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Communication about psychotic symptoms in psychiatric consultations

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Abstract

Background: Communicating about psychotic symptoms can be challenging. This study aimed to identify (1) how psychiatrists and patients communicate about psychotic symptoms from a research and clinical perspective, and (2) whether communication patterns depend on patients' symptom levels.

Sampling and Methods: Consultations of 27 psychiatrists and 100 patients with long-term schizophrenia/schizoaffective disorder in outpatient clinics were video-recorded, transcribed and coded. Symptoms were assessed on the Positive and Negative Syndrome Scale. Avoidance or engagement with psychotic symptoms was coded separately by researchers and three clinical psychiatrists.

Results: Psychotic symptoms were not mentioned in 27% of consultations. Patients reported their absence in 34% and avoided talking about symptoms in 6%. Researchers rated psychiatrists as engaged in talking about psychotic symptoms in 15% consultations and avoiding talking about them in 18% consultations. Psychiatrists identified somewhat less avoidance (10%) and more engagement (23%). Psychiatrist avoidance was seen when the patient raised the topic and the psychiatrist gave brief responses and/or changed the topic. When psychiatrists engaged, they asked specific questions about symptoms, responded to patient concerns and provided explanations about symptoms. Psychotic symptoms were more often discussed with patients with more negative and general symptoms.

Conclusions: There is considerable variation in whether psychotic symptoms are discussed or not in outpatient consultations. Whether psychiatrists discuss psychotic symptoms is influenced by patients' symptoms but not by their psychotic symptoms but the presence of negative and general symptoms. Psychiatrists' ratings of communication identify similar patterns as detailed research analyses.

Introduction

The role of good communication is highlighted in achieving good therapeutic relationships with patients in medicine and in psychiatry [1, 2]. As Cruz and Pincus note [3], the psychiatrist attempts to balance data gathering from patients with the development of a trusting and caring relationship. Patients report that the therapeutic relationship is the most important component of good psychiatric care [4, 5]. The therapeutic relationship is negotiated and reflected in patient–clinician communication and appears to predict outcome in different samples and settings across mental healthcare [6, 7]. A recent systematic review concluded that the therapeutic relationship also predicts outcomes of complex psychiatric treatment in patients with psychosis [8].

If communication may be influential in patient outcome, there is a challenge to understand how these processes work in psychiatry [9]. This may feel especially difficult when communicating with patients with psychosis whose contributions may appear to be inappropriate in their content and placement in the interaction. On the other hand, communication about psychotic symptoms is part of daily clinical practice and regarded as fascinating by many psychiatrists. To date, there is little systematic research on how patients and psychiatrists talk about psychotic symptoms in routine practice. Nor are there (evidence based) guidelines on how they should communicate about psychotic symptoms. Recommendations vary, including the suggestion not to 'encourage' the patient to talk about their symptoms because it amounts to inadvertent collusion with the illness [10].

Previous research found that psychiatrists sometimes avoid talking to patients about the content and meaning of psychotic experiences, focusing rather on the frequency and severity of their psychotic symptoms in order to adjust medication [11]. This study was conducted on a small sample of 32 psychiatric consultations using a resource intensive micro-analytic research method, i.e. conversation analysis. Hence, these findings require further investigation in a larger dataset. In addition, for translating the findings into clinical practice, the question arises whether the communication patterns identified using detailed analyses can also be identified by psychiatrists when they conduct a more global rating of the consultation. If psychiatrists arrive at similar findings, future research may be simplified and not always require detailed analytical methods. Also, it will be easier to apply the findings to clinical practice and supervision where psychiatrists do not have research analyses at their disposal and need to trust their own more global judgment.

Against this background, this study aimed to identify (1) how psychiatrists and patients communicate about psychotic symptoms as analysed in detail by researchers and globally by psychiatrists, and (2) whether communication patterns are influenced by the level of patients' symptoms.

