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Engagement of Patients with Psychosis in the Medical Consultation:

A Conversation Analytic Study

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Abstract

Aim

There is a growing interest in improving engagement of people with psychotic illness, who present a particular challenge, in the health services. This study investigated how doctors engage with patients with psychotic disorder in naturally occurring consultations.

Procedures

Thirty-two consultations between seven psychiatrists and 32 patients with schizophrenia or schizoaffective disorder were audio-visually recorded using digital video. The consultations were transcribed according to standardised transcription conventions and qualitatively analysed using conversation analytic techniques.

Findings

Patients actively attempted to raise the content of their psychotic experience in the consultations by asking direct questions, repeating their questions and utterances, and producing these utterances in the pre-closing phase. In response to these attempts, doctors hesitated, responded with a question rather than an answer, and smiled or laughed (when informal carers were present), indicating that they were reluctant to engage with patients' concerns about their psychotic symptoms.

Conclusions

This study is the first to undertake a naturalistic analysis of engagement in actual consultations with psychotic patients. We found that patients repeatedly attempted to talk about the content of their psychotic experience, which was a source of marked interactional tension and difficulty. Addressing patients' concerns about troubling aspects of psychotic illness may lead to a more satisfactory outcome of the consultation itself and ultimately improve patient engagement in the health services.

Key words: Communication; Psychotic Disorders; Physician-Patient Relations

Introduction

The National Health Service (NHS) Plan (1), promises substantial financial investment, which will fund both new mental health service teams and additional medical staff. Some of these initiatives such as assertive outreach teams are specifically designated to address a national priority, i.e., engaging patients with severe psychotic disorders in the mental health services (2). Non -engaged patients are more unwell and socially impaired than those who are successfully engaged in services (3). The idea behind the new initiatives is that, in order to increase engagement, patients with severe and enduring mental illness need at least more service input and perhaps even qualitatively different input. While these additional teams may soon be in place, little is known about what inputs will make them "more responsive to (patients') needs" (1).

In practice, engagement with 'services' means engagement with the clinicians in a service who provide treatment. An approach which is gaining increasing attention in the analysis of medical consultations is ethnomethodology and conversation analysis (4). It examines the practices through which participants produce, recognise and coordinate their actions and activities with each other. The focus on naturalistic interactions makes this method particularly suited to the task of identifying patients' needs as they arise in service encounters. Two previous studies have been conducted on psychiatrist-patient interaction: one on how psychiatrists conduct intake interviews (5) and the other on how psychiatrists identify delusions (6). The aim of the present study was to draw on ethnomethodological and conversation analytic techniques to analyse how doctors and patients with psychotic illness engage with each other in routine consultations.

Subjects and Methods

Patients meeting Diagnostic and Statistical Manual-IV criteria for a diagnosis of schizophrenia or schizoaffective disorder attending two psychiatric outpatient clinics in East London and the City Mental Health NHS Trust and SouthWest London and St. George's Mental Health NHS Trust were asked to participate in the study. Consecutive attenders between June 2000 and June 2001 were approached in the waiting room by an independent researcher. 52% of those approached gave written informed consent. 9 psychiatrists working across 5 catchment areas were randomly selected and asked to participate, and 7 agreed. 32 naturalistic psychiatrist-patient interactions were audio-visually recorded using digital video. Ethical approval for the study was granted by the local research ethics committees.

The analysis involved detailed examination of the audiovisual recordings and written transcripts of every consultation. Talk was transcribed using Jefferson's orthography (cf. 7) to analyse the characteristics of speech delivery (e.g., pauses, overlap, stress, intonation, pace). We also transcribed visual and tactile features of the participants conduct in relation to the talk. The recordings and detailed transcripts were examined to identify systematic and recurrent patterns of interaction (cf. 4, 8) across the consultations. The verbatim material presented in this paper is simplified and does not include the detailed transcription symbols (Appendix 1). These are retained in the material in the accompanying tables.

