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Communication Study

Discrepancies between adolescents' attributed relevance and experiences regarding communication are associated with poorer client participation and learning processes in psychosocial care

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ABSTRACT

Objective: To examine adolescents' attributed relevance and experiences regarding communication, and whether discrepancies in these are associated with clients' participation and learning processes in psychosocial care.
Methods: Adolescents receiving psychosocial care ($n = 211$) completed measures of communication in three domains: affective communication, information provision, and shared decision-making. Participation involved clients' attendance and adherence (professional-reported). Learning processes involved clients' improved understanding and improved confidence (client and professional-reported).
Results: Important but less often experienced affective communication was associated with low adherence (odds ratio, 95% confidence interval: 2.8, 1.1–6.8), less improvement in understanding (3.7, 1.5–9.0), and less improvement in confidence (4.5, 1.8–11.6). If information provision or shared decision-making was important but less often experienced, adolescents were more likely to demonstrate less improvement in understanding (3.1, 1.1–8.5; 4.2, 1.7–10.8). The combination "less important but experienced" only had an effect regarding affective communication; these adolescents were more likely to demonstrate less improvement in confidence (6.0, 2.3–15.4).
Conclusion: Discrepancies between attributed relevance and experiences frequently occur. These discrepancies negatively affect adolescents' participation and their learning processes, although the pattern differs across communication domains.
Practice implications: Care professionals should pay considerable attention to their clients' communication preferences and adapt their communication style when necessary.

1. Introduction

One out of every four to five adolescents suffers from at least one mental health problem [1,2]. In the Netherlands about 10% of these adolescents receive psychosocial care for emotional or behavioral problems [2,3]. However, clients often display poor treatment adherence, and approximately one-third of all adolescents drop out from psychosocial care, undermining the effectiveness of treatment [4,5]. Care may be more effective if clients participate actively, for instance, by keeping scheduled appointments and adhering to recommendations [4]. Furthermore, adolescents with emotional and behavioral problems need to learn how to deal with and manage these problems. This is important because youth with lower problem-solving abilities demonstrate higher levels of problem behavior [6]. In this learning process adolescents can improve on a cognitive level (e.g., understanding of problems and how to handle these), as well as on an emotional level (e.g., self-confidence).

Clients' participation and learning processes may be positively influenced by client-centered communication, in which care professionals adapt their communication to their clients' preferences. The concept of client-centeredness, originally defined as the acknowledgment of every client as a unique person [7], is generally

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considered to be the standard for high-quality care, and an effective way to involve and motivate clients. Stewart [8] stated that truly client-centered communication means being aware of clients' preferences. This allows the professional to approach the client in the desired way, to provide the desired level of information, and to involve the client in decision-making as much as he or she wishes. Research in various healthcare settings, such as general practice, oncology, and diabetes care, found associations between client-centered communication and beneficial outcomes such as client satisfaction, participation, and health [9].

However, when it comes to adolescent psychosocial care, little is known about client-centered communication and its association with outcomes. The present study sought to examine the relevance adolescent clients attribute to different aspects of client–professional communication and their experiences with these aspects, and whether discrepancies in these are associated with adolescents' participation and learning processes in psychosocial care. General theories about client–professional communication in healthcare have described various relevant communication functions, such as information exchange, responding to emotions and making decisions [10,11]. Studies performed in psychosocial care mainly focus on the client–professional relationship and clients' participation in decision making [12–15]. To be able to participate in decision making processes, clients should be provided with sufficient information about their options. Therefore, we chose to assess communication across three domains: (a) affective communication, (b) information provision, and (c) shared decision-making. We expect that when discrepancies between adolescents' attributed relevance and experiences exist, this will lead to low attendance, low adherence, and less improvement in understanding and confidence (toward oneself and toward the situation one is in).

For psychosocial care professionals this study provides insight into the degree to which relevance-experiences discrepancies regarding communication affect their clients' participation and learning processes. These insights may stimulate them to work on adjustment of their communication to their clients' needs.

2. Methods

2.1. Study design

This study was conducted within the framework of TakeCare, a large longitudinal prospective cohort study, designed to investigate the trajectories in and outcomes of care for youth with emotional and behavioral problems. The study captures all new cases entering this care in one Dutch region. We obtained data from different sources (adolescent, parent, professional). This report is based on data from the first (T1; before psychosocial care started) and the second (T2; three months after T1) measurement waves, which respectively ran from April 2011 through June 2013, and from July 2011 through September 2013. Informed consent was obtained from participating adolescents (and their parents if below the age of 16) after the nature of the study had been fully explained. The study was approved by the Medical Ethical Board of the University Medical Center Groningen.

2.2. Sample

All adolescents (12–18 years old) who enrolled in an organization for child and adolescent social care or for child and adolescent mental healthcare were invited to participate in this study ($n = 766$). Potential participants were excluded if they were older than 18, had severe mental retardation, were not living in one of the three northern Dutch provinces, did not speak Dutch, did not start treatment after all, or had already received treatment within the organization ($n = 26$). In some cases adolescents could not be contacted because we did not receive the correct telephone number ($n = 50$), or the parent did not grant permission to contact the adolescent ($n = 65$). Of the 625 eligible adolescents, 416 (67%) were reached and agreed to participate in the study.

In the present study we included adolescents who filled in both the questionnaire at the first (T1) and second measurement wave (T2), for whom professional information was available, and who had had at least two appointments with the professional ($n = 211$). There were several reasons why clients had none or only one contact with the professional: treatment did not start yet ($n = 37$), treatment was aimed at the parent(s) ($n = 27$), clients were referred to another psychosocial care professional or organization ($n = 39$), or treatment just started and there had only been one contact yet ($n = 19$). Some respondents did not indicate a reason ($n = 12$). Fig. 1 shows the selection of the subsample.

The participants included in this sample did not differ significantly from the original sample with respect to socio-demographic characteristics (e.g., family composition, $p = 0.75$) and total mental health problems ($p = 0.75$). However, more girls were included in the subsample ($p = 0.02$), and a higher score was found for the domain emotional symptoms ($p = 0.02$).

2.3. Procedures

Upon entry into care, adolescents and their parents received written information about the study. Approximately two weeks later, they were invited to participate. If willing, participants then received a questionnaire, the latter either by e-mail (80%) or on paper (18%), depending on the preference of the participant. If needed, telephone interviews or home visits were arranged (2%).

2.4. Measures

Discrepancies between attributed relevance and experiences regarding communication were measured using an adapted version of the Consumer Quality Index (CQI) [16]. The CQI assesses both the importance of and experiences with different aspects of care. Items concerning client–professional communication were derived from three existing CQI versions that have been used in

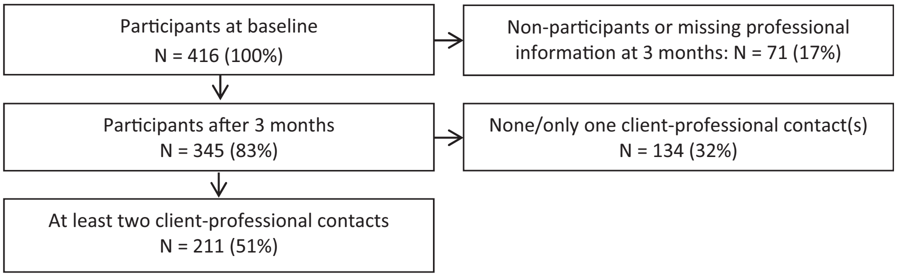

Fig. 1. Flowchart sample.