



Review

A 3-stage model of patient-centered communication for addressing cancer patients' emotional distress



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ABSTRACT

Objective: To describe pathways through which clinicians can more effectively respond to patients' emotions in ways that contribute to betterment of the patient's health and well-being.

Methods: A representative review of literature on managing emotions in clinical consultations was conducted.

Results: A three-stage, conceptual model for assisting clinicians to more effectively address the challenges of recognizing, exploring, and managing cancer patients' emotional distress in the clinical encounter was developed. To enhance and enact recognition of patients' emotions, clinicians can engage in mindfulness, self-situational awareness, active listening, and facilitative communication. To enact exploration, clinicians can acknowledge and validate emotions and provide empathy. Finally, clinicians can provide information empathetically, identify therapeutic resources, and give referrals and interventions as needed to help lessen patients' emotional distress.

Conclusion: This model serves as a framework for future research examining pathways that link clinicians' emotional cue recognition to patient-centered responses exploring a patient's emotional distress to therapeutic actions that contribute to improved psychological and emotional health.

Practical implications: Specific communicative and cognitive strategies are presented that can help clinicians better recognize a patient's emotional distress and respond in ways that have therapeutic value.

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1. Introduction

From first diagnosis to treatment to survivorship or end of life, people with cancer often experience considerable emotional distress. Receiving a cancer diagnosis, making decisions about treatment, undergoing treatment, and concerns about recurrence

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can generate much anxiety, anger, sadness, fear, and worry for cancer patients. Emotional trauma, if unmitigated, not only is a cause of psychological morbidity, it can contribute to poorer biopsychosocial (e.g., pain, loss of physical and social functioning, fatigue) and economic outcomes (e.g., longer hospital stays and use of more money for care) [1]. Because the cancer diagnosis and treatment add a significant emotional dimension to clinician–patient interactions [2], a clinician's ability to help patients manage their emotional distress is essential. Unfortunately, clinicians often have a difficult time assisting their patients in coping with their emotional distress because they may not recognize the distress, may not know what to do when negative emotions are exhibited, may think helping with emotions is another provider or family member's job, or believe discussing the distress will harm the patient rather than help him or her [1,3,4].

While past research has indicated communication in medical consultations can influence patients' emotional experiences [3], and potentially have positive impacts on psychosocial health outcomes [2], more research needs to focus on the processes through which clinicians move through recognizing a patient's emotional needs to ultimately providing therapeutic resources as needed. The purpose of this paper is to model a pathway through which clinicians can more effectively identify and respond to patients' emotions in ways that contribute to betterment of the patient's health and well-being. The model lays out the important role communication plays in helping clinicians move from recognizing emotional distress to responding in empathic and validating ways to therapeutic value of communication, which may include, as appropriate, discussion and referral for medical intervention.

Such a model fills an important gap in the literature. First, though there is an impressive body of research that examines clinicians' (in)abilities to recognize patients' emotional cues and concerns and the reasons for this (e.g., [1,3–5]), this literature typically leaves out ways clinicians could help patients cope with negative emotions. Second, the model draws upon previous

research focused on empathic and patient-centered communication so to present ways clinicians can explore patients' preferences for discussing emotions and concerns as well as appropriately acknowledge and validate these feelings (e.g., [6–9]). Yet, 'talking' about feelings and the reasons underlying them may not alleviate emotional distress. Thus, the model also addresses communication as it relates to the possible need for therapeutic interventions such as cognitive behavioral therapies or medication.

Following a brief review of the literature on emotional distress experienced by cancer patients and its potential deleterious effects on health outcomes, a three-stage model is described to examine the challenges of recognizing, exploring, and managing patients' emotional distress in the clinical encounter.

