



NATIONAL BREAST
AND OVARIAN
CANCER CENTRE

COMMUNICATION SKILLS TRAINING INITIATIVE

ELICITING AND RESPONDING TO EMOTIONAL CUES

**EVIDENCE FROM THE LITERATURE
AND RECOMMENDED STEPS**

This literature review forms part of a communication skills training module presented in a professionally facilitated and interactive workshop

PREPARED BY THE NATIONAL BREAST AND OVARIAN CANCER
CENTRE

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Eliciting and responding to emotional cues - Evidence from the literature and recommended steps was developed by the Centre for Health Research & Psycho-oncology on behalf of the National Breast Cancer Centre in 2007.

The National Breast and Ovarian Cancer Centre

Level 1, Suite 103 355 Crown Street Surry Hills, NSW 2010 Australia

Locked Bag 3, Strawberry Hills NSW 2012 Australia

Telephone +61 2 9357 9400

Facsimile +61 2 9357 9477

Website www.nbocc.org.au

www.breasthealth.com.au

Email: director@nbocc.org.au

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NATIONAL BREAST AND OVARIAN CANCER CENTRE

COMMUNICATION SKILLS TRAINING INITIATIVE

Benefits of effective communication between treatment team members and people with cancer include improvements in the patient's psychosocial adjustment, decision making, treatment compliance and satisfaction with care.¹ Since 1997 National Breast and Ovarian Cancer Centre (NBOCC) has sought to improve the communication skills of oncology health professionals in Australia through the provision of the Communication Skills Training Initiative.

The NBOCC Communication Skills Training Initiative is implemented through:

- development and provision of standardised communication skills training modules and recommendations for best practice
- building capacity to implement communication skills training by training communication skills facilitators
- supporting the implementation of local interactive training workshops for health professionals that use a best practice approach.
- development and maintenance of a website to support and promote communication skills training for health professionals.

The Communication Skills Training Initiative supports the implementation of the NBCC^{*} and National Cancer Control Initiative's *Clinical practice guidelines for the psychosocial care of adults with cancer*.¹

For further information on the NBOCC's Communication Skills Training Initiative:

<http://www.nbocc.org.au/commskills>

¹ National Breast Cancer Centre and the National Cancer Control Initiative. *Clinical practice guidelines for the psychosocial care of adults with cancer*. National Breast Cancer Centre, Camperdown, NSW: 2003.

In 2008, National Breast Cancer Centre Incorporating the Ovarian Cancer Centre (NBCC) changed its name to National Breast and Ovarian Cancer Centre (NBOCC).

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Module developers

- Professor Afaf Girgis and Ms Amy Waller, Centre for Health Research & Psycho-oncology, The Cancer Council NSW and the University of Newcastle, NSW

NBOCC Communication Skills Steering Committee

- Professor Phyllis Butow, Psychologist, University of Sydney, NSW
- Associate Professor Dorothy Keefe, Medical Oncologist, Royal Adelaide Hospital, SA
- Mr Peter Malycha, Surgeon, Royal Adelaide Hospital, SA
- Ms Pam Robertson, Consumer, Breast Cancer Network Australia, ACT
- Dr Jane Turner, Psychiatrist, University of Queensland, QLD
- Professor Kate White, Nurse, Faculty of Nursing and Midwifery, University of Sydney, NSW

Module Reviewers

- Dr Suzanne Steginga, Psychologist, Director, Community Services and Research Program, Queensland Cancer Fund, QLD

National Breast and Ovarian Cancer Centre Staff

- Ms Caroline Nehill, Program Manager
- Ms Heidi Wilcoxon, Senior Project Officer

INTRODUCTION

This module includes direct reference to work completed by the CUES research team² as part of an NHMRC-funded grant evaluating the effectiveness of a consultations skills training program in improving the psychosocial outcomes of people diagnosed with cancer and health professionals' skills in detecting and addressing emotional cues.

² The CUES team was headed by Prof Jill Cockburn from the University of Newcastle, who died of metastatic breast cancer in 2003; and included Afaf Girgis, Deborah Bowman, Catherine D'Este and Elizabeth Stojanovski from the Centre for Health Research & Psycho-oncology, The Cancer Council NSW and the University of Newcastle; Phyllis Butow and Martin Tattersall from the University of Sydney, Penelope Schofield from the Peter MacCallum Cancer Centre; and Jane Turner and Chris Doran from the University of Queensland.

LITERATURE REVIEW

RECOGNISING AND MANAGING PSYCHOLOGICAL DISTRESS IN CANCER PATIENTS

The following publication has been included with permission.

Peer-reviewed publication by the CUES team:

Ryan H., Schofield P., Cockburn J., Butow P., Tattersall M., Turner J., Girgis A.,
Bandaranayake D. & Bowman D. (2005). How to recognise and manage
psychological distress in cancer patients. *European Journal of Cancer Care*; 14, 7-15.

How to recognize and manage psychological distress in cancer patients

H. RYAN, BSC (HONS), *Centre for Health Research @ Psycho-oncology, University of Newcastle, Newcastle*, P. SCHOFIELD, PHD, *Peter MacCallum Cancer Institute, Melbourne*, J. COCKBURN, PHD, *Centre for Health Research @ Psycho-oncology, and Discipline of Health Behaviour Sciences, University of Newcastle, Newcastle*, P. BUTOW, PHD, *Medical Psychology Research Unit, University of Sydney, Sydney*, M. TATTERSALL, MD, *Medical Psychology Research Unit, University of Sydney, Sydney*, J. TURNER, FRANZCP, *Department of Psychiatry, University of Queensland, Queensland*, A. GIRGIS, PHD, *Centre for Health Research @ Psycho-oncology, and Discipline of Health Behaviour Sciences, University of Newcastle, Newcastle*, D. BANDARANAYAKE, PHD, *Centre for Health Research @ Psycho-oncology, and Discipline of Health Behaviour Sciences, University of Newcastle, Newcastle*, & D. BOWMAN, BA, *Centre for Health Research @ Psycho-oncology, and Discipline of Health Behaviour Sciences, University of Newcastle, Newcastle, Australia*

RYAN H., SCHOFIELD P., COCKBURN J., BUTOW P., TATTERSALL M., TURNER J., GIRGIS A., BANDARANAYAKE D. & BOWMAN D. (2005) *European Journal of Cancer Care* **14**, 7–15

How to recognize and manage psychological distress in cancer patients

Psychological distress is common in cancer patients, however, it is often unrecognized and untreated. We aimed to identify barriers to cancer patients expressing their psychological concerns, and to recommend strategies to assist oncologists to elicit, recognize, and manage psychological distress in their patients. Medline, Psychlit, and the Cochrane databases were searched for articles relating to the detection of emotional distress in patients. Patients can provide verbal and non-verbal information about their emotional state. However, many patients may not reveal emotional issues as they believe it is not a doctor's role to help with their emotional concerns. Moreover, patients may normalize or somatize their feelings. Anxiety and depression can mimic physical symptoms of cancer or treatments, and consequently emotional distress may not be detected. Techniques such as active listening, using open questions and emotional words, responding appropriately to patients' emotional cues, and a patient-centred consulting style can assist in detection. Screening tools for psychological distress and patient question prompt sheets administered prior to the consultation can also be useful. In conclusion, the application of basic communication techniques enhances detection of patients' emotional concerns. Training oncologists in these techniques should improve the psychosocial care of cancer patients.

