

## ORIGINAL ARTICLE

# Using personality characteristics to individualize information to cancer patient

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## Summary

*Disclosure of information to cancer patients is an issue of continuous and great interest. There is a wide-scale debate underway about the questions “do we disclose diagnosis or not”, “what should we tell”, “how much information should we reveal”. Usually, the answers to those questions are general rules of approaching the patient, instructions and general communication skills.*

*What we are missing here is individualization, tailoring information and communication to each patient according to their own personality characteristics.*

*The purpose of this paper was to provide a guide that will make individualization possible, taking into account personality characteristics.*

*We provide a description of the main personality types*

*and of how we can use character traits to inform a patient or otherwise, how do we tailor information to a patient’s personality characteristics.*

*Thus, we address the questions of how much do we inform, what words should we use, what do we say, when do we say it and how can information be in line with the therapeutic relationship and patient follow up.*

*On the whole, there is the view that information within the context of doctor-patient communication should be a subject of training.*

*We agree with this view and that is one of the reasons why training workshops are being held at the Metaxa Cancer Hospital.*

**Key words:** cancer patient, informing, personality

## Introduction

The issue of informing a patient about his/her health problem is of particular concern to the healthcare community, but also to laymen using healthcare services. It is also an issue that has always preoccupied man; in our days, however, it is even more prominent as the debate on human rights comes up more often and the so-called “personal data” are more clearly defined affecting our daily lives.

It is worth noting that informing the patient is a recurring issue during scientific discussions in workshops, round tables, even when the main topic is not at all that. The questions “Do you tell diagnosis or not; how; how much information do you reveal; who do you inform about the diagnosis and/or what do you tell” are pressing and looking for answers, especially by doctors

who are mostly concerned, if not exclusively concerned with the role of informing the patient.

Discussion and answers often serve as a guide to seek a general and/or absolute rule on which informing would be based. There is no absolute answer about informing, because it is a fundamental factor of the therapeutic relationship, which is addressed to a distinct individual suffering from a particular health problem with medical facts possibly different for each individual patient. All this is true if we agree that our goal is to cure the individual-patient and not the illness *per se* [1-5]. The issue of informing the patient concerns all patients irrespective of their ailment. The major part of the discussion revolves around cancer disease in terms of the information strategy to be followed, whereas other diseases such as the coronary disease and diabetes mellitus are all the more frequent [6-9].

But why informing the cancer patient is a subject for discussion more than informing patients with other health problems?

Cancer is enveloped in a myth based on an old reality. Throughout mankind's history, we often see that the myth is still here, despite the fact that reality has changed. Cancer disease or simply the word "cancer" is automatically associated with incurability, pain, distress, fear of social exclusion, ruining of human dignity and death. Indeed, the picture that the myth is associated with has greatly changed and is improving constantly; nonetheless, the myth has lost none of its power. As shown by the experience gained from other diseases, which trouble or have troubled mankind such as tuberculosis or schizophrenia, we are more afraid of the myth and its social impact than the actual disease [10].

As a result, a large-scale debate is under way, whereas there are numerous bibliographical data dealing with the issue of disclosing information and communicating with the patient. The debate on information usually refers to the quantity rather than the quality. Thus, the emphasis is usually placed on the number of doctors who are willing or reluctant to inform the patient about the diagnosis or prognosis of their illness. The quality issue, on the other hand, is less addressed. Thus, general conclusions are being drawn and recommendations are given like, say, that the mentality, personality, education, patient age etc should be taken into account. Nothing is said about what these concepts mean exactly and most of all how we should approach the quality aspects of information.

Indeed, advice and approaches offered are of general application, and although sound in theory, when applied to different patients they produced mixed results. This occurs because the doctor, having his own personality characteristics, communicates his view or advice to a patient with his own personality characteristics. If we assume that the doctor and his personality are unchanged, it is obvious that the same doctor will develop a different therapeutic relationship with each patient, depending on the latter's personality characteristics.

Thus, what doctors are lacking is individualization, the tailoring of information and communication to each patient according to their personality characteristics. What we need here is a guide that will be used by physicians to disclose individualized information effectively and achieve good patient-doctor communication, while developing a specific strategy adapted to each patient.

