Communication

Louise Pembroke continues her series on how we improve relationships between service users and psychiatrists

You've only got one chance to make a first impression, and not looking at a person speaks volumes. If the service user did that it would be pathologised! Service users notice psychiatrists who write incessantly and whose demeanour is defensive. Some are left with the distinct impression that their psychiatrist really dislikes face-to-face work, when consultations are timed at four minutes with exactly the same questions – typically, whether the person is feeling low or high and checking medication. One user said to me, "He could just email me two tick-boxes every six months instead."

It never ceases to amaze me just how bad some psychiatrists can be at communication. However, to be fair, that is not exclusive to psychiatry. There seems to be a problem teaching communication skills to medical students, so the rot sets in at a much earlier stage. A young friend who is a final-year medical student during her obstetric and gynaecology placement had a colleague completely unable to say the word 'vagina'. He could not get consent from a patient because the woman didn't understand what he saying.

My friend has very good communication skills: she uses the language of her patients. So whatever words they use to describe something, she will use. She doesn't shy away from anything that might feel embarrassing or difficult, unlike a psychiatrist I once met who told me that he didn't "open Pandora's Box" with his service users and talk about child sexual abuse.

In an analytic study investigating how psychiatrists engage with people diagnosed as having a psychosis,[1] the researchers found that service users repeatedly tried to talk about the content of their experiences but the psychiatrists were uncomfortable and reluctant to engage. Yet addressing the service users' concerns might actually lead to a better outcome.

The content of what service users say can be missed because too much attention is paid to appearances. Women service users have worked out that 'care' with appearance can help gain leave or discharge or avoid being viewed as needing assessment. When a friend kept getting sectioned from A&E after harming herself I wondered what was going on, so I accompanied her to find out. One problem was the waiting time, which advocacy shortened, and another was appearance. I suggested she take off the cartoon T-shirt and put on her best clothes. Outward appearance, combined with maintaining eye contact and speaking a sentence, meant that she was viewed as more 'together' because she *appeared* so, and this helped to prevent her from being sectioned from the department.

Likewise when another friend rang me from a ward on section with a diagnosis of schizophrenia, I suggested changes to her appearance and *how* rather than what she communicated to speed up discharge. She was discharged with exactly the same experiences as on admission, the only difference was in how she communicated this and how she appeared to staff.

My mum was highly amused on being described by a psychiatrist (after all of two minutes) as a "respectable woman" with a nice black jacket, as she failed to see how the psychiatrist could have known whether she was respectable or not from her appearance.

Diagnosis by appearance is not new to me because I've heard of psychiatrists saying that people with condition X wear too much make-up or look a certain way, just as a woman diagnosed as bipolar knew not to wear bright colours on seeing her consultant otherwise he assumed she was getting a touch manic. I'm avidly awaiting for diagnosis by make-up with a colour shade chart, which isn't as daft as it sounds given that an old Reboxetine drug company advert sported the slogan, 'When you next see a depressed patient, ask her which shade of lipstick she wears.'

I've often wanted to see a study where actors would speak of voices/visions, some articulately and being physically 'presentable' whilst others would give the same content but inarticulately with a disheveled appearance, to see how this affects diagnosis and perception of need and risk.

1. McCabe, R., Heath, C., Burns, T., Priebe, S. (2002) 'Engagement of patients with psychosis in the consultation: conversation in analytic study', *BMJ 325,* 16 November.