Journal of BUON **15:** 601-606, 2010

ORIGINAL ARTICLE

Informing cancer patient in relation to his type of personality: the controlling-orderly (obsessive) patient

G. Kallergis

Department of Mental Health and Behavioral Sciences, School of Health, University of Athens, Athens, Greece

Summary

The questions "Do you tell the diagnosis or not? How much information do you reveal? Who do you inform about the diagnosis and/or what do you tell" are very frequent during scientific discussions. Must the patients know or do they also have the right not to know? Is it possible to determine who should be told what, when and how?

Is it possible individualizing the informing of a cancer patient according to his character or type of personality?

The aim of this paper was to describe the Controlling-Orderly (C-O) character, so any therapist can build up an information strategy to cancer patients.

This study took place within the framework of Consulting-Liaison (C-L) psychiatry and included:

1) *Training groups in which doctors and nurses participated.*
2) *The section of C-L Psychiatry of the Psychiatry Department.*
3) *The training activity in the framework of C-L Psychiatry.*
4) *The annual seminars of psychooncology for health professionals.*

How a doctor could use the characteristics of a C-O patient for an empathetic approach and correctly inform him. And how to approach his denial and family in order to tailor the information strategy.

Understanding the personality type of C-O patient, his denial mechanisms and the dynamics within his family maximizes the therapist's empathetic approach towards the cancer patient. The therapist can respond at "what, when and how" about to break bad news.

A therapist must take into account the main C-O patient characteristics (control and order), as well as the attributes or cognitions: the tendency to use reason, the mechanism of rationalization by which he exercises mental control that leads to doubt.

The denial degree is small to minimal, while the degree of information is large to very large.

Key words: cancer patient, controlling, orderly, perfection seeker, punctual, self-control

Introduction

Informing the cancer 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 bad news to the patient, knowing that the news will inevitably put a strain on his relationship with patient. Bad news is any information that changes a person's view of the future in a negative way [1,2].

Cancer is also 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 [3]. This fact makes the task of informing cancer patient harder.

The questions "Do you tell diagnosis or not? How much information do you reveal? Who do you inform about the diagnosis and/or what do you tell" are very frequent during scientific discussions. Must the patients to know or do patients also have a right not to know? Is it possible to determine who should be told what, when and how? [4] Certainly there is no absolute rule about informing, if we agree that our goal is to cure the individual-patient and not the illness *per se* [5-9].

Since 1989 we have studied the characters or types of personality [10] in the framework of C-L psychiatry

Correspondence to: Georgios Kallergis, MD. 11, G. Theotoki Street, 185 38 Piraeus, Greece, Tel: +30 210 60 40 681, Fax: +30 210 45 39 826, E-mail: gkallerg@nurs.uoa.gr

Received 26-11-2009; Accepted 03-01-2010

in order to elucidate how the characters or types of personality could be useful to inform cancer patients. This work was based on the studies of Kahana and Bibring [11,12] and we'll try to describe 10 characters or types of personality in a series of consecutive articles.

We studied how a therapist can tailor the information strategy to each individual patient at the Metaxa Cancer Hospital and at the School of Health Sciences of the University of Athens [13].

The result was that to understand the patient and be able to disclose him information, and to accomplish individualized informing one should take into account each patient's personality characteristics [13], as well as the denial mechanism [14] and the family [15] in relation to his type of personality.

The aim of this paper was to describe the C-O type of personality or character in an analytic way, so that any therapist can make a diagnosis with an aim to tailor the information strategy.

Methods

This study took place in the psychiatric department of Metaxa Cancer Hospital since 1989 and in the framework of C-L Psychiatry and it is continued at the School of Health Sciences of the University of Athens [13].

To this aim the following actions were used:

1) Training groups in which doctors and nurses participated.
2) The section of C-L Psychiatry of the Psychiatry Department.
3) The training activity in the framework of C-L Psychiatry [12].
4) The annual seminars of psychooncology for health professionals.