Method:

Setting and participants

Data were collected in psychiatric outpatient and assertive outreach clinics in three centres in the United Kingdom, one inner city, one semi-urban and one rural centre. Patients meeting Diagnostic and Statistical Manual-IV [12] criteria for a diagnosis of schizophrenia or schizoaffective disorder, aged 18-65 years, with no organic brain disorder or substance misuse, and speaking fluent English without the need for an interpreter, were asked to participate in the study. Consecutive attenders at out-patient clinics were approached in the waiting room by an independent researcher. Prior to the clinics, 579 patients were identified as eligible based on medical records, of whom 188 did not attend their appointment and 42 were not approached because they were considered too ill to approach for consent by the treating psychiatrist or their appointment overlapped with another study participant and the two consultations could not be recorded simultaneously. A further 211 patients did not consent.

After complete description of the study to the patients, written informed consent was obtained from 138 (40%) of those approached. From this, a random selection of 100 consultations were selected. The consent rate for psychiatrists was 86%. Ethical approval for the study was granted by the local research ethics committees.

Psychiatrist-patient consultations

Routine outpatient consultations were audio-visually recorded using digital video. One digital video camera was placed in the corner of the consultation room, using a wide-angle lens if necessary, and recording was started prior to the consultation assuming written informed consent had been gained beforehand.

Symptoms

Researchers independent of the patients' treatment, and unaware of the content of the psychiatric consultation, assessed patients' symptoms on the 30-item Positive and Negative Syndrome Scale (PANSS) [13]. The scale assesses positive, negative and general symptoms and is rated on a scale of 1-7 (with higher scores indicating more severe symptoms). Inter-rater reliability [14] using videotaped interviews for PANSS was good (Cohen's kappa=0.75) [15].

Data analysis:

Research analysis of avoidance and engagement

All of the transcripts were read to identify excerpts in which patients and psychiatrists talked about the content of, emotional aspects of (e.g. fear, shame, guilt, happiness) and ideas about psychotic experiences using the following inclusion and exclusion criteria.

Inclusion criteria: talk about experiences over the last two months even if currently asymptomatic; past experiences if the patient still believed that it actually happened instead of viewing them as a part of his/her illness; negative emotions related to the absence of psychotic symptoms (e.g. fear, loneliness, anger).

Exclusion criteria: the psychiatrist asking the patient about their understanding of current or previous psychotic symptoms; psychiatrist asking the patient questions to “display” or give an account of symptoms, or doing “reality testing”; a third party (e.g. formal or informal carer) talking to the patient about psychotic symptoms when the psychiatrist was not involved.

The excerpts were coded using operationalised criteria defining avoidance and engagement (see Table 1). These criteria were derived from previous conversation analysis of communication about psychotic symptoms [11]. Most of the criteria relate to avoidance. The absence of these criteria indicate engagement. The coding was conducted using the transcripts and the videos of the excerpts. Inter-rater reliability applying these criteria to 10% of the data was calculated by two raters.

Insert Table 1 here.

For each excerpt, we also identified how the topic of psychotic symptoms arose in the consultation: the psychiatrist asks the patient specifically about psychotic symptoms (e.g., “Are you hearing voices at the moment?”); the patient starts talking about psychotic symptoms when the preceding interaction has created an opportunity (e.g., “How are you doing?”); the patient starts talking about psychotic symptoms when the preceding interaction has not created an opportunity (e.g., when another topic is being discussed). These distinctions were also based on previous detailed analyses [11] as they reveal important information about how easily the topic of psychotic symptoms are introduced into the conversation. If the patient raises psychotic symptoms when no opportunity has been created, this is more likely to indicate avoidance. For examples of each, see Table 2.

Insert Table 2 here.

