



# Communication Skills and Psychological Training in Oncology

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Preserving the best possible quality of life for cancer patients and their families has become a major goal in cancer care. However, the cumulative effect of stressors related to cancer care, many of which involve communicating with patients and relatives, may lead to the development of burnout in staff. Many health care professionals lack the psychosocial knowledge and communications skills needed to identify patients' problems because general professional training focuses on technical care. Teaching strategies known as psychological training programs (PTP) are therefore being developed to help improve health care professionals' sensitivity to communication problems with patients and relatives. Cognitive (e.g. theoretical information), experiential (e.g. case-history discussions), behavioural (e.g. role-playing exercises) and supportive (e.g. stressor identification) training techniques are used to teach the essential skills of good communication, i.e. listening, empathy, response to cues and appropriate use of reassurance. PTP range from one-day courses and residential workshops to full-time 1- or 2-year curricula. However, one of the main obstacles to implementing PTP is scepticism among health care professionals about its usefulness. Research on training effectiveness should therefore be developed to assess the impact of communication skills on quality of care and patients' quality of life. © 1997 Elsevier Science Ltd.

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## INTRODUCTION

SEVERAL STUDIES provide evidence that psychosocial interventions reduce patients' psychological distress [1]. Sanson-Fisher and Maguire [2] argue that the way that doctors communicate with their patients affects not only the adequacy of the clinical interview and the detection of psychological disturbance, but also patients' compliance and satisfaction with care.

Unfortunately, a substantial proportion of the problems developed by cancer patients remain untreated [3-5]. This failure to identify many of the patients' problems seems mostly related to insufficient psychosocial knowledge and deficient communication skills among health professionals who care for these patients and their families.

Moreover, it is often recognised that caring for cancer patients is highly stressful [6,7]. Stressors are usually cumulative in oncology: critical decisions, errors yielding important consequences, communication of bad news, numerous therapeutic failures, administration of treatments with serious side-effects, contacts with mutilated/disfigured patients, emotionally loaded relationships, death of patients. Many of these stressors imply communication with patients, relatives

and colleagues. They may lead to the development of burnout which may influence quality of care, occupational life and/or institutional functioning.

Interventions and strategies have been proposed to help staff to deal with cancer care: staff selection, financial and organisational facilities, staff support groups, and also training and research opportunities. Psychological training programs (PTP) are probably the best cost-effective ways of reducing stress in cancer care and of improving satisfaction with care and enhancing quality of care [8].

## PTP OBJECTIVES

Health professionals are confronted with numerous clinical situations in which communication cannot be avoided: diagnostic disclosure, uncontrolled chronic pain, compliance problems during curative treatments, aggressive patients, informed consent, euthanasia request, suicidal risk and breaking bad news (such as poor prognosis or death). The main objective of PTP remains to make health care professionals sensitive to communication problems with patients and relatives. These problems are influenced by personal difficulties: coping with fear of death, fear of the unknown, fear of being unable to respond to patients' questions and fear of reactivating patients' distress. Good clinical practice suggests

that these complex situations should not be handled only on basis of personal intuition, but needs to acquire an expertise in communication. PTP should help health professionals to develop these skills.

Basic communication includes interviewing, informing and supporting skills. All are useful in daily professional situations for obtaining a case history, conveying information about treatment, reassuring patients, achieving patients' satisfaction and monitoring the adaptation of patients and relatives to illness and treatment. In clinical practice, some health care professionals still find it hard to elicit psychosocial as well as physical problems, or to do so without taking too much time. They frequently express a need for communication strategy guidelines. Some abilities are fundamental for a good communication, whether it is breaking bad news or eliciting patients' needs and concerns. These skills include listening, empathy, response to cues and appropriate use of reassurance.

First of all, listening gives the health professional a reference point to evaluate the problems, perceptions, needs and personal resources of the patient. Listening is a very difficult task for physicians, who are primarily inclined to act. Moreover, in medical education, the art of listening is not taught enough. Listening is facilitated by using techniques that encourage the patient to express him/herself (calm attitude, possibility of silence, etc.) and it can be usefully integrated into the process of evaluating the patient's need for information. This process must include an assessment of what the patient already knows and what she/he wishes to know. After the transmission of information, listening offers an opportunity to check whether new information has been understood [9].

Listening requires an empathic attitude which makes it possible to create confidence between the patient and his/her physician, and to obtain information on the emotions and perceptions of the patient. Empathy, however, must be conceptually differentiated from sympathy and identification with the patient and, of course, must be used in an appropriate way to suit the numerous clinical situations encountered [10].