Keywords: anxiety, cancer, communication, depression, emotions, review.

INTRODUCTION

Depression, anxiety, and other forms of psychological morbidity such as adjustment disorders are common in cancer patients. Research from the USA estimates between 35 and 50% of cancer patients are affected by psychological problems (Spiegel 1996; Zabora *et al.* 2001), with adjustment disorder with depressed mood being the most common clinical diagnosis (Spiegel 1996). Austra-

Correspondence address: Jill Cockburn, Room 243A David Maddison Building, Cnr Watt and King St. Newcastle, NSW, Australia (e-mail: jill.cockburn@newcastle.edu.au).

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lian research suggests 42% of early stage breast cancer patients experience anxiety, depression or adjustment disorders (Kissane *et al.* 1998), indicating a significant proportion of cancer patients are affected by psychological difficulties.

Estimates of psychological morbidity are likely to be influenced by the methods used and the patients sampled. For example, Stark and colleagues (Stark *et al.* 2002) found that 48% of people with mixed types of cancer had an anxiety disorder when assessed by questionnaire. However, when reassessed by diagnostic interview only 18% of the sample fulfilled the criteria for an anxiety disorder. Estimates may also under-represent the true prevalence of psychological morbidity because particular groups, such as people with a poor prognosis who may have comparatively high levels of distress, are often excluded from this type of research (Sellick & Crooks 1999).

Irrespective of the true prevalence, a diagnosis of cancer is a stressful event that often generates a great deal of fear and uncertainty; therefore symptoms of anxiety, depression, and other forms of psychological distress are not surprising. A survey of 888 people undergoing treatment for cancer revealed that five of the 10 highest unmet needs were in the psychological domain (Sanson-Fisher *et al.* 2000). For instance, 40% of the sample reported that they had a moderate or high unmet need related to 'fears about the cancer spreading'. Accurate detection of psychological distress is important for the optimal care of people with cancer given that reducing psychological morbidity enhances a person's overall well-being, and may even provide a small survival benefit (Spiegel *et al.* 1989; Fawzy *et al.* 1993).

Comorbid psychological conditions can have an impact on the treatment and recovery of patients. Depressive symptoms can result in greater pain and poorer physical and social functioning (Wells *et al.* 1989). Depression can also affect both the severity and number of side-effects, and lead to greater anxiety and fatigue experienced by cancer patients (Badger *et al.* 2001). Moreover, depressed patients have higher utilization of medical services, higher medical costs, and longer hospital stays than non-depressed patients (Fulop *et al.* 1987; Levenson *et al.* 1990; Simon *et al.* 1995), and therefore place an added burden on the health system.

Given these potential consequences, it is important that any indication of psychological distress in cancer patients receives attention and is managed appropriately. It is often difficult to determine the difference between distress which is a normal response to a potentially life-threatening event and a clinically significant condition. It is common for cancer patients to experience transient

feelings of low mood, apprehension and worry during their diagnosis and treatment. When these feelings become persistent, or begin to affect functioning, they become clinically significant (American Psychiatric Association 1994). This may occur particularly if the initial feelings are not acknowledged and dealt with.

Despite the frequency of distress in people with cancer, many cases are undetected and untreated (Maguire 1985). For example, Fallowfield and colleagues (Fallowfield *et al.* 2001) conducted a large-scale study to assess the sensitivity and specificity of oncologists' identification of clinical distress in cancer outpatients. Only 29% of patients were correctly identified as having psychiatric morbidity. Similarly, a study of the perceptions of oncologists about their patients' symptoms and needs revealed that only 17% of patients classified as clinically anxious and 6% of those classified as clinically depressed according to their Hospital Anxiety and Depression Scale scores were recognized as such by their oncologists (Newell *et al.* 1998).

There is clearly scope to improve the detection of psychological distress among people with cancer. The detection of distress and its management in cancer patients is an important aspect of clinical care. This review identifies the main barriers to recognizing distress in cancer patients, and proposes methods to improve the elicitation of emotional cues and the accuracy of identifying distress and psychological morbidity within a cancer consultation.

METHOD

This paper reviews the literature relating to promoting emotional discussions and recognizing psychological distress in patients. There was a particular focus on literature relating specifically to oncology consultations. However, where this literature was lacking, sources pertaining to medical consultations with other diagnoses were used, including those relating to primary care or interactions between nursing staff and patients.

Data source

A staged process was used to locate as many relevant articles as possible. First, an extensive literature search was conducted using Medline, Psychlit, and the Cochrane databases. Each database was searched for articles published in English from the year 1980 to the latest issue at the time. The search terms were deliberately kept broad to capture as much relevant literature as possible. Examples of search terms were: physician communication; non-verbal communication; doctor-patient communication; cues; detection of distress. Additional literature searches

were performed on key authors in the area. Experts in the field were also contacted and asked if they could recommend relevant references. The reference lists of all the located articles were then scanned for additional relevant articles. All relevant literature was included, regardless of the type of study conducted. The resulting pool of published papers was synthesized into this review.

RESULTS

Types of emotional cues

A patient can give an emotional cue in one of two ways: explicitly, such as verbally describing symptoms of concern, or non-explicitly, where patients' cues to their feelings or internal state are indicated through their non-verbal behaviour. Non-verbal behaviour is less easy to interpret, particularly by people not specially trained in this area. As doctors usually receive only limited training in communication skills it is likely that they rely more on the verbal information provided to them by their patients. Many clinicians assume that patients will mention their psychological distress during consultations; however, less than one-quarter of patients actually do so (Maguire 1985). It is therefore important for clinicians to be aware of any non-explicit cues to distress that their patients may provide.

Patients experiencing emotional distress are likely to provide verbal cues or report symptoms of a psychological nature in primary care consultations (Del Piccolo *et al.* 2000), e.g. 'I'm feeling really upset about my diagnosis'. In contrast, a review of the literature by Maguire (Maguire 1985) found that few cancer patients disclose psychological distress, and therefore verbal cues are likely to be indirect (Fallowfield *et al.* 2001), e.g. 'I guess a lot of people feel down when they get cancer'. Patients with higher levels of emotional distress are more likely to mention psychological symptoms, signal emotional needs, and request information during a medical consultation (Davenport *et al.* 1987; Street 1991).

Non-verbal behaviour often conveys more information than verbal behaviour in the communication process (Egan 1994). Non-verbal behaviours that suggest possible psychological morbidity include postural or movement cues, such as dejected pose or excessive or lack of movement, and vocal cues, such as an unmodulated or distressed tone (Davenport *et al.* 1987).