We followed the qualitative method of research [16-18], through groups with doctors and nurses, while research within groups lasted for 5 years.

During these 5 years 8 groups were formed, 3 with doctors and 5 with nurses. The number of members in each group was 12-15, they met once a week and each meeting lasted 90 minutes. They took place for one academic year and the total of time was 60 hours per year.

The discussion process in groups was based on that of analytic group, taking into consideration the therapeutic factors, particularly the cohesiveness, interpersonal learning and universality, while the group coordinator should be trained in group psychotherapy.

The procedure of discussion was based on the inductive and the Socratic method according to Beck and Perris [19,20] and takes into account:

1) The Balint's group studies on countertransference feelings in the doctor-patient relationship [5, 21].
2) The psychodynamic concepts in the understanding the medical patients [22,23].
3) The understanding of patients through the types of personality [11].

In the framework of C-L Psychiatry, in collaboration with the medical, surgical and radiotherapeutic departments, the psychiatric department participated in training programs which dealt with clinical issues about informing cancer patients. The annual seminars of psychooncology for health professionals consisted of 6 sessions (total 42 hours) per year, where the results in groups and in C-L Psychiatry were discussed with a larger sample.

The mean number of attendants in any seminar was 60 individuals.

Results

From several studies [11,21-23] from the literature, especially those of Kahana and Birbing [11,12], Schneider [24,25], Oldham [26,27], Manos [28], Livesley [29] and Reich [30] emerges the profile of C-O character or type of personality.

The most prominent characteristics are *control* and *order*. These behavioral traits usually constitute manifestations of a certain type of a person. The degree of manifestation however may be analogous or differ. This means that a high level of control may be accompanied by an analogous or a different level of order. The following may also be true and *vice versa*: a high level of order can be accompanied by an analogous or a different level of control.

Control and order that are prominent in behaviors aim to help the person face stressful situations and life events or other negative feelings (sorrow, fear, etc), but also feelings perceived as positive (joy, etc). Negative or positive feelings, especially when intense, disrupt *order* and cause loss of *control*.

Control and order mechanisms, therefore, aim to counter manifestations that disrupt a person's stability. We are interested in the manifestation of stress brought on by the disruption of order in the life of a person under pressure due to loss of a loved one, loss of one's health, divorce or separation etc., since it is the first and main manifestation we become aware of. The sense of control and order intervene in order to face, abate and manage the stress that tends to overcome our patient when feeling threatened by loss of health and/or pressurizing events.

The traits of control and order are present in all people and what differs is the degree of manifestation

in each person. A person is classified as a C-O type when these elements dominate his daily life in terms of behavior. In other words, these are the mechanisms that are first deployed to a great extent in order to protect a person, to create a line of defence against threats to his being, whilst doctors have to face the results of this defence procedure against the threat, which are anxiety and other emotions.

The person undergoing treatment must also understand that anxiety, the symptom in general, is the result of the struggle by defence procedures to face the threat. Anxiety therefore, as well as any other behavioral symptom, must be perceived as a visible point, a lever for unravelling Ariadne's clew and exploring our personal labyrinth.

Next, we shall describe the behavior profile of the C-O person, namely his behavior in daily life.

These individuals seem to use *logic* when dealing with problems and are preoccupied with the concepts of right and wrong. They tend to believe that pure logic is enough for dealing with daily problems, while some of them may even consider any emotional intervention as negative and thus suppress their feelings rather than express them. Control is also expressed in an individual's work as well as in activities, interpersonal relationships, observation of working hours etc. Daily expressions that describe such individuals are as follows: "he is conventional, obsessed with detail, nothing gets past him". Other words are "perfection seeker", "perfectionist". The term "perfectionist" is often heard in interviews given by theatre actors, for whom "perfectionism" is used in connection with the aesthetic presence of a play and is mainly an emotional characteristic, while others wish to promote the fact that they are hard workers without being C-O. If someone objects such behaviors, the controlling person will explain to him, will find all sorts of reasonable excuses for him, will express his opinion about what should take place, about what is right and what is wrong. This kind of person exerts the same control over himself too, suppressing his emotions and appearing to have self control and self restraint. In his daily life he is orderly, precise, consistent, over-responsible and conscientious. He is punctual to the minute for meetings and appointments and feels very bad if, despite his efforts, fails to turn up on time.

