Interactions between Nurses and Patients with Mental Illness during Home Visits: A Conversation Analysis

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Abstract

Purpose: To explore how nurses and patients with mental illness communicate with each other in natural interactions during an annual home visit.

Design: Qualitative observational study.

Methods: An observational study was conducted during home visits at patients' homes in a northeastern province of Thailand in 2017 and the data were 32.2 hours of videotape recording with 4 nursing staff and 6 patients with mental illness. Conversation analysis technique was used to analyze nurse-patient interactions.

Main findings: Turn-taking or ordering of speakers was frequently controlled and allocated by the nurses. However, patients sometimes interrupted the conversation and had very little input because most questions asked were closed-ended. Patients used pause, silence techniques and changed the subject to avoid their dispreferred responses.

Conclusion and recommendations: Theoretically, patient-centered communication model should be focused for nurse-patient interaction, but in this study nurses controlled the conversation mostly about the topic of nursing tasks. It is essential to provide a special training program for nursing staff to develop patient-centered communication skills during home visits.

Keywords: conversation analysis, home visits, mental illness, nurse-patient interaction

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ปฏิสัมพันธ์ระหว่างพยาบาลและผู้รับบริการที่มีปัญหาทางจิตระหว่างการเยี่ยมบ้าน: การวิเคราะห์การสนทนา

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บทคัดย่อ

วัตถุประสงค์: การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อสำรวจรูปแบบการสื่อสารระหว่างพยาบาลและผู้รับบริการที่มีปัญหาทางจิตจากการปฏิสัมพันธ์ที่เกิดขึ้นระหว่างการเยี่ยมบ้านเพื่อประเมินอาการผู้ป่วยประจำปี

รูปแบบการวิจัย: การวิจัยเชิงคุณภาพแบบใช้การสังเกต

วิธีดำเนินการวิจัย: การศึกษาแบบใช้การสังเกตได้ดำเนินการในปี พ.ศ. 2560 ระหว่างการเยี่ยมบ้าน ของผู้รับบริการที่มีปัญหาทางจิต ในจังหวัดหนึ่งของภาคตะวันออกเฉียงเหนือ ประเทศไทย ข้อมูลการปฏิสัมพันธ์ระหว่างพยาบาลจำนวน 4 คน และผู้รับบริการจำนวน 6 คน ถูกรวบรวมด้วยเครื่องบันทึกเทปวีดีทัศน์ รวมระยะเวลาที่ใช้ในการบันทึก 32.2 ชั่วโมง การวิจัยนี้วิเคราะห์ปฏิสัมพันธ์ระหว่างพยาบาลและผู้ป่วยด้วยเทคนิคการวิเคราะห์บทสนทนา

ผลการวิจัย: ผลการวิเคราะห์พบว่า พยาบาลเป็นฝ่ายควบคุมการสนทนาเป็นส่วนใหญ่ จากบทสนทนาบางครั้งผู้รับบริการมีการขัดจังหวะการสนทนาและพูดน้อย เนื่องจากคำถามส่วนใหญ่เป็นแบบปลายปิด ผู้รับบริการมักใช้การหยุดสนทนา การใช้ความเงียบ และการเปลี่ยนเรื่องของการสนทนาเพื่อหลีกเลี่ยงการสนทนาเรื่องไม่พึงประสงค์

สรุปและข้อเสนอแนะ: ในเชิงทฤษฎี ปฏิสัมพันธ์ระหว่างพยาบาลและผู้รับบริการจะมุ่งเน้นรูปแบบการสื่อสารที่ยึดผู้รับบริการเป็นศูนย์กลาง ในขณะที่ผลการศึกษานี้พบว่า พยาบาลควบคุมการสนทนาโดยมีหัวข้อการสนทนาเกี่ยวข้องกับงานของพยาบาลเป็นหลัก การศึกษานี้บ่งชี้ถึงความจำเป็นของการฝึกอบรมเพื่อพัฒนาทักษะการสื่อสารที่ให้ผู้ป่วยเป็นศูนย์กลางให้แก่พยาบาลระหว่างการเยี่ยมบ้าน

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Background and Significance

People with mental illness are often discharged from hospital in a partially remitted state[1]. A home visit, therefore, is needed to reassure patients and families that they are not abandoned. Home visits are useful for people with mental illness in various situations, including helping reluctant patients access to mental health services, performing a comprehensive health assessment and health counseling[2], strengthening support networks, managing patients in the community when their condition deteriorates, helping patients comply with taking their medications[3], and working towards keeping the whole family healthy[2]. Regular visits have also been associated with reduced re-hospitalization for people with mental disorder[2].