Barriers to identifying patients' emotional concerns

The identification of psychological conditions is largely dependent on information patients provide to the clinician

about their feelings and emotions. Many patients do not spontaneously disclose emotional difficulties during medical consultations (Maguire 1985; Fallowfield *et al.* 2001); therefore, clinicians need to elicit this information through the use of appropriate communication skills. Rapport between the patient and clinician is essential for effective communication (Egan 1994), and requires clinicians to be interested in the feelings and concerns of their patients, and to generate an atmosphere in which patients feel comfortable enough to disclose feelings and concerns. This process involves active listening and the identification of verbal and non-verbal cues (Egan 1994). If clinicians are not familiar with these techniques, they may unintentionally create barriers to communication. Additionally, patients may also conceal their emotions or block discussions of this nature for a variety of reasons.

Patient attributes

Patients' attitudes and beliefs

Patients' attitudes about the doctor's role can affect the amount of information they disclose about psychosocial issues. Patients perceive their doctors to be too busy to be burdened with this type of information (Maguire 1985). Cape and McCulloch (Cape & McCulloch 1999) interviewed patients experiencing high levels of psychological distress, and found that almost half of them did not disclose their symptoms because they felt embarrassed or hesitant to trouble the physician with their problems, while almost 20% felt deterred by the behaviour of the doctor. Other commonly mentioned factors were a perceived lack of time and the idea that the doctor could not help anyway. Frequently, these ideas are supported by the behaviour of clinicians. For example, in an analysis of audio-taped oncology consultations, Butow and colleagues (Butow *et al.* 2002) found that patients gave more verbal cues relating to information needs than emotional needs, and oncologists were more likely to respond to cues for information than the emotional cues, thereby reinforcing the patients' attitudes and beliefs. When patients believe that part of the clinician's role is to deal with these issues, they are more likely to discuss non-medical symptoms (Street *et al.* 1995).

Patients' attitudes towards their own condition can also influence their willingness to disclose information. Data suggest that patients may perceive that their fears and concerns are silly or unreasonable, or that their symptoms are a predictable result of their illness, and therefore do not disclose them to their doctor. Patients may also be embarrassed about discussing psychosocial issues as they

feel it reflects badly on their coping abilities (Maguire 1985).

Patients' demographic characteristics

Differences in patients' willingness to disclose emotional concerns may be related to demographic factors; however, these associations are not consistent. Studies investigating the effects of age (Davenport *et al.* 1987; Street 1991; O'Connor *et al.* 2001; Butow *et al.* 2002) and gender (Hall & Roter 1995; Kroenke & Spitzer 1998; Lunn *et al.* 1998; Macintyre *et al.* 1999; Butow *et al.* 2002) have failed to determine systematic differences. However, the relationship between educational level and communication style appears more consistent. Patients with higher levels of education are more likely to request information and provide evidence of emotional needs (Davenport *et al.* 1987; Street 1991). Because of the high level of contradictory evidence, demographic characteristics are not reliable indicators of distress or psychological morbidity.

Patients' physical presentation

The detection of psychological distress in patients is related to the presence of comorbid conditions. A series of studies has demonstrated that patients who present with a physical symptom are much less likely to have their depression recognized (Freeling *et al.* 1985; Tylee *et al.* 1993), especially if psychological symptoms are mentioned late in the consultation or not at all (Tylee *et al.* 1995). This could potentially result from patients' somatizing or normalizing their feelings of depression (Kessler *et al.* 1999).

Somatization refers to experiencing physical symptoms for a problem that is psychological in origin, such as suffering nausea that is caused by anxiety or stress rather than a medical illness. Therefore, instead of presenting with easily recognized psychological symptoms, patients may display physical symptoms such as gastrointestinal problems, chronic pain, or fatigue (De Wester 1996). People with cancer commonly experience these types of physical symptoms as a result of their disease or as side-effects of chemotherapy, radiotherapy or pain control medication. Hence, oncologists expect to observe and treat these symptoms in their patients and, in the absence of other indications of distress, may not suspect an underlying emotional cause. Kirmayer and colleagues (Kirmayer *et al.* 1993) found that around three-quarters of patients who have clinically significant anxiety or depression present with somatic symptoms, and that accurate recognition of psychological distress becomes less likely with increasing somatization.

Patients normalize symptoms by attributing them to their life circumstances (Kessler *et al.* 1999), such as explaining their depression as a normal consequence of their disease. Freeling and colleagues (Freeling *et al.* 1985) found that patients with undetected depression were less obviously depressed as evidenced by their physical presentation, and their illness had lasted longer than patients whose depression had been recognized.

Clinician attributes

Doctors' attitudes and beliefs

Attitudes of clinicians can have a strong impact on the way they communicate (Main *et al.* 1993; Jenkins & Fallofield 2002). If clinicians feel it is not their role to deal with the psychosocial concerns of patients, they are unlikely to encourage communication on that topic, or to notice cues suggestive of distress in their patients. Even if clinicians do see it as their role, they may not have the appropriate skills to actively solicit this type of information. Clinicians' expectations of their patients also appear to play a role. Many practitioners believe that patients will request help for any problems they may be experiencing, and therefore do not prompt patients for information (Maguire 1985; Detmar *et al.* 2000). However, patients and oncologists differ in their expectations as to who should take the lead in initiating discussions about emotional functioning and daily activities. Although all patients in one recent study wanted these issues to be addressed, about one-quarter were only willing to do so at the initiative of their doctor. At the same time, although patients were willing to discuss a wide range of quality of life issues, all the doctors in the study indicated that they generally defer to their patients to initiate discussions of psychosocial issues (Detmar *et al.* 2000).

Many doctors are not comfortable dealing with patient emotions, both because of their perceived lack of training and ability to help the patient, and because of the belief that taking on patient emotions will be time-consuming and an emotional burden for themselves. Distancing techniques such as changing the topic, ignoring cues, normalizing the problem, and offering either false or premature reassurance are often used to avoid dealing with patients' psychological problems. However, open communication about the emotional concerns of the patient is beneficial for both the patient and doctor. Doctors who report deficiencies or an absence of communication skills training, even when they have postgraduate qualifications in a medical specialty, manifest the most anxiety and least confidence when dealing with patients' problems

(Ramirez *et al.* 1996). These doctors are also those who are most at risk of 'burnout' (Ramirez *et al.* 1996). Additionally, appropriate responding to patients' emotional cues can actually shorten consultation times (Butow *et al.* 2002).

Negative attitudes towards patients, such as blaming depressed patients for causing or exaggerating symptoms, can significantly decrease a physician's ability to detect psychological distress (Robbins *et al.* 1994; Girón *et al.* 1998). On the other hand, positive attitudes towards psychosocial aspects of patient care result in more statements of empathy and reassurance by clinicians and more psychosocial discussions with patients (Levinson & Roter 1995). However, Badger and colleagues (Badger & *et al.* 1994) found that interest in psychosocial issues did not necessarily translate into use of behaviours such as patient-focused interviewing techniques, psychosocial questions, inquiry about depressive symptoms or a depression diagnosis. Therefore, while clinicians need to perceive that it is part of their role to recognize distress, a positive attitude is not sufficient to deal with psychological issues among their patients.