In order to link this qualitative analysis with quantitative data (e.g. patient symptoms, length of illness, etc), a single index of avoidance/engagement was required. The frequency of the communicative behaviours (see Table 1) in the excerpts were examined along with the transcripts of the excerpts to identify the most discriminating communicative behaviours. As expected, some behaviours could be present in avoiding *and* engaging behaviour, e.g., pauses and hesitating devices and minimal responses during an utterance. Hence, we identified more discriminating behaviours, i.e., the patient’s and psychiatrist’s full sentences (the balance of the exchange) and inappropriate change of topic. The avoidance / engagement index was calculated as follows: (full patient’s sentences ÷ total line numbers in the excerpt) minus (full psychiatrist’s sentences ÷ total line numbers in the excerpt). If the patients were producing full sentences significantly more than the psychiatrist, this value was ≥ 0.20 and indicated avoidance by the psychiatrist. If the psychiatrists were producing full sentences in response to the patient less (<20%), the same or more than the patient, this value was <0.20 and indicated engagement. For example, in the following excerpt 1, the patient discusses his voices:

EXCERPT 1

1 P: the voices seem to have stopped
2 C: right
3 P: occasionally I hear a voice (.) but they were very persistent then
4 C: right
(3.4)
5 C: so that must be quite a a a
6 P: mm mm mhm
7 C: sense of something, some improvement do you think from
8 your point of view
9 P: they used to be (.) a (.) real (.) nuisance because I'm trying to concentrate or talk to
10 someone
11 C: mm
12 P: and these voices would be constantly interfering and um
13 C: and how long ago did you (.) change (.) can you remember roughly (.) when did you
14 P: um (1.6) well I changed the medication about 2 years ago I think it was (4) and um
15 (3.2) there was a great improvement from then on really

This excerpt displays minimal responses such as 'right' and 'mm' (lines 2, 4, 6, 11), a long pause of 3.4 seconds (between line 4 and 5) and a change of the topic to medication (line 13). It is composed of 15 lines: 2 psychiatrist full sentences (lines 5 and 7): 3 psychiatrist minimal responses including a change of topic (lines 2, 4 and 13), 7 patient full sentences (lines 1, 3, 9, 10, 12, 14 and 15) and 1 patient minimal response. According to the formula above, $(7/15=0.47) - (3/15=0.2) = 0.47-0.2=0.27$ indicating avoidance.

The next excerpt (Excerpt 2) shows an exchange that is considerably more balanced with respect to the effort the psychiatrist and the patient make to discuss the patient's voices.

EXCERPT 2

P My voices are much the same
C You've done great
P But they do play with me Dr XX
C From our sessions before, generally speaking, you find it worse in the afternoons
P Yeah
C So you can sleep ok
P Yes
C They bother you going off to sleep, you get up in the morning and
P I'm alive.
C You're alive, go down your road or whatever and do stuff with people
P Mmm
C Is that right? And the voices aren't bothering you then, in any way at all?
P No they're not
C Not even a whisper in the background?
P No
C All right
P But the other thing is Dr XX whether I, when they come on whether I say something or not it does not deter them. Whether I'm acting, writing or erm talking, talking is not so bad an activity, it still intrudes, so you know sometimes I just go home, put a bit of music on
C Does music dull them down?
P It makes me feel better
C (Laughs) Yes
P Doesn't get rid of them
C Doesn't get rid of them. What about other things, you know like, I don't know, maybe carpentry or physical things
P No
C Talking, can that...
P Yes
C So having a conversation with someone
P Yeah
C So that sort of
P Yeah
C The voices sort of stand aside
P Yeah

C	Is that right
P	Yeah
C	Do you actually hear them?
P	No
C	What they simply, they get blocked out
P	They get blocked out, yeah
C	By you talking
P	Yeah
C	Or by other people talking
P	By, by engaging in conversation
C	By engaging in conversation
P	Yeah
C	Mmm
P	But of course you can't always be in company
C	Right

The psychiatrist actively explores the patient's experience and the effect of the voices on the patient (And the voices aren't bothering you then, in any way at all? Not even a whisper in the background?). There are few minimal responses (such as mhm, right, okay) and many full sentences. He positively reinforces the patient (You've done great. You're alive, go down your road or whatever and do stuff with people). There is not a premature change of topic. There are no long pauses or hesitating devices (such as ehm, well) in the psychiatrist's utterances. There are 12 patient full sentences and 20 psychiatrist full sentences. Hence, according to the formula above, $(12/50=0.24) - (20/50=0.40) = 0.24 - 0.40 = -0.16$ indicating engagement.

