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Communication barriers in therapist – patient – caregiver relationship

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Abstract: *The success or failure of a therapeutic approach, medical or psychological, are influenced by many factors. Among them we can mention the patient's insufficient knowledge about the disease, preconceptions of patient or caregiver's fear of stigmatization, the issue regarding duration and side effects of treatment, cost of medicines and so on. Last but not least, the therapist's ability to communicate accordingly to the beneficiaries' comprehension and barriers encountered in the communication between actors directly involved in the therapeutic process (patient caregiver, psychologist, and doctor) can change the opportunity to obtain a suitable therapeutic benefit yet from beginning.*
Materials and methods: In order to assess the concordance between the messages sent by doctors and how they are received by patients and caregivers, we have applied a different questionnaire for the three categories of respondents mentioned above. These three distinct sets of questions were completed during 100 psychiatric consultations, in ambulatory regimen.
Results: Comparative analysis of the questionnaire results has shown major differences between the information that doctors thought they had sent and what was actually received by patients and caregivers. Paradoxically, the more medical explanations were elaborated and detailed, the less volume of adequate information was taken home by beneficiaries.
Conclusions: It is necessary for each of us to have a self-assessment of how we communicate with patients and which is the real benefit that we offer through our words. It is also mandatory to adapt the „language of medicine" to the common people understanding abilities (without medical training).

Keywords: *communication, relationship therapy, case management, psycho-education, occupational health, therapeutic benefit, therapeutic alliance.*

ADHERENCE TO TREATMENT

1 of 2 patients does not follow the therapeutic/ psychotherapeutic prescribed program.

Theoretically, the psychotherapeutic process should be simple, direct and fast, so that the service beneficiaries to have access as early as possible to a specialized consultation, after which to establish an optimal therapeutic conduct in order to provide significant improvement or even cure the health issues.

Everyone involved in this process of health (re) generating are convinced that everything is impeccable in respect of themselves: conforming to Oath of Hippocrates, the physician ensures that "... as long as my strength and my reason will help me, my prescriptions will be made only against sickness and

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for the benefit and good condition of the sick people" and provides a correct diagnostic (psycho-diagnosis) and an appropriate treatment, the patients and their relatives understand the information provided about the disease and the importance of following a correct conduct, the patient strictly follows the treatment schema and returns to periodical control and psychological advising, ideally considering that the psychologist and the psychiatrist complement each other no matter the case case.

Comparative assessment of the amount of prescription drugs in medical offices and pharmacies obtained (EFPIA - European Federation of Pharmaceutical Industries and Associations) shows that only 50% of prescriptions are being released from pharmacies. In Europe, the non-adherence to treatment "costs" annually state budgets for health about 125 billion euros and contributes to 200,000 premature deaths recorded per year.

Poor therapeutic adherence can have an immediate negative impact on the clinical benefits of treatment (impact felt by the doctor, the patient and the patient's relatives) and also a negative social echo, more extensive on medium and long term because of sub-optimal health problems solving, lack of quality remission, incomplete recovery or when the certain diseases become chronic.

To improve this alarming situation that 1 of 2 patients simply do not succeed in adhering to the prescribed treatment, increasing collaboration among all involved factors in the therapeutic process is more than evident. Especially, the interaction between health professionals and patients should be improved in order to ensure not only to diagnose and treat properly, but also that the therapeutic recommendations are eventually complied with. Most often the subject „passes over" the psychological counseling, which is absolutely necessary because, during the specialized clinical interview, helpful elements are revealed in order to achieve a correct approach.

TYPES AND CAUSES OF NON-ADHERENCE

The problem of non-adherence to intervention of any kind is not new. Hippocrates (460-370 BC), the most famous physician of ancient Greece considered to be the "father of medicine", recommend that the physicians "to be aware of the reasons why patients tend to lie about how they take the prescribed medicines". More recently, Charles Everett Koop (1916 - 2013), vice-admiral of the US Public Health Service Commissioned Corps, chief-physician of the US from 1982 to 1989, summarized this problem in the dictum "Medicines do not work in patients who do not take them!"

Sokol et al. (2005) and Ho et al. (2009) have mentioned two types of non-adherence to the intervention, everyone having a different point of view regarding the patient.

The first way of seeing the patient presents a patient "guilty" of unwillingness, uninterested in his health, lazy, disobedient, who simply does not make a minimal effort in taking prescribed medications.

The second pattern highlights the non-adherence caused by a rational, intentional response of the patient facing with some disagreed recommendations. In this situation the patient, who, after leaving the cabinet or the hospital, never completes the recipe, raises medicines from the pharmacy or takes these, even if purchased on his behalf by someone else.

