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## Original Paper

# Helping Cancer Patients Disclose Their Concerns

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Health professionals are reluctant to enquire actively about cancer patients' concerns and feelings. They fear that probing will damage patients psychologically and believe they have had insufficient training in the relevant interviewing skills. In considering how their interviewing skills might be improved, the key question is which interviewing behaviours promote patient disclosure and which inhibit it. To test our predictions about the utility of specific interviewing behaviours, we asked 206 health professionals, who were attending workshops on communication and counselling skills, to interview a simulated patient before and after the workshop to establish the patient's current problems. They were given 20 min to do this and the interviews were tape-recorded and transcribed to permit detailed assessment by trained raters using an utterance by utterance analysis. This permitted the form, function, content and emotional level of each utterance to be rated. Correlation coefficients were calculated between specific interviewing behaviours and patient disclosure of significant information. Significant information was defined as any information disclosed by patients about their perceptions of their illness or prognosis or any adverse physical, psychological or social sequelae of their cancer and treatment. Spearman correlation coefficients were calculated between specific interviewing behaviours and patient disclosure. The use of these behaviours by those 41 (20%) of interviewers who achieved most disclosure was compared with those 41 (20%) who obtained least disclosure. Patient disclosure of significant information was promoted by the use of open directive questions, focusing on and clarifying psychological aspects, empathic statements, summarising and making educated guesses. The use of leading questions, focusing on and clarifying physical aspects, moving into advice and reassurance mode inhibited patient disclosure. Inhibitory behaviours were used 2–3 times more frequently before training than facilitative ones. Training of health professionals involved in cancer care should, therefore, ensure they acquire these positive skills and relinquish the inhibitory behaviours.

**Key words:** interviewing skills, patient disclosure, training workshops

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## INTRODUCTION

PATIENTS WITH cancer are reluctant to disclose their concerns about their disease and treatment [1]. They are even more secretive about any psychological and psychiatric problems they develop [2]. The belief that their problems are an inevitable consequence of diagnosis and treatment and there is no point in mentioning them.

Their reticence is reinforced by the reluctance of health professionals to enquire actively about patients' concerns and related feelings [3]. They fear that probing will damage patients psychologically and believe that their training has not equipped them with the relevant interviewing skills.

We, therefore, established residential multidisciplinary workshops to help health professionals involved in cancer care improve their interviewing skills through watching videotape demonstrations of key communication tasks and practicing key skills in role play [4]. We emphasised those interviewing behaviours which have been found to increase disclosure of psychological problems by patients [5–8] or relatives [9] since our experience of training health professionals in these skills suggested their use also improved disclosure of physical and social problems.

While our workshops were well received, participants questioned whether it was the use of specific interviewing skills that affected patient disclosure rather than non-specific characteristics of the health professional. While there is a consensus that specific communication skills can be taught effectively [10], it is less certain that their use increases patient disclosure of key

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information [11]. We conducted, therefore, a study to test our hypotheses about which behaviours promote and which inhibit disclosure.

## MATERIALS AND METHODS

All those health professionals who participated in one of 12 consecutive workshops were included.

### *Workshops*

The workshops were residential and of 3 or 5 days duration. Between 16 and 20 health professionals attended each one. The agenda was set by the participants who identified the communication tasks they most needed help with and put them in order of priority. A videotape of a consultation which demonstrates a model of assessment was then shown and discussed. Participants were next split into two groups so that they could practice assessing patients' concerns and other key tasks in role play [4]. There was a further videotape session on how to break collusion, a discussion on emotional survival and a final session on 'unfinished business', that is, communication issues which had not been dealt with.

### *Assessment*

Immediately before the workshop began, each participant interviewed a simulated cancer patient. The participant was asked to spend 20 min eliciting the patient's current problems. The interview was recorded on audiotape to permit later transcription and rating.

At the end of the workshop, each participant interviewed a different simulated patient but under identical conditions. Simulated patients were used because they allow the complexity of the patient history to be standardised and yet provide an accurate picture of how an individual would perform with a real patient [12, 13]. Their value in training has been well described [14]. On each assessment occasion, each simulator was interviewed by three participants. Each simulator attended on three or four occasions.