This paper aims at providing a guide that will make individualization possible, or better, will enable  $\alpha$  disclosure of information to the patient, taking into account personality characteristics. It is based on a 15-year research carried out at the Metaxa Cancer hospital,

Piraeus, Greece. Fields of study included liaison psychiatry, group psychotherapy with nurses and doctors, and a 5-day psychooncology workshop of the Psychiatric Department at the Metaxa Cancer hospital [11].

Informing the patient is an issue of ecumenical interest that has preoccupied all societies, regardless of local cultural differences. We specifically refer to cases where the doctor has to break the bad news to the patient, knowing that the news will inevitably put a strain on his relationship with the patient. Bad news is any information that changes a person's view of the future in a negative way [12,13].

Communicating cancer diagnosis has always been reported as a hard task for doctors and laymen alike. Over the last 50 years during which diagnosis communication has been explored, mentalities have changed. In the 1950s, physicians routinely withheld cancer diagnosis, whereas today they tend to be open about it [14-16].

No matter how different this development seems to be across countries, the tendency to inform is similar. In the United States, this tendency has reportedly reached 100%. This result, even though it has not been disputed, it is checked as to whether it is a quality social development, since this decision is reached under the pressure of lawsuit filings and damages claimed by insurance companies.

Three tendencies have been recorded in terms of information disclosure. The first purports that "the illness should not be disclosed to the patient". The main advantage of this course of action is that it avoids the psychological problems secondary to the disclosure. The second purports that "all cancer patients without any exception should know exactly what they are suffering from, whereas doctors should be alert about any psychological repercussions". The third purports that "the extent and the method of disclosure should be individualized" [17].

We obviously favor the last solution of individualization. Indeed, the knowledge of character traits enables the therapist to tailor the information strategy to each individual patient. Individualization seems to offer the best ground for this, because, on one hand, it addresses the worries of the first tendency that the patient will have psychological problems, and on the other it copes with the patient's psychological reactions to the bad news according to the second tendency.

## **Personality characteristics and information individualization**

Individualization determines the information

strategy, namely how much information the patient can endure, when it should be disclosed and how, in order to help maximize patient benefit, ensure treatment compliance and foster a good therapeutic relationship.

Disclosing information to the patient is a crucial procedure in the context of the doctor-patient communication, where questions and dilemmas in the exercise of therapy are being dealt with. Therefore, information is successful in the context of a sound therapeutic relationship where good communication has been achieved.

To understand the patient in the therapeutic relationship and be able to disclose information regarding him as a human being and to accomplish individualized informing one should take into account each patient's personality characteristics. Successful information takes into account other factors as well, such as family and the patient's defense mechanisms with an emphasis on the denial mechanism.

The knowledge of the patient's character increases understanding of that person as a human being and helps tailor the approach and information to the patient.

In this paper we will describe the main characters found in clinical practice, which can be found within the context of a therapeutic relationship [11,18,19]. The characteristics we are dealing with are normal manifestations and not disorders. Therefore, the characters we will describe can be addressed by any therapist without necessarily resorting to consultation - liaison psychiatry.

We could argue that each character requires a different handling, a special approach, a disclosure tailored to each character. The knowledge of characters contributes to patient understanding and may be the key to tailoring one's approach and adapting to each patient separately.

In the light of those factors, the therapist will ask himself certain questions: the answer to those questions will contribute to creating a tailored information strategy, to answering the "how and in what way" should the therapist inform the patient. We use the term "strategy" because information is a dynamic event in a therapeutic relationship.

The main questions posed by the therapist while planning his information strategy are:

1. Who among the therapeutic team will inform the patient?
2. Is anything good coming out of communicating this information to the patient? Why should I inform?
3. When? At what time?
4. How much information should I disclose?
5. What words will we use, what will we say?
6. Where will we inform, possible setting?
7. What are the stages followed while informing?
8. Whom will I inform?