Global clinical ratings of avoidance and engagement

Three practicing clinical psychiatrists read all of the transcripts. One psychiatrist was in the final year of her training, one had been qualified for 2 years and the other for 25 years. All had worked in another country in addition to the UK. They were independently asked to identify talk about psychotic symptoms and categorize it into one of four categories as displayed in Table 3: no symptoms, psychiatrist avoidance, psychiatrist engagement or patient avoidance. Psychiatrists defined, post hoc, what they considered to be avoidance and engagement. They considered avoidance to include: symptoms are not discussed or discussed very briefly; asking about the presence of voices or delusions but not about the content; talking most of the time about other issues such as medication, benefits, daily living; responding with long pauses and short answers; and, changing the topic while the patient is talking about psychotic symptoms. They considered engagement to include: asking more than once about psychotic symptoms in order to understand how intense they are and also how much they affect the patient's life; asking about the patient's feeling about the symptoms; giving some explanations in relation to the patient's concerns or fears; and empathising with the patient's emotions. Inter-rater reliability was conducted on 10% of the data.

Insert Table 3 here.

Four groups of consultations (psychotic symptoms not discussed, patients explicitly report no psychotic symptoms, patients or psychiatrists avoid psychotic symptoms, patients and psychiatrists engage in discussing psychotic symptoms) were compared on: patients' positive, negative and general symptoms; length of illness; and number of admissions in one-way ANOVAs. Statistical analysis was conducted using SPSS 18 [16].

Results:

Sample

100 consultations were analysed involving 100 patients and 27 psychiatrists. A carer (formal or informal) was present in 22 consultations. The consultations lasted on average 18.1 minutes (SD 10.1). 67 excerpts meeting the inclusion criteria were identified in 33 consultations.

74 patients were male and 26 female. The mean age of patients was 42.6 years (SD 12.1). 69% were White British, 8% Black/ Black British/ Black African, 6% Asian/ British Asian/ Pakistani and 17% from an other ethnic background (White Irish, other white background, Black or Black British-Caribbean, Asian or Asian British – Bangladeshi, Chinese or other ethnic background – Chinese, Other Asian background, Asian or Asian British – Indian). Their average length of illness was 19.4 years (SD: 12.3) and the mean number of admissions was 2.8 (SD: 2.4). Their mean PANSS scores were: negative symptoms: 12.6 (SD: 5.6), positive symptoms: 12.6 (SD: 5.9) and general symptoms 28.2 (SD: 9.1).

23 psychiatrists were male and 4 female. 33% were white British, 45% other white background and 22% other (Black, Asian, Asian British Indian, White Irish, Other).

Rating of consultations

Across the 100 consultations (see Table 3), psychotic symptoms were not discussed in 27% of the consultations. In 34%, patients reported they were absent. In 6%, patients avoided. On the avoidance/ engagement index, above 0.2 is avoidance and below 0.2 is engagement: the mean was 0.22 (SD=0.23, range -0.29 to 0.83), suggesting slightly more avoidance than engagement. Using the cutoff of 0.2 on the avoidance/engagement index, psychiatrists engaged with psychotic symptoms in 15% of consultations and avoided in 18% of consultations. On global clinical ratings, psychiatrists engaged in 23% and avoided in 10% cases. Inter-rater reliability in objectively coding the excerpts was good ($\kappa=0.68$) and among psychiatrists was high ($\kappa=1.0$).

The two methods show broadly similar patterns. However, there are some interesting differences. There is less avoidance identified in global clinical assessment than on objective qualitative analysis, i.e., 10% and 18% respectively. Conversely, there is more engagement identified in global clinical assessment than on objective qualitative analysis, i.e., 23% and 15% respectively.

Detailed analysis

Analysing the excerpts in more detail, compared to analyzing on the consultation level, suggests that there is a subgroup of patients with whom the communication about psychotic symptoms is more problematic. In 33 consultations, 67 excerpts were identified in which there was more extensive discussion of psychotic symptoms. There was a mean of 2 excerpts per consultation (SD 1.4, range 1 to 6). An excerpt lasted on average 1.7 minutes (SD 1.5, range 10 seconds to 8.2 minutes).