2. Emotional distress and its sequelae

Emotional distress has been conceptualized in a number of ways. For our purposes, the National Comprehensive Cancer Network guidelines offer a useful definition: emotional distress is defined as "an unpleasant experience of an emotional, psychological, social, or spiritual nature that interferes with the ability to cope with cancer treatment. It extends along a continuum, from common normal feelings of vulnerability, sadness, and fears, to problems that are disabling, such as true depression, anxiety, panic, and feeling isolated or in a spiritual crisis" (p. 115) [10]. Important in this definition is that emotional distress exists along a continuum from normal or common negative feelings (frustration, disappointment, nervousness, bad mood) to disabling emotional states in need of treatment (depression, anxiety, hopelessness). Ineffectual management of negative emotions may also be an economic burden as emotionally distressed patients use more medical services, have higher medical costs, and stay longer in hospitals [11,12]. In short, cancer patients with intense and/or sustained emotional distress are at risk of additional biomedical and psychosocial harm in addition to that of the cancer and its treatment.

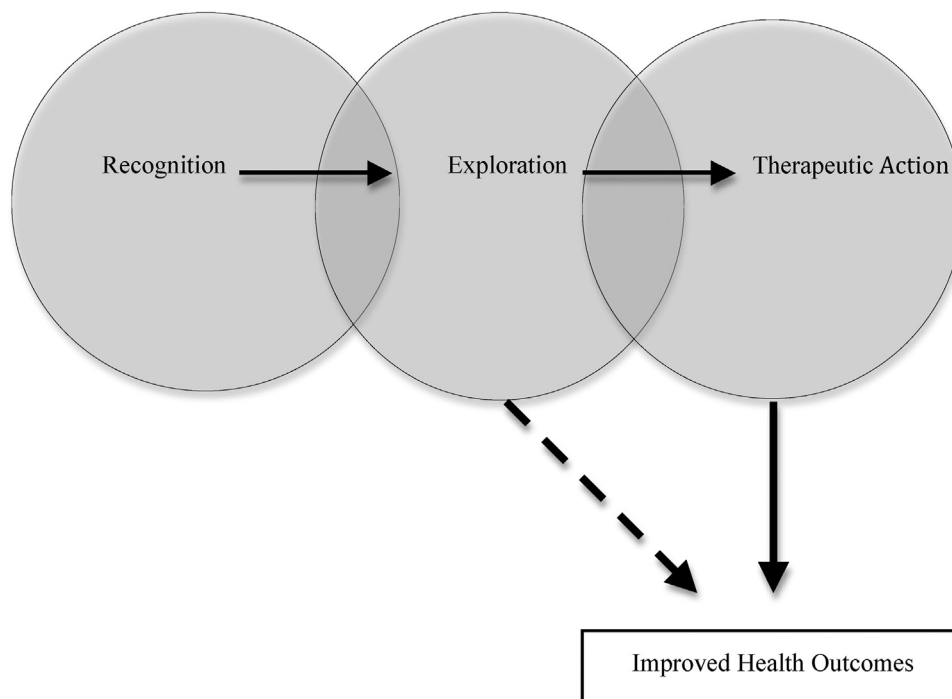


Fig. 1. A 3-stage model of patient-centered communication for addressing cancer patients' emotional distress.

3. A therapeutic approach to emotional management and support

Though the ability to effectively respond to and, if necessary, medically treat a patient's emotional distress can be a difficult challenge for cancer care providers, clinicians must still provide assistance in helping their patients deal with their negative feelings. In this next section, the three-stage model—recognition, exploration, and therapeutic action—for clinicians to help their patients more effectively and appropriately manage emotional distress is discussed (see Fig. 1). The solid line represents a direct pathway from therapeutic action to improved health outcomes as therapeutic action includes more clinical interventions for managing emotions. The dotted line represents an indirect pathway to improved health outcomes because there is some therapeutic value in recognizing and exploring emotions in terms of support offered in the relationship but not to the same extent as the stage of therapeutic action.

Next, each of these stages is described, highlighting specific cognitive and communicative strategies clinicians can utilize to

optimize clinicians' responsiveness to helping patients cope with emotional distress. Also, Table 1 provides some examples of possible clinician responses. It is important to note however that these statements are flexible in nature and rather than using them as standard language, the statements seek to determine and reveal the patient's preferences as it relates to discussing negative emotions and coping and treatment options.