Results:

Fifty-five percent of the patient sample was male. Fifty percent were White British/Irish, 28% were Asian, 12.5% were African, and 9.5% were African-Caribbean. Eighty-seven percent were unemployed and 35% lived alone. The age range of patients was 28-66 and they had a mean length of illness of 14.2 years (SD 9.8). All of the psychiatrists were male and 6 were consultant level. The consultations were approximately 15 minutes long. Informal carers (e.g., partner, parent) were present in one-third of the consultations.

A representative trajectory for a consultation involved the psychiatrist reviewing the patient's mental state, medication and associated side effects, daytime activities (e.g., attendance at a day facility, work, training), social activities and sometimes living arrangements, finances, and contact with other (mental) health professionals. Not every topic was covered in every consultation and psychiatrists varied in how they addressed each topic. The consultation typically started with the psychiatrist asking how the patient had been and often asking specific questions about mood, sleep, appetite, thoughts and symptoms. This sometimes involved eliciting the carer's account of how the patient had been. Patients' participation in the consultation predominantly involved responding to psychiatrists questions to inform them about their wellbeing and the effect of treatment (medication, rehabiliation) since the last consultation.

Patient's attempts to raise the content of their psychotic experience as a consultation topic

Specific talk about psychotic symptoms occurred approximately 1.4 times per interaction (range 0-4), lasted on average 67 seconds and was initiated by doctors on 21 occasions, by patients on 22 occasions and once by a carer. In general, doctors tended to ask about the frequency of these symptoms or refer to their severity when the patient was on different kinds

of medication while patients actively attempted to raise the content of their psychotic symptoms. In addition to telling their troubles and describing their symptoms (9), patients also asked the doctor's opinion about the cause of their troubles and about others' disbelief in relation to their experience, accounted for why they had their symptoms/illness or discussed the pros and cons of medication with respect to the severity of their symptoms.

Two situations are identified where the patient raises the content of their psychotic symptoms. Firstly, where the preceding interaction has created a specific opportunity for the patient to talk about their experience and secondly, where patients interject or even inappropriately position this talk. In the latter case, patient initiated talk about psychotic symptoms indicated that these concerns were not easily introduced. When patients did succeed in topicalising their concerns about these symptoms, it was frequently a source of tangible interactional problems. To illustrate these difficulties we will discuss one or two examples in more detail. Additional data is provided in the accompanying tables.

In excerpt 1, the psychiatrist asks the patient quite early on in the consultation how he is. The patient uses this second position to report feeling afraid and thinking that everyone hates him. The doctor responds with "Oh why?". 'Oh' is often used to indicate receipt of information and acts to accept the truth or adequacy of that information (10). The subsequent animated question "why?" promotes further continuation of the informing by the patient. After the patient says "well because I think everyone hates me", the doctor acknowledges this in line 11 with "yeah" and looks down to write in the patients' notes. The patient continues his troubles telling through lines 13-26, which is marked by many pauses where the doctor might reply but withholds response (lines 14, 20, 22). He responds verbally only with the minimal acknowledgement token 'mm'. The patient finishes his account in line 26. This is followed

by a very long pause of 7 seconds and the doctor then looks up from the notes to ask the patient's mother what she can tell him. Through his vocal and visual conduct therefore, the doctor successfully realigns the focus of consultation away from the patient's disclosure of his symptoms to the mother's version of the troubles. The patient is provided with no further opportunity at that stage of the consultation to further discuss the character of his symptoms.

(1) C1

1.	Dr:	Ye exactly ye so how (0.2) how are you at the moment? [at this] time?	
2.	P:	[We]ll (1.2) like I said I have ups and downs (.) swings of moods you know	
3.	D:	mm (0.4) mm	
4.		(3.0)	*{doctor writing}*
5.	→ P:	**I (have) felt very afraid to come here (.) this morning**	
6.		(0.4)	
7.	Dr:	Oh why?	
8.		(0.2)	
9.	P:	**well because I think everyone hates me**	
10.		(0.4)	
11.	Dr:	yeah	*{writing}*
12.		(0.6)	
13.	→ P:	**An doesn't like me because I'm God right they (want) they are (.) against me I can't give them what they want**	
14.		**(0.8)**	
15.	P:	**and people you know sometimes they walk past me and they look at me and they spit on the floor to insult me**	
16.		(0.2)	
17.	Dr:	mm	*{writing}*
18.		(.)	
19.	P:	**an when they walk past me**	
20.		**(1.0)**	
21.	P:	**I notice that aswell**	
22.		(1.2)	
23.	P:	when(ever) I'm walking on (the street) I feel uncomfortable and unsafe	
24.		(0.8)	
25.	Dr:	mm	
26.	P:	so I try to stay indoors most of the time	
27.		(0.2)	
28.	Dr:	mm	*{writing notes}*
29.		(7.2)	
30.	Dr:	So what can you tell me?	*{smiles at mother}*