### *Simulated patients*

These were recruited by advertisement in local newspapers. Respondents who had experienced cancer themselves but recovered from it or had experienced it in close relatives and wished to put that experience to good use were shortlisted. They were assessed at interview to determine if they had worked through their experiences sufficiently to be able to cope with simulations and to check if they could represent their experiences as though they were happening currently. Those meeting these criteria were helped to develop a realistic history. Since these histories were based on real experiences of cancer, they naturally contained concerns and problems (physical, social, psychological and spiritual) which were representative of true cancer patients' concerns. Patients were re-interviewed 1 week later to elicit a history of their current problems to check that they portrayed these realistically. The interview was recorded on videotape to permit feedback and discussion of the history. Particular care was taken to check that simulators could portray the problems and related emotions without detriment to their psychological adjustment.

### *Rating system*

To examine our hypotheses, we needed a rating system which would allow us to examine the sequence of utterances and frequency of key events [15]. Since an utterance by utterance

analysis permitted this [6,7], we adopted that method. Since no existing rating system was specific enough to meet our needs, we developed a new one according to four criteria.

- (1) It can accommodate distinctive and special features of clinical interaction [16].
- (2) It can identify infrequent but vital exchanges [17].
- (3) It can measure subtle verbal cues given by the patient [18].
- (4) It provides a multidimensional framework consisting of internally consistent categories which are exhaustive but mutually exclusive [19].

Each interviewer's utterances were rated according to their form (for example, statement, question), function (for example, checking, clarifying) and content (for example, physical, social, psychological). Patients' utterances were rated according to their content (physical, social, psychological) and emotional level (0 = no mention of feelings; 1 = hint of feeling; 2 = mention of feeling; 3 = actual expression of feeling).

The manual detailing the rating system is described in a report to the Cancer Research Campaign [20] (available from the first author).

Each audiotape was transcribed to permit a trained rater to rate each utterance made by the interviewer and simulator.

### *Reliability of ratings*

Agreement between two raters was determined by asking them to rate three transcripts. The assessment of reliability was based on a total of 322 interviewer and 131 patient utterances. Acceptable levels of agreement were obtained for form (91%), function (81%), content (87%) and emotional level (82%).

### *Significant information*

The content of patients' utterances was judged to be 'significant' if it included information about their perceptions of their disease or prognosis or any adverse physical, psychological or social sequelae of their cancer and treatments. Thus, information elicited about the severity of pain, worry about prognosis or concerns about loneliness were rated as significant.

### *Hypotheses about disclosure*

Our predictions were based on work by Cox and associates [9], Marks and associates [5], Goldberg and associates [6,7], Maguire and associates [8] and Maguire [2], and our experiences of training health professionals in cancer care.

We predicted that disclosure of significant information would be facilitated by using open questions ('How has chemotherapy been affecting you?'), questions with a psychological focus ('What do you think is wrong with you?'), clarification of psychological aspects ('You say you have been worrying. In what way?'), screening questions ('Any other problems?'), and educated guesses ('I get the feeling you have more problems than you have admitted?').

We predicted that disclosure would be inhibited by closed questions ('Have you had any pain?'), leading questions ('You have taken chemotherapy in your stride, haven't you'), focusing on physical aspects which might direct disclosure away from psychological impact ('How has your breathing been?'), clarifying these ('What is it like at worst?'), giving advice ('Let me tell you what we should do next') and reassurance ('I'm sure we'll get you better'). We hypothesised that reassurance and advice would inhibit disclosure especially if offered before the patients' problems had been fully explored (premature advice, premature reassurance).

### *Hypotheses about mention of feelings*

We predicted that open directive questions, questions with a psychological focus, clarification of psychological aspects and educated guesses would encourage patients to mention feelings. We also hypothesised that educated guesses put in a negotiating style ('As we talk I get the feeling that you could be feeling very angry') versus direct style ('You are feeling angry') and use of empathic statements ('It sounds like you have been to hell and back') would also be effective.

