

Managing patients' emotions

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Background

A patient has an unwanted pregnancy ... is coming to terms with infertility ... gets a cancer diagnosis. All these scenarios occur if not often, at least regularly. All stir up strong feelings – tears, rage, fear, crisis – emotions that may spill out at any time, particularly in the consulting room. So I haven't been unduly surprised that in conversations with various health professionals over the past months one topic of conversation has kept recurring, namely "What should we do when a patient gets emotional?"

Of course there is no unilateral 'what to do'; each health professional gives their own response informed by their own experience and training and the triggering problem. But while there's no one answer, there are certainly consistent guidelines on what emotions mean, how they reach boiling point, and how they can best be managed when that point is reached.

What do emotions mean?

First, some background. Emotion is an inbuilt human response – in fact, lack of emotion is so unusual and unwise that society labels it a mental illness. From birth, children naturally feel sad when they suffer a loss, feel angry when resisted, feel scared when there's a threat. They then cry, shout, tremble – not only because such activity reduces stress levels physiologically, but also as a way of 'enrolling the tribe', gathering social support for a problem and thus surviving it.

Over time, of course, children learn that it's socially inappropriate to display a constant flow of feeling and that they must contain it, and by the time they reach adulthood it is only when crisis occurs and all the containment in the world is not enough that they display strong emotion. The patient who cries, rages or shakes with fear in your consulting room has reached that point.

But when – and how – does anyone reach that point, where they are so overwhelmed that they break down? I've developed a simple formula (Box 1) to reflect what I've observed: a person's emotional level rises as a result of the opportunity to express emotion, the lack of internal strategies to self-calm, the perceived threat of the trigger, and the lack of external support.

Four key elements

So first, how much emotion people feel and display will depend on the opportunity they have to do so. In short, if it's 'safe' to cry, they will; if it doesn't feel safe, if there is no time, if other people aren't receptive, they will not only try to hold back the tears but also push down the inner feelings. This is why some patients seem to take devastating news so calmly in the consulting room. Once they are in the comfort of their own homes and in the shelter of their partner's arms they may well fall apart completely.

Box 1: The "Emotions Formula"

$$\text{LPE} = (\text{O} + \text{LIS} + \text{PT} + \text{LES})$$

LPE	Level of Painful Emotion
O	Opportunity to express the emotion
LIS	Lack of Internal Strategies
PT	Perceived Threat of trigger
LES	Lack of External Support

The second element that influences emotion is whether patients already have their own internal strategies for calming themselves down. A patient who knows how to reduce their own stress levels, to relax in the face of emotion, to think positively and use positive 'self-talk' will both feel and display less distress.

A third factor is how threatening a situation seems to be. On one level this is obvious: a diagnosis of cancer is going to stir up much more anxiety than a diagnosis of ingrowing toenail. But people perceive threats in different ways according to their personality, history and background. A cancer diagnosis will stir up emotion in direct proportion to, for example, whether numerous close friends and family have survived cancer or not.

Finally, external resources are vital. If a patient has easy access to useful information, is blessed with an understanding partner and friends, knows of relevant helplines and feels supported by health professionals it is unsurprising – but worth remembering – that they will be far more able to emotionally cope. The fewer of these factors that are present, the more likely it is that the person will fall apart.

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Given this knowledge of the 'operating elements', coping with an emotional patient becomes, if not simple, at least comprehensible. Alter any element, and you will alter the patient's emotional level and their ability to handle the situation.

What to do for the patient

Work with opportunity

So first, look at just how much opportunity you give a patient to express their emotion. And here, immediately, we meet a fact that may seem counterintuitive. Contrary to external appearances, once a patient initially becomes emotional, it may actually help them to be given the opportunity to express this emotion. Given the opportunity to cry or rage they will release stress, feel supported and – much more quickly than you may imagine – come back into balance and be able to handle the rest of the consultation constructively. To facilitate this, simply do nothing. Give the person your full attention and they will do the rest themselves.

But what if that initial burst of emotion just isn't appropriate? You may have limited consultation time and need to bring the appointment to an end. You may feel uncomfortable and want to move on. If so, it is possible to close down the opportunity. Say the patient's name to catch

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Box 2: Using the “Emotions Formula”

Alter any of the elements of the “Emotions Formula” and you will alter the patient’s Level of Painful Emotion (LPE). Health professionals should therefore:

- Work with opportunity
- Encourage self-calming
- Lower perceived threat
- Maximise external support

their attention and then ask a factual question that will distract their focus. Using a calm, cool voice, query some detail of their case notes, ask the date of their last appointment, get them thinking rather than feeling. Almost always, if you close the window of opportunity, the patient reasserts self-control.