Clinician gender

Roter and colleagues (Roter *et al.* 2002) conducted a meta-analysis to investigate gender effects on clinician consultation styles. No gender differences were found for information giving in terms of amount, quality or manner; however, differences were apparent for psychosocial aspects of the consultation. Women were shown to engage in more psychosocially focused behaviours such as counselling, questions, and use of emotion-focused words, and to have a more patient-centred style than men. Female clinicians also appeared to have a greater awareness of non-verbal communication than male clinicians, and responded to a higher proportion of patient cues, though the latter result was strongly influenced by one participant. However, techniques needed to improve consultation skills should be easily learned by both genders. Importantly, the analysis demonstrated that patients tended to copy the behaviours exhibited by clinicians; therefore, clinicians with a psychosocial focus will receive more psychosocial information from their patients.

Clinicians' lack of knowledge about symptoms of distress

To properly assess patients, doctors need to be aware of symptoms of distress and which symptoms are most informative. Evidence shows that clinicians are strongly influ-

enced by explicit depressive symptoms, such as crying and depressed mood (Passik *et al.* 1998); however, these symptoms are not necessarily the most reliable indicators of depression. Non-physical factors such as loss of pleasure or interest, guilt, hopelessness, and impairments in social functioning are more reliable, especially in cancer populations where physical symptoms of treatment can be very similar to physical symptoms of depression (Passik *et al.* 1998). It is difficult to determine when anxiety becomes pathological in cancer patients, as the threat is real rather than imagined, and the degree of threat changes over the course of the illness and treatment. It has been suggested that symptoms that are unacceptable to the patient, and/or that cause impairments in functioning should be used to assess anxiety in oncology patients (Stark & House 2000).

Although untrained doctors have difficulty responding to non-verbal cues (Butow *et al.* 2002), these cues are very important when detecting distress. For example, vocal cues such as tone of voice are strongly related to psychological symptoms, and are easily detected by those trained to do so (Davenport *et al.* 1987).

Strategies to recognize patient cues

Active listening

Perhaps the most important technique of identifying cues and distress is the use of active listening. Active listening involves attending to and observing verbal and non-verbal behaviours, and understanding them in the context of the patient's life and circumstances (Egan 1994). There is special emphasis on attention to non-verbal communication, which increases detection of cues and distress (Cohen & Alpert 1981; Robbins *et al.* 1994). Active listening involves using eye contact, having an attentive posture, and facilitating the patient's disclosure through behaviours such as nodding and making noises of agreement or encouragement (Goldberg *et al.* 1993; Girón *et al.* 1998). Therefore, the patient is often aware of whether or not they are being listened to, and are more likely to disclose information if the listener is conveying empathy and interest both verbally and non-verbally. A brief summary of what the person has conveyed at the end of their statement confirms that the listener has accurately heard and understood, and permits the speaker to correct any misconceptions. Active listening requires an objective state of mind and a genuine interest in the concerns of the patient, and thereby leads to the ability to detect cues that may convey information about the patient's state (Robbins *et al.* 1994).

Patient-centred consulting style

A patient-centred style is one where the needs and wants of the patient are put first, dealing with the patient holistically rather than their specific illness. This style involves listening, allowing the patient to explain their issues and expectations, and can also involve shared decision making (Lewin *et al.* 2001; Price & Leaver 2002). Thus the patient is involved in making treatment decisions, and their true needs are addressed. This style of consultation is preferred by the majority of patients (Dowsett *et al.* 2000), and is conducive to more effective communication when compared with doctor-centred consultations where the clinician makes the agenda.

Strategies to increase frequency of patient cues

The behaviour of doctors during consultations can affect the amount and type of information a patient discloses. While some behaviours encourage expression of concerns, other behaviours can actually inhibit this. The following behaviours are summarized in Table 1.

Uninterrupted patient talk time

Techniques to be used in conjunction with active listening include allowing the patient to speak without interruption, and not providing them with information before they have finished (Goldberg *et al.* 1993). Particularly when the diagnosis is known, as is the case with many oncology consultations, patients should be allowed to explain fully the reasons for their visit. Marvel and colleagues (Marvel *et al.* 1999) found that family physicians asked patients about the reason for their visit in only 75% of interviews, and that patients' initial statements of concerns were completed in 28% of these. Patients allowed to complete their statement

Table 1. Methods to increase the frequency and identification of patient cues

-
- Listen to the patient with an open mind
 - Allow patients to speak their concerns without interrupting
 - Be open to the idea that patients may express psychological distress
 - Be patient-led, i.e. take the consultation in the direction the patient leads
 - Acknowledge patients' concerns and respond empathically
 - Use questions appropriately
 - Use words that have emotional content
 - Make direct requests for self-disclosure
 - Summarize patient statements/clarify patient needs
 - Be willing, and have the confidence to tackle psychological issues
 - Consider the use of external aids, such as prompt sheets or questionnaires that measure quality of life
-

of concerns used only 6 s more on average than those who were redirected before completion of concerns. Once patients have had a chance to state their concerns, the doctor can give information so that patients can see it is relevant to them and their concerns. It is also important that clinicians are open to the idea of psychological distress (Cohen & Alpert 1981; Robbins *et al.* 1994), rather than ascribing all symptoms to a physical cause.

Respond appropriately to patient's cues

It is also important to respond appropriately to the patient's verbal and non-verbal cues (Maguire *et al.* 1986). This includes acknowledging what the patient has said or suggested through their non-verbal behaviours, and addressing the issues raised. Closely associated with this is clarification and interpretation of what a patient has expressed (Cox *et al.* 1981; Maguire *et al.* 1986). This involves restating in the doctor's own words what he or she believes the patient has expressed. Empathic comments are also helpful (Cox *et al.* 1981; Goldberg *et al.* 1993) by illustrating interest and understanding of the patient's concerns. Questions with a direct psychological focus can also help to elicit information from the patient (Cox *et al.* 1981; Goldberg *et al.* 1993).

Use questions appropriately

Using questions has varied effects, depending on the general style of the consultation. Open questions are questions that require more than a yes or no answer. Open questions used together with factual questioning (i.e. asking for facts) generate less expression of feelings and self-disclosure, while open questions used with a psychological focus (i.e. feelings) tend to increase expression of feelings and self-disclosure (Cox *et al.* 1981). However, closed questions used in a psychological context can also result in disclosure (Cox *et al.* 1981), with one study showing that the number of cues increased with closed psychosocial questions (Del Piccolo *et al.* 2000). A similar effect can be seen with directive social questions, such as asking about events at home. When these questions are asked in an appropriate context they can lead to further disclosure; however, they can have the opposite effect when inserted aimlessly into the interview (Goldberg *et al.* 1993).