Precise identification and assessment of the patient's problems are essential and constitute the first phase of active support. This enables health professionals to understand

patients' feelings and to anticipate (if possible) their future reactions. The attention given by health professionals to both present and future problems helps the patient in his/her own assessment of the situation. This, in turn, helps to avoid confusion and distress, which are frequent consequences of a loss of control over poorly assessed outside events. A physician assisted re-evaluation of implications associated with reality often enables the patient to regain control.

Reassurance is an important component of support. Patient reassurance takes place on two levels: by introducing external resources, for example the possibility of responding to an experimental treatment, and by utilising internal resources, for example the patient's capacity to control anxiety.

In clinical practice and during training sessions, information and emotional support are often used without any previous information taking or assessment of patients' needs. A major objective of PTP in oncology is thus to develop an understanding of the cognitive, emotional and behavioural factors influencing the information process for patients and families. It should enable one to identify the patient's objectives and requests, to detect emotional distress and to evaluate the patient's understanding of transmitted information. Each communication function is achieved by using evaluative, informative and supportive strategies. For assessing the patients' problems, evaluative strategies may use open questions, clarification and checking. According to Maguire and associates [11], the disclosure of significant information would be facilitated by using open questions, questions with a psychological focus, clarification of psychological aspects, screening questions and educated guesses. Conversely, disclosure would be inhibited by closed questions, leading questions, focusing on physical aspects which might direct disclosure away from clarifying psychological impact and might lead to give advice and reassurance prematurely, before the patients' problems had been fully explored.

Training may help health care professionals improve their ability to clearly identify the exact nature and extent of the problems encountered by patients and to feel and recognise their emotional reactions. Information has a well-known function in clinical practice but is used most often without elaboration of what has been understood. PTP allows participants to experiment with the advantages of progressive

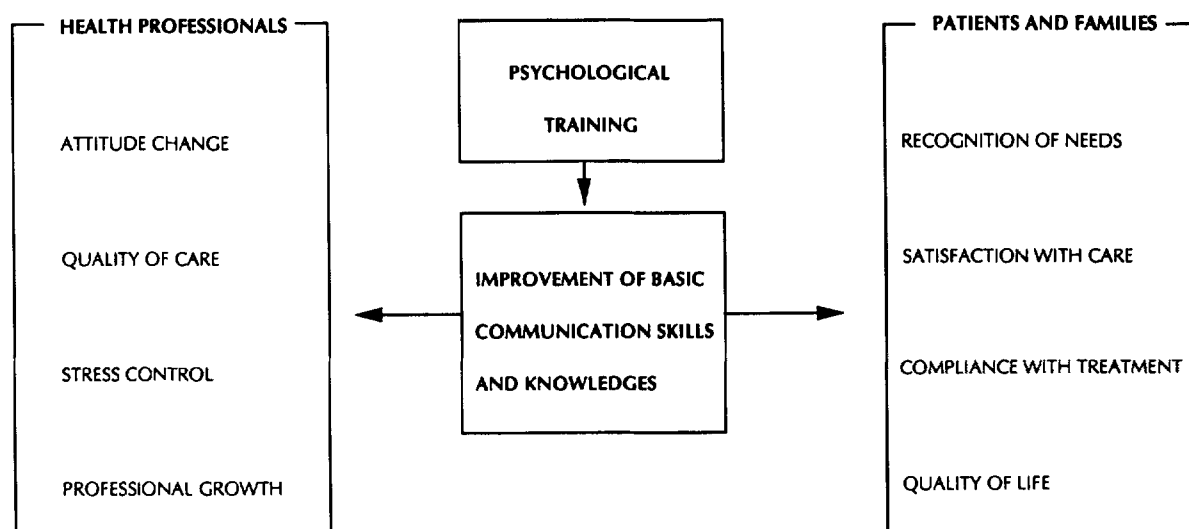


Figure 1. Impact of PTP on health professionals and on patients and their families.

information. It also highlights the need for basic but often neglected strategies such as introducing oneself and ending the interview. Support includes many verbal and non-verbal strategies such as setting up the interview and the relationship, and use of silence and empathy. Training sessions have demonstrated that all these supportive strategies often facilitate the evaluative function.