The main characters studied are [11,18-21]:

1. Controlling-organized
2. Dependent
3. Emotional-hyperthymic
4. Emotional-hypothymic
5. Arrogant
6. Avoidant
7. Suspicious-irritable
8. Giving/self-sacrificing
9. Isolated-distant

We will elaborate on two characters/personality types as examples of approach and individualization [11]. We have chosen these two characters for educational purposes, as they require the use of two almost entirely opposite approaches. As regards the rest, a brief overview will be supplied.

### *Dependent personality*

- Relies on others looking for support and safety.
- Gives a tone of urgency to his demands.
- Demands special attention, constant advice and anticipates infinite care from the staff.
- Appears to be generous on many occasions, however, expects reciprocation from nursing staff. If they fail to respond, he becomes resentful.
- If his needs are not satisfied, he gets angry and melancholic.
- He may eat, smoke and drink to excess or take easily drugs exposing himself to the risk of addiction. He regards food, medication and special care as equal to love.
- He has an unconscious fear that he will be abandoned and like a small child feels that he is danger and that he will die. He tends to regress to infancy when he feels completely safe and protected.
- To counter these wishes and fears, he will follow the following solutions:
  - a) He may become overly dependent on the doctor's and nurses' communications.
  - b) Out of fear to be dependant, he may resist to any form of treatment and care.
  - c) He may end up feeling sad and withdrawn like a small child that is not loved enough.
  - d) He may accuse the nursing staff of not alleviating the pain secondary to his illness.

### *Controlling - organized personality*

- Main characteristics: control and order.
- He has self-control, self-containment.
- Using reason to cope with his problems, he manages to control stress.

- He is organized, punctual, restrained, reliable, hyperresponsible, conscientious, over-indulged in the concepts of right and wrong, stubborn.
- His illness threatens to assume control over his impulses. He is trying to cope with the risk by doubling his efforts. As a result, he becomes even more orderly, self-constrained, strict, stubborn, rigid and obstinate.
- The need for cognitive control leaves him feeling hesitant and doubtful as to how well he has been informed of his problem.
- He needs to feel that the medical and nursing staff is properly qualified, careful, effective, punctual and clean.

By reading the traits that make up each personality's profile, you may ask yourself the following question: To which one of the two do I reveal all the truth and to which one do I not? Elaborating on and understanding these traits will eventually direct the therapist to the right answer.

Disclosing information to a person with a controlling-organized personality should be done as simply as possible. This will satisfy his demand for control, because the patient knows and has control over the situation, which makes him feel secure. In addition, he can organize his life, which also gives him a sense of security.

Using the same approach for the dependent patient would bring about the opposite results, causing him stress or even panic. The dependent patient asks to rely on others and the therapist as well. It should be noted that in the context of a therapeutic relationship, the controlling - organized patient desires to learn, whereas the dependent patient avoids asking.

By taking into consideration the personality characteristics of the patient, the therapist is able to answer the question: how much do I reveal, what words should I use, and when and how will I inform the patient in the context of a therapeutic relationship and patient follow up.

As illustrated in the previous examples, information is handled in a way that is respectful toward the basic defense mechanisms and the vulnerable spots of a personality. The same would apply to the rest of the personalities.

The patient with an emotional-hyperthymic personality is mainly characterized by: A powerful emotional communication, emotionalism and seductiveness. This picture deceives physicians about how strong they really are. As much as they want to learn, therapists should also bear in mind that deep down they can take much less than they show. To this type, the success of a therapeutic alliance is much more important, as it can be used by the patient to guide the therapist through the most appropriate approach. Information is being

given gradually and it ranges between the amount of information disclosed to the controlling-organized personality and the dependent personality.

The same applies for the patient with an emotional-hypothymic personality. However, there exists an additional difficulty, which can be attributed to the introvert nature of this personality.

In terms of the arrogant personality type, one needs to watch for two parameters: On one hand, that the illness is perceived as a direct threat to the image of perfection and magnificence they have created for themselves and, on the other, that the therapist may countertransfer the patient's arrogance. Furthermore, an emphasis should be placed on the ill person without undermining the importance of the doctor and nurses. In this case, denial is usually high. For this type, it is crucial to have answered the questions of "when" and "how much", as the narcissistic blow caused by the illness is more intense. It appears that there is a great chance of a major depression episode and suicidal ideation.