The fact that the patient does not comply with treatment recommendations, usually generates revolt and frustration for therapist. Basically, the therapist believes that he consumes his time, energy and skills to act in the interest of a person who seems not to do the same for himself. However, in real life, the events do not evolve so simple and linear as we have described in the earlier theoretical model.

The therapist (clinical psychologist) has not always have the necessary time, patience, understanding, empathy or absolutely necessary communication skills for a discussion with beneficiaries. It happens sometimes that the patient does not get to have a face-to-face contact with the therapist, so a conversation about diagnosis, disease severity or efficacy and safety of treatment is even less probable. Studies have shown that 50% of patients do not agree with the posed diagnosis or recommended treatment

and the lack of proper communication with mental health professionals, reach either at self-psycho-diagnosis or even at self-treatment, either to seek pseudo-medical aid (provided by relatives, friends or internet). That issue touch a relatively new domain in Romania, namely the concept of Occupational Health obviously correlated with the education of population in that domain. Occupational health psychology has earned a special place in psychological theory and practice, being related to health psychology and derived from organizational psychology. The objective of this sub-domain of psychology is to study healthy work environments, defined as those in which individuals, using their skills and talents, achieve high performance, high satisfaction and psychological well-being.

This context in which the pro-intervention information is not consistent enough to counter the avalanche of counter-intervention arguments (generated by fear of disease or treatment, feeling of shame or dysfunctional emotions, financial reasons, fear of stigma, preconceived ideas and so on), pops up an issue: patients do not come to specialist!

COMMUNICATION – AN ESSENTIAL FACTOR IN THERAPEUTIC SUCCESS

In nowadays medical world when the professional activity is exercised more and more along the lines of "poor funding - lack of time - Increased request" is harder to remember that we are treating people, but not medical cases. The image of therapist today is different of patient expectations: instead of a benevolent advisory actor, a counselor of the patient concerning what is good or bad for him, the pattern of common doctor is rather of an exhausted and annoyed person, in a permanent rush between ambulatory cabinet and inmate patients in the ward and patients in the emergency room.

In the preface of his book "A Curious Calling: Unconscious Motivations for Practicing Psycho-therapy" (M. Sussman - Ed. Three, 2011), the author says that "narcissistic and exaggerated aspirations as well as overestimation seem to be almost universal among the beginner therapists (Sharaf and Levinson, 1964). What are their aspirations? Maltsberger and Buie (1974) believe that the three most common traps are narcissistic aspirations to cure everyone, to know everything and to love everyone - all doomed to failure, leading therapists to magical and destructive answers." Thus, the lack of communication with the beneficiary can conduct to a slightly defensive behavior of the therapist meant to build a protective shield against questions, indecision or doubts related to his clinical approach, coming from the patient or his caregivers.

O. Sacks, neurologist and psychiatrist, in his book "A Leg to Stand On" (Humanitas Ed., 2013) describes the personal experience of a doctor who, after an accident, pass to the other side of "the fence" and becomes a patient. On this occasion is analyzed, initially with surprise, then with consternation and anger, finally with comprehension, the distant and professional attitude of the doctor which is in conflict with almost desperate need for information and ensuring of the patient.

LIMITS OF COMMUNICATION WITH THE PATIENT (BENEFICIARY) AND THE CAREGIVERS

In accordance with current legal provisions, the duration of medical consultation should be limited to a maximum of 15, 20 or 30 minutes, depending on the specialty. In that time the specialist, psychologist or psychiatrist, should receive the patient, introduce himself, find out the reasons of the visit, obtain as complete history of the problem, listen carefully to establish one or more diagnoses, debate an intervention scheme with the patient and caregivers, provide information about intervention (benefits, side effects, duration, risks, warnings, others) and regimen, register data in registry and computer, release documents as appropriate (electronic prescriptions, treatment regimens, medical letters, sick leave etc.).

In this context, verbal communication is strictly reduced and, instead of empathy, ensuring and benevolent neutrality, a non-verbal recommendation appears: "you have to do as I say, because I know better what disease you have and what treatment do

you need"!

The patient perceives such behavior as mandatory and discretionary, which further increase his previous resistance in coming to specialist as a defense mechanism against unpleasant feelings.

The problem of time allocated to the communication with patient is widely considered worldwide.

At a minimum, the patient should be informed, has to understand and must accept that:
1. He has a problem;
2. The problem may present health risks if not treated;
3. The recommended treatment, if necessary, is appropriate, safe and effective.

Prelipceanu et al. (2011) has suggested that all patients visiting a psychiatrist should be informed in detail about the therapeutic effects and side effects of any pharmacological agent that they receive. From the psychodynamic perspective, the notions of transfer, counter-transference, resistance and therapeutic alliance are equally important when prescribing medication as when psychotherapy is performed. A positive transfer and a therapeutic alliance could have a positive influence on adherence to treatment. The benefits of combining psychotherapy with drug therapy are supported by numerous studies and consist in improving compliance and ensuring a complex care of the patient, more efficient.