If the potential effect of PTP is the enhancement of communication skills, there are still many questions related to other potential effects such as: the impact of training on health care professionals—their attitudes, quality of care, coping with stress, professional growth—and the impact on patients—their satisfaction with care, detection of their needs, compliance with treatment, quality of life (Figure 1). The effects of training on communication skills and attitudes could be linked with a better quality of care (with higher diagnostic and therapeutic competencies) and with a more effective way of coping with occupational stressors met in oncology; however, there is insufficient empirical evidence of these relationships [12].

### PTP TECHNIQUES

In order to be effective, PTP in oncology must relate to clinical practice and the training techniques should be active. The techniques available are cognitive, behavioural, experiential, supportive. All these techniques are used more or less extensively in available training modules depending on their objectives or the trainer's skills. Table 1 describes the main training techniques.

Experiential techniques include case-history discussions, staff observations and supervisions. During a training session, case-history observation gives the participants the opportunity to present, discuss and analyse practical situations in all their complexity. The benefits of this technique are: outlining the personal strategies in communication; heightening the self-awareness of health care professionals; clarifying the areas to be explored in order to determine the nature and the extent of the patients' problems; and, finally, it also offers opportunities for exchanging information with colleagues about psychosocial aspects, which is often lacking in clinical practice. To be effective, this technique has to be used in small group sessions in order to stimulate discussion. Helping the participants to present the clinical situations seems useful: the methodology for presentation should include information on the purpose of the interview, the history of the patient, the history of the present illness, specific physical and psychosocial problems, attitude towards illness and available sup-

port. The clinical presentation should end with a question from the participant in order to stimulate discussion.

Behavioural techniques include role-playing exercises, patient interviews under observation and walking rounds. Role play has been widely used for teaching communication skills [13]. It consists of asking participants during a training session to play different roles (patient, family, nurse, physician, etc.) and then to discuss the simulated interview. Identification with roles enables participants to observe and analyse feelings, attitudes, perceptions and behaviours induced by clinical practice. It also helps in experimenting with communication strategies, like setting up the interview, getting the patient talking, controlling an interview, using assessment questions before informing and counselling. Role playing is perhaps one of the most formative techniques, but trainers must use the tool carefully, with clear instructions, in the secure context of small group sessions. When scripts are proposed, they should be as close as possible to clinical practice and realistic situations. The use of audio-visual techniques such as videotaped role-playing and video- or audiotaped patient interviews should be encouraged. According to Maguire [14], training which includes handouts detailing the skills to be learnt and areas to be covered with real patients and feedback of performance by videotape or audiotape has been found to be much superior to the traditional apprenticeship method in training medical students to elicit patients' problems. Moreover, any PTP in oncology should take into account the concerns of the health care professionals about getting too emotionally involved with patients. Such training would therefore have to address both the issues of the skills to be learnt and prevalent attitudes.

Staff support and stress management programmes include stressor identification, symptom recognition and monitoring, occupational and personal objective clarification, discussion about communication problems and sometimes behavioural techniques (relaxation). Staff support programmes benefit from a small number of participants (no more than 8–12). The good atmosphere of a group support is also related to participants' motivation, positive inputs from the authorities, experienced leadership and a regular and convenient meeting time and place [15].

### Programme content

General professional training essentially targets technical care with only limited concern for the psychological problems generated by cancer diagnosis and treatment. Few doctors and nurses involved in cancer care receive any formal training in basic interviewing, assessment and counselling skills. For those that do, the training is usually limited to non-directive methods such as listening and reflecting. While such methods are of value in some situations, they can be counterproductive with cancer patients [16].

In order to help particular specialists (such as breast cancer care, stoma care, pain and symptom control, care of children with cancer), the training programme should also focus on the psychological dimensions of supportive care and rehabilitation. Different training programs are now being proposed and the need for specific training in palliative care is now also acknowledged [17–23]. Although efforts have been made to train future professionals during their undergraduate years [24–32], this is often insufficient, because basic education focuses mostly on technical care. Time limitation does not allow for any extensive training on psychosocial aspects [33–

Table 1. Main training techniques in PTP

Cognitive courses
Behavioral role playings
Experiential case discussions staff observations supervision
Stress management stressors identification symptoms recognition and monitoring occupational and personal objectives clarification

35]. According to Walker [36], a survey carried out by the U.K. General Medical Council in 1992 found that only seven British medical schools included communication skills as a part of their final examinations.

PTP are being developed for several groups of professionals involved in cancer care (physicians, nurses, mental health professionals) working in institutions (cancer centres, general hospitals or hospices) or in home care programmes. PTP range from one-day courses to longer specific curricula which require mild to intensive involvement of participants. Most are residential workshops that take place during the weekend and are increasingly organised away from the working environment. These PTP vary in form, content and duration. They include basic and postbasic training.