The patient however does not abandon all attempts to discuss the details of his symptoms (see also Table 1). As the consultation is drawing to completion (see excerpt 2), and the doctor and patient's mother are finalising the arrangements for the next consultation, the patient

interjects a question 'why don't people believe me when I say I am God'. This dramatic interjection is positioned just as the doctor utters 'so' following the mothers confirmation of the arrangements; an utterance which foreshadows movement into the end of the consultation itself (12). The patient's dramatic interjection (11) serves to forestall progression into the close of the consultation and encourages the doctor to reopen discussion of the one of the more significant symptoms of the patient (see also Table 2).

(2) C1

1.		M:	okay (0.8) [three months t[ime *{smiling}*
2.		Dr.:	[so: *{writing}*
3.	→	P:	[why don't people believe me doctor when I say I'm God (0.2)
4.		P:	why don't they believe me (.) cos everyone knows I am (0.4) I think
5.		M:	****** ** *{smiles /laughs}*
6.		P:	everyone knows (.) (I mean) its not nonsense it's true
7.			(0.6)
8.	→	Dr.:	what should I say now? (.) ha-ha-ha
9.		M:	ha-ha
10.			(0.4)
11.		P:	(I don't know) I believe it anyway
12.			(0.5)
13.		Dr.	well you you are free to believe it anyway (0.6) but people are (.) people are free
14.		P:	(mm) *{nods}*
15.		Dr:	(0.1) not to believe you
16.			(.)
17.		P:	mmhmm *{nodding}*
18.		Dr.:	you know what I mean (0.8) alright (.) this is your card
19.		P:	*{slight nod}*

The patient's formulation as a **direct question** in line 3 (see also Table 3) departs from the more typical communicative pattern in doctor-patient interaction, i.e., question (doctor) - answer (patient) - acknowledgement (doctor), with doctors asking more questions than patients (5, 13, 14). In conversation, on being asked a question, the recipient (the doctor) is expected to provide a relevant response (15). If they fail to do so, this behaviour is accountable: in other words, the speaker (the patient) makes sense of it in terms of the recipient (doctor) having some problem in responding (15). In our data (see Table 4), the

questions posed by the patients are a source of some interactional tension as patient and doctor attempt to realign the focus and trajectory of the consultation in rather a different direction.

The doctor's response to the patient's question (excerpt 2, line 11) about why people don't believe him when he says he is God is a question to the patient "What should I say now?". Not only does responding with a question to a question mark its problematic status, the wording of the question conveys the doctor's difficulty in finding a way to respond. In general, the doctors' response to patients' questions about psychotic symptoms are marked by lengthy pauses, both before and during their responses and hesitating noises such as 'well', 'eh', and 'ehm' (see Table 4). These 'delay devices' (15) indicate reluctance or discomfort on being asked to respond to these questions. Although the doctors' questions follow this hesitation, they do allow a continuation of the topic while avoiding taking a position in relation to the problematic utterance, a typical strategy used by professionals in different therapies.

After the doctor responds with the question in line 11, he laughs. This was characteristic of the doctors' responses when carers were present. In excerpt 3, the patient (P) in response to a question from the doctor is talking about why she got sick. Her husband (H) is also present in this interaction. At the end of the patient's utterance about why she got sick, the doctor smiles, then laughs, pauses and says 'ye' quietly. The patient appears to be sensitive to this particular response and asks in line 5 whether he believes what she has said. There is a short pause, her husband laughs (line 8) and the doctor, while smiling, delivers an assessment of what the patient thinks as a question "so you think somebody's done something to you" continued in line 15 "like some kind of black magic kind of thing?".