Use emotional words

Razavi and colleagues (Razavi *et al.* 2002) investigated the effects of training nurses to use words that have emotional content, and found that this facilitated patients' expres-

sions of emotions. Use of emotional words demonstrates empathy, and leads to greater patient disclosure.

Recognize and acknowledge distress

When physicians recognize their patients' emotional distress, patients give more information in general, and more information about psychosocial issues in particular, than patients who do not have their distress acknowledged (Del Piccolo *et al.* 2000).

Use self-completed quality of life questionnaires

Detmar & Aaronson (1998) conducted a pilot study where they asked patients to complete the EORTC QLQ-C30, a standardized cancer-specific quality of life questionnaire. The patients' responses were computer-scored and transformed into a graphic summary that was given to patients and oncologists before the medical consultation. Subsequently, the physicians raised three times as many quality of life topics than was the case prior to its use, and there was an overall increase in the average number of quality of life issues discussed per consultation.

Use patient question prompt sheets

A recent study by Brown and colleagues (Brown *et al.* 2001) found that cancer patients who were given a question prompt sheet shortly before their first consultation with an oncologist asked more questions, and were given more information about prognosis by their oncologists. Importantly, the study showed that when only the prompt sheet was provided, patients' anxiety increased and consultations were longer. However both these trends were reversed when the oncologist specifically endorsed and addressed the prompt sheet. Therefore, it is essential for facilitatory material to be used appropriately.

CONCLUSION

The detection of distress in cancer patients and its management is an important aspect of clinical care. Patients may indicate that they are emotionally distressed either verbally or non-verbally. However, many barriers inhibit the ability of doctors to detect whether their patients are distressed. Patients may normalize or somatize their feelings, or feel it is not appropriate to discuss them. Clinicians may not possess the skills and knowledge needed to detect distress. As anxiety and depression can mimic the physical symptoms of cancer or treatments, this can also reduce the probability of detection.

The use of relatively simple techniques in consultation affects the amount and type of information patients give during consultations. Examples of these techniques include active listening, using open questions and emotional words, responding appropriately to patients' emotional cues, and use of a patient-centred consulting style. In addition, screening tools for psychological distress and patient question prompt sheets may be useful in the identification and facilitation of discussions of emotional concerns.

Unfortunately, there are limited opportunities for oncologists to receive adequate training in these skills. An important step is to devise effective training programmes to enhance clinicians' communication techniques to elicit, recognize, and respond appropriately to their patients' emotional cues. A randomized controlled trial of such training programmes should determine whether implementing these skills successfully reduces patient psychological morbidity.

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COMMUNICATING WITH PATIENTS WHO ARE ANXIOUS

Although some anxiety in response to a stressful life event is normal, in some cases anxiety can interfere with relationships, social or occupational functioning and health-related behaviours. Prevalence estimates for anxiety in patients with cancer range from 15% to 23%¹ with 30% experiencing clinically significant anxiety problems.²

Symptoms associated with anxiety include heightened physical arousal, sleep disturbance, impaired concentration and decision-making, agitation and anger. Avoidance of distressing issues and situations, and excessive reassurance-seeking, may also indicate anxiety problems. These responses can have a major impact on the individual's functioning and that of their family. In addition, such disorders adversely impact on capacity to cope with disease burden, and may reduce patient adherence to recommended treatments.

Ask scanning questions: When talking to people with cancer about their concerns and psychological well-being, it is helpful to ask specifically about anxiety. For the person who raises concerns, further questions will clarify the extent of anxiety symptoms and their impact. It is difficult to determine when anxiety becomes pathological in cancer patients, as the threat is real rather than imagined, and the degree of threat changes over the course of the illness and treatment. It is suggested that symptoms that are unacceptable to the patient, and/or that cause impairments in functioning should be used as indicators of anxiety in oncology patients.³ Furthermore, when the health professional does not rush to reassure the patient, it models that the distress is not overwhelming and can be dealt with.

Acknowledge and normalise anxiety: Cancer is threatening, and understandably many patients are anxious in response to that threat. However, it is important not to give simple reassurance. While this may result in a short-term dissipation of anxiety in the course of the consultation, it is often ineffective in durably resolving the patients' anxiety.³

Suggest taking some deep breaths: It is difficult to communicate with patients when they are overtly displaying symptoms of anxiety, particularly when speech is rapid and jumbled, and the person is agitated and restless. By asking the patient to take a few deep breaths, the clinician can gain the patient's attention and manoeuvre a break in the patient's conversation, to enable the degree of anxiety to be assessed.

Explore the main source of anxiety: When patients are asked to assess their symptoms and functional status, they may selectively report the problems which are most threatening to them. The patients' perceptions of the extent of threat related to some symptoms may differ from the perceptions of clinicians.³ Therefore, eliciting the concerns of the patient beyond a symptom itself and exploring and correcting the ways

patients interpret the symptoms they experience may be most likely to enduringly reduce anxiety.

As well as the threat of cancer itself, many of the treatments, procedures and investigations can cause anxiety. The major perceived threats to patients from these procedures include fear of pain, possible diagnoses, anaesthesia, death, disability, loss of control and separation from family.⁴ Furthermore, patient's families often transmit their own fears and anxieties that reinforce patients' concerns.

Explore how anxiety has been managed in the past: Many people have previously been experienced stressful situations, and developed strategies to cope with these. It is useful to explore with people what has worked in the past, and to reinforce this.⁵

Encourage and reinforce the use of coping strategies: If patients are anxious about particularly threatening procedures, specific coping skills such as simple relaxation and breathing exercises, or cognitive coping skills such as attention diversion exercises or coping statements can be useful.⁶

Check that informational needs are met: Giving information can help anxious patients.³ Many patients want more information about their cancer but may be reluctant to ask for information. Other patients may not know what information they need. Without accurate and easy to understand information patients may retain lay perceptions that are 'worse than the facts'.⁷ Knowledge may therefore achieve reduction in anxiety, when it is tailored to the patient's individual needs.⁸

Repeat information as retention of information will be lower: Studies have shown that patients forget up to one-third of what they are told in consultations, even under non-anxiety provoking situations. Giving simple concrete advice, and repeating it, enhances recall.⁹

Tell patients they don't need to rush to make decisions: Give patients a timeframe for decision making: It is difficult to make decisions when feeling anxious. It is also likely that decisions made under these conditions will contribute to later anxiety about whether the right decision has been made. To reduce this likelihood, clinicians can recommend a timeframe within which to work.

Give additional written information: Ley and colleagues⁹ have reported that providing written information increases knowledge of investigations and improves compliance. It is important, however, that written information is not used as a substitute for verbal information. A variety of strategies have been found to increase recall of information, including providing written information, using diagrams, summarising and repeating important information.

