

Communicating about psychotic symptoms in the medical consultation

A shared understanding or agreement about psychotic phenomena between patient and psychiatrist is a valid therapeutic goal and key to enabling patients' ongoing engagement with mental health services and the outside world.

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PEOPLE WITH schizophrenia are among the most socially excluded in our society. One in four have no contact with their families and one in three have no contact with friends.¹ For some, contacts with mental health professionals are among their few social contacts. However, many disengage from services and those who drop out of treatment are also the most unwell.² Specialist assertive outreach services have been established to improve their engagement with services, and there is some evidence that assertive outreach is more successful than standard care in maintaining contact with clients.³ However, the focus is on service configuration – little is known about what actually happens when mental health professionals and people with schizophrenia interact and what might make a difference on this individual level.

We recently conducted a study of 32 audio-visually recorded outpatient consultations

between psychiatrists and people with a diagnosis of schizophrenia or schizoaffective disorder.⁴ Informal carers, typically the patient's partner or parent, were present in about one-third of the consultations. The consultations lasted approximately 15 minutes and were analysed using a qualitative method: conversation analysis, which analyses what people do rather than what they say they do. It involves transcribing both what people say and how they say it. What people say is quite simply the words they use. The 'how' includes aspects of talk delivery such as pauses, stress, intonation and overlapping speech.

A typical consultation involved the psychiatrist asking the patient about how they had been since the last visit, asking the carer for their account of how things had been, reviewing medication and side effects and discussing social aspects of care such as daily activities and living arrangements. The psychiatrist tended to ask the patient about whether they were (still) experiencing symptoms, such as hearing voices or having unusual thoughts, and if so how often and to what degree. This kind of talk was not especially problematic.

The patient, on the other hand, attempted to talk about the content of their psychotic symptoms, along with the emotional consequences (such as fear or embarrassment) and why others disagreed with their claims and beliefs. This kind of patient-initiated talk was not easily introduced into the consultation. Patients used certain conversational strategies in an attempt to make

these concerns a legitimate topic for discussion. For example, they repeated statements or questions about their symptoms, asked direct questions and introduced this talk in the pre-closing phase of the consultation. When patients did succeed in topicalising their concerns about these symptoms, it was a source of tangible interactional problems. Psychiatrists displayed reluctance and discomfort in talking about these aspects of psychotic symptoms; they hesitated and avoided answering these questions. When a carer was present, they also smiled or laughed in response to patients' assessments of and questions about their symptoms.

In the talk that patients were trying to topicalise, they were either attempting to articulate the content of their symptoms and how the symptoms made them feel, or to make sense of their symptoms and illness. The following are verbatim quotes from patients recorded during consultations.

Why don't people believe me when I say I'm God?

Do you think what I'm telling you even when I was working in (place) I asked my supervisor because she was dealing with the psychiatry people and do they exist that there are people that are causing this eh sickness because I'm fully confident fully satisfied now it's not the medication that makes me with all the symptoms it's the those people that I'm that are (after me) that I feel sick an everything I blame them.

Is my mind unbalanced?

I'm starting to get I'm not starting I (keep) I still get those funny thoughts you know coming into my head an stuff an they cause me a bit of ehm trouble...well I can't (really) well I don't tell anybody well hardly anybody exactly what's happening in my head but ehm because I'm ashamed of it really you know?...I'm ashamed of what I think you know? It's...It makes me feel angry at myself and so on you know?

Constructing meaning from one's experience is a fundamental human activity and an inherently social one. We discuss our experiences with others and assess them in this way. As Hinshelwood⁵ suggests, creating meaning out of strange experiences may become particularly important for people whose illness means they are vulnerable to losing personal meaning. Developing meaning and a narrative for one's experience creates order for the self, the boundaries of which can be especially threatened when someone is psychotic.

The questions that caused the greatest interactional tension were those from patients highlighting others' disbelief in their claims. In any interactive domain, successful communication rests on participants creating mutual understanding and resolving sources of misunderstanding. Jaspers⁶ described psychotic symptoms as non-understandable experiences, although possibly explainable. These findings show the practical problem of coming to a shared understanding or agreement about psychotic phenomena and the challenge of responding therapeutically to questions about the 'reality' of patients' anomalous experiences. For psychiatrists, this might present a paradoxical task. On the one hand, their role is to diagnose these symptoms as based on 'unreal' perceptions and thought contents and therefore pathological. On the other hand, patients are trying to seek a shared understanding of their 'unreal' experiences in a therapeutic exchange, which the psychiatrist cannot confirm as real for them.

The difficulty for professionals is that they are presented with questions that pose a genuine dilemma. A patient asks, "Why don't people believe me when I say I'm God?", or "These people that are drilling holes in my head, they are the cause of my problems. What do you think?" The psychiatrists' role as specialists leads to expectations that they know the answers to these questions. But what is the right response? And is this the same thing as the most therapeutic response?

The jury is still out on the most therapeutic way to respond to these concerns, and how this is linked with longer term outcome is an issue for future research. However, our study suggests that if clinicians are prepared to engage with patients by taking up a dialogue about the content of their thoughts and experiences, patients might find it easier to engage with clinicians.

We may need to think about reformulating psychological distress in medical practice and psychiatry in particular. Psychosis renders the world we normally inhabit meaningless and gives rise to enormous distress for patients. If they cannot talk to their psychiatrist about the content of these symptoms, the typically negative emotional consequences and their difficulty understanding why others disagree with their claims, whom should they talk to? Communication is about establishing understanding and resolving sources of misunderstanding. It must be a valid therapeutic goal to seek to understand a patient's world of meaning. Otherwise, what may be the patient's only opportunity for ongoing communication with the outside world disappears. ●

REFERENCES

1. Harvey CA. The Camden schizophrenia surveys I: the psychiatric, behavioural and social characteristics of the severely mentally ill in an inner London health district. *Br J Psychiatry* 1996;168(4):410-17.1.
2. Killaspy H, Banerjee S, King M et al. Prospective controlled study of psychiatric out-patient non-attendance: characteristics and outcome. *Br J Psychiatry* 2000;176:160-5.
3. Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. *Cochrane Database Syst Rev* 2000;(2):001089. Review. Oxford: Update Software.
4. McCabe R, Heath C, Burns T et al. Engagement of patients with psychosis in the medical consultation: a conversation analytic study. *BMJ* 2002;325(7373):1148-51.
5. Hinshelwood RD. The difficult patient. The role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or severe personality disorder. *Br J Psychiatry* 1999;174:187-90.
6. Jaspers K. General Psychopathology (Translated by J. Hoenig & M. Hamilton, 1963). Manchester: Manchester University Press, 1959.

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