Encourage self-calming

Whether or not you have given the patient the opportunity to express what they feel, there will come a point where the first outburst is over and they are ready to calm themselves. How can you help them do this?

Avoid using rallying cries such as “It isn’t as bad as all that ... you really must look on the bright side ... I’m sure you’ll cope in the end”, any of which would make even the most co-operative patient feel resistant. Instead, first turn to calming their physical state – suggest that they take a deep breath, try to relax, look around the room, get up and move about. Gentle physical activity will typically dissipate stress.

Next, start the patient on calming their mental state. Here, “What would work best, right now, to calm yourself down?” or “You probably have your own ways of feeling better when the going gets rough ... I wonder what those are?” might be appropriate. The more you can encourage the patient to lead here the more successful you will be at this stage.

Lower perceived threat

As the patient calms further, you can move into talking through the trigger problem in a way that gets it more into perspective. This is what we often try to do when we deliver a negative (bad news) diagnosis accompanied by words such as “There’s a very good chance of recovery”. Such approaches often do have the effect they aim for because they help the patient move away from mental visions of catastrophe and to feel just a little more hopeful.

Where such reassurance doesn’t work is where it sounds – or is – false. How can you avoid this? First, always be truthful – even if it means giving an edited version of the truth – otherwise the patient will sense your prevarication and feel even more anxious. Second, avoid blanket reassurance in favour of (real) facts and figures that give the patient something to believe in. Here a statement such as “80% of patients recover” is preferable to “I’m sure you’ll get better”, while “We send patients to Smith Street Hospital; I know the consultant Miss Jones and she is excellent” will work better than “We’ll sort this out”.

Also, use normalisation – showing the patient that there are many other cases like hers. If a patient knows that their case is typical, they not only feel taken seriously but also more convinced that they can be helped. “I get a lot of patients feeling like this ... yours is the third case I’ve had this year, and the others are doing well.” “Of course it’s difficult to come to terms with childlessness – anyone in your situation would feel like you do.” It’s immensely reassuring for a patient to know that they are treading a road successfully travelled by others.

Maximise external support

By this time the patient should be much calmer and focused not on catastrophe but on possibility. This is the time to start shifting the conversation towards what can be done, what help is available and what the treatment plan is. There can be a tendency among health professionals to attempt this stage right at the start, as a way of calming patients down; however, leaving specific talk of treatment until after the patient is calmer means they will be much more able to understand and remember what is said.

Once you’ve covered treatment and action plans, start preparing the patient to leave the consulting room and go back to their world. Check support systems – ask whether they have a partner, friends or family they can turn to. Hand over any leaflets, and mention any books or Internet sites that the patient may find useful. If relevant, refer on to a counsellor, or offer a few local referral organisations; it’s vital to keep a list of such resources for crisis occasions. Most useful of all, fix another appointment or at least offer the possibility of one – “Pop back if you need to” – so that the patient knows that you are available. Remember that distress is radically reduced if someone knows that they are being supported. If your patient knows you are even theoretically available for that support then they will feel much more resourced.

What to do for yourself

The above suggestions comprise a tried and tested route for coping with patient emotions in the consulting room, and I trust they will help Journal readers. But hidden among those notes is, sneakily, a route for health professionals to cope with their own emotions while consulting. In short, if you yourself feel shaky while working, the formula will help you too.

You can work with the opportunity. If, as can happen in a professional situation, you feel grief, anger or anxiety when supporting a patient, then close down the opportunity by fixing your attention on facts and figures. Later, however, give yourself the chance to express your emotions in private.

“ If you yourself feel grief, anger or anxiety when supporting a patient, then close down the opportunity by fixing your attention on facts and figures. ”

You can encourage your own internal strategies, distracting yourself, taking a deep breath, looking round the room, perhaps getting up and walking around. It will also help to use positive ‘self-talk’, mentally reminding yourself that you are a professional who can cope.

You can lower the negative significance. Whatever the situation, remind yourself of positive aspects of the situation and try to get things in perspective. If, for example, you are delivering a pessimistic diagnosis to a patient, remember that at least they are now receiving help.

You can make sure you get enough external support from friends, partner or colleagues. Counsellors get regular ‘supervision’ to help them cope with the emotional strain of helping. Make sure you do the same.

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