In Great Britain, for example, 3–5-day residential workshops in small groups are proposed for physicians, nurses, social workers and chaplains [16, 37]. Videotaped interviews and structured role play are used. Sharing and discussing experiences gives insight into how a patient or a relative may feel, outline the positive aspects of coping with stress, help the participants to identify the risk of projective attitudes and also offer alternative communication strategies. As participants progress through the workshops, they begin to reflect on how they can apply their new skills within their own work and still survive emotionally.

Another PTP using cognitive, experiential and behavioural techniques was proposed in Belgium to health care professionals working with terminal patients [38]. The scheduling of modules was flexible to allow attendance by busy doctors and nurses. They lasted 12 h spread over 4, 6, 8 or 10 sessions. The aims were to develop a better understanding of issues related to death and dying from cancer and to foster more positive attitudes toward care of the dying.

For those who offer workshops or short training programs, a key challenge is to help participants apply what they have learned to clinical practice. Attempts to organise consolidation modules have been made. Peripatetic teachers may organise regular, short workshops for already trained participants working together [39]. The distance-learning approach may be used for individual feedback of audiotaped material; two-way radios are being developed that will enable health care professionals to be supervised during their live interviews with patients or relatives [16].

Longer PTP are increasingly being recommended and full-time courses are now available. These 1- or 2-year courses are dedicated to training in clinical practice and research; they may benefit from a third year, to consolidating the skills acquired and for training to train others. Some experimental workshops have been developed for medical consultants on the teaching of clinical communication skills. Bird and associates [40] adapted a 3 1/2 day residential workshop from a faculty development model used successfully in the U.S.A. Participants worked mostly in small groups helped by experienced trainers. The teaching style was learner centred and therefore the details of the problem-based agenda and the choice of working methods were largely determined by the participants themselves. There were also some conventional lectures and demonstrations. Evaluation by participants was generally positive.

#### *PTP effectiveness*

Up to now, little has been done to evaluate the existing training for health care professionals dealing with cancer

patients [41]. Training effectiveness can be evaluated by attitudinal, behavioural or cognitive changes. Psychological stress-related symptoms are supposed to be another variable because of their potential influence on quality of occupational life and on quality of care.

Several authors have investigated whether attitudes towards cancer or death change as a result of participation in training groups. Results reported are usually positive but evaluation is often informal. [42–47]. More formal assessment of training effectiveness does not always support the perceived success of the training programme [48–50].

Several other methodological and theoretical problems are still unresolved. What are the short- and long-term emotional, cognitive and behavioural changes induced by training? Are attitude changes linked with behaviour changes? What are the optimal content and duration for effective PTP?

Putnam and colleagues [51] studied the effects of teaching internal medicine residents interviewing techniques on verbal behaviour and health outcome. Residents were taught interviewing behaviours, mostly in individual sessions for an average of 3.7 h. The sessions covered exposition (patients talking about their concerns using their own words, rather than giving 'yes' or 'no' answers) and physician explanation (giving patients objective medical information, in addition to instructions and advice). The clinic visits during a 3-month period from both groups (11 experimental and 8 control subjects) were audiotaped, transcribed and coded according to a verbal response mode system. Using telephone interview, patient satisfaction, compliance and symptom status were determined for all patients. Two hundred and sixty-eight interviews (156 in the experimental group and 112 in the control group) were included in the study. Training effectiveness on interviewing behaviours led to a 43% increase in frequency of patient exposition (from 66.5 utterances pre-training to 95.1 post-training).

Patient exposition also increased in the interviews of the residents in the control groups, but not significantly. The results also showed that training increased physician explanation, from a mean of 24.3% to 28.2% of utterances, an increase of 3.9%; the increase was not significant. Physician explanation did not change in the interviews of the control residents. Moreover, the training intervention did not improve patient outcomes. The authors conclude that the effects of the training were probably too small to influence outcomes. Another possible reason for the lack of training effectiveness on patient outcomes is the insensitivity of the outcome measures. Patient responses show very limited changes on the satisfaction scale (most were highly satisfied) and on the symptom improvement measure (most had minor illnesses from which they recovered). The measurement of patient compliance was complicated by the heterogeneity of patients' problems and medical regimens.

