain branch of literature and a reference text of medicine, parallel medical records need to adhere to the three elements of attention, listening and attribution. As part of a functional text, it is essential to summarize a cohesive model of writing, to improve the categorization and collection of valid information, and to summarize the concepts and theories of writing, all of which are yet to be matured in real life due to the niche nature of the subject matter. Therefore, this project focuses on keeping records during the whole process of text creation (i.e., interviewing, writing, etc.), observing effective ways of introduction and real-time reflections of the patients, such as "Introducing pleasantries related to drinking tea, so that the interviewees can relax," "Paying attention to the interviewees' body movements, and if necessary, making a certain amount of physical contact ", "advancing the conversation along the interviewee's line of thought", etc., expanding the depth and breadth of language narrative research, providing a new paradigm for the study of medical narrative texts, and providing new answers to the solution ideas of realistic medical literature.

At the same time, due to the conversion of the creative background, the marginalized line of thought and angle of material in traditional narratology will find a new stage here, thus supplementing the integrity of narratology. Under the postmodern perspective supported by medical humanities and technology, more compassion and empathy will be born. The project team will sensitively capture the new features and directions of narratology in the current era, enrich the clinical connotation of narrative research, and promote the confirmation and positioning of text writing in medical research.

Conceptualization and Existing Research on Narrative Patient-centered Counseling

Narrative patient-centered counseling is targeted education provided to patients by physicians during the consultation process, guided by the philosophy of narrative medicine. The aim is to enable patients to understand preventive, therapeutic and rehabilitative measures related to their health problems in order to promote self-care and increase adherence to therapeutic measures. During the educational sessions, healthcare professionals need to strictly practice the three elements of medicine: observation, listening, and attribution, in order to achieve effective communication of information and successful formation of awareness. Existing research suggests that patient education is more oriented towards popularization of science itself, aiming to reduce patients' anxiety by improving their medical literacy, thus achieving mutual understanding and cooperation between doctors and patients. Adding graphics to educational materials can improve patients' attention, recall, comprehension, and compliance. As a combination of text and images, the medium of comics can simplify and facilitate understanding of complex processes.

Pre-study: Patient Screening

Clinical screening was performed among oncology patients and a sample of 90 cases was planned to be included with the following patient inclusion criteria:

1. Patients or their families with a preliminary diagnosis of malignant tumor;
2. Patients or their family members who are visiting the department for the first time;
3. Patients or their family members who experience a progression or relapse of the disease;
4. Emotionally unstable patients or their families;
5. Other: patient-initiated participation in the study or special circumstances, etc.

Experimental Procedure

1. Screening patients were assessed with the Distress Thermometer (DT) and the Hospital Anxiety Depression Scale (HADS), and healthcare professionals who were to participate in the Narrative Patient Education were assessed with the Empathy Test and implicitly assessed for narrative competence.
2. Supportive environment setting
   2.1 Relatively private and quiet place (separate psychotherapy room in the department);
   2.2 Ensure adequate time (scheduled time is 45 minutes);
   2.3 The healthcare worker's cell phone is turned to silent;
   2.4 One healthcare professional and one to three patients or family members participate at a time (separate patients from family members).
3. Obtain consent from the patient and family
   3.1 Patients and families are informed;
   3.2 Inform the affected person of the purpose of the church;
   3.3 Sign the informed consent form.
4. Seven parts of the process:
   4.1 Gathering information: understand the experimental subjects' personality traits, literacy level, and socio-cultural-psychological types; review the patients' basic case data information; delineate the communication baseline and determine the communication theme.
   4.2 Listening: the doctor should empty himself, not let his personal joys and sorrows affect the process of patient education, and during the patient education, he should listen clearly, listen in, listen to understand, and have a response (give the patient an appropriate and simple response).
   4.3 Feelings: Acknowledge the patient's (family member's) painful experience and try to find out the feelings and messages behind the other person's words, such as what the speed and tone of voice mean, and what the body posture, gestures, or facial expressions are expressing.
   4.4 Empathy: Give a moderate amount of empathy to the patient (family member) as they tell their story.
   4.5 Needs: identify what information and guidance the person wants.
   4.6 Guidance: moderate guidance is given to the patient (family) in response to questions of a specific nature.
   4.7 Emotional support: the education session will end with a session to give emotional support to the patient or family, e.g., let's work together to come up with a final plan for the patient, we'll work with you on this, etc.
5. Participate in writing parallel medical records for health care workers
6. Follow-up assessment of patients or family members was conducted after one day and again after one month with patient satisfaction assessment. The healthcare workers were also implicitly assessed for empathy testing and narrative skills.
7. Collect data, organize data, use SPSS software, according to the questionnaire data before and after the education session for statistical comparison, analyze the changes in the degree of psychological pain and depression and anxiety of the patient or family members before and after the education session, and analyze the changes in the empathic ability and narrative ability of the participating health care workers, to find the clinical significance, and to provide guiding significance for the clinical practice of narrative medicine. This study and the collection of patient samples, the time span is long, and there are more patients with tumor patient review. The study involves the follow-up tracking of patients, the need for good patient compliance, tumor patients are mostly advanced, rapid changes in