He also exerts mental control over his own mind. He feels the need to control, to set his thoughts in order so as to ensure that he is aware of all the details concerning his problem. When mental control is very intense, he is usually hesitant and second-guess his awareness of details and his thorough control. Therefore, this person repeats the mental check many times until he is sure. In cases that are considered to be pathological, the individual cannot cease the abovementioned mental control to such an extent that it becomes torture.

When hospitalized, this individual is at ease when the clinic is in order and he needs to feel that the medical and nursing personnel is well-trained, careful and efficient with accuracy, consistency and cleanliness.

A loss or a disease is a threat to every individual and causes disorder in the balance of his daily routine. The impact of such a threat is magnified in its perception by controlling individuals precisely because it costs them the sense of control and order, two fundamental mechanisms they use in order to meet life's daily challenges. He therefore reacts to this threat with the methods and mechanisms that he commonly uses in similar cases of minor or major threats. Thus control and order levels increase so as to enable him to deal with the stressful situation that threatens to overpower him. It must be noted that this is a subconscious and not a conscious reaction. The result of this effort is a climax of all the behavioral manifestations we described earlier. The person appears to be more headstrong to the point of becoming inflexible, and obstinacy increases as an element of the person's fighting spirit. He becomes more concerned with formality and demands that his physicians do the same and be consistent and "proper".

This is the profile, the outline of the C-O personality.

Some questions that would help us to better depict the profile of a C-O patient are the following: "Do you generally tend to control your environment in your daily life?"; "Do you like to know all the details?"; "Do you exercise self-control, are you a restrained person?"; "Are you orderly (with your things, your schedule)?"; "When you have an appointment what happens? Are you late, exactly on time or do you arrive earlier?"

By posing these and similar questions the person is given the opportunity to describe himself and the therapist can detect the presence of some of the traits we have described. Gathering information from a person's environment can also be helpful. They usually say that "he has always been formal and conventional but lately he's gone too far, he has become weird". To preserve his self-awareness and facilitate communication with the patient, the therapist must ask himself the same questions.

A significant communication parameter is the degree of the denial mechanism present in each person, coupled with his personality which must be properly assessed during the interview [14]. This helps answer the issue of "when" we can start informing the patient. Even though the assessment of denial differs in individuals, we can receive significant help from the dominant personality traits. Generally speaking, a C-O type of person tends to deal with his denial and can soon minimize it.

Usually, C-O personalities appear to be more realists, they seek the truth, sometimes the absolute truth, so that they can *control* it and avoid *doubt* which torments them. When doubt is overwhelming, it seems to carry on forever. When someone is not direct with them, they believe that he is avoiding the truth or taunting them. The therapist can also facilitate information and communication by trying to determine the amount of information that can be shared with the patient and the proper timing for divulging it. On his part, the patient can facilitate communication by providing information about himself.

Often in their daily lives, C-O types are considered by others (usually different personality types) as blunt and cynical. While this may be far from true, they can be blunt and cynical when it comes to themselves. A patient with such a personality traits once referred to his therapist: "If I am operated on, I want to know what is going to be removed, how the operation is to be held, I want to know every single detail".

He may seem coolheaded to the therapist and ready to learn the bare truth but we must not forget that this person is suffering inside and has been hurt by the blow that life has inflicted upon him. For this reason we must not be blunt just because the patient seems to be so collecting and coolheaded. Patients do appreciate that their therapist treats them with sensitivity but in a consistent and honest way.

Therapists that happen to have controlling traits themselves may believe that they are "misleading" the patient by not revealing the blunt truth to such a composed person and therefore do not take into consideration the patient's deeper sensitivities.