Referral: It is important that clinicians recognise their own level of training and skill in psychological care, and refer patients whose problems are complex or beyond their training and expertise to specialised services. It is also recommended that patients considered to be at risk for psychological problems are referred to specialised psychological services early in the course of treatment, as this may minimise the likelihood of their developing significant disturbances.¹⁰ Establishing optimal methods for referring patients to professional help is vital in ensuring good psychosocial care for patients with cancer. All health professionals need to develop their own referral network for supportive and psychological care of their patients. This network would optimally comprise psychiatrists, clinical psychologists, social workers and/or occupational therapists with expertise in cancer issues and with whom the health professional can communicate about their patients.¹¹

RESPONDING TO PATIENTS WHO BECOME DISTRESSED IN CONSULTATIONS

Distress which is a normal response to a potentially life threatening event is not the same as a clinically significant condition. The difference between the two is often difficult to determine. It is common for cancer patients to experience transient feelings of low mood, apprehension and worry during their diagnosis and treatment. When these feelings become persistent, or begin to affect functioning, they become clinically significant.¹² This may occur particularly if the initial feelings are not acknowledged and dealt with. The National Health and Medical Research Council (NHMRC) in Australia have adopted the position that any indication of distress requires attention and should be managed appropriately.¹³

Clinicians are responsible for the psychosocial care of their patients as well as their surgical and medical care. Provision of such care and support entails more than referral to psychosocial services, and may be as simple as a shared emotion, an encouraging personal word or a physical touch.¹¹ Patients who are provided with an opportunity to explore feelings with a member of the treatment team or a counsellor experience less psychosocial distress than patients not provided with this opportunity.¹⁴

Sit quietly through the tears: Clinicians often feel uncomfortable when patients start crying, and feel that they should 'do' something. However, crying is a natural reaction to information that is distressing, and when discussing personal issues related to cancer and its impact. Patients should be encouraged to express their feelings.¹¹ No-one has ever failed to stop crying.¹⁵

Offer tissues: Offering tissues gives patients “permission” to express their emotions.

'Normalise' the experience: Patients experience a range of emotional and social difficulties. Episodes of intense, unpleasant and distressing emotions such as tearfulness, fear and anger are part of the normal range of responses to a stressful event. These reactions are very common, are usually occasional, rarely last more than a day or two, and are not indicative of disorder.¹¹ The aim of normalising is to let patients know that they are not alone. One way to "normalise" the experience is to refer in a de-identified way to other patients who have experienced similar distress which they have overcome. However, it is important not to trivialise patients' experiences, by explaining away distress as "normal" and not worth discussing and dealing with.¹⁶ Simple statements along the lines of: "This is really tough" or "This would be distressing for anyone" are really useful.

Respond appropriately and with empathy: Empathy is the ability to perceive accurately the feelings of another person and the ability to communicate this understanding to them.¹⁷ When empathy is accurately conveyed, a patient may react with strong emotions and tears. Patients may feel that "At last someone who understands how I feel and doesn't tell me to put on a brave face." Patients' psychological adjustment improves when clinicians express empathy and listen actively.¹⁸

Move closer, lean forward: Non-verbal aspects of communication are important for conveying attention and openness to a client/patient. Facing patients squarely is a posture that indicates involvement. A slight inclination towards the patient is interpreted as "being with the patient", and being interested in what they are saying and doing.

If writing, put your pen down: Writing while a patient is speaking indicates that they are not being listened to, and what they are saying and expressing is not important.

Give the patient your full attention: Facing the patient squarely and actively listening to what they say, indicates interest in what the patient is saying, and gives legitimacy to the emotions expressed and information that is given. Patients who are provided with an opportunity to explore feelings with a member of the treatment team or a counsellor experience less long-term psychosocial distress than patients not provided with this opportunity.¹⁴

Ask "Do you want to talk about this now?": Patients may at first feel reluctant to discuss the reasons behind their distress and, in fact, may not have articulated them previously. If patients do not wish to discuss underlying issues in a particular consultation, it is important to leave the way open for this discussion in future consultations. How?

Don't advise or reassure until all information is on hand: If the person does feel able to talk about their concerns, it is essential that the clinician has all relevant information on hand, before stepping in to advise and/or reassure. The first issues that

are raised may not necessarily be those that are causing most distress to patients. Premature reassurance may act to block the person from expressing the issues that are affecting them most.¹⁶ Standing back from premature reassurance is often surprisingly difficult for clinicians who often have a deeply held sense of wanting to ease distress and offer reassurance.

Explore social support: Members of the treatment team should ask patients about their key support people, to define the level of involvement of these people, and clarify if they are providing the type and extent of support desired by the patient.¹¹ Special attention should be paid to the partners of patients, recognising that this may be someone of the same sex. Explicit conversations are needed between clinicians, patients and their family to negotiate the expectations and needs of each.¹⁹ Once the level of support from a partner has been established, couple therapy may be considered. This has been shown to improve the couple's supportive communication, reduce emotional distress and coping effort, and improve sexual adjustment in women with breast and gynaecological cancer.²⁰ Early interventions can help with emotional distress and family functioning and support.²¹

Offer practical support, e.g. cup of tea: Expressing strong emotion and discussing personal issues can be draining. Offering a hot or cold drink can be helpful. It also allows an opportunity for the patient and the clinician time to gather thoughts, and continue with other aspects of the consultation, if appropriate.

RESPONDING TO PATIENTS WHO ARE ANGRY

Anger is a common and normal reaction, signalling frustration and annoyance when events go contrary to expectations and needs are not met. Patients may react with anger to the knowledge that they have developed a serious disease that may lead to bodily mutilation and shorten their life. Patients may feel it is unfair that this has happened to them and not others.

Loss of control is another common cause of anger, for example, when patients find themselves dependent on others, especially if they have previously been dominant and independent. They may feel angry at their own powerlessness to affect the outcome, and angry with themselves if they feel that their past behaviour has contributed to the disease.

Patients may also be angry for a specific and justifiable reason, such as a late diagnosis, delayed referral, and perceived inadequate care or uncontrolled pain. Importantly, anger may be caused by events unrelated to their illness, such as family problems. It is important not to overlook the possibility that alcohol or drug use or withdrawal may be involved in presentations where the person is irritable or angry. Similarly, delirium is common but often overlooked in cancer patients, and may present as irritability and uncooperative behaviour.

In moderation, anger can be a useful motivator for action and an antidote to depression and hopelessness. Inappropriate levels of anger, out of proportion to the reasons being disclosed, can lead to verbal and even physical abuse, and decisions which may later be regretted.

Stay calm: Initially, it is useful to acknowledge that a difficult situation has arisen and use a calming strategy such as taking a deep breath, counting to ten, or looking away for a moment. Others suggest turning the body slightly, so the force of the anger seems to go past. Most people are unable to sustain a high level of anger for very long, especially if there is an empathic response to the anger. Just staying in the room can be helpful.

Listen actively: It is helpful to begin by actively listening to understand what the patient is saying, and why he or she is angry. Active listening involves making good eye contact, nodding, and listening to what the problem is without interrupting.²²⁻²³ It is also useful to paraphrase what the patient says and to ask clarifying questions.

Do not take it personally and do not get defensive: Directly challenging patients' interpretation or criticising them for their reaction usually escalates the situation. It is more important to try to understand the underlying causes of the patient's anger.