the condition, shorten the follow-up time frame, all patients to establish a health management file, to protect the follow-up as scheduled.

The Following Assessment Scales Used in the Study

Emotions play an important role in most illnesses, and your doctor will be able to help you more if they are aware of changes in your mood. Please read through each of the following items and put a tick in brackets after the option that most closely matches your mood over the past month. Don't think too much about your answers to these questions - immediate answers are often more realistic.

Name:____ Sex: Male□ Female□ Age:____Years Old

Education:____ Occupation:____ Marriage: Unmarried□ Married□ Divorced□

1) I feel nervous (or miserable):

Not at all ()

Sometimes ()

Most of the time ()

Almost all the time ()

2) I'm still interested in things that used to interest me:

Definitely the same ()

Not as much as before ()

Only a little ()

It's basically gone ()

3) I feel a little scared as if I have a premonition that something terrible is going to happen:

Not at all ()

A little, but it doesn't make me bitter ()

Yes there is, not too serious ()

Very definitely and very seriously ()

4) I was able to laugh out loud and see the good side of things:

I do this all the time ()

Not so much anymore ()

Definitely not too many now ()

Not at all ()

5) My heart is full of troubles:

By chance so ()

When it is, but it is not easy ()

From time to time ()

Most of the time ()

6) I feel pleasant:

Most of the time ()

Sometimes ()

Not often ()

Not at all ()

7) I was able to sit comfortably and easily:

Affirmative ()

Frequently ()

Not often ()

Not at all ()

8) I lose interest in my grooming:

I still care as much as ever()

I may not be terribly concerned ()

Doesn't care about me as much as I should ()

Affirmative ()

9) I was a bit fidgety, as if I felt compelled to be active:

Not at all ()

Not very rarely ()

Not less ()

Very much so ()

10) I'm optimistic about everything moving forward:

Pretty much do this ()

Doesn't quite work that way ()

Rarely do so ()

Almost never ()

Findings

In this study, data were processed using repeated observation ANOVA. This analysis is mostly used in the medical field to detect whether the dependent variable is significantly different in several measurement groups. In cleaning and processing the raw data, the following measures were taken: elimination of duplicates, elimination of anomalies, and uniformity of data format. The effective sample size of this survey totaled 87, which is greater than 45 and conforms to normal distribution by default. Readers should understand that M is the mean and SD is the standard deviation. ω is the test of sphericity, and $p<0.05$ indicates a significant difference between the data.

1. Results of DT index analysis

There were 87 valid data after collation. As shown, each patient was measured for DT index after treatment completion (M=5.05, SD=3.046), 1 day post-treatment (M=4.48, SD=2.519), and 30 days post-treatment (M=3.66, SD=1.910). The Greenhouse-Gessler estimate of deviation from sphericity, ω=.84, was significantly different for the DT index at treatment completion/day 1 post-treatment/day 30 post-treatment, F (1.68, 144.29)=25.77, $p<0.01$.

	平均值	标准差	N
第一次DT值	5.05	3.046	87
第二次DT值	4.48	2.519	87
第三次DT值	3.66	1.910	87

测量: MEASURE_1

源		III 类平方和	自由度	均方	F	显著性	偏 Eta 平方
检测时间	假设球形度	85.157	2	42.579	25.771	<.001	.231
	格林豪斯-盖斯勒	85.157	1.677	50.770	25.771	<.001	.231
	辛-费德特	85.157	1.707	49.892	25.771	<.001	.231
	下限	85.157	1.000	85.157	25.771	<.001	.231
误差 (检测时间)	假设球形度	284.176	172	1.652			
	格林豪斯-盖斯勒	284.176	144.248	1.970			
	辛-费德特	284.176	146.788	1.936			
	下限	284.176	86.000	3.304			

2. Results of the analysis of anxiety indices

There were 88 valid data after collation. As shown, each patient was measured for anxiety scores after treatment completion (M=7.48, SD=4.91),1 day post-treatment (M=6.35, SD=4.10), and 30 days post-treatment (M=5.58, SD=3.69). According to Figure 5, the Greenhouse-Gessler estimate of deviation from sphericity, ω=.65, was significantly different for the DT index at treatment completion/1 day post-treatment/30 days post-treatment, $F(1.30, 113.53)=21.07$, $p<0.01$.