A DETAILED COMMUNICATION IS NECESSARILY BETTER?

In a symposium held at the National Conference of Psychiatry in 2013 (Targu Mures) Michael Davidson, professor of psychiatry at the Sackler School of Medicine Tel Aviv University and Mount Sinai School of Medicine NY, launched a provoking debate on consistency between messages that the therapist believes them transmitted to the patient and what the patient actually received.

The subject is too large to be analyzed in depth without an enlarged study, well structured, multicentered and extremely well balanced between the various medical specialties. However, to evaluate the messages sent by therapists and how they are perceived by patients and caregivers, we have designed and implemented a simple questionnaire with similar questions for the three categories of respondents. The three distinct sets of questions were completed for 50 psychiatric or psychological counseling sessions (both initial consults as well as control) under specialty ambulatory (each lasting 30 minutes).

Subjects and their caregivers were randomly selected, with the only conditions of being sure they can understand the questionnaire requirements and they can freely provide required answers. The questionnaire included both open-response questions and closed-answer questions, as follows:
1. Please note, with a note between 0 to 10, the allocated time for information about the diagnosis and treatment (0 = totally insufficient; 10 = extremely high);
2. Please note, with a note between 0 and 10, availability of necessary information provided to patient/received from psychologist/psychiatrist (0 = very difficult to understand; 10 = very easy to assimilate);
3. Please note, with a note between 0 and 10, specialized information relevance provided to patient/received by the psychologist/psychiatrist (0 = completely irrelevant; 10 = highly relevant);
4. Please indicate the most important three (3) peaces of information that you have transmitted to patient/you have received from specialist, related to diagnosis and/or to received treatment;
5. Please indicate what other information you wish you had transmitted to patient/you wish you had received from the therapist, related to the diagnosis and/or to the received treatment.

For the questions from 1 to 3 differences between the scores given by the therapist and those of recipients were not significant: an average score of self-assessment of therapists 8.4 versus 7.8 of the patients and 8.0 of caregivers. Given the open nature of the questionnaire and respondents awareness that the evaluation will take place, it is expected that health professionals manifest a little more than usual the interest to communicate and the politeness of

beneficiaries may have result in sparing pride of the therapist.

Surprises however occurred at comparative analysis of open responses, which showed significant differences between what information therapist thought he had sent and what was actually received by the patients and caregivers.

Frequently encountered types of answers to the question referring to messages sent, in descending order of frequency of occurrence, were related to questionnaire.

They may say that if specialist considered important messages related to objective reasons to be followed for effective treatment, patients and caregivers were more interested in the subjective aspects of the disease and treatment.

Questionnaire:

Therapist	Patient	Caregiver
Information transmitted to the patient/caregiver by therapist		
1. risks of untreated disease	1. disease severity	1. side effects of treatment
2. efficacy of the treatment	2. risks of untreated disease	2. risks of untreated disease
3. disease severity	3. side effects of treatment	3. efficacy of the treatment
Information that would have been transmitted		
	• causes of disease • duration of treatment • impact on family life, professional, social • risk of transmission to others	

For me, the need of some additional information regarding these differences between disease and intervention is directly and indirectly involving: the psychologist/psychiatrist believes that said everything there is to say, while the beneficiaries want to know what triggered the disease, how long therapeutic approach must be followed and what to do once he is at home.

Another aspect worth to be mentioned is that, paradoxically, the more space for the therapist was filled with information complete and complex, the less was completed by beneficiaries. In other words, the more explanations were elaborated and over-detailed, the less information beneficiaries took home.

DISCUSSIONS

The quality of "public employee" of health professionals brings not only the attribute of service provider, but also a bit of self-protective and annoyed attitude of one who does not want to be excessively strained with others problems. So, if I do my job well in the profession what I learned and I perform it with so many sacrifices, the patient is obliged to follow my decisions without comment. If he does not, then you are fully entitled to revolt, refusing other consults and even being a little more incisive when he will ask for help.

From another point of view, the patient knows that he depends on the help of the therapist, the skill and his dedication for the work, but is scared that the disease is his (not of the therapist), with major implications on his life and intimates and approach to be followed is his and not of someone else (good or bad, well tolerated or not accessible or very expensive). And all these worries are multiplied by stories published by media with doctors not very helpful or not very competent.

Between these two points of view a binder, a solid bridge must be found. This may be the communication between all involved factors, most reliable basis for the concept of "therapeutic alliance".

In conclusion, it is necessary, for each of us, an objective and rigorous self-evaluation of how we communicate with patients and of the real benefit we offer by words.

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