Avoidance was identified in 45 of these excerpts (67%). Inappropriate change of topic occurred in 25 excerpts (37%). In 14 excerpts, the change of topic was to medication and in 11 cases to another topic (e.g. family, mood, benefits). In 17 excerpts from 13 consultations, patients talked about psychotic symptoms in response to a general enquiry from the psychiatrist. In 27 excerpts from 22 consultations, the psychiatrist asked a specific question about psychotic symptoms. In 22 excerpts from 14 consultations, patients interrupted to raise the topic of psychotic symptoms. Patients interrupting to raise their concerns in 14% of the consultations suggests that they are not accommodated elsewhere in the consultation, and cross-validates the picture of avoidance in 18% of the consultations. Engagement was identified in 22 excerpts (33% of the excerpts).

Association with symptoms

Patients' symptoms were associated with communication patterns. In a one-way ANOVA, the 4 groups (psychotic symptoms not discussed, patients explicitly report no psychotic symptoms, patients or psychiatrists avoid psychotic symptoms, patients and psychiatrists engage in discussing psychotic symptoms) differed significantly on negative ($F=7.5$, $p<0.001$) and general ($F=7.7$, $p<0.001$) but not positive symptoms on the PANSS (see Table 4). Post-hoc tests showed that when symptoms were not discussed or reported as absent, these patients had lower levels of negative and general symptoms than when psychotic symptoms are avoided or engaged with. Conversely, when psychotic symptoms were discussed, these patients had higher levels of negative and general symptoms than when these symptoms were not discussed or reported as absent. Communication patterns were not associated with length of illness ($F=2.0$, $p=0.13$) or number of admissions ($F=0.1$, $p=0.95$). 11% of the total variability in avoidance/engagement was due to variability between psychiatrists (Intra-cluster correlation coefficient 0.11, CI -0.43 to 0.65).

Insert Table 4 here.

DISCUSSION

There are three main findings from this study. Firstly, there is considerable variation in whether psychotic symptoms are discussed or not in outpatient consultations and either patient or psychiatrist can avoid discussing them. Secondly, psychiatrists' behaviour in this respect is influenced by patients' symptoms but not as might be expected by their psychotic symptoms. Rather, psychotic symptoms are more likely to be discussed when patients have higher negative and general symptoms. Thirdly, a global clinical assessment of engagement/ avoidance matches relatively well with more detailed research assessment, suggesting that these communication patterns could be assessed in clinical practice, which could be applied in training and supervision.

These findings should be considered in the context of the limitations and strengths of this study. As this was an observational study, the sample was not selected according to predetermined characteristics. As a result, the sample may be biased as those who agreed to participate may be less unwell than those who refused or were considered too unwell to approach. This may mean that the patients in these consultations had less severe psychotic symptoms than patients who did not participate. On a related note, patients with substance abuse or organic brain disorder were excluded from the study and such co-morbidities are present in clinical practice. The findings are based on patients in outpatient and assertive outreach clinics in the UK and as such reflect the set of patients cared for in these settings. Moreover, the patients had a long history of illness, on average more than 19 years. Unfortunately, data on the history of the particular patient-psychiatrist relationship was not available but most pairs already had a relationship established and a certain degree of shared history. Given the length of illness and the fact that the patients are cared for by psychiatrists who typically know the patient's clinical presentation, this is very likely to influence the type of discussion that is had about psychotic symptoms. They may implicitly assess the patient's mental state based on existing knowledge of the patient rather than asking explicitly each time they see the patient. The profile of patients in these services in other countries may differ. In identifying relevant exchanges about psychotic symptoms, it is not always absolutely clear where the exchange begins and ends. This is not surprising as topic identification is a complex area in its own right [17].