It is estimated that 50% of patients with mental illness do not comply with their medication regimens[4]. Therefore, effective communication between nurses and their patients is an essential part of ensuring that vital information about treatment options and maintaining contact with services is understood and followed to by the patient[5]. For patients with mental illness, effective communication can be challenging. There are various negative outcomes for patients with mental illness who encounter ineffective communication with health professionals, which include alienation, increased severity of symptoms and possible compulsory hospitalization[6]. It is believed that when effective communication skills are used by health professionals, their patients are more satisfied, follow advice and adhere to the prescribed treatment[5]. Moreover, effective communication is not only important in nursing but also indispensable in a patient-centered approach for quality healthcare delivery[6].

Even though good communication between nurses and patients is essential for the successful outcomes, most researchers have highlighted that nurses tend to focus on physical care and interact in a routine and superficial way[7]. Furthermore, previous studies reported that the structure of conversation during a first home visit by a healthcare provider to a new mother typically consists of question-answer-comment sequences, with healthcare providers always asking the questions; the providers talk with patients using what is termed a task-based approach[6-7]. Other studies have also shown that nurses often control the interaction, affirm their expertise, and use inadequate communication skills[8]

Conversation analysis has been useful in examining the detail of interactions between healthcare providers and clients[9]. It has also been effective in analyzing health providers-patient

interactions and/or communication in different contexts, such as home visiting, counseling, differential diagnosis, immunization situations and mental health[8]. Analysis of these interaction and/or communication can be productively used by nurses to critically reflect on their practice as a method of learning and professional improvement[9]. Although there is increasing in awareness of patient-centered approaches, very few studies have conducted to examine naturally occurring interactions between nurses and patients with mental illness during home visits[10-11]. To date, conversation analysis has not been widely used in healthcare research particularly in the area of mental health research. Therefore, the purpose of this study was to explore how nursing staff in northeastern Thailand communicate with patients with mental illness in naturally occurring interactions during annual follow-up home visits.

Objectives

To explore how nurses and patients with mental illness communicate with each other in natural interactions during an annual home visit in a community setting.

Research Question

How do nurses and patients with mental illness communicate with each other in natural interactions during an annual home visit?

Methodology

This was an observational study using video recordings of interactions between community nurses and patients with mental illness during an annual home visit, using a conversation analytic approach.

Conversation Analysis

Conversation analysis technique is a qualitative method for studying human social interactions[12]. As a branch of ethnometho dology, conversation analysis is a form of oral discourse analysis that focuses on the verbal communicative practices in situations of everyday life[12-13]. Conversation analysis also utilizes a naturalistic, observational strategy for actual behavior (both verbal and non-verbal)[9]. It aims to identify and describe the particular ways in which both parties accomplish their tasks through sequential organization of interaction in everyday contexts; for example, turn-taking, adjacency pairs and preference organization[14]. Turn-taking refers to the process by which people in a conversation decide who is to speak next. Drew and Heritage[15], and Sidnell[13] indicated that the mechanism in turn-taking may vary by culture and community. The adjacency pair is defined as pairs of utterances such as greeting-greeting and offer-acceptance. The speaking of the first utterance (the first-pair part) provokes a responding utterance (the second-pair part). The preferred response to a question is an expected

answer, whereas the dispreferred response is a non-answer or an unexpected answer[6].

Ethical Considerations

This study was granted ethics approval by the Mahasarakham University Ethics Committee (No. 014/2560). Both nurses and patients were assured that they would not be affected in any way by the research. In order to protect confidentiality, personal identities were coded during data analysis so that the participants' names did not appear. Finally, they gave written, informed consent to participate and be videotape recorded.

The Study Context

The Tambon (sub-district) Health Promotion Hospitals (THPHs) were introduced in 2009 for delivering preventive medicine and health promotion and treatment for minor trauma or non-serious illness[16-17]. The THPHs also provide access to pharmaceuticals from the national essential drugs list, but not psychotropic drugs[16]. Each THPH is responsible for 7-8 villages with a catchment population of around 10,000 with 1,500-1,800 families[17]. The THPH is always open and staffed by 2-3 registered general or community nurses (RNs) and 4-6 other health personnel. Only one RN has the responsibility for caring for people with mental illness in a catchment area. Usually, a nurse has schedules the annual visits in advance. However, the visiting times could be changed due to unexpected matters.