We considered that mention of feelings would be inhibited by focusing on and clarifying physical aspects, giving advice and offering reassurance.

### *Analysis*

Correlation coefficients (Spearman) between specific interviewing behaviours and the amount of significant information elicited were calculated. Correlations between interviewing behaviours and mention of feelings were determined similarly. To further test specific behaviours, the top and bottom 20% of participants in respect of their ability to promote disclosure of significant information were compared using the Mann-Whitney *U* test. The top and bottom 20% of participants in respect of promoting the mention of feelings by patients were also compared. The interviews before and after the workshops were analysed separately since it was inappropriate statistically to pool the data as a training intervention had occurred between the assessments and the data were not comparable.

## RESULTS

### *The final sample*

Two hundred and six (95%) of the 216 health professionals who attended the 12 workshops completed the interviews before and after the workshops. This sample included 49 (24%) doctors, 134 (65%) nurses, 15 (7%) social workers, eight (4%) psychologists and others. All were experienced in cancer care.

### *Disclosure of significant information*

Questions with a psychological focus ( $r = 0.38$ ,  $P < 0.001$ ), clarifying the responses ( $r = 0.34$ ,  $P < 0.001$ ), educated guesses ( $r = 0.19$ ,  $P < 0.003$ ), open directive questions ( $r = 0.14$ ,  $P < 0.026$ ) and empathy ( $r = 0.16$ ,  $P < 0.01$ ) correlated positively with patients' disclosure of significant content before training. Screening questions correlated negatively with disclosure of significant information before training ( $r = -0.14$ ,  $P < 0.025$ ).

After training open directive questions ( $r = 0.42$ ,  $P < 0.001$ ), questions with a psychological focus ( $r = 0.39$ ,  $P < 0.001$ ), clarification of psychological aspects ( $r = 0.54$ ,  $P < 0.001$ ), educated guesses ( $r = 0.15$ ,  $P < 0.02$ ) and empathy ( $r = 0.18$ ,  $P < 0.005$ ), and summarising ( $r = 0.17$ ,  $P < 0.009$ ) correlated significantly with disclosure of significant information. Disclosure of significant information before training was inhibited by the use of leading questions ( $r = -0.34$ ,  $P < 0.001$ ), clarifying physical aspects ( $r = -0.31$ ,  $P < 0.001$ ), questions with a physical focus ( $r = -0.14$ ,  $P < 0.027$ ), giving advice ( $r = -0.17$ ,  $P < 0.008$ ), and premature advice ( $r = -0.14$ ,  $P < 0.024$ ).

After training only three of these behaviours were still inhibitory: leading questions ( $r = -0.20$ ,  $P < 0.003$ ), giving advice ( $r = -0.17$ ,  $P < 0.008$ ) and premature advice ( $r = -0.16$ ,  $P < 0.011$ ).

The top 20% (41) of participants in obtaining significant information before training when compared with the bottom

20% (41) had asked more questions with a psychological focus ( $P < 0.001$ ) and clarified the responses more often ( $P < 0.001$ ). They used fewer screening questions ( $P < 0.02$ ), gave more advice ( $P < 0.03$ ) and clarified physical aspects less ( $P < 0.01$ ). After training, the top 20% (41) asked more questions about psychological aspects ( $P < 0.001$ ), clarified these more ( $P < 0.001$ ) and made more educated guesses ( $P < 0.03$ ) than the bottom 20% (41). They gave less advice ( $P < 0.01$ ) and clarified physical aspects less ( $P < 0.014$ ).

### *Mention of feelings*

Before training, the mention of feelings by the patient was positively correlated with questions with a psychological focus ( $r = 0.17$ ,  $P < 0.009$ ), clarification of psychological aspects ( $r = 0.19$ ,  $P < 0.004$ ), the use of educated guesses ( $r = 0.24$ ,  $P < 0.001$ ) and empathy ( $r = 0.15$ ,  $P < 0.017$ ). After training, mention of feelings was promoted by the use of open directive questions ( $r = 0.24$ ,  $P < 0.001$ ), questions with a psychological focus ( $r = 0.24$ ,  $P < 0.001$ ), clarification of psychological aspects ( $r = 0.42$ ,  $P < 0.001$ ) and empathy ( $r = 0.23$ ,  $P < 0.002$ ).