(3) C6

1. P: then they cannot see because they can't work you know so they keep telling me and so I don't know when they talk to me like this you know I go sick you know (0.5)
2. Dr.: *{Nods head once}*
3. P: I go sick like that you know and then after you know I get more and more you know after (0.6) some jealous people you know I don't know what they're doing you know
4. → **Dr.:** *{2 quick nods, 2 slower nods}* *** ***{smiles}*** **Hahaha** (0.6) ye
5. (0.3)
6. P: you believe that?
7. (0.2)
8. H: Hahaa
9. → **Dr.: so you think somebody's done something to you?**
10. ********** ***{smiling}***
11. P: yea-eh
12. (0.4)
13. P: mmhmm
14. (0.3)
15. **Dr.: like some kind of black magic kind of thing?**
16. *
17. P: ye
18. (0.2)
19. Dr.: ye (0.4) do you have any proof for that? I mean
20. P: ye well I been to somebody and they told me
21. Dr.: okay

While it is not possible to present a detailed analysis of how the doctors' and carers' laughter is related to each other, in some cases the carer starts smiling/laughing before the doctor (excerpt 2) and in other cases, it is the doctor who smiles/laughs first (excerpt 3). It is worth

noting that the reluctance to respond to patients' concerns cannot be explained by a disruption in a two-way doctor-carer conversation as it also occurs in two-way doctor-patient conversations.

Discussion

This is the first study to systematically analyse how doctors engage with psychotic patients in routine consultations. The main finding is that patients actively attempted to raise the content of their psychotic symptoms. Some patients explicitly articulated that telling others, including psychiatrists, about these symptoms was problematic. Despite this, they clearly attempted to discuss their psychotic symptoms and actively sought information during the consultation about the nature of these experiences and their illness.

When patients attempted to topicalise their psychotic symptoms, the doctors hesitated and avoided answering the patients' questions indicating reluctance (cf. 15) to engage with these concerns. This reluctance might be institutional, e.g., it is not considered helpful or productive to deal with the content of patients' symptoms. The presence of carers also appears to influence the patients' ability to express their concerns. When there was a carer present, the doctor also smiled and/or laughed in response to patients' assessments of and questions about their symptoms. In troubles telling, it is usually the troubles teller who laughs and the troubles recipient who produces a serious response (16). In medical interaction, laughter tends to be used more by patients than doctors, often for delicate interactional tasks (17, 18). In the present study, the doctors' use of laughter seems to be problematic as a response to serious talk (questions) from the patient and may indicate embarrassment when faced with such delicate questions from patients about the causes of their distress.

Research in general practice has shown that patient-centred skills, particularly information giving and counselling, are related to increased treatment compliance (19), improved satisfaction (20, 21), decreased emotional distress (22) and symptom burden (23). The

growing number of organisations initiated by patients and carers (e.g., the Hearing Voices Network) to provide an opportunity to specifically talk about psychotic symptoms reflects a wish for this aspect of the illness to be addressed.

Our study was conducted across two services in urban areas, which may limit the generalisability of the findings. There may be a recruitment bias as participants were consecutive attenders at outpatient clinics. In addition, identifying patients' needs from what they say in routine consultations will require validation using other methods. The strengths of this study are that it is the first of its kind to focus on interactional engagement with this patient group, it employed an analytic method with robust validation procedures and identified systematic patterns of interaction across the consultations.

Conclusions

Our results suggest that patients actively attempt to talk about their symptoms, especially their psychotic content. These findings are based on a qualitative study and it is not known to what degree these behaviours are linked to other outcomes. However, given the well-established association between interactional engagement and outcomes in primary care research (20, 21, 23), addressing patients' concerns about their psychotic symptoms, might facilitate better engagement with services. At least, it does appear that such an approach would meet the immediate needs of a significant number of patients leading to a more satisfactory outcome of the consultation itself.