Participants and Setting

Four community nurses working in four THPHs each recruited patients who were diagnosed with a mental disorder by the psychiatrist in their respective catchment area in a northeastern province in Thailand. Exclusion criteria included the following patients with mental illness: requiring acute care for symptoms of mental illness including suicidal, homicidal and/or violent behavior; having a primary diagnosis of developmental disability; having problems of verbal communication during recruitment period. Eight patients with mental illness were asked by the community nurses for permission to be contacted by the study team; and six of them volunteered to participate in the study. All four community nurses working for patients with mental illness were also invited to participate through home visits. The community nurses were female with a mean age of 42.5 years (range, 35-48 years) and had been practicing as a community RN for an average of 20.5 years (range, 14-26 years). Four of the 6 patients were female (66%). The average patient age was 40.3 years (range, 35-50 years). All patients were unmarried and unemployed with an income from a living allowance for low-income persons (800 Thai baht/month).

The patients' education was below the high school level. All of the patients were in the stable mental state and on medicine.

Data Collection

Video recording and concurrent field notes were utilized to collect data during April and August 2017. Each video recording took about 40-60 minutes. One trained video data collector installed the recording equipment in the patient's house about a half hour prior to the home visit, started the video recording equipment, and left the house. Before beginning each videotaped recording, the researchers read to both nurse and patient the purpose of the study and an informed consent form. They agreed to participate voluntarily on the understanding that they could withdraw at any stage without prejudice to any future care or employment. The researchers also reminded the patient and nurse that the visit was being recorded. During the nurse-patient interaction, the researchers took notes on the details of the observation. Finally, each patient received a packet of milk as a token of appreciation after finishing recording.

Data Analysis

Data were analyzed by the principal researcher who is a nurse instructor with experience in psychiatric nursing and qualitative research. The step of data analysis started with listening and watching the whole interaction two or three times for understanding overall communication context. The specific areas of focus during general conversation analysis were organization of turn-taking, adjacency pairs, preferred response and sequence organization[13]. In this study, the first two of these were analyzed and discussed. Then the researcher listened for all interactions from all the patients and analyzed to find significant events and patterns of the focused area. The unique communications were chosen as the resource materials for the analysis, each of resource materials contains approximately 5 minutes of the video recording. Sequential analysis of the interactions was performed, including detailed transcription of verbal and non-verbal communication with eye gaze and body movement. The verbal transcription notation used was adapted from those developed by Jefferson[18]. The most important symbols are described as follows

[ ]	Overlapping of two or more voices
=	continuity of utterance between two expressions
::	The longer the colon row, the longer the prolongation
( )	Words in round brackets are indistinct, or altered
°°	The sounds are quieter than the sur rounding talk
↑	High or low pitch

In a conversational analysis method, the validity of the work is based on interpretation of directly observable data such as turn taking, and does not entail subjective interpretation of the data[13]. Data analysis was performed in Thai. Selected quotations were translated into English. To provide some protection of the participants' identities, each data extract was referenced to indicate an interaction code, position on the videotape record, and date. Also, nurses were coded with the letter N and patients with mental illness with the letter P. In reporting the results, pseudonyms have been used to shield the identity of the participants.

Findings

Features of the conversation

Of the 32.2 hours of recording, fifteen patterns emerged and the four distinct patterns were chosen to be analyzed. Evidence can be seen through two analytically distinguishable, but interlinked conversation organizations: turn taking and adjacency pairs.

Analysis 1: Turn-taking

In extract 1, the interaction was between the nurse (Mary) and her 37-year-old patient (Ann) who had been suffering from mental illness for 17 years. When opening a conversation, the nurse greeted the patient, introduced herself, and explained the reason for the visit. In the conversation, the nurse introduced herself as a nurse, only to later refer to herself as a *mor* (meaning, doctor). The nurse called her patient, (Ann) in order to select a next speaker to respond (line 02). The majority of the interactions were to assess patient's health problems. Analysis of turn-taking in conversations showed that only one person talked at a time. In this extract, the nurse controlled the conversations by controlling the topic and asking close-ended questions. Then the patient quickly replied with one-word answers in a very low and soft voice, continued throughout the passage.

The nurse asked broad questions about symptoms (line 55) and medications (line 62). Because the patient always answered affirmatively, the nurse was speechless as what to ask next. The nurse used high pitch and a pause (line 57) before starting to ask for more details about symptoms. In line 63, where the patient responded, "It's all good," the nurse restated the answer and asked a new question instantly.