Do not get into an argument and do not yell back: A study from the USA found that doctors whose patients reported that they had been yelled at by their doctor were more likely to be sued than other doctors.²⁴

Acknowledge anger and explore the reasons for anger: It is important that patients know early in the consultation, in a non-judgmental way, that their anger is recognised. The words used to acknowledge anger need to be at the appropriate level of emotion, otherwise the situation may be escalated. Patients whose anger is acknowledged feel listened to and validated.

Focus on the person's needs, not their manner or words: Unless the person's underlying needs are ascertained and addressed, it is unlikely that the anger will dissipate.

Apologise if appropriate: If a genuine wrong has occurred for which the health professional is responsible, it is important to apologise. Apologies for major problems such as delay in the clinic, or a mix-up in appointments can reduce patient distress and reduce the chance of angry complaints from patients who thus feel acknowledged and respected. Patients who have undertaken medical litigation report that an explanation and apology would usually have satisfied them and averted the need for legal action.²⁵

Brainstorm options and offer help: Once there is a clear understanding of the problem, it may be appropriate to brainstorm solutions with the person. However, it is important that the clinician does not leap in to 'fix the problem'; as the solution may be simpler or different to the clinician's perceptions. If a solution can be decided upon, the clinician may be able to offer assistance. If the problem cannot be resolved immediately, an explanation can be given on how long it will take, and when the clinician can back with a solution, eg an appointment with another staff member.

Look for other emotions (fear, sadness) and explore appropriately: Once anger has been expressed, underlying feelings of anxiety or fear may emerge. It is very useful to begin exploring these feelings, where the real needs may lie.

After the consultation: Reflect on factors which may have contributed to the situation, including identification of personality factors within the patient, the system in which they are being treated, and your own responses and those of other staff, and consider strategies to reduce the risk of similar problems for this patient and others in the future.

RESPONDING TO PATIENTS WHO SHOW SIGNS OF CLINICAL DEPRESSION IN CONSULTATIONS

The key symptoms of depression include low or flat mood or loss of interest in things that used to be enjoyable. The diagnosis of a major depressive episode in physically healthy people relies heavily on symptoms such as anorexia, insomnia, anergia, fatigue, weight loss and reduced interest in sex. In patients with cancer, these symptoms may also be related to the disease process or treatment side-effects.^{13,26}

Evidence shows that clinicians are strongly influenced by explicit depressive symptoms, such as crying and depressed mood²⁶; however, these symptoms are not the most reliable indicators of depression. Nonverbal cues to depression include a depressed face, downward gaze, self-touching, drooping posture, and slowed speech.²⁷

Ask scanning questions: A diagnosis of a major depressive episode in patients with cancer is best evaluated by the severity of depressed mood, loss of interest and pleasure, the degree of feelings of hopelessness, guilt and worthlessness, and the presence of suicidal thoughts.²⁸ Recurrent tearfulness is often accompanied by social withdrawal and loss of motivation. The patient may feel they are unable to control the negative feelings and these feelings begin to dominate the day, on most days for two weeks or more. Ask about thoughts of self-harm. Clinicians may feel concerned that to ask such a question will put the idea into a person's head, but there is no evidence that this is the case, and patients are often relieved to discuss the distress they feel.

Identify risk factors: Patients who are younger, have higher disease or side-effect burden, and poorer prognosis have increased risk of depression. Social isolation and perceived poor support are also risk factors. A past history of depression is one of the single biggest risk factors for development of depression in cancer patients. Identification of risk factors may be helpful in evaluating if distress amounts to a major depressive episode.

Indicate concern about the patient: The extent to which a person with cancer has support and feels supported has been identified as a major factor in their adjustment.²⁹

Indicate that depression is common and important: Studies report prevalence rates for depression among patients with cancer that range from 20%-35%.³⁰⁻³² Patients who are diagnosed with cancers with poor prognosis, such as pancreatic cancer, and high disease burden are especially vulnerable to psychological distress, and high depression rates have been reported in these populations.³³ Significant psychological distress has been reported in 43.4% of patients with lung cancer.³⁰ Without trivialising the significance of the problem to the person, it is important to acknowledge that depression is a common and highly treatable consequence for many people coping with stressful and difficult situations. Co-morbid psychological conditions can severely impact the treatment and recovery of patients. For example, depressive symptoms can result in greater pain and poorer physical and social functioning.³⁴ Depression can affect both the severity and number of side effects, and lead to greater anxiety and fatigue experienced by cancer patients.³⁵ Moreover, depressed patients have higher utilisation of medical services, higher medical costs, and longer hospital stays than non-depressed patients.³⁶⁻³⁷ There is some also evidence that patients who are depressed may be less likely to accept treatment for their cancer.³⁸

Emphasise that depression is worth treating and that there are effective treatments: It is important for all health professionals involved in the care of patients with cancer to have an understanding of depression, and to be aware of the effective treatment modalities. Staff who are well-informed will be able to more confidently support patients who are receiving specialised psychological treatment. Psychotherapy, along with pharmacotherapy, is integral to treatment, and has a positive effect on depression in patients.³¹ Psychotherapy includes specific attention to the unique meaning of the cancer, and the fears and concerns of the particular patient. Specific components may include facilitation of emotional expression, and coping skills training, as well as cognitive techniques to deal with distressing thoughts and feelings.³⁹ Cognitive-behavioural and stress management techniques have been shown to reduce depression in women with breast cancer.⁴⁰ A range of pharmacological agents have been shown to have an effective role in the management of anxiety or depressive disorders. In many instances, a psychiatrist will initiate treatment with these medications.

Suggest that the patient be referred to a specialist in psychosocial matters: Some patients may resist referral, as they may not want to acknowledge psychosocial difficulties or their inability to cope with these. Such attitudes might also come from patients' families who feel they can look after their own or fear an adverse community response to psychosocial referral. Patients might also resist referral if they do not wish to disclose concerns to another person, or want to stay with a member of their treatment team with whom they are already comfortable. Stigma can be overcome by normalising emotions and psychosocial referral.

Arrange referral: Most large metropolitan hospitals also have a psychiatric consultation-liaison service, staffed by psychiatrists, clinical psychologists, registered mental health nurses and sometimes occupational therapists who are qualified in counselling. In many cases, these services can arrange appropriate longer-term follow-up, when indicated. For those working within the private health sector, the lack of ready access to an existing multi-disciplinary team may mean the provision of psychosocial support for patients poses some difficulty. It is crucial that clinicians working in the private sector develop a referral network. Urgent psychiatric consultation should be considered for any patient who appears at risk of suicide.

Continue to monitor: Depression is a significant co-morbidity to cancer that can directly impair clinical care, as there is evidence that patients who are depressed are less likely to accept adjuvant chemotherapy.³⁸ Patients who are undergoing specialised psychological care, also need to feel supported. It is therefore important to check progress with the treatment of depression as part of routine follow-up care.

