Softening the blow

Andy Millington and **Dr Helen Court** take a look at the importance of communication skills and the appropriate response to patient anxiety

Optometrists frequently encounter situations in which they need to communicate 'bad news' to their patients. This may range from advising a newly presbyopic patient that they require spectacles, to explaining to a patient with early dry AMD that an updated prescription will not improve their near vision. Receiving bad news can often elicit a range of emotional responses from patients, including considerable concern and anxiety.[1] However, in these situations, the patient will often look to the optometrist for further guidance and help. For this reason, it is important that optometrists are equipped with the necessary communication skills to elicit and respond to patient concerns and fears.

Counselling is one area of healthcare which provides many communicative techniques which are useful when dealing with anxious and fearful patients. Interestingly, the role of the optometrist can often shift from 'problem-solver' to 'counsellor' when delivering bad news to a patient. Within the role of eye care practitioner, optometrists are intrinsically problem-solvers. The patient makes an appointment with the optometrist because they have a perceived problem. By the end of the appointment, the patient would like the optometrist to have identified and rectified this problem. However, there are occasions when the practitioner is either unable to rectify the problem or the solution is not to the patient's satisfaction ie the optometrist delivers 'bad news'. The optometrist now moves from 'problem-solver' to 'counsellor'. In this scenario many patients will bottle up their emotions, and while releasing them is healthy, many optometrists are not comfortable or feel inadequately trained to deal with the raw emotions that are released. Therefore, the aim of this article is to show how some of the skills used in counselling can be applied to day-to-day optometric practice which will benefit both the patient and the optometrist.

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Background

Counselling has been called 'the talking cure'.[2] It has come a long way since the pioneering work of Sigmund Freud at the turn of the last century. Both Freud and Jung were analytical psychologists and Freud coined the term 'psycho-analysis' to reflect this. In the 1940s and 50s Carl Rogers developed the 'person-centred approach' which has become the basis of most current practice.[3] Using this approach, the process of counselling is achieved through attentive listening by the counsellor, allowing them to perceive the difficulties from their patient's or 'client's' point of view. This then allows the counsellor to help the client see things more clearly and possibly from a different perspective. The process is the means by which one person helps another to clarify his or her life situation and decide on lines of further action. Indeed, lack of clarity can cause anxiety; most people are frightened by what they don't know or understand.

As optometrists, we frequently give advice to our patients during a consultation. However, a counsellor will rarely offer advice ie they are not problem-solvers. Rather, the cornerstone of counselling is that a counsellor helps facilitate client choices by listening, helping, empowering and befriending. It is a relationship built on trust.

Types of counselling

Broadly speaking, there are three main types of counselling: supportive, informative and bereavement.[4] Within optometric practice, there are scenarios

in which each of these may be appropriate. These are described below.

Supportive counselling

Supportive counselling aims to help people adapt to a new or difficult situation. This type of counselling is akin to listening to a friend as they share a problem. The role of the counsellor is to act as a sounding board for ideas, plans and suggestions. The main skills needed are listening, empathetic understanding and commitment. The counsellor aims to provide reassurance, explanation, encouragement and support.

Optometrists can often find themselves in situations in which they are drawn into a supportive role. For example, many patients are concerned when they are told they need to be referred for ophthalmic investigation. The patient may have questions and concerns about the possible course and implication of the condition which the optometrist has discovered. The whole process of referral can be stressful for both the practitioner and the patient. By recognising this and using the appropriate skills the burden can be eased for both parties.

Informative counselling

The aim of this type of counselling is to provide information to aid an individual with decision making. For example, within healthcare this would be encountered in genetic counselling. The counsellor seeks to help an individual understand the possible treatment options or the likely outcomes. It is important to remember that health is a very personal issue and what matters to the patient is how the medical findings will affect their wellbeing and future. Within the optometric context, practitioners assume the role of informative counsellor when a colour vision defect is detected in a child. The optometrist has a responsibility to explain the nature and implications (in terms of possible occupational consequences) of the colour vision defect to the parents and child.

Bereavement counselling

This type of counselling involves helping individuals adapt to personal loss. The aim of the counsellor is to help the client work through their grief and perhaps identify coping styles which will help them with day-to-day life. Considering that eyesight is the most valued sense, it is perhaps unsurprising that vision loss has been equated to a bereavement process.[5] Interestingly, Elizabeth Kubler-Ross described the five stages of 'mourning' which everyone passes through as they adapt to major life changing events. These are: denial (eg this can't be happening to me), anger (eg it's not fair!), bargaining (eg I'd give anything for…), depression (eg what's the point?) and acceptance (eg it's going to be OK).[6] Optometrists are not counsellors, and clearly any patient who appears depressed should be referred to a general medical practitioner. However, optometrists can draw on counselling skills to help a person through these stages of mourning to acceptance that their vision is lost forever. Indeed, in terms of low vision patients, individuals will only be truly receptive to the use of low vision aids once they have reached 'acceptance'.