The avoidant patient is in fact the introvert side of the arrogant personality; he is constantly worried about being exposed, since the illness can force him to expose himself and show his inner weaknesses. So, the therapist needs to be encouraging and supportive making sure not to uncover the patient's weaknesses. Disclosing information to this type is equally difficult with the previous one and the risk not to become aware of suicidal ideation is great.

As regards the suspicious-irritable patient, it is vital for the therapist to respond without countertransferring the aggressiveness expressed by the patient, which aims at not engaging in a conflict. The therapist should be friendly, while keeping a safe distance. The therapist needs to recognize that his anger and aggressiveness are merely a cover for a well-hidden sensitivity. Information should be given at an early stage and the amount should be similar to that of the controlling-organized personality. The therapist should also bear in mind suspicion and paranoid ideation.

Patients with a giving/self-sacrificing personality should be handled as follows: The therapist should present the attempt to improve his health as a fight to be well so that he can be useful to others, help his family etc. It should be noted that this individual has the unconscious need for punishment; the illness offers him the chance to conciliate with himself and put his strength to trial. How much it is disclosed should be similar to that disclosed to the controlling personality but in a milder way, also underlining that the improvement of the patient's health will make him useful to himself and others.

For the patient with an isolated-distant personality, illness is perceived as a threat to the individual's



sensitive balance, making him more indifferent and even more distant. The therapist should respect his lack of sociability, maintain an interest on him but without pressing him to become more sociable or be reciprocal. If the same amount of information is disclosed as to the controlling-organized personality, the therapist should bear in mind that this individual is vulnerable. Thus, the amount of information revealed should be between the information given to the controlling and the dependent personality styles.

Therefore, the study of personality traits can contribute to establishing a good therapeutic relationship in the context of which information can be tailored to the individual's own characteristics.

As shown in the approach used to inform a patient, the therapist needs to take into account the defense mechanisms of personality characteristics and try to address those. In that way he can accomplish a good therapeutic relationship where the patient feels that the therapist cares for him as human being and respects his personality traits. It should be noted that the therapist could adopt the different approaches without sacrificing more time than usually spent on patient follow up. The only additional time spent will be the hours needed to be trained and familiarize with this approach.

## Conclusion

The third tendency of information disclosing is becoming increasingly more accepted by healthcare professionals who report that they are not receiving any effective education in terms of how to develop communication skills with the patient [22]. There is also a doubt as to whether usual continuing education by means of oral presentations can actually alter the therapists' mentality [22].

To this end, it would be helpful to combine theoretical information with exercises such as role playing, experiential groups as part of Liaison Psychiatry, when Liaison Psychiatry develops an educational aspect in everyday clinical practice [23,24].

At the Metaxa Cancer hospital we attempted to develop these 3 training dimensions. To this end, we have created an annual 5-day workshop. We also participated in the Europe Against Cancer programme (1993-1996) which was dealing with informing the cancer patient. The outcomes of this programme have contributed to this paper.

Educating therapists in terms of communication skills and conveying the bad news have been advocated by many scientists focusing on communication skills around the globe [25-27].

Among others, educational videos such as the video set of Buckman and Maguire "Why won't they talk to me?" are used in training workshops [12].

Personality characteristics play a role in providing an answer to "when do I tell", "how much do I tell", "what words shall I use", "how will I tell", by making individualization in information possible and easy in practice.

It is certain that no such training is offered to clinicians and healthcare professionals either at an undergraduate or postgraduate level. Besides, all training efforts are being focused on communication skills very generally without offering any specific skills, ways or methods to inform an individual patient according to his/her personality characteristics.

In our view, drawing from our training experience in teams of medical and nursing staff, it is necessary to educate healthcare professionals in individualizing information to cancer patients. The duration of this training ranges between 10 to 30 hours. The best way to acquire sound knowledge on this subject is as part of a healthcare professional training team. In this way, members can make optimum use of the therapeutic factor inherent in intrapersonal learning. It is desired that such training would be offered at a pregraduate level.

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