Once the therapist has assessed the degree of denial he can proceed to describe *how* the patient is to be informed. A therapist can be assisted regarding the manner in which he shall inform his patient by observing his characteristics, his behavioral tendencies and the purpose these elements serve.

The details of diagnosis and treatment planning must be explained. This is even more so in the case of a C-O type.

In this way, the specific patient can control and prepare himself to deal with his problem and can organize his life accordingly. This manner of providing information is absolutely correct for this specific type of personality but this is not necessarily the case for other personality types. For a Dependent type for example, this may prove to be damaging.

The C-O type wishes to become familiar with his disease. He may demand this either in a direct and absolute manner or less persistently, but nevertheless he always does. However, even in cases where the patient strongly demands it, the truth must be told tactfully and delicately, and the therapist must also allow extra time for his patient so that he does not feel hurried. The patient appreciates this and trusts his therapist even more.

Also, the therapist must also pay attention to *doubt* and *ambivalence* expressed through questions and disputes by the patient. For this reason his words must be carefully selected, laconic and focused. Terms and names that may impress but also lead to questions and stress must be avoided since they do not actually offer anything substantial.

Understanding the patient's need for control and order helps the therapist avoid misunderstandings and conflicts with the patient. When a patient with controlling behavior tendencies asks the therapist to explain about the medication he will be taking or what a specific test means etc, the therapist may interpret this as lack of confidence in his own abilities which may lead him to feel angry and react in a manner that may impair his relationship with the patient. He may for example say "Why are you asking? Are you a doctor?" or scold the patient by telling him "Here you must do exactly as you are told". However, the C-O patient does do what he is told, but first he needs to be informed regarding the diagnosis and treatment procedures and to feel that he is in control.

Capable of countertransferring the feelings evoked within him by the patient, the therapist must satisfy his need for control without, however, relinquishing his role as a therapist. This is of course what the controlling patient wishes for, since he wants to feel that his doctor is responsible and proficient.

As mentioned earlier, the issue of "When", the point in time at which the patient will be given the information concerning his disease, depends on the degree of denial [14] and the personality traits [13].

In the case of the C-O patient, this point in time is sooner rather than later. The faster the better, as long as there is significant information material. In any case, a *timetable* during which the informing will take place must be set out and adhered to.

Another way that contributes positively to the process is to seek the patient's participation in decisions regarding his treatment, something that he greatly appreciates since this satisfies his need for control and order, whilst at the same time rewards him for his reasonable attitude and good cooperation. For example, the patient's participation in planning his diet can be very helpful. It is a painless process that wins him over when the therapist presents him with his diet and lets him know that he can make his own adjustments. Also when planning to administer treatment, it is good to explain its purpose to the patient and ask his opinion by saying "What do you think?" instigating conces-

sion. Provided that our management is successful, the patient's answer should be "Fine, whatever needs to be done, I agree…".

Sometimes the patient demands to know the result "Can you guarantee that I will get well?". The answer must convey eagerness, persistency and firmness, something like, "We will try to achieve the maximum result; we always make a committed effort to succeeding, rest assured of this".

A rigid answer which will contain a high degree of uncertainty may cause doubt and distrust.

One must remember that details or terms that increase doubt, such as scientific terminology or the chemical names of medications for example, are not beneficial.

Usually people who are in a therapeutic relationship, as in any other relationship, appreciate the effort, the availability, the feeling that they are treated as human beings and not simply as an anonymous case; the feeling that the therapist understands them, that he feels their pain.

The Controlling-Orderly patient and his family

The C-O patient, as already said, wants to know, wants to learn and tends to eliminate everyone else from the disclosure. The partner and the family can accept the patient's behavior or –to a bigger or lesser degree– act similarly. The full mosaic of the relationship dynamics within the family is now revealed and the therapist has to deal with any versions of these dynamics. Tension is usually present, and conflict as well, when the family intervenes and the patient is not informed properly. As already stressed, doubt and stress become more acute. Therapists feel that the overprotective attitude of such relatives obstructs, disorients and causes anger. Communication within the family can be impaired when the patient's doubt levels increase and he becomes distrustful about anything that is being said.