The asking of questions with a physical focus ( $r = -0.15$ ,  $P < 0.02$ ), clarifying physical aspects ( $r = -0.24$ ,  $P < 0.001$ ), and giving advice ( $r = -0.17$ ,  $P < 0.009$ ), correlated negatively with the mention of feelings before training. After training, only giving advice ( $r = -0.18$ ,  $P < 0.006$ ) and giving reassurance ( $r = -0.14$ ,  $P < 0.024$ ) correlated negatively with mention of feelings.

When the top 20% (42) of participants were compared with the bottom 20% (41) in respect of their ability to promote the mention and expression of feelings in the interview before training they used significantly more educated guesses ( $P < 0.001$ ) and less clarification of physical topics ( $P < 0.006$ ). After training, the top 20% (41) used more clarification of psychological aspects ( $P < 0.001$ ), more empathy ( $P < 0.002$ ), and educated guesses ( $P < 0.024$ ) and more advice ( $P < 0.007$ ) than the bottom 20% (40).

## DISCUSSION

We were encouraged that most of our predictions about facilitatory and inhibitory behaviours were confirmed. However, we acknowledge that some of the correlations were relatively weak despite being statistically significant. Inspection of the transcripts confirmed that use of the key behaviours produced important effects in the predicted directions. This was especially true of questions with a psychological focus, clarification of psychological aspects and the use of open directive questions which increased disclosure of significant information two- to three-fold. The use of leading questions and clarifying of physical aspects strongly inhibited subsequent disclosure of significant information.

The benefits of open directive questions and empathy in promoting mention of concerns and feelings were more pronounced after training because they were used infrequently beforehand. They appear effective because they signal to patients that the interviewer is interested in eliciting their concerns and feelings about their illness and treatment. Our findings accord with those from general practice [21] and a study of mothers whose children were referred for psychiatric help [22].

In contrast, leading questions which focused on physical aspects and time spent talking only about physical aspects led patients to believe that the doctor or nurse was only interested in these. However, the differing effects of questions with a

psychological versus physical focus pose a real dilemma for the health professional. How can both aspects receive adequate attention within a consultation, especially when time is short.

The health professional with a physical focus will tend to cover only psychological and social aspects towards the end of a consultation. Those who begin by emphasising psychological aspects may lead patients to believe they have no interest in physical matters. Only an integrated approach where a history of presenting complaints is accompanied by questions about a patient's perception of events and emotional reactions are likely to overcome these barriers.

The inhibitory effects on disclosure of moving into advice and reassurance mode confirms findings from general practice [23, 24]. Most doctors offer advice before patients have had a chance to mention all their key complaints [25], and these hidden problems remain undisclosed at subsequent consultations. Lack of time is often given as a reason for doctors and nurses limiting their attention to the first problem offered by the patient. However, it takes only an average of 60 s longer for the physician to elicit all the patient's current problems [26].

The unexpected benefits of summarising were due to patients feeling that the interviewer was listening to them. Against our predictions, screening questions failed to promote disclosure of significant content. This appeared to be due to screening questions being limited to enquiry about physical symptoms.

Before training, the health professionals used significantly three times more inhibitory than facilitative behaviours regardless of their age and experience. This should not be surprising given the lack of training in these interviewing skills at undergraduate and postgraduate level, and their fears that probing psychologically may harm the patient. This may also explain why so few interviews contained any expression of emotions by patients.

Future training of health professionals in cancer care should, therefore, concentrate on helping them adopt a more effective style of questioning, focus on and clarify psychological aspects, use empathic statements and educated guesses. They also need to learn to delay offering advice and reassurance until they have established their patients' key problems and related feelings, particularly as the number of undisclosed and unresolved concerns has been found to be an important predictor of later anxiety and depression [27].

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