The study has several strengths. One hundred consultations were analysed, which is a large sample size for a naturalistic observational study of how patients and psychiatrists communicate about psychotic symptoms in clinical practice. The data was collected across urban, semi-urban and rural areas and from different treatment settings (i.e. outpatient and assertive outreach clinics), which increase the generalisability of the findings. There was variance in patients' symptoms and patients were from a wide range of ethnic backgrounds. The study included a rigorous research

analysis and a global clinical rating, and good inter-rater reliability was achieved for both assessments.

This descriptive study provides some empirical evidence on how psychiatrists and patients communicate about psychotic symptoms in these treatment settings. It raises the question of whether certain ways of communicating are preferable over others, which was not addressed in this study. Nonetheless, models of doctor-patient communication, such as patient centredness [18], advocate a focus on the patient's concerns. While this may be more feasible in the context of specific psychotherapeutic interventions [19], this may be more challenging in ongoing routine meetings, as psychiatrists may feel these concerns have previously been addressed. However, it is clear from this study that psychiatrists sometimes do focus on the patient's concerns when they engage with patients' presenting these concerns, even repeatedly within a single consultation.

Although it might be expected that psychotic symptoms would be more likely to be discussed with patients with higher levels of positive symptoms, this was not the case. Psychotic experiences were more likely to be discussed with patients with higher levels of negative and general symptoms.. That psychotic symptoms are not discussed more with patients experiencing positive symptoms might suggest that there is a subgroup of patients with whom it is more difficult to communicate about psychotic symptoms. This is supported by the detailed analysis of multiple attempts to discuss these symptoms within single consultations. One can only speculate about the extent to which different communication patterns are the result of explicit therapeutic decisions. Psychiatrists may view it to be less beneficial to engage in discussions about psychotic symptoms with some patients at particular points of time. Future research could elicit this information from psychiatrists with reference to specific discussions with patients.

As there is little previous research and established methods to use in this area, we built on previous conversation analytic research to develop a valid way of measuring communicative responses. The analysis highlighted that these responses can be reliably measured by focusing on the effort of the patient and psychiatrist to respond to each other with full rather than minimal responses and not changing the topic prematurely. This relatively simple method could perhaps be used in evaluating practice and in training of communication skills about a range of topics, not just psychotic symptoms. Finally, although psychiatrists rated slightly higher engagement (and hence lower avoidance) than the research ratings, it is noteworthy that psychiatrists had broadly similar judgment on communicative response to the 'gold standard' research method.

With respect to practical advice on how to communicate about psychotic symptoms, it is important to bear in mind that some patients may not wish to discuss these symptoms. However, the findings suggest that when patients do wish to discuss them, it may be helpful to be aware of a tendency sometimes to give very brief responses (such as 'mhm' 'right'), have long pauses and change the topic quickly (e.g. to medication). More active communication about psychotic symptoms can be achieved by not changing the topic quickly and asking the patient open questions about what the experience is like, how it effects him/her and what helps the patient to manage these symptoms.

Conclusions

There is wide variation in how psychiatrists and patients communicate about psychotic symptoms, with some choosing to avoid discussing them. This may reflect the lack of guidance on best practice in this area. However, psychiatrists' behaviour is influenced by patients' symptoms, with psychotic symptoms more likely to be discussed when patients have higher negative and general symptoms. Moreover, this study shows that psychiatrists can arrive at global judgments of communication that are similar to those arrived at in detailed research analyses, although possibly with a tendency to identify more engagement. This should help simplify future research facilitating larger studies and support the application of the findings to clinical practice.

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Table 1: Operationalised criteria to identify avoidance and engagement