If the partner has depending characteristics, the patient will cede all manipulations to the C-O partner and will assume the entire burden but will then get angry when he feels the need to lean on someone [15].

Discussion-Conclusions

Understanding the personality type of the C-O patient, his denial mechanisms and the dynamics within his family maximizes the therapist's empathetic stance towards the patient. It is obvious that it also maximizes the quality of patient approach and information.

The therapist can respond at "what, when and how" [4] about breaking bad news to the patient.

Empathy is considered as the more important parameter during the proceeding of breaking bad news [31], and in this way the therapist reaches the better empathetic approach possible when informing the patient over his real health situation.

The C-O patient usually gives information during the diagnostic procedures whence the diagnosis of his prominent character may be easy.

In many patients these personality characteristics do not appear in the beginning as prominent, due the compensation mechanisms, while the really prominent character may be another one, like the emotional-hypothymic or avoidant etc. [13]. The therapist must insist to discern the really prominent character in order to achieve an empathetic informing.

Summarizing the main points (Table 1), we con-

Table 1. Controlling - Orderly Personality

Main characteristics: control, order

Attributes or Cognitions

- He has self-control, self-restraint.
- Using reason to cope with his problems, he manages to control stress.
- He is organized, punctual, restrained, reliable, overly responsible, conscientious, over-indulged in the concepts of right and wrong, stubborn.
- His illness threatens to assume control over his impulses.
- In his attempt to deal with danger, he doubles his efforts. As a result, he becomes even more orderly, self-constrained, strict, stubborn, rigid and obstinate.
- The need for cognitive control leads him to hesitation and doubt as to how well informed he is about his illness.
- He needs to feel that the medical and nursing staff are properly qualified, careful, effective, punctual and clean.

Managements

- Explain the details of his disease and the stages that are to be followed during diagnosis and treatment, so that he can mentally control his stress.
- Avoid providing useless details that trigger ambivalence.
- Encourage patient's participation in various decisions concerning his treatment thus rewarding his logic.

ventionally propose a scale of the degree of denial and the degree of information provided to the patient, thus providing a point of reference for these parameters:

minimal, small, medium, large, very large [32].

We take into consideration the main characteristics: *Control* and *Order*.

From the patient attributes: the tendency to use reason, the mechanism of rationalization by which the patient exercises mental control that leads to doubt.

The degree of denial is "small" to "minimal".

The degree of information is "large" to "very large".

Satisfying the need for control and order is a tendency that overcomes the blow dealt by the announcement of the disease, and the patient believes that with the help of these mechanisms he shall manage as he has always done.

Family: the patient asks to learn and tends to exclude the rest. Relatives may act similarly so there is usually conflict and tension.