Extract 1 (Ann, 03.40, 12/06/17)

01 N: Swasdee ka (Hello)

02 N: Swasdee ka, my name is (Mary). I'm a nurse visiting in order to ask some questions of (Ann)'s symptoms.

03 P: ka (Okay)

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55 N: Is there anything wrong or unsettling during period that you would like to tell mor?

56 P: °mi ka° (no)

57 N: Is that so?↑(.) Why is everything looking so good? ((laughs- short)) Aw↑(.) If that's the case, then I don't have to visit a lot then ((laughs-short)). Nothing at all?

59 P: °mi ka°

60 N: (.hhh) (.) You're okay with this?

61 P: °ka°((clasping her hand))

62 N: Is the medicine alright?

63 P: °It's all good.°((smile))

64 N: Good, DO YOU STILL HAVE AUDITORY HALLUCINATION?

65 P: °mi ka°

66 N: What about…muscle rigidity?

67 P °mi ka°

In Extract 2, the interaction occurred between a nurse (Lilly) and a 45 year-old person with mental illness (Emmy) for over 15 years. We came across the following sequence in the nurse's opening visit. In line 08, the nurse's to::*day*:::with its very lengthened sound began before introducing herself. When the nurse initiated the conversation, the patient began to respond midway, interrupting the nurse's speech. In this extract, the nurse had a hard time continuing her conversations. In this interaction, the nurse tried to personalize the conversation by attempting a joke, making the interaction more social than using therapeutic communication.

Extract 2 (Emmy, 0.28, 02/05/17)

08 N: To::day::: Mor is here for the first time right?(.) [mor]=

09 P: [I remember]

N: =once [met(Emmy) right?]=

10 P: [ka]

N: =and I just came right? [mor (Lilly)]

11 P: [ka]((smile))

12 N: You might not be familiar with [my face]

13 P: [Where did mor (Jane) go?] ((asking about the previous nurse)) ((turns and pointing to another direction))

14 N: Oh (hhh) Um mor (Jane) was appointed to another THPH.

15 P: Ohh::: ↑I see, so that's why you've come to replace her right?

16 N: From now on you will be in my care and I will come visit a lot, [please remember my face]

17 P: [ka]

18 P: Did mor (Jane) leave permanently?

19 N: Yes:::mor (Jane) went to Ban [Nong Wang] ((another village))

20 P: [Ban Nong Wang] (rubs hands on face)

21 N: I'm (Lilly) mor [(Lilly)] =

22 P: yeah [mor(Lilly)]

N: = [Okay?]↑

23 N: Yes (Lilly): okay? Beautiful like a lily ((laugh - short))

Analysis 2: Adjacency pair

The interaction in extract 3 went on between the nurse (Lilly) and her 43-year-old patient (Smith) who had been suffering from mental illness for 5 years. In conversation, the nurse asked questions and demanded answers. The patient responded in a soft, low voice. The nurse wanted to know if the patient was angry at her. The nurse believed that the patient was angry because he left quickly and surreptitiously from the THPH. Shortly afterwards, he returned with medicine but did not talk. The patient used silence (line 566) as a means of not answering and tried to diverge from the topic by asking personal information of the nurse (line 567), followed by a preface (uh : m) and a pause. The nurse was surprised and used a high pitch voice. Nearing the end of the conversation, the nurse asked once more about the patient's feelings. He mumbled that he was angry (line 578). Then the nurse pressed on about what he was angry. The patient took a pause to show hesitation and replied with a minimum of delay (line 580).

Extract 3 (Smith, 43.36, 23/07/17)

560 N: When you had a medicine injection, were (Smith) angry at me ((smile))?

561 P: °mi khrab°(No)

562 N: When the injection hadn't been completed, were you angry at me?

563 P: °mi°

564 N: ((laugh - short)) It was because of the needle. It was unlocked and the medicine got out. So, I asked you to get a new bottle and you just left without a word. I was afraid that you were angry. When you came back silently with another bottle, I was even more concerned that you were angry at the doc.