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Contributors

RM was involved in the conception and design of the study, collection, analysis and interpretation of the data, writing the article and approval of the final manuscript and is guarantor for the paper. CH contributed to the design of the study, interpretation of the data, and revision and approval of the final manuscript. TB contributed to the design of the study, collection and interpretation of the data, and revision and approval of the final manuscript. SP was involved in the conception and design of the study, interpretation of data, critical revision of the article and approval of the final manuscript.

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Appendix 1: Transcription conventions

.hhh	Audible inhalation
hhh	Audible exhalation
:	Extended sound
↑	Rising intonation
↓	Falling intonation
?	Rising inflection
____	Emphasis (word or part of word underlined)
° °	Talk is quieter than the surrounding talk
< >	Talk is faster than the surrounding talk
UPPERCASE	Talk is louder than the surrounding talk
!	Animated tone
=	Latched utterance, no interval between utterances
[ ]	Beginning and end of overlapping talk
( )	Transcriptionist doubt
***	Smiling
(.)	A pause of less than 0.2 seconds
(0.0)	Silence measured in seconds and tenths of seconds
Dg:	Doctor gaze
Pg:	Patient gaze
….._ _ _ _ _	Gaze moving towards another person
_ _ _ _ _ _ _	Gaze at another person
_ _ _ _ _ _ ,,,	Point at which gaze moves away from person

Table 1: Repeat Utterances

C3: H = patient's husband; P = patient; Dr. = psychiatrist

55. H: =(yeh) she's no problems sleeping (.) the only ti:me is tha::t (.)

56. [when she when she lie:s down *{reading notes}*

57. P: **[?YOU KNOW DOCTOR** *{turns from husband to doctor}*

58. Dr.: °mmhm° *{looking at her}*

59. (0.2)

60. _ ,,,

61. P: the::s:e people that I'm see:ing ar:e (0.4) I:: thi:nk (.) not see::ing *{laughs}*, I mea:n

62. H: ********************** * * * *

63. …. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

64. P: I'm (0.6) I'm: lis::teni:ng to: them (0.4) the::y are the cause of my trouble

Later in C3

91. Dr.: so it's not really (ahn) I wuddin really consider it an ↑increa:se in (°dose°)

92. P: !SO ↑DO: Do: you thi:nk what I'm telling you >even when I was working in Newham general< I as:ked my supervisor (0.8) b'cos she was dealing with the psychiatry people an (1.0) do th do they ex↑ist that there are people that are cau:sing this:: (0.2) eh sickness (0.6) b'cos I'm fully confide fully satisfied now it's not the medica:tion that makes me: with all the symptoms (0.4) it's theh (.) those people that I'm (0.3) that (.) ar (after me) that I I

93. Dr.: yea:h: °mhmm°

94. P: feel si:ck an everything (.) I blame the:m:

95. (.)

96. Dr.: yeahe (1.2) well what do ↑you think I think?

97. * *starts smiling*

98. (0.2)

99. P: mhm?

C12: P = patient; Dr. = psychiatrist

57. P: I can handle it as long as it's not too bad you know (0.2) cos I suppose I spend seventy-five

percent

58. Dr.: hmm

59. P: of my life in bad states you know

60. (0.2)

61. Dr.: mm-hmm *{looking through notes}*

62. (1.2)

63. → **P:** but then again emm (3.0) I'm starting to get I'm not starting I (keep) *{doctor looks from notes to patient}* **I still get those funny thoughts you know *{looks back down at notes}* coming**

64. Dr.: (* smiles)

65. **P: into my head an stuff an**

66. (0.4)

67. Dr.: mm hmm *{turning pages of notes}*

68. (.)

69. **P: they cause me a bit of ehm (0.6) trouble**

70. Dr.: how do you how do you cope with funny thought thoughts?

Later in C12

131. → P: alright okay (0.2) EM what I got to tell you em (1.2) **when I have these bad thoughts I get like feelings to do things you know** (.) an em

---

C9: P = patient; Dr. = psychiatrist; H = patient's husband

103. H: her sister you know she the same (0.8) they took her scanning for her head (.) why the? I don't know

104. (.)