References

1. Buckman R, Maguire P. Why won't they talk to me? An introductory course in communication (5 tapes). Linkward Productions, Shepperton, Herts, England, 1989.
2. Buckman R. Communicating with the patient. In: Stoll B (Ed): Coping with cancer stress. Martinus Nijhoff Publ, Netherlands, 1986, Ch 18, pp 165-173.
3. Sontag S (Ed). Illness as Metaphor and AIDS and its Metaphors. Picador Editions, USA, 2001.
4. Novack HD, Plumer R, Smith RL et al. Changes in physicians' attitudes toward telling the cancer patient. JAMA 1979; 241: 897-900.
5. Balint M. The doctor, his patient and the illness. In: Balint M (Ed): Problems of human pleasure and behaviors. Maresfield Library, London, 1957, pp 198-220.
6. Street RL Jr. Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics. Soc Sci Med 1991; 32: 541-548.
7. Street RL Jr. Communicative styles and adaptations in physician-parent consultations. Soc Sci Med 1992; 34: 1155-1163.
8. Beach MC, Roter DL, Wang NY et al. Are physicians' attitudes of respect accurately perceived by patients and associated with more positive communication behaviours? Patient Educ Couns 2006; 62: 347-354.
9. Dowsett SM, Saul JL, Butow PN et al. Communication styles in the cancer consultation: preferences for a patient-centred approach. Psychooncology 2000; 9: 147-156.
10. Kallergis G (Ed). Information and Communication Guide with the Patient. Medical Graphics Editions, Piraeus, Greece, 2003 (in Greek).
11. Kahana R, Bibring G. Personality Types in Medical Management. In: Zinberg N (Ed): Psychiatry and Medical Practice in a General Hospital. International University Press, Madison, USA, 1964, pp 108-123.
12. Kahana JR. Teaching Medical Psychology through Psychiatric Consultation. J Med Edu 1959; 34: 1004-1009.
13. Kallergis G. Using personality characteristics to individualize information to cancer patient. J BUON 2008; 13: 415-420.
14. Kallergis G. Using the denial mechanism to inform the cancer patient. J BUON 2008; 13: 559-563.
15. Kallergis G. Informing the cancer patient and family. J BUON 2009; 14: 109-114.
16. Pope C, Ziebland S, Mays N. Education and debate. Qualitative research in Health care. Analysing qualitative data. BMJ 2000; 320: 114-116.
17. Silverman D (Ed). Qualitative Research, Theory, Method and Practice. Sage Publ. London, UK, 2004, Ch 1, pp 1-9; Ch 10, pp 177-200.
18. Elliott R, Fisher CT, Rennie DL. Evolving guidelines for publication of qualitative research studies in psychology and related fields. Br J Clin Psychol 1999; 38 (Pt3): 215-229.
19. Beck AT, Emery G (Eds). Anxiety disorders and phobias. Basic Books, New York, NY, USA, 1985, Ch 10, pp 167-188.
20. Perris C (Ed). Cognitive therapy with schizophrenic patients The Guilford Press, New York, NY, USA, 1989, Ch 3, pp 20-27.
21. Balint M (Ed). The Doctor, His patient and the Illness (2nd Edn). Churchill, Livingstone 1990, Ch 14, pp 203-226; Ch 15, pp 227-251.
22. Bibring LG, Kahana RJ. Lectures in Medical Psychology: An Introduction to the Care of Patients. Arch Gen Psychiatry 1969; 21: 638-639.
23. Bibring LG. Psychiatry and medical practice in a general hospital. N Engl J Med 1956; 254: 366-371.
24. Schneider K (Ed). Klinisch Psychopathologie (5th Edn). Georg Thieme, Verlay-Stuttgart, Germany, 1959, Ch 2, pp 37-63.
25. Schneider Kurt (Ed). Psychopathic personalities London: Cassel, 1950 (original work published in 1923).
26. Oldham J, Morris L (Eds). The new personality self-portrait. Bantam Books, New York, NY, USA, 1995, Ch 3-17, pp 31-384.
27. Oldham J. Psychodynamic Psychotherapy for Personality Disorders. Am J Psychiatry 2007; 164: 1465-1467.
28. Manos N. The Fundamentals of Clinical Psychiatry. University Studio Press, Thessaloniki, Greece, 1987, pp 456-469 (in Greek).
29. Livesley W (Ed). Handbook of Personality Disorders. The Guilford Press, New York, NY, USA 2001, Ch 1-3, pp 3-83.
30. Reich J. State and trait in personality disorders. In: Reich J (Ed): Personality disorders. Routledge, Taylor and Francis Group, New York, NY, USA 2005, Ch 1, pp 3-20.
31. Baile WF, Buckman R, Lenzi R et al. SPIKES- A six step protocol for delivering bad news: Applications to the patient with cancer. The Oncologist 2000; 5: 302-311.
32. Kallergis G (Ed). Informing the Cancer Patient. Medical Graphics Editions, Piraeus, Greece, 2008 (in Greek).