Psychiatrist Avoidance	Pauses <i>during</i> psychiatrist utterances before possible turn completion	Sign of hesitation if he/she needs more time to answer (can also occur if the psychiatrist needs to write down something about the interview, which is not counted as avoidance)
	Pauses >1 sec	Pauses have been measured in 10ths of seconds (≥ 0.1 seconds)
	Pauses <i>between</i> patient's utterance and psychiatrist's response, i.e., after patient possible turn completion	Pauses measured in 10 ^{ths} of seconds (≥ 0.1 seconds).
	Psychiatrist does not take a turn	Patient has completed turn and there is a gap (delay) owned by psychiatrist. Typically the patient will take another turn.
	Psychiatrist hesitating devices during their utterance	E.g. eh, well, em
	Psychiatrist minimal responses	E.g. yes, right, mm mhm, mhm, okay
	Psychiatrist responds to a patient question with a question reversing the order of the talk	E.g., What should I say now? What do you think I think?
	Psychiatrist changes the topic inappropriately to medications	
	Psychiatrist changes the topic inappropriately to another topic	E.g., mood, family, benefits, sleep, drugs.
	Psychiatrist addresses another person other than the patient	E.g., informal carer (parent, partner), keyworker
	Inappropriate, non-reciprocal, psychiatrist smiling or laughter.	
Patient avoidance	Patient minimal responses	E.g. yes, right, mm mhm, okay
Psychiatrist engagement	Psychiatrist full sentences	
Patient engagement	Patient full sentences	

Table 2: How the topic of psychotic symptoms can arise in the consultation

Psychiatrist asks about the patient's psychotic symptoms

C: Uh hmmm. Are you experiencing any psychotic symptoms?

P: Err, no,no.

C: Hearing things that aren't there?

P: No, no. I'm not hearing voices. None of that good stuff.

C: and getting paranoid about people?

P: Oh! Yeah there are some things that did happen, I got mugged, I got mugged

Patient talks about psychotic symptoms in response to a general question

C: Anything you're worried about?

P: No, it's just that when the voices do come on. I seem to be tortured, that is something that concerns me. It seems to affect me so badly although it doesn't because I seem to maintain the thread of normality and I can talk and respond.

Patient talks about psychotic symptoms when another topic is being discussed

C: there's something a bit better for you about being on this medication
.hhh what side effects were you having before then

P: mm mm mm

P: well the main one was um (.) a very dry mouth all the time

C: right

P: and also my legs (1.4) the nerves in my legs were constantly on edge and I couldn't control them I couldn't sleep because of it

C: right

P: **and also um (1.6) I don't know I was hearing voices as well**

C: right

P: the voices seem to have stopped

C: right

P: occasionally I hear a voice (.) but they were very persistent then

Table 3: Global clinical assessment of consultations

No symptoms	Psychiatrist does not ask and patient does not report psychotic symptoms	7 %	34%
	Psychiatrist asks and patient reports no psychotic symptoms	27 %	
Avoidance (psychiatrist)	Psychiatrist does not ask & patient does not talk about psychotic symptoms	27 %	37%
	Psychiatrist does not ask, patient starts and psychiatrist avoids	6 %	
	Psychiatrist asks, patient reports psychotic symptoms & psychiatrist avoids	3 %	
	Other (carer) asks, patient reports psychotic symptoms & psychiatrist avoids	1%	
Engagement (psychiatrist)	Psychiatrist does not ask, patient starts and psychiatrist engages	4 %	23%
	Psychiatrist asks, patient reports psychotic symptoms & psychiatrist engages	19%	
Avoidance (patient)	Psychiatrist asks, patient provides minimal responses & avoids	4 %	6%
	Other (caregiver) asks and patient reports minimal responses and does not want to engage with psychiatrist	2%	

Table 4: One-way ANOVA comparing discussion of symptoms and patients' symptom scores

	Symptoms not discussed N=27	Absence of psychotic symptoms N=34	Psychiatrist or patient avoidance N=24	Psychiatrist and patient engagement N=15	F	Sig.
PANSS negative	M: 10.3 SD: 3.4	M: 10.6 SD: 3.7	M: 15.4 SD: 5.2	M: 15.6 SD: 7.5	7.529	<.001
PANSS positive	M: 11.4 SD: 5.2	M: 11.4 SD: 5.2	M: 15.1 SD: 7.8	M: 13.2 SD: 5.6	1.507	.218
PANSS general	M: 23.4 SD: 5.9	M: 25.3 SD: 5.9	M: 32.2 SD: 7.8	M: 32.2 SD: 11.5	7.733	<.001