3.1. Recognizing emotional distress

One of the biggest challenges for clinicians treating cancer patients and their families is recognizing emotional distress. This is due to several factors. On the one hand, cancer patients are often reluctant to disclose or they try to hide their emotions [1,13,14,20], in part due to embarrassment or not wanting to burden the clinician with their emotional distress [15,16]. In addition, patients often believe feelings such as fear and anxiety are just part for having cancer and are unavoidable [17]. Patients also differ in whether they think it is within the purview of the clinician's responsibility to help address their emotions and feelings [1,18]. Finally, some patients

Table 1

Model's stages and example clinician responses for seeking patients' preferences for addressing emotional distress.

Model's stages	Sample responses	Conversational context
Recognition	"I know you are scared about the future given this diagnosis." "I am concerned about you, and it sounds like recently you have been feeling worried a lot. Would it be correct to say that?"	C: So I know this is stressful for you, and I can tell by the way you are looking at me. P: Yes, I am pretty devastated. It's just so upsetting. C: I know it's hard, but we are going to do all we can to get you through this. P: It is so much to comprehend right now. I mean I have to make a decision about surgery, chemotherapy, and radiation. C: It sounds like you are overwhelmed with all the possible options for treatment. P: Yes, exactly!
Exploration	"As your clinician, I also want to be here for you emotionally. So if you ever want to talk about how you or your family members are feeling or how things are going dealing with all of this, please let me know." "I know this news can be scary. I cannot imagine how difficult it must be for you, your husband, and your children."	C: How have you been doing this last week? P: Well the first round of chemo was terrible. There were so many side effects. C: Uh-huh (nodding and not interrupting) P: I felt nauseated all the time for the first day, and I was so tired. (The patient continues to elaborate and the clinician actively listens through verbal and nonverbal communication.) P: I can't believe this is happening to me. C: Tell me about what's going on? P: What I mean is I am doing everything right—I am taking the medication you prescribed and going to the therapy you suggested. Why am I not getting better? C: I understand. I have patients who feel discouraged when they aren't seeing the results they would like, so you are not alone in feeling this way.
Therapeutic action	"We will figure this out together. I will be with you every step. I am not going anywhere." "There are several social support groups for patients going through similar experiences as you. I recently had a patient who had the same diagnosis as you, would you like him to contact you?"	C: I can see that you are having a difficult time. I want to help you. P: I just feel sad and alone. I hate feeling this way. C: I think there may be other clinicians who may be able to help support you during this time. Would you like to talk to a counselor or social worker? P: I am not sure. I never considered doing something like that before. C: That's fine. Why don't you think about it for a little while and get back to me. I would be happy to talk to some of my colleagues for you. Remember, we are here to help you in whatever ways we can. C: I can see that this cancer diagnosis and treatment is really taking a toll on you. P: I just feel depressed all the time. I am starting to wonder if there is any hope for me. C: I know this can be a difficult time. Would you like to try an anti-depressant, at least for a little while? It may help you feel better and cope with everything that is going on currently.

may not disclose their feelings because they are unsure whether it is important to their care, and because clinicians rarely ask about their emotional state [2].

In addition to patients' reluctance and uncertainty about disclosing negative emotions, clinicians often do not recognize a patient's (or family's) emotional cues and concerns or, when they do, they fail to appropriately respond [3,4]. Clinicians may consciously ignore emotional cues and concerns [19], perhaps because they believe addressing such emotional needs will take too much time or think their primary agenda is to focus on biomedical issues. Lastly, clinicians may not have sufficient skills or training for dealing with emotional distress [1].

So recognizing emotional distress in cancer care is problematic because many patients are unwilling or uncertain about discussing their emotions, and clinicians are either poor at recognizing a patient's emotional distress or are reluctant to address it. Clinicians need to not only provide opportunities for patients to talk about their emotions but also be more attuned when patients express emotional distress. In other words, it is not enough for clinicians to simply acknowledge their role in recognizing emotional distress; they must also enact certain strategies in order to enhance their recognition of troublesome emotions [1].

Effectively recognizing a patient's emotional distress requires both cognitive (e.g., mindful practice, self-situational awareness) and communicative strategies (e.g., active listening, facilitative communication). First, a clinician can enact mindful practice and self-awareness by being attentive to all moments, people, and tasks, by being curious, and by reflecting upon the features of emotionally difficult or unique situations [20–22]. By being attentive in this way, clinicians are better able to recognize distressed patients and respond to their concerns while not experiencing emotional contagion [23].