Razavi and colleagues assessed the effectiveness of PTP specifically designed for health care professionals working with cancer patients. In a controlled study, the effect of a 12 h PTP was assessed with a semantic differential attitude questionnaire. The assessment was made just after the end of the training and then again one year later [41, 52, 53]. The results showed that post-training changes were particularly significant for subjects reporting negative attitudes before training. However, one year after training post-training changes were no longer noticed.

In order to improve effectiveness, longer modules were tested successively. In one of these studies, 72 oncology nurses were randomly assigned to a 24-h PTP or to a waiting list [54]. Attitudes assessed by a semantic differential questionnaire [48], occupational stress assessed by the Nursing Stress Scale [55] and communication skills assessed by standardised videotaped role-playing exercises were used to compare trained and control subjects. The results showed a significant training effect on attitudes, especially on those related to self-concept, and on the level of occupational stress related to inadequate preparation. Limited changes were found regarding post-training communication skills. Trained subjects were significantly more in control of the interview compared with control subjects. The results show that a 24-h PTP is effective. However, post-training changes in attitudes were no longer seen 2 months after training. The same trend was observed for post-training Nursing Stress Scale scores [54].

The lack of consolidation observed 2 months after training may be explained by the loss of the 'peer support group effect'. It can also be hypothesised that the trained participants do not find support and/or time in their institutions to give them the opportunity to practice their skills.

Therefore, the question of whether or not PTP should be longer and/or consolidated by several follow-up sessions should be investigated. Different questions related to the optimal number of sessions, the duration and content of the training remain unanswered. In a pilot study, consolidation modules (three monthly full-time weeks of 35 h) were assessed after an initial 35-h training week. Consolidation modules allowed more behavioural training techniques to be used (such as case discussions and role playing exercises) and discussion of the implementation of skills in every day work. The results showed a significant consolidation effect of post-training attitudes changes (8 and 17 weeks after the training) [56].

Other possible predictors such as the benefit of multidisciplinary versus monodisciplinary groups should also be investigated. A pilot study assessing post-training changes of multidisciplinary training groups shows that attitude changes were still noticeable not only just after training, but also 2 months later. This contrasts with the lack of consolidation of post-training attitude changes in the monodisciplinary group reported above. An advantage of multidisciplinary versus monodisciplinary groups may thus also be hypothesised [56].

Maguire and associates have contributed substantially to the assessment of training effectiveness. Their interest focused on key interviewing skills and in the 1980s they wrote a detailed manual assessing the form, function, content, emotional level of each patient and interviewer utterance designed to assess health care professionals' communication skills. In a recent study [57], 169 health professionals, mostly nurses, participated in a 3- or 5-day workshop. Training effectiveness was evaluated by assessing participant interviews with a simulated patient before and after the workshop and then again 6 months later. The training led to significant increases in the use of three behaviours which promote patient disclosure of key concerns: open directive questions, questions with a psychological focus and clarification of psychological aspects. There were significant reductions in behaviours which inhibit disclosure, including the use of questions with a physical focus, utterances clarifying physical aspects and giving advice prematurely. There were significant

improvements in the ability of health professionals to elicit patients key problems. There were no increases in the use of educated guesses and empathic statements, which promote disclosure of key problems and feelings.

Participants continued to worry about harming patients: inspection of the interview transcripts found that although there was a better clarification of psychological aspects and more open discussion of the patients' feelings, there was also use of blocking behaviours by the health professionals. While there were still significant improvements at 6 months follow-up, there had been some deterioration. Participants felt that they needed more practical and emotional support. This raises again the importance of the maintenance of skills over time, the follow-up support required and the need for 'booster' or 'consolidation' sessions.

Maguire's studies contribute to the evidence that, within limits, communication skills can be improved significantly with some training modules. However, there is a need for further randomised studies to evaluate the various training techniques that have been proposed (role-playing, group discussion, model interviews, discussion of video recordings of interviews containing key problems). Moreover, the impact of environmental variables on training effectiveness remains unknown: clinical practice, feedback from patients or colleagues, staff support systems.

The importance of teaching communication skills to undergraduates has been highlighted. Unfortunately, some studies have shown that communication skills deteriorate during clinical practice [36]. Maguire and associates [58] reassessed 36 young doctors who, five years earlier as medical students, had been randomly allocated to either video feedback training or conventional teaching in interviewing skills during a psychiatry clerkship. Each doctor interviewed 1 patient with a psychiatric illness and 2 with a physical illness. Each interview was rated by a trained psychologist who did not know which doctors had been given feedback training. Both groups had improved since the fourth year clerkship, but those given feedback training had maintained their superiority in the skills associated with accurate diagnosis. Both groups, however, still used closed questions and were reluctant to cover psychosocial problems in physically ill patients. Both groups also had poor performance in beginning and ending the interviews. Some of these results may be explained by doctors hurrying to complete their interviews within the allotted time in clinical practice. These results clearly justify continuation of training.