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The listener should give full attention to verbal and non-verbal cues, including body language

All the scenarios described above (eg referring patients, explaining colour vision defects etc) are part of an optometrist's everyday working life. Having the appropriate communicative skills will protect practitioners from burnout and benefit patients. Therefore, the next section will outline the key skills of the counselling process and how they can be applied to optometric practice.

The skills

There are two groups of skills used during the counselling process: 'attending and listening' and 'verbal counselling interventions'. These are both described below.

Attending

This is the skill of truly giving another person your full attention, including what they are doing and saying.[7] To borrow from mediation terminology, it involves being 'fully focused outside of oneself'.[4] Full attention is given to the patient's verbal and non-verbal cues, including body language and pauses in the conversation. When a person feels that they are being fully attended and listened to, they are more likely to communicate openly and honestly. Therefore, as optometrists, it is important that our patients perceive they are being fully attended.

However, attending can be a challenging process because it requires that the practitioner ignores their own thoughts and feelings. In reality what tends to happen is that an individual will pay full attention to the patient for a while before drifting back to notice their own thoughts and feelings. As the practitioner becomes aware of this, they are able to fully attend to the patient once more. The skill lies in recognising these two zones and being able to move between them easily. However, it should be noted that there is a third 'zone' which should be avoided. This is known as the internal 'fantasy' state. In this state the practitioner starts to make judgements, such as 'I know what he really means by that'. We can never truly know what someone else means and imagining that we can is unhelpful.

Being aware of these 'zones' allows us to control our focus. It also allows a degree of self awareness which is essential for our own well-being. It is difficult to concentrate when we are under pressure or emotionally stressed. By recognising this we can reflect upon it and avoid bottling up our own problems.

Listening

Truly attentive listening hears not just the words but attends to the phrases and figures of speech used. This can give clues to a patient's beliefs about their condition. The para-linguistic elements, the volume, tone, pitch and the 'ums and ahs', all give clues about the patient's emotional state. Whereas the non-verbal body language, the facial expressions, gestures and use of touch and proximity give clues to a patient's internal struggles. As the patient displays any emotional expressions via these cues, it allows the practitioner to focus the patient on the specific area causing distress.

However, a note of caution needs to be sounded, we need to be aware that it is very easy to slip into the 'fantasy zone' and believe that we can read all these cues. We need to listen attentively and avoid the urge to interpret.

Verbal counselling interventions

Attending and listening are key communicative skills as they allow identification of patient concerns. However, it is also important that the practitioner can focus the patient's attention on these areas of concern and expand upon them. The simplest way of doing this is the use of 'minimal prompts'. These are the head nods, the 'ums' and the 'go ons'. This not only shows the patient that they are being listened to, but also encourages them to continue talking. However, while it is important to use them, it is even more important not to over use them and end up as the 'nodding dog in the back of a car'.

As optometrists, we also need to be aware of our posture and behaviour. Egan offered the acronym SOLER to help in this situation:[8]

S: facing the client Squarely,
O: adopt an Open, non-defensive posture
L: Lean forward toward the family to show interest
E: make good Eye contact
R: stay Relaxed.

Sitting facing the patient 'sets the scene' for the encounter. Ironically it is easier to describe a close posture than an open one. A closed posture is arms and legs crossed, head down, a defensive position which is surprisingly effective at blocking conversation. We need to sit with feet flat on the floor and hands comfortably in our lap. It is also important to avoid the temptation to make copious notes at this stage. Leaning slightly forward encourages the patient and makes them feel understood. We need to offer as much eye contact as the patient desires. Our eyes should always be 'available' for the patient, but they should never feel intimidated by our eyes boring into them. Finally remember to relax, as we said earlier the patient is the centre of our concentration and worrying about the gas bill or 'rehearsing' our responses will impede our listening.

Time limit

It should be noted as optometrists there is a finite amount of time for each patient consultation. Indeed, counsellors always place a time limit on their discussion at the start of the session. This contract means that the client tends to use the time constructively as many important issues arise towards the end of a session. It also means that the counsellor can structure the session. This normally follows a three stage model:

Practitioners need to be aware of posture. Sitting facing the patient 'sets the scene'

- Relationship building
- Exploring and clarifying
- Action and closing.

This has obvious parallels with our own role of:

- History and symptoms
- Examination
- Action and closing.

The final action and closing section is the most important part of both types of encounter as it allows us to summarise the objectives and form a plan of action. This can be as simple as 'We need to change your glasses. Come through and see our dispenser'.

Interrupting a session because of time constraints may seem disrespectful. In actual fact it is more beneficial to the patient than your failure to listen because of worries about the next patient being kept waiting. As part of the closing we can arrange another appointment or referral to another professional who has the skills to help that individual.

Summary

Using the skills outlined above will encourage patients to voice their concerns, improve patient-practitioner communication and reduce overall patient anxiety. This is important, because it has been shown that high levels of patient anxiety can lead to reduced levels of patient satisfaction, recall of information and compliance.[9,10]

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