Second, clinicians must create or allow an opportunity for emotional distress to be a topic for discussion by engaging in active listening and facilitative communication, behaviors that help create the conversational space for patients and families to more openly discuss negative feelings [24]. Active listening means noticing and attending to both verbal and nonverbal communicative behaviors and trying to understand those behaviors from the patient's perspective [25]. Razavi and Delvaux [26] state listening is the first essential step as it is a reference point to understanding the patient's problems, needs, resources, and perceptions. Active listening, in addition to showing a genuine interest in the patient's well-being, increases clinicians' ability to detect their patients' emotional distress [27].

Additionally, facilitative communication such as partnership-building, supportive communication, and rapport building can also assist patients in sharing and help clinicians recognize emotional disclosure. For example, when clinicians ask about patients' concerns, show interest in and respect for their experiences, and avoid interruptions, patients are more willing to discuss their worries, fears, and negative feelings [28–30]. Furthermore, building rapport with patients by being interested in their feelings and concerns can generate an environment where patients feel more comfortable to discuss their feelings [31,32]. Detmar and colleagues [33] reported that, although most cancer patients were willing to discuss their emotional distress with their clinicians, an additional 26% said they would only do so if the clinician initiated the discussion. In sum, recognizing emotional cues as well as conversationally opening space for the patient to talk about their emotions often provides clinicians opportunities to explore as well as evaluate the patient's degree of emotional distress.

3.2. Exploring emotional distress

By creating and allowing the space for patients to reveal emotional distress, clinicians can smoothly move into the next phase of responding to emotions—exploration. Clinicians must open the door for exploration with the patient through acknowledging and validating emotions and providing empathy. Using open-ended questions, eliciting concerns, clarifying emotional concerns, and being empathetic often leads patients to talk about their emotional distress and feelings [24,28,31,34,35]. Given that clinicians are more apt to respond to explicit cues [36], encouraging and allowing patients to express their feelings may provide both the opportunity and license for patients to talk about feelings.

Empathy is another important way a clinician can explore a patient's emotional distress. Empathy is a process where one shares and understands another's emotions and thoughts [37]. This includes the clinician showing respect, being a partner, and providing support [35]. Clinicians can provide empathy during the diagnosis saying, "I know this news is scary to hear." They can then demonstrate their understanding by saying, "I cannot imagine how hard it must be for you and your family" (p. 1410) [38]. It is important to note that such empathetic responses from clinicians can either encourage more patient disclosure or end future opportunities. For example, Pollak et al. [7] analyzed clinical encounters between patients and oncologists, finding the oncologists responded either with an empathetic continuer (e.g., "It's not easy for anyone in your family.") or an empathetic terminator (e.g., "Give us time. We are getting there.") (p. 5750).

Lastly, as noted earlier, some patients may be reluctant to talk about their feelings either because they see their feelings as private or think it may not be that clinicians' job to address emotional distress [1,18]. This is why clinicians should explore the patient's preferences for dealing with issues of emotional distress [16]. In sum, exploring patients' emotional distress through encouragement, acknowledgment, validation, and empathy enables patients to talk about their feelings to the extent they want or are comfortable, and as discussed below, these behaviors may also have therapeutic value.

3.3. Therapeutic action

Clinicians can use a number of communication strategies to have therapeutic value for patients with some degree of emotional distress. First, clinicians' efforts to acknowledge and explore has some therapeutic value that alleviates some of cancer patients' emotional distress [6] and responding empathetically to negative emotions does decrease patients' distress and increases their quality of life [39]. Thus, these three exploration strategies do provide some comfort for patients within the context of a caring, supportive relationship. Second, clinicians can reassure their cancer patients and their families that they will not be abandoned and make them "feel heard and known" as well as help them talk about the future [8,9]. Third, information also may have therapeutic value, especially for some patients who might be less willing to discuss their feelings. For example, clinicians can offer clear and detailed explanations about their patients' health and treatment options to assist them in managing their uncertainty, gaining some control, and increasing hopefulness [40]. Important here though is the information should be provided in empathetic and caring ways. The manner in which a clinician talks to the patient (e.g., his or her communication style) is equally important as the information (e.g., content) provided. Finally, clinicians can also identify possible resources for their patients such as social support groups as such groups have been found to reduce distress [41].