105. Dr: yeh

106. (1.0)

107.⟶ P: **do you think it's mental ment ment (_ _ _ illness) because I'm getting disability allowance an I don't I don't find myself mentally ill ment (0.6) I think it's <u>fear</u> (1.0) some kind of <u>fear</u> I have**

108. (0.4)

109. Dr: ↑oh↓<u>kay</u>

110. (2.9)

111. P: and it probably <u>will</u> come out

112. (1.2)

113. Dr: well (0.2) I think think that ehh (0.4) weh eh at the moment you are quite disabled aren't you? (.) in (0.2) uh many respects (I mean)?

114. (0.6)

115. P: I don't know Dr. (name_ _ _ _ _ _ _) I'm so confused I don't know what's wrong with me (.) I mean (_ _ _ _ _ _ _ I don't think _ _ _ _ _ _ _ I don't)

116. (0.8)

117. Dr.: I mean I must say for (0.2) for once (.) that eh (0.2) you know (1.0) eh (0.8) over time it's a lot easier to talk to you than it was in the past

118. (0.2)

119. P: mm-hmm=

120. Dr: =you know (0.2) because eh when I first saw you eh you ehm (0.4) you know were you know able to: hh

121. (0.4)

122. P: **I think it's im<u>puls</u>ive isn't it? (0.6) what do you think?**

123. (0.8)

124. P: I'm too <u>impuls</u>ive (0.2) or too (fright to wait) I don't know

125. (0.8)

126. Dr: °mmhmm°

132.⟶ P: **Do you think it's a <u>rea</u>:l pro(b)lem that?**

133. (0.3)

134. Dr. I thought it was done (.) didhin't okay (I mean) I:: I might be wrong *{looking at Husband}*

135. (.)

136. H: whahds thah wha(h)ds that actually for?

137. (0.8)

138. Dr: it's just eh that in some cases (.) what happen

139. H: see if there's anything blocking or something isn't it

140. Dr: that there might be some other reason for this illness

141. (1.2)

142. ⟶ P: **<I mean> unbalanced**

143. Dr. (but) I wuddint rea::lly (0.3) worry about it

144. (.)

145. H: no ↑thaht's al↓right (I was)

146. ⟶ P: **ih(t)s unbal↑anced Dr.? (0.2) (name)**

147. Dr. °pardon°?

148. (.)

149. ⟶ P: **°(I mean)° iht's unbalanced?**

150. (1.2)

151. ⟶ P: of mi::nd?

152. (.)

153. H: unbalanced she mean=

154. ⟶ P: =**do you think my mi:nd is unbalanced?**

155. (1.0)

Table 2: Talk produced by patients in the pre-closing phase

		C1: M = patient's mother; Dr. = psychiatrist; P = patient
206.	M:	**↑oh°ka:y° (0.8) [three months °t[ime°** *{smiling}*
207.	Dr.:	**[so:** *{writing in notes}*
208.	P:	**[!why dohn people belie::ve me:** doctor
		when I sa:y I'm Go:d (0.2) >why dohn they< belie::ve
209.	M:	hhhh ******
210.		me (.)co[s everyone kno::ws I am (0.4) [I thi:nk everyone knows (.) (I mean)
		ih(t)s not non.sense it's ↓tru:e
130.	**Dr.:**	**…so th they will write to me: if they need anything=**
Pg		*{looking down while putting form in envelope}* ..…_ _
131.	**P:**	**=↑al↓righ(t) ohkay (0.2) EM what I ah: I go(t)ha tell you (.) em::** (1.2) when I 'ave
Dg.:		_ _
Pg:		_ ,,,, *{putting -form in envelope}*
132.	P:	these bad thoughts I get like fee:lins to do things ↑yunno (.) am em::
Dg:		_ *{at P putting form in envelope}*
Pg:		*{down at bag}*
133.	Dr.:	↑aw↓h
Dg:		_ _,,,, *{ down and then at notes}*
134.		(0.6)
Pg:		*{down while putting envelope in his bag}* ……_ _ _ _ _ _ _ _ _ _ _ _ _ _
135.	P:	I w(h)ell: (3.6) it's just em: (0.5) yunno eh: (2.6) I:: mm I'm ba:s:ically stoppin myself
Dg:		*{writing in notes----------}* …..._ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Pg:		_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
136.	P:	from doing the:se things ↑yunno:
Dg:		_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Table 3: Questions from patients about their psychotic experience