A second part of the same study assessed the impact of feedback training in interviewing skills. It was shown that most young doctors are bad at giving information. There was no difference between the interviews scores of 20 trained (feedback training) and 20 control doctors (conventional psychiatry clerkship). Most gave simple information on diagnosis and treatment, few mentioned investigations, aetiology or prognosis. Very few obtained or took an account of patients' views or expectations.

In a study evaluating the effectiveness of a 10-week teaching programme [59] using video modelling and audio feedback, 33 hospice nurses were asked to complete a audiotaped recorded assessment interview with a patient, before and immediately after training and again 9 months after training. Patients' concerns and nurses' interviewing skills were rated from audiotapes. Improvement in interviewing skills was shown to be significant from pre- to postassessment and from

pre- to follow-up assessment, for utterance forms (increase of open questions). From pre- to follow-up assessment, psychological focus but also blocking significantly increased. The authors suggest that acquired post-training skills, although significant, are still limited; for example, an average of only 10 open questions per interview were used. Moreover, the study showed a lack of improvement in the outcome of the communication, i.e. the nurses' ability to elicit and identify their patient's concern, despite their increased use of skills known to increase patient disclosure. To date, training studies have focused on the acquisition of specific microskills, recognition of psychiatric and psychological morbidity and strategies for dealing with specific situations. They have not looked at the effect of training on general ability. The present study has highlighted that basic skills training is not enough to improve nurses' ability to elicit their patients' needs. The following factors could have reduced the overall effectiveness of the training programme: the level of the nurses' objective skills; their own perception of their skills and self-efficacy; their personal beliefs and attitudes towards communicating with patients; their beliefs about the outcomes of the communication for patient and for themselves and their needs in terms of professional support. Further training modules should perhaps incorporate teaching on handling of emotions, work on attitudes and beliefs both about participants' communication skills and about the impact of their skills on patients, and thereby addressing issues of self-efficacy.

### CONCLUSION

Good communication with a cancer patient is essential in facilitating his or her best possible adjustment. For instance, it enables the patient to anticipate problems, assists rehabilitation in patients with curable cancers and avoids unnecessary distress. For some people, good communication provides an opportunity to prepare for death which is sometimes more bearable than a future which is uncertain.

However, communication is a complex process. Nowadays medicine in general and oncology in particular, face an exponential growth of scientific knowledge, and this often adds to the difficulties in the process of decision making [60]. Within this context changing attitudes of health care professionals, in favour of good communication, require more detailed knowledge of patient reactions and need for support. The more the health care professional attempts to communicate, the more the patient will react on a verbal or non-verbal level. These reactions require additional attention with regard to the patient's needs and increased readiness to offer emotional support.

However, it is unrealistic to expect physicians and nurses to support their patients in that way, and break bad news optimally for example, unless they are equipped with the necessary skills through training which is generally still unavailable. There is thus an urgent need to offer training in communication skills.

To improve the psychological and social care of cancer patients, health care professionals must be trained in basic interviewing, assessment and counselling skills. PTP should, therefore, give participants the ability to: detect, clarify and organise key verbal and non-verbal cues that patients and relatives give about their problems; to control the interview and maintain its focus, acquire precision in assessment strategies and open directive questions (e.g. dates, names, symptom intensity) and explore emotionally-loaded areas (e.g.

wish to die, prognosis, death) in a manner that is helpful and not too distressing or painful.

PTP should be available in all health care settings devoted to cancer care. Consolidation training programs should also be available to stimulate the implementation of learned skills. A special effort should also be devoted to broader competence and skills in order to respond more adequately to complex problems encountered in oncology. Ethical issues, for example, are numerous in oncology and they are often related to psychological, social, legal and spiritual aspects. Thus, ethical education may focus specifically on problems that are not targeted by PTP. Ethical education should aim at improving clinicians' ability—mostly of physicians—to identify and discuss ethical problems with patients, relatives and colleagues [61]. This specific training should prepare health care professionals to analyse and cope with the complexities of difficult clinical situations such as truth-telling, informed consent, euthanasia, 'do-not resuscitate' orders, deciding curative and palliative treatments.

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