However, sometimes patient-centered communication alone is not enough to mitigate patients' emotional distress. As discussed earlier, emotional distress extends along a continuum from common negative feelings such as frustration and nervousness to disabling emotional states that require treatment like depression, anxiety, and hopelessness. Thus, clinicians may need to recommend therapeutic intervention, and the appropriate course of action should be based on the emotional distress displayed.

Clinicians should provide a referral when the patient is experiencing psychological morbidity and needs expert help that they can no longer offer. An appropriate referral includes expressing willingness to assist, reviewing next steps, inviting questions, making partnerships, offering delays in decisions, and summarizing content [42]. These communicative skills can then assist in the patient's treatment for psychological morbidity. Unfortunately, only 15–50% of cancer patients who require psychiatric intervention are referred to mental health services for counseling [43–45]. This is a serious problem, but following this three-stage model can assist clinicians in better managing their patients' emotional distress and knowing when they are no longer able to provide the required assistance. In short, therapeutic value encompasses making choices and taking steps regarding patient care based on displayed emotional distress in order to produce positive, health outcomes.

4. Conclusions and implications

4.1. Research and practical implications

This three-stage model provides structure for understanding the role of communication in assisting cancer patients with managing and coping with their emotional distress. To conclude, three implications for the present model for research, education, and practice are noted.

First, because communication serves different purposes, this model provides a way for researchers to target specific communication elements within each stage. Researchers can use these elements to better test communication's impact on patient health outcomes. For example, when assessing if clinicians' exploration behaviors can decrease patients' distress and increase their quality of life, researchers should focus on the communication elements of acknowledging and validating emotions and providing empathy. This is important because, as Finset [46] points out, more research is needed to assess if clinicians' behaviors may indeed impact health outcomes.

In addition, medical educators can use this proposed three-stage model to teach clinicians how to enact specific communication elements within each stage in order to produce positive, health outcomes. For instance, the model addresses the Accreditation Council for Graduate Medical Education's (ACGME) [47] concept of emotional intelligence, which includes perceiving, using, understanding, and managing emotions. Specifically, recognition speaks to perceiving emotions (accurately identifying emotional states); exploration gets at using emotions (knowledge and experience with emotions) and understanding emotions (analyzing and connecting emotions); and lastly, therapeutic action speaks to managing emotions (consciously regulating emotions). So by teaching this model as it relates to emotional intelligence, it can enhance the quality of cancer patient care by explicating medical standards further and providing specific and practical language.

Finally, communication training for clinicians needs to include all stages of this model, especially therapeutic action. To teach recognition, training sessions could focus on mindfulness and

self-situation awareness through self-reflection writing and rapport building and active listening through role-playing. To teach exploration, training could emphasize acknowledgment and validation of emotions as well as empathy through interactions with standardized patients (SPs) in medical school, residency, and even as a practicing clinician. Also, feedback should be provided in this stage, discussing communication and encouraging improvement. Lastly, to teach therapeutic action, training sessions could highlight how to identify when a patient is experiencing psychological morbidity and when it is necessary for clinicians to make a medical decision and/or refer the patient to an expert. Guidance, if not training, regarding emotional expression may be beneficial for cancer patients as well.

4.2. Conclusions

In conclusion, this paper presents a three-stage model through which clinicians can better address the challenges of recognizing, exploring, and managing patients' emotional distress through particular strategies and techniques in ways that contribute to betterment of patients' health and well-being. Clinicians can recognize emotional distress by engaging in mindfulness, self-situational awareness, active listening, and facilitative communication. Clinicians can explore emotional distress by acknowledging and validating patients' emotions and providing empathy to their patients. Finally, clinicians can assist their patients in managing their emotional distress through therapeutic action such as making medical decisions and taking steps regarding care. In short, although cancer patients are often reluctant to disclose or hide their emotional distress, and sometimes clinicians are not able to recognize or fail to respond appropriately and effectively, clinicians must continue to assist cancer patients and their families in dealing with emotional distress, and this proposed model is one way to do that.

Conflicts of interest

The authors report no conflicts of interest.

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