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EDITORIAL

People-centred care: new research needs and methods in doctor–patient communication. Challenges in mental health

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Communication in psychiatry is nowadays called to create bridges between different levels of observation (biological, functional and relational levels) and therapeutic intervention (social and educational) with important implications for therapeutic practice and communication research in the mental health context. New research challenges and windows of opportunity for therapeutic practice will be addressed in this contribution, as they relate to the three main tasks that psychiatrists have to meet when talking with their patients: understanding patient's problems and concerns; establishing the therapeutic alliance by acknowledging and responding to patient's emotion; informing and involving patients and their families, when appropriate. Therapeutic decisions need the elaboration of valid strategies of shared decision-making, which still have to be implemented and adapted to psychiatric context. Moreover, in the research field, emerging biomarker research may contribute to better explain what makes the difference in an empathic relationship either in terms of psycho-physiological reactions and in brain changes. Finally, the influence of new technologies and of Internet has to be more and more considered during clinical consultations.

Key words: communication in psychiatry, patient-centred communication, psychiatry, research challenges.

Introduction

The policy framework of people-centred health care published by the WHO (WHO, 2007), suggests that 'Improving health care quality and safety and enhancing the people's experience of care require attention not only to health system design but also to the focus and process of patient care' (p. 3). This focus on process implies that the way care is devolved is as important as the treatment itself. Among process indicators, doctor–patient communication is one of the most important channels to improve the quality of care. According to the three functions model proposed by Cohen-Cole (1991), an effective medical interview should accomplish three goals: (1) gathering data to understand patients' problems; (2) developing a relationship and responding to patients' emotions and (3) educating patients about their illness, negotiating a treatment plan and motivating them. These goals are relevant also for psychiatric consultations, although communication with psychiatric patients presents specific aspects. In a recent conceptual review, Priebe *et al.* (2011) suggested five guiding principles for good communication in psychiatric clinical practice: (1) a focus on the patient's concerns, in the sense that patient's complaints and wishes have to guide the consultation; (2) positive regard and personal respect towards a patient who is valued as a person, regardless of the observed behaviour; (3) appropriate involvement of patients in decision making, respecting the level of involvement preferred by the patients; (4) genuineness with a personal touch, knowing how to be in the relationship, not only what and how to do; and (5) the use of a psychological treatment model to induce therapeutic change.

In the following sections, new insights and challenges in doctor–patient communication will be discussed according to the main objectives suggested by Cohen-Cole (1991) and the guiding principles of Priebe *et al.* (2011).

Gathering data to understand patients' problems and concerns

The therapeutic encounter may be considered as a meeting between two different experts: the psychiatrist who is the expert of general psychopathology and the patient who is the expert of his/her specific mental distress, affecting his/her everyday life in several, different and individual ways. Patients should feel that their contributions are essential for the diagnostic and therapeutic process and that they are not only passive recipients of a therapy decided and handled by the therapist alone. Nowadays the traditional