GUIDELINES FOR DETECTING AND ADDRESSING EMOTIONAL CUES

<p>1. A patient can give an emotional cue in one of two ways:</p> <p>a) Verbal cues are explicit and may describe symptoms of concern, eg “I’m feeling really upset about my diagnosis”, “I guess a lot of people feel down when they get cancer”.</p> <p>b) Non-verbal behaviours that suggest possible psychological morbidity include postural or movement cues, such as dejected pose or excessive or lack of movement, and vocal cues, such as an unmodulated or distressed tone.</p> <p>Since many patients do not spontaneously disclose emotional difficulties during medical consultations, health professionals need to elicit this information through the use of appropriate communication skills, which include active listening (see point 2) and the identification of verbal and non-verbal cues.</p>
<p>2. Perhaps the most important technique of identifying cues and distress is the use of active listening. Active listening involves using eye contact, having an open posture, slight lean forward and facilitating the patient’s disclosure through behaviours such as nodding and making noises of agreement or encouragement. The patient is more likely to disclose information if the health professional is conveying empathy and interest, both verbally and non-verbally.</p>
<p>3. Some patients may perceive that their fears and concerns are silly or unreasonable, or that their symptoms are a predictable result of their illness, and therefore do not disclose them to their doctor. When patients believe that part of the clinician’s role is to deal with emotional issues, they are more likely to discuss non-medical symptoms. Therefore, reassuring the patient that their concerns are important to address will encourage them to disclose them.</p>
<p>4. Patients and health professionals differ in their expectations as to who should take the lead in initiating discussions about emotional functioning and daily activities, with patients largely expecting the discussion to be initiated by their doctor and doctors expecting patients to raise their concerns. Asking open questions, such as “How are you feeling/finding things at the moment?” may be helpful in initiating discussion about emotional concerns, if the patient has any.</p>
<p>5. Patients with higher levels of education are more likely to request information and provide evidence of emotional needs. Health professionals should be aware of the need to probe about information and emotional needs with all patients, irrespective of educational level.</p>
<p>6. Many health professionals are not comfortable dealing with patient emotions, both because of their perceived lack of training and ability to help the patient, and because of the belief that taking on patient emotions will be time-consuming and an emotional burden for themselves. Health professionals should avoid using distancing techniques such as changing the topic, ignoring cues, downplaying the level of patient distress, or offering either false or</p>

<p>premature reassurance to avoid dealing with patients' psychological problems. Health professionals should also be reassured that appropriate responding to patients' emotional cues can actually shorten consultation times.</p>	
<p>7. The following methods can increase the frequency and identification of patient cues:</p>	
<ul style="list-style-type: none"> a) Listen to the patient with an open mind. b) Allow patients to speak their concerns without interrupting. c) Be open to the idea that patients may express psychological distress. d) Be patient-led, i.e. take the consultation in the direction the patient leads. e) Acknowledge patients' concerns and respond empathically. 	<ul style="list-style-type: none"> f) Use questions appropriately. g) Use words that have emotional content. h) Make direct requests for self-disclosure. i) Summarise patient statements/clarify patient needs. j) Be willing, and have the confidence to tackle psychological issues. k) Consider the use of external aids, such as prompt sheets or questionnaires that measure quality of life.
<p>8. Patients who are anxious during the consultation may display the following cues:</p>	
<ul style="list-style-type: none"> a) Rapid speech/Jumbled words. b) Agitation/restlessness. c) Lots of questions or repeating questions. d) Words that indicate apprehension and worry. e) Nervous laughter. f) Rapid breathing. 	<ul style="list-style-type: none"> g) Palpitation and sweating. h) Vague appearance. i) Distracted. j) Fatigue/sleeplessness. k) Impaired concentration/decision making. l) Avoidance of distressing situations/issues.
<p>The following strategies may assist health professionals to communicate with patients who are anxious during the consultation:</p>	
<ul style="list-style-type: none"> a) Ask scanning questions. b) Acknowledge anxiety. c) Suggest taking some deep breaths. d) State that anxiety is common - but avoid simple reassurance. e) Explore the main source of anxiety - explore meaning of events. f) Explore how anxiety has been 	<ul style="list-style-type: none"> g) Encourage and reinforce the use of coping strategies, e.g. relaxation, thought-stopping. h) Check that informational needs are met. i) Repeat information as retention will be lower. j) Tell patients they don't need to rush to make decisions. Give them

managed in the past.	a timeframe. k) Give additional written information. l) Refer, if warranted.
<p>9. Patients who are distressed during the consultation may display the following cues:</p> <p>a) Eyes downcast. b) Sighing. c) Hunched/closed posture. d) Short responses to questions. e) Crying. f) Verbal indications of sadness and distress.</p>	
The following strategies may assist health professionals to communicate with patients who become distressed during the consultation:	
<p>a) Sit quietly through the tears. b) Offer tissues. c) “Normalise” the experience. d) Respond appropriately and with empathy. e) Move closer, lean forward. f) If writing, put your pen down.</p>	<p>g) Give the patient your full attention. h) Ask “Do you want to talk about this now?” i) Don’t advise or reassure until you have all the information. j) Explore social support. k) Offer practical support, e.g. cup of tea.</p>
10. Patients who are angry during the consultation may display the following cues:	
<p>a) Raised voice. b) Flushed face. c) Angry words. d) Rigid control. e) Withdrawal.</p>	<p>f) Sarcastic comments. g) Dismissive comments, throwaway lines. h) Complaints about other doctors. i) Interrogatory questioning.</p>
The following strategies may assist health professionals to communicate with patients who become angry during the consultation:	
<p>a) Stay calm – breathe deeply, open posture. b) Listen actively - focus on the issue. c) Do not take it personally and do not get defensive. d) Do not get into an argument and do not yell back. e) Acknowledge anger and explore</p>	<p>f) Focus on the person’s needs, not their manner or words. g) Apologise if it is your fault. h) Explicitly indicate your desire to work with the patient to address his/her concerns i) Brainstorm options and offer help. j) Look for other emotions (fear,</p>

the reasons.	sadness) and explore appropriately.
11. Patients who are depressed may display the following cues:	
<ul style="list-style-type: none"> a) Low, flat mood. b) Little bodily movement. c) Expressionless face. d) Sadness, recurrent tearfulness. e) Loss of interest and pleasure. f) Feelings of hopelessness. g) Feelings of guilt or worthlessness. 	<ul style="list-style-type: none"> h) Social withdrawal. i) Loss of motivation; feelings of futility about treatment. j) Unable to control negative feelings. k) Dissatisfaction with relationships. l) Death wishes. m) Suicidal thoughts.
The following strategies may assist health professionals to communicate with patients who are depressed :	
<ul style="list-style-type: none"> a) Ask scanning questions. b) Indicate concern about the patient. c) Indicate that depression is common and important. d) Emphasise that depression is worth treating and that there are effective treatments. 	<ul style="list-style-type: none"> e) Suggest that the patient be referred to a specialist in psychosocial matters. f) Arrange referral. g) Ask about thoughts of self-harm to determine urgency of referral h) Continue to monitor.

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