	平均值	标准差	N
第一次焦虑评分	7.48	4.908	88
第二次焦虑评分	6.35	4.097	88
第三次焦虑评分	5.58	3.685	88

测量: MEASURE_1

源		III 类平方和	自由度	均方	F	显著性	偏 Eta 平方
检测时间	假设球形度	160.280	2	80.140	21.073	<.001	.195
	格林豪斯-盖斯勒	160.280	1.305	122.822	21.073	<.001	.195
	辛-费德特	160.280	1.317	121.725	21.073	<.001	.195
	下限	160.280	1.000	160.280	21.073	<.001	.195
误差 (检测时间)	假设球形度	661.720	174	3.803			
	格林豪斯-盖斯勒	661.720	113.533	5.828			
	辛-费德特	661.720	114.557	5.776			
	下限	661.720	87.000	7.606			

3. Results of depression index analysis

There were 88 valid data after collation. As shown, each patient was measured for depression scores after treatment completion (M=8.56, SD=5.74),1 day post-treatment (M=7.41, S D=5.20), and 30 days post-treatment (M=6.55, SD=4.55). According to Figure 8, the Greenhouse-Gessler estimate of deviation from sphericity, ω=.78, there was a significant difference in depression scores at treatment completion/1 day post-treatment/30 days post-treatment, $F(1.56, 135.87)=18.66$, $p<0.01$.

	平均值	标准差	N
第一次抑郁评分	8.56	5.743	88
第二次抑郁评分	7.41	5.201	88
第三次抑郁评分	6.55	4.548	88

测量: MEASURE_1

源		III 类平方和	自由度	均方	F	显著性	偏 Eta 平方
检测时间	假设球形度	179.189	2	89.595	18.659	<.001	.177
	格林豪斯-盖斯勒	179.189	1.562	114.742	18.659	<.001	.177
	辛-费德特	179.189	1.585	113.047	18.659	<.001	.177
	下限	179.189	1.000	179.189	18.659	<.001	.177
误差 (检测时间)	假设球形度	835.477	174	4.802			
	格林豪斯-盖斯勒	835.477	135.866	6.149			
	辛-费德特	835.477	137.903	6.058			
	下限	835.477	87.000	9.603			

Conclusion

The results of the analysis of the three sets of data have shown that after the implementation of Narrative patient-centered counseling for patients suffering from malignant tumors, the patients' DT index, anxiety index, and depression index have decreased significantly, and the therapeutic effect of Narrative patient-centered counseling is very significant. Narrative medicine, as a humanistic medicine that provides soul care and creates a harmonious environment, has an important role in hospital humanistic construction. It is the duty of healthcare practitioners to participate in medical data analysis with academic research, to promote the deep integration of industry, academia and research on treatment means, and to take responsibility for promoting research on the treatment of various conditions. Hospitals are often a collection of extreme reality and extreme sensibility, in which people can not decide life and death, but people's hearts have temperature. Therefore, the degree of control of the two is very important, neither for the sake of the rigor of the data will ignore the warmth of the human heart, and can not be lost for the sake of warmth and the loss of the seriousness of medicine. Narrative medicine, as a clinical tool, takes into account both humanistic and scientific aspects, both warm and serious, with the aim of increasing patients' compliance. In conclusion, narrative medicine research is the humanistic corner of hospitals, and it is more than that; it will cover more details and treatment research will be more comprehensive. It can be imagined that in the future, more patients will come out of the darkness under the joint collaboration of themselves, health care workers and even research scholars. To sum up, the two disciplines, medicine and literature, are very different from each other, yet the fundamental undertones of humanistic care of the two possess a spiritual resonance like intermingling in the post-modern era where the speed of life is accelerated and the barriers of interaction are thickened. In fact, whether it is narrative medicine, parallel medical records, or any social narrative, it must be good and warm. The two can complement and serve each other, and walk out a unique path of scientific research amidst reverence and compassion for life.

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