P:	"[!**why dohn people belie::ve me: doctor** when I sa:y I'm Go:d (0.2)" (1)
P:	"!SO ↑**DO: Do: you thi:nk what I'm telling you** >even when I was working in (place) < I as:ked my supervisor (0.8) b'cos she was dealing with the psychiatry people an (1.0) do th do they ex↑ist that there are people that are cau:sing this:: (0.2) eh sickness (0.6)" (3)
P:	"**it's not the peo::ple you think**? ha-ha-ha-ha" (3)
P:	"↑**you belie:ve tha:d**?" (6)
P:	"**do you think** my mi:nd is unbalanced? (9)

Table 4: Psychiatrist responses

C3: P = patient; Dr. = psychiatrist

91.	P:	!SO ↑DO: Do: you thi:nk what I'm telling you >even when I was working in (place) < I as:ked my supervisor (0.8) b'cos she was dealing with the psychiatry people an (1.0) do th do they ex↑ist that there are people that are cau:sing this:: (0.2) eh sickness (0.6) b'cos I'm fully confide fully satisfied now it's not the medica:tion that makes me: with all the symptoms (0.4) it's theh (.) those people that I'm (0.3) that (.) ar (after me) that I I
92.	Dr.:	yea:h: °mhmm°
93.	P:	feel si:ck an everything (.) I blame the:m:
94.		(.)
95.	**Dr.:**	**yeahe (1.2) we::ll what do ↑you think I think?**
96.		***** ***smiling***
97.		(0.2)
98.	P:	mhm?
99.		(0.8)
100.	Dr.:	**well I th I thi:nk you hav:e an ↑ill::↓ness: that's:: ↑fairly well under control at the mom:ent (0.1) but th eh an that's what's trou:bling you (0.2) buht**
101.		(0.8)
102.	P:	it's not the peo::ple you think? Ha-ha-ha-ha
103.		**(1.2)**
104.	Dr.:	t↑ha:t's not mhy o↓pinion

Table 4: Psychiatrist responses (cont.)

C9: P = patient; Dr. = psychiatrist; H = patient's husband

142. P: <I mean> unbalanced

143. Dr. (but) I wuddint rea::lly (0.3) worry about it

144. (.)

145. H: no ↑thaht's al↓right (I was)

146. P: ih(t)s unbal↑anced Dr.? (0.2) (name)

147. Dr. °pardon°?

148. (.)

149. P: °(I mean)° iht's unbalanced?

150. (1.2)

151. P: of mi::nd?

152. (.)

153. H: unbalanced she mean=

154. P: =do you think my mi:nd is unbalanced?

155. (1.0)

156. **Dr. I mea::n ah (2.0) whaa:::h:t (2.0) you do:: ha:ve is eh (0.2) yu you-ouh have eh (.) been suffering from an ill:ness em:: (0.6) (name) (1.4) wh-which has you**

157. P: (but I'm not a child)

158. Dr.: **know-mm (2.0) ehh which has meant that you know you (.) you've found it very**

159. P: mhmm

160. Dr. **diffi:cult eh::m (0.4) to cope (with)**

161. P: I mean I can cope with it a lot better than I could before that (0.4) an that's some kin(d)of (1.2).hhh that's some kind of (0.2) °he:hlp°

162. Dr. ye-eh *{nodding}*

163. (0.8)

164. **Dr. !Okay now what we'll do now:: (.) is that ehm you're on two tablets of procyclidine isn't it?**

What is already known on this topic
Patients with psychotic illness are difficult to engage in the health services. No research has been published on how doctors engage with these patients in the medical consultation.
What this study adds
Patients actively attempt to talk about the content of their psychotic symptoms. Doctors' reluctance and discomfort in engaging with this topic is apparent. Addressing patients' concerns about their symptoms, consistent with a patient centred approach, may lead to a more satisfactory outcome of the consultation itself and ultimately improve engagement with services.