Communication and psychosis: it’s good to talk, but how?

Rose McCabe and Stefan Priebe

Summary
Communication between clinicians and patients is at the heart of psychiatric practice and particularly challenging with psychotic patients. It may influence patient outcome indirectly or be therapeutic in its own right. Appropriate conceptual models, evidence on effective interventions and specific training are required to optimise communication in everyday routine practice.

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Clinicians communicate with patients. In psychiatry, this is arguably the main part of what they do in their daily practice. Yet, does it matter how they communicate? Both the General Medical Council and the Royal College of Psychiatrists highlight the role of good communication in achieving therapeutic relationships. Effective communication, and the related construct, the therapeutic relationship, may have an impact on patients’ engaging in treatment in the first place, following treatment suggestions, satisfaction, symptom severity, referral to other services and willingness to file lawsuits.1 It may even be therapeutic in its own right. The therapeutic relationship is negotiated and reflected in patient–clinician communication and appears to predict outcome in different samples and settings across mental healthcare.2 If communication may be influential in patient outcome, there is a challenge to understanding how these processes work in psychiatry. This may feel especially difficult when communicating with patients with psychosis whose contributions may appear to be inappropriate both in their content and placement in the interaction. The first step is good research.

Studying communication
Communication is difficult and cumbersome to study. A typical approach involves recording the interaction. Videotaping one session can be the minimum. This is easier in a clinic setting than in various community settings. Audiotaping alone is problematic given how much information is contained in non-verbal aspects such as posture and gaze. A long gap in a consultation has a different meaning if the clinician is writing notes in that gap or has eye contact with the patient and is not responding to a patient’s question. Most methods involve transcription, ranging from basic (content only) to highly detailed transcripts (content plus intonation, pauses, overlap, gaze, etc.) followed by time-consuming and labour-intensive analysis; linking one-off consultations with long-term clinical outcome is inappropriate given the complexity of treatment processes. It is likely that a series of consultations need to be studied to establish factors that have an impact on clinical outcomes. Simpler methods may need to be developed to capture intermediary outcomes of communication so that they can be assessed in pragmatic studies with sufficiently large samples.

Setting aside the methodological problems, a key conceptual issue is that, even in the social sciences, there is no definitive model of ‘good communication’. A focus of positive communication throughout healthcare is patient-centredness. One component is shared decision-making. People with schizophrenia have a slightly stronger preference for shared decision-making than primary care patients.3 Among those with schizophrenia, younger people and those with more negative views of medication want more participation.4 Some research has been carried out on shared decision-making in relation to antipsychotics. Scale et al audiotaped psychiatric consultations and interviewed psychiatrists about their negotiating styles.5 In interviews, psychiatrists were committed to achieving concordant relationships with patients although they felt there were obstacles particular to psychiatry, mainly if the patient was deemed too ill to make decisions and the patient’s honesty about their medication use. Analysis of the consultations themselves showed how side-effects may remain unaddressed (by offering no response, changing the subject or disagreeing with the patient’s interpretation of the experience) or be acknowledged through sympathetic and supportive listening.

What should I say now?

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In a detailed study of how psychiatrists and patients communicate about psychotic symptoms in out-patient consultations, patients repeatedly attempted to raise the content and emotional consequences of their hallucinations and delusions.5 Psychiatrists frequently avoided engaging with these concerns, leaving both patients and doctors very uncomfortable. One patient asked ‘Why don’t people believe me when I say I’m God?’ to which the doctor, after initial avoidance, replied ‘What should I say now?’ In ‘normal’ interaction, avoiding sensitive issues that might expose conflicts of opinion is typically a good strategy. This might also apply here where the clinician avoided a confrontation about beliefs on which agreement was unlikely to be reached. Yet, in interactions with patients with psychosis, initial avoidance by clinicians seems to lead to explicit confrontation and disagreement about the very reason the patient is there. With patients who are not well-engaged, this might lead to further disengagement during treatment.

Despite the fact that communication about psychotic symptoms is a frequent challenge and regarded as fascinating by...
Interventions to improve communication

In medicine generally, alerting clinicians to the patient’s concerns/emotions and changing clinicians’ beliefs about communication have led to communication change. However, interventions to improve communication, and in turn outcome, in psychosis are rare. A simple communication checklist completed by patients may improve communication, and in turn, outcome, in psychosis. A qualitative study of psychiatrists’ experiences, which goes far beyond any therapy, that is, beyond anything that can be planned or methodically staged (p. 798). Thus, not all aspects of how psychiatrists and patients communicate might be identifiable in research and teachable in the classroom or individual supervision. Yet, the challenge is to advance the state of the art to reveal as much as possible so that patients benefit from communication that is, either indirectly or directly, therapeutic. Clinicians may also benefit from enriching their therapeutic options and professional expertise.

Concluding remarks

If psychiatrists want to make better use of everyday communication as a core component of their trade, the ambition must be to develop better competence and skills to maximise its therapeutic effect, preferably based on sound conceptual models and evidence derived from them. Some of the required skills may be generic, whereas others are likely to be specific to communicating with patients with psychosis. Jaspers’s noted that ‘the ultimate thing in the doctor–patient relationship is existential communication, which goes far beyond any therapy, that is, beyond anything that can be planned or methodically staged’. Thus, not all aspects of how psychiatrists and patients communicate might be identifiable in research and teachable in the classroom or individual supervision. Yet, the challenge is to advance the state of the art to reveal as much as possible so that patients benefit from communication that is, either indirectly or directly, therapeutic. Clinicians may also benefit from enriching their therapeutic options and professional expertise.

References

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