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Communication Study

Shared understanding in psychiatrist–patient communication: Association with treatment adherence in schizophrenia

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ABSTRACT

Objective: Effective doctor–patient communication, including a shared understanding, is associated with treatment adherence across medicine. However, communication is affected by a diagnosis of schizophrenia and reaching a shared understanding can be challenging. During conversation, people detect and deal with possible misunderstanding using a conversational process called repair. This study tested the hypothesis that more frequent repair in psychiatrist–patient communication is associated with better treatment adherence in schizophrenia.

Methods: Routine psychiatric consultations involving patients with (DSM-IV) schizophrenia or schizoaffective disorder were audio-visually recorded. Consultations were coded for repair and patients' symptoms and insight assessed. Adherence was assessed six months later. A principal components analysis reduced the repair data for further analysis. Random effects models examined the association between repair and adherence, adjusting for symptoms, consultation length and the amount patients spoke.

Results: 138 consultations were recorded, 118 were followed up. Patients requesting clarification of the psychiatrist's talk and the clarification provided by the psychiatrist was associated with adherence six months later (OR 5.82, 95% CI 1.31–25.82, $p = 0.02$).

Conclusion: The quality of doctor–patient communication also appears to influence adherence in schizophrenia.

Practice implications: Future research should investigate how patient clarification can be encouraged among patients and facilitated by psychiatrists' communication.

1. Introduction

In medicine, the quality of doctor–patient communication is associated with patient outcome, in particular patient satisfaction and treatment adherence [1]. In a recent meta-analysis, the odds of having adherent patients were twice as high if doctors were good communicators [2]. However, relatively few studies of communication and outcome have been conducted in mental health care, with many relevant studies excluding psychiatric populations (e.g., [2,3]). Replicating the association between communication and adherence in the treatment of schizophrenia would be of interest given the high rate of non-adherence. The CATIE study found that 74% of patients stopped taking medication prematurely [4]. Meanwhile, a survey of patients found that 38% came off their anti-psychotic medication without telling their psychiatrist [5].

Shared understanding is central to effective doctor–patient communication (e.g., [6]). Most approaches to doctor–patient communication rely on external observers' interpretation of whether participants in a conversation have a shared understanding rather than the participants themselves. A different approach is

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offered by conversation analysis, an established approach to the study of communication, which analyses what people do rather than what they say they do. It is based on micro-analysis of communication. In this framework, participants' utterances demonstrate their understanding or misunderstanding of the previous person's talk. Moreover, a specific practice used by speakers to identify and clarify misunderstandings during conversation is called repair [7,8]. This is pervasive, highly systematic and measurable in conversation [9]. It is a more sensitive measure of shared understanding than is offered by other approaches to communication that is directly linked to peoples' own assessment of how well they understand each other. The amount of repair used by both speakers is a collaborative activity, reflecting how much effort they make to reach a shared understanding that is tied to the specific local context.

The conversation analytic (CA) literature describes three important features of repair (a) initiation: who signals a problem – whether it is the speaker of a problem turn ('self') or a recipient of it ('other'), (b) completion: who completes the repair and actually makes a change (self or other), and (c) position: where in the conversational sequence these events occur; in the same turn as the problem, in the turn after the problem turn or in some subsequent turn [7,8].

For the present purposes, there are two important types of repair. Firstly, a speaker initiating and completing repair of their own utterance while producing it (self initiated, self repair) e.g., "I saw you three, **no two** months ago". This reflects how hard a speaker works to formulate talk that is understandable to their conversational partner. Secondly, a listener initiating repair of their partner's previous utterance (other initiated self repair), e.g., a patient requesting clarification of the psychiatrist's talk, with the psychiatrist providing the clarification:

Dr: Yep well that is a possible side effect
Pat: **Side effect?** [request for clarification]
Dr: **Of the haloperidol** [clarification]

Often people ignore possible differences in interpretation on the assumption that they are not important enough to threaten the business of the conversation. As a result, the points where they choose to signal or address a misunderstanding are, all things being equal, of special significance for the success of the interaction. However, it is well documented that some type of language breakdown is central to schizophrenia. Difficulties on the levels of semantic, syntactic and pragmatic language use have been found [10]. With reference to repair, patients with schizophrenia have been shown to use less self-repair [10]. This may, in turn, affect how they reach a shared understanding with their psychiatrists in treatment.

The current study applies the conversation analytic approach to shared understanding to psychiatrist–patient communication in the treatment of schizophrenia. This study focuses on patients in outpatient clinics in secondary mental health care in UK because they are seen primarily by psychiatrists, making it possible to link treatment outcome with one psychiatrist rather than multiple professionals' communicative input. The study design is longitudinal, focusing on communication at baseline and adherence six months later to allow hypothesis testing about relationships over time.

1.1. Objective

The objective of this study was to test the hypothesis that a better shared understanding, indexed by more occurrences of repair, in psychiatrist–patient communication is associated with higher treatment adherence in schizophrenia.

2. Methods

2.1. Design overview

This was a prospective observational study. Communication, symptoms and insight were assessed at baseline and adherence was assessed after six months.

2.2. Setting and participants

Collection of baseline data began in March 2006 and follow-up data collection ended in January 2008. Ethical approval for the study was granted by the local research ethics committees. Thirty six psychiatrists were randomly selected to participate, and 31 agreed (86%). Patients meeting Diagnostic and Statistical Manual-IV (APA) criteria for a diagnosis of schizophrenia or schizoaffective disorder attending psychiatric outpatient and assertive outreach clinics in 3 centres (one urban, one semi-urban and one rural) were asked to participate. Consecutive attenders were approached in the waiting room by an independent researcher. 579 patients were eligible, 188 did not attend their appointment, 42 were not approached (considered too ill to approach by the psychiatrist or their appointment overlapped with another study participant) and 211 did not consent. After complete description of the study to the participants, written informed consent was obtained from 138 (40%) of those approached.

2.3. Baseline measurements

Psychiatrist–patient consultations were audio-visually recorded using digital video. The consultations occurred within the context of an ongoing relationship. Patients were interviewed, after the consultation, to assess their symptoms and insight. Length of illness was documented.

2.3.1. Communication

Video consultations were transcribed by two independent researchers (AS and ML) who were not involved in patients' treatment. The standardised repair protocol [9] was applied to the written transcripts (by AS and ML) in order to assess the frequency of repair. The protocol has been validated in patients with schizophrenia [11]. Inter-rater reliability was good (Cohen's kappa = 0.73).

The protocol consists of a binary branching decision tree of yes/no questions that are applied to each utterance to identify all instances of repair. The protocol is based on Schegloff et al.'s [8] system of repair, which yields 9 parallel types of repair for the psychiatrist and 9 for the patient defined according to who initiates the repair (self or other), who completes the repair (self or other) and the position of the repair (1, 2 or 3) (as set out in Table 1). Approximately half focus on producing understanding and modifying the other's understanding of one's own talk and the other half focus on clarifying understanding of another person's talk. This captures what participants themselves highlight in producing and clarifying understanding.

2.3.2. Symptoms

Two researchers (AS and ML) not involved in patients' treatment and unaware of the content of the psychiatric consultation and adherence ratings, assessed patients' symptoms on the Positive and Negative Syndrome Scale (PANSS) [12]. Inter-rater-reliability was good (Cohen's kappa = 0.75).

2.3.3. Insight

Insight was measured with the Recovery Style Questionnaire [13]. This is a self-report measure consisting of 39 statements