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paternalistic model where the 'doctor knows the best' and the patient is just a passive and silently compliant receiver of care, has been gradually changed into a more interactive model where the patient is considered an active agent of its own care (Edwards and Elwyn, 2009; Evans *et al.* 2003). As a result, patient and therapist have to be considered as partners in the consultation and every outcome (including the level of patient involvement) is the result of this fruitful interaction (Goss *et al.* 2011). Therefore, patients' perspective becomes an important source of information that can help to better understand his/her problems and to create a more personalised and effective treatment plan. Improved health outcomes occur when patients feel free to express topics of perceived immediate importance, and when physicians pay appropriate attention to what the patient wants or needs to convey (Smith, 2002). According to this approach psychiatrists are called to collect not only the medical agenda but also the patient's agenda, trying to 'enter the patients' world, to see the illness through the patients eyes'. To gather this type of information active listening skills are helpful such as open-ended inquiry, reflections, empathic statements and solicitation of question asking (Rimondini *et al.* 2009). Such communication skills are part of the 'patient-centred approach' (Stewart *et al.*, 1995; Mead & Bower, 2002). Thus good patient care and cure require that the physician explores at the same time both biomedical and psychosocial dimensions of illness (Smith, 2002) and remains attentive to patients' cues and concerns. However, although the importance of collecting and managing expressions referring to affective aspects is intuitive, it is indeed difficult to put into practice, because of the elusive and vague nature of language related to cues and concerns. This difficulty is reflected also in the wide range of different definitions found in the literature (Zimmermann *et al.* 2007). To solve this difficulty, a consensus definition, based on the work of an international group of experts in health communication research, has been published in a recent paper (Zimmermann *et al.* 2011). The authors define a concern as a 'clear and unambiguous expression of an unpleasant current or recent emotion, with or without a related issue (e.g. "I feel frightened" or "I am worried about my high blood pressure")' (p. 144), and cues as 'verbal or non-verbal hints which suggest an underlying unpleasant emotion and therefore would need to be clarified or explored by the health provider' (p. 144). Cues are then distinguished in terms of seven subcategories that describe the way emotional talk is introduced by the patient and the content by which the emotion is expressed (vague use of words, physiological or cognitive correlates, emphasis, unusual words, unusual description of symptoms, profanities, exclamations, metaphors, ambiguous words, double negatives, expressions of uncertainties and hope, non-verbal behaviour, repetitions, and references to past concerns). The system includes also a classification of the health provider responses, coded according to two major conceptual factors: explicitness of the reference to the emotional component expressed in the cue/concern and space provision for further disclosure of the cue/concern (Del Piccolo *et al.* 2011). The Verona coding definitions of emotional sequences (VR-CoDES) is now applied in different contexts (Vatne *et al.* 2010; De Maesschalck *et al.* 2011; Hilde *et al.* 2011; Hunziker *et al.* 2011), including psychiatry (Del Piccolo *et al.* in press), to be validated. Also in qualitative research, McCabe *et al.* (2002) have analysed how patients with psychotic illness expressed their concerns about their symptoms. As a result the authors evidenced that patients actively attempted to focus on their psychotic symptoms, but psychiatrists hesitated and showed reluctance to engage with patient's concerns on this topic. Therefore, the recognition of cues and concerns, and their management shows the need for an in-depth analysis, also in the psychiatric context. The expected effect of this shift in attention towards cues and concerns is to improve psychiatrists' diagnostic and relational abilities and therefore, as a consequence, the therapeutic alliance.

Knowing how to be in the relationship, responding to emotions and building the therapeutic alliance

Psychiatrists must be able to grasp and manage emotional content offered by their patients, since the verbalisation of one's feelings in the presence of an attentive and interested listener facilitates emotion regulation (Nyklicek *et al.* 2011), predicts competent coping (Zachariae *et al.* 2003), generates greater patient satisfaction with interpersonal care (Epstein *et al.* 2007) and collaboration (Cruz & Pincus, 2002). An aid to assist clinicians in becoming more attuned to patients' emotional needs has been suggested recently by Riess (2011). This aid, called E.M.P.A.T.H.Y., is established on the basic idea that enhancing the awareness of the biological markers of a therapeutic relationship and the shared neurobiology of empathic responses, improves empathic capacities in trainees. Moreover, as sustained by the author, there are evidences which show that during psychotherapeutic encounters patients and physicians are highly reactive to each other. Using simultaneous autonomic arousal (heart rate and skin conductance) as a measure of rapport, physiological responses could vary together in 'concordance' or in 'discordance'. When the degree of skin conductance shows a 'concordance' there is the highest correlation between affect

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intensity and perceived empathy by the patient (Marci & Orr, 2006). In addition to physiological correlates of empathy, significant overlap exists between neural structures that control skin conductance fluctuations and the neuroanatomical structures implicated in neuroimaging studies of empathy. These neuroanatomical correlates contribute to the assumption that a therapeutic relationship is just as strongly rooted in brain plasticity as psychopharmacologic interventions (Furmark *et al.* 2002). These same results find evidences also in recent research on placebo effects (Finset & Mjaaland, 2009; Benedetti & Amanzio, 2011). An anticipation of this line of thinking was suggested also by Kandel (1998) more than 10 years ago. In a special article entitled 'A New Intellectual Framework for Psychiatry' Kandel proposed that the analysis of the interaction between social and biological determinants of behaviour, could represent a new intellectual framework for psychiatry on the basis of five basic principles: (1) all mental processes derive from operations of the brain, (2) these operations are expressed by genes and protein products which (3) may either exert a control over behaviour or be modified in their expression by social behaviour (4) through alterations that change the patterns of neural connections. Insofar (5) 'as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells of the brain. [...] As our words produce changes in our patient's mind, it is likely that these psychotherapeutic interventions produce changes in the patient's brain. From this perspective, the biological and socio-psychological approaches might be joined' (p. 460). In light of this way of thinking, psychiatry has the opportunity to explain empathy and the therapeutic role of a healing alliance by explicating the biological correlates of this process, creating a bridge between the brain, the body psychophysiology and the overt characteristics of a therapeutic relationship.

Appropriate education and involvement of patients in decision making

The evidence of low level of treatment adherence reported for psychiatric patients (Nosè *et al.* 2003) and the finding that patient participation in decision making has positive effects on outcomes and adherence to treatment, especially for chronic diseases, Joosten *et al.* (2008) have contributed to attract researchers' attention on shared decision making (SDM) concepts and patient involvement skills also in the field of psychiatry (Hamann *et al.* 2005; Adams & Drake 2006). Psychiatric patients themselves seem to prefer a more collaborative relationship with their psychiatrist and ask for an active involvement in decisions regarding their own health care (Paccaloni *et al.* 2004, 2006). Despite the evidence that patients demand for a more active role, recent studies in the psychiatric context (Goss *et al.* 2008) have shown low levels of patient involvement, suggesting that a doctor-centred approach is still prominent in this setting. These observations raise the question whether psychiatrists are aware of the potential benefits of sharing treatment decisions with their patients. Some studies show several barriers that still impede psychiatrists to implement a collaborative approach into practice such as the fear of stigmatising patients or worsening their mental status, with the consequent fear of lowering patients' motivation for subsequent treatments (Paccaloni *et al.* 2005). Cognitive impairment has been claimed as a major barrier in sharing information and decisions with psychiatric patients, especially for those suffering from schizophrenia (Paccaloni *et al.* 2005). At present there is no strong evidence to confirm these concerns; even if a correlation seems to exist between the level of decisional ability and the presence of delusions, poor insight and poor cognitive test results (Hamann *et al.* 2009). Health professionals seem to inaccurately guess their patient preferences and behave accordingly with their assumptions, whereas decisional capacity of patients can be maximised by developing individual abilities (educational program) or/and simplifying the decisional tasks. How to adapt and to simplify the approach is illustrated in the literature on motivational interviewing, where several adaptations of the model to the cognitive impediments of psychiatric patients are proposed (Bellack & Di Clemente, 1999; Carey *et al.* 2001, 2007; Martino *et al.* 2002). Different types of interventions to promote patient involvement can also be adopted by encouraging patients to ask questions they have listed before the consultation (Kidd *et al.* 2004), or by selecting questions from a list of many possible queries (prompt-sheet) available before meeting the doctor (Clayton *et al.* 2007). Helpful interventions in encouraging greater patient participation can also include the use of informative advices, feedback on psychiatrists' current performance and an increase in consultation length. In a recent review on intervention studies to improve treatment adherence in psychiatric patients, Nosé *et al.* (2003) showed that all the included studies failed to consider the role of patient involving communication skills. Therefore, the implementation of the SDM model in psychiatry via the development of specific interventions could provide an important step towards meeting patients' needs and improve adherence to treatment.

Conclusion

Following the very broad model of a consultation, described by Cohen-Cole (1991) more than 20 years ago, we have evidenced that in psychiatry there are still new challenges and methodological issues to deal with, in research as well as in clinical practice. In terms of research, psychiatry has the opportunity to relate biology and observed behaviour by referring to a model that combines the different levels at which human behaviour can be explained and clarifies the biological correlates of therapeutic relationships. Regarding the clinical practice, literature results show that psychiatrists have to improve the ability to recognise and manage emotional content in terms of cues and concerns. They also need to understand patient values, preferences and their desired involvement and information, by adopting a shared approach towards therapeutic decisions. This implies to have more effective and transparent ways to produce relevant research results (Liberati, 2011) and to disseminate them in an appropriate manner (Internet may help or be harmful and its influence has to be considered more during clinical consultations). Moreover, research results and patient knowledge have to be reconciled and should emerge during the consultation in a way that is not stigmatising for the patients or their families, who also have the right and the need to be informed, educated and, whenever possible, involved. Programmes where families are engaged in the therapeutic process and actively involved in psycho-educational projects have been shown to have positive outcomes, in particular if they are correctly tailored to the needs of the individual family (Onwumere *et al*. 2011). Therefore, communication in psychiatry is nowadays called to create bridges (as communications by definition implies) between different levels of observation (biological, functional or behavioural level) and therapeutic intervention (social and educational) with the challenging use of new informatics, technical and relational competencies.

Declaration of Interest

None.

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