566 P: (2.5)

567 P: uh : m (.) Where do you live? ((changing the subject and not wanting to answer))

568 N: Huh::: ↑((sounds surprised))

569 P: Is it in Vapee? (the district in Mahasarakham province)

570 N: Vapee↑

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577 N: You look happy(.) Do you get angry easily? (continues asking for details about the anger)

578 P: °Well: (.) sometimes yes°

579 N: What do you get angry about?

580 P: about (1.5) Nah, I don't think there is anything ((change his mind))

In Extract 4, the interaction was performed by the same patient (Emmy) and the nurse (Lilly) in Extract 2. The patient answered unexpectedly, caused by a state of confusion in the patient. In line 340, the nurse was shocked by the patient's answers. The nurse repeated 'World Trade' with a loud voice. Then in line 344, the nurse was speechless and thought that she could no longer continue the conversation. Therefore, the nurse abruptly ended the interaction with the word *'Okay'*.

Extract 4 (Emmy, 36.31, 02/05/17)

338 N: Where is your house? (.) The one you used to live in↑

339 P: >My house<↑ It at WORLDTRADE↑((big shopping centre in Bangkok))((smile))

340 N: Huh ↑WORLD TRADE! (.) [Where's that](2.1) =

341 P: [It's outside, the big one]((smile))

N: = Kalasin ((patient's brother house))

342 N: HAA:::↑

343 P: The big World Trade. I rode from See Tanya=((psychiatric hospital in Bangkok))

344 N: Hum:::(0.5) ((shakes head up and down))

P: = They said that I have to go back home↑I'm bringing back the medicine [So I rode back hereby a van that I hired] (picking her nails) (not making eye contact)

345 N: [I couldn't understand anything today, it usually isn't like this. Or perhaps she didn't take the medicine properly causing her to get confuse]

346 P: Em….

347 N: (hhh) No further questions. Okay?

348 P: (4.5) ((smile))

Discussion

This study was to explore the interaction between community RNs and patients with mental illness during annual home visits. Conversation analysis, which was rarely used in the Thai literature, was chosen as the study method to achieve the study aim. Our results provided a glimpse into the nurse-patient interactions that took place in the patients' home.

Interaction between the nurses and the patients was characterized by an understandable use of language appropriate in a friendly environment. The nurses called the patients by their first name; she sat near the patient with constant eye contact. The nurses were always smiling and listened to the patient carefully. The nurses called themselves *mor*. In Thailand,

the word *mor* means a doctor or a person who provides treatment to people[19]. In addition, people may call health personnel a *mor* to show respect and appreciation.

Our results show that turn-taking is often controlled and allocated by the nurse. Next turn is usually allocated by the nurse's selecting a patient. Moreover, the nurse used close-ended questions. This may be because nurse tried to get specific information about patient's condition. The results are consistent with a previous study[7] that the nurse was always asking the close-ended questions and the patient responded to questions with short answers.

What is unique in our results comes from extract 2 in which the nurse-patient interaction was not characterized by the usual question-answer sequence. Instead, the turn distribution was indicated by the patient's questions. Also, the patient frequently interrupted the conversation. This transaction shows that the patient attempted to have more control over the interaction. An explanation could be that the patient was a person with mental illness who appeared to have occasional unstable moods, unexpected emotions and mood swings. The interaction is inconsistent with a model proposed by Sacks, Schegloff and Jefferson[14] that ordinary conversation is constructed through a series of turns. For example, one person speaks at a time and the turn transition is frequent and quick. Other studies have found that interruption is an instrument for exercising power and control in a conversation[20-21].

Our results show that the patients used a very low voice volume, silences, pauses, and diverged from the topic to avoid the nurse's question. The nurses used high pitch levels to indicate a feeling of surprise. This initially caught the nurse off guard, but she regained her focus by resuming the pertinent question. The nurse heard the patient mumble a preferred response and, therefore, asked again. Similarly, Aquino[22] indicated that the use of high pitch level indicates a feeling of surprise, joy, or happiness, whereas Borg[23] indicated that people who speak too softly can be seen as insecure and lacking of confidence.

The results are congruent with Videbeck[5] who concluded that sometimes pauses and silences indicate that the patient is thoughtfully considering the question before responding. Furthermore, pauses and silences in conversations may derive from a fear of appearing inadequate or incompetent in front of others[24] and finding the question troubling or disagreeing with it[6]. In addition, Jones[6] indicated that the patients usually replied to the nurse's question with a dispreferred response with a minimum of delay.

On the other hand, silence of the nurse in our results indicates that she was listening attentively to the patient, even though there was some overlap in the conversation. The nurse also did not show signs of boredom with the patient's wordings. Once the nurse realized that she could no longer elicit a relevant response, she terminated the conversation. Ideally, therapeutic communication should end by summarizing the conversation, giving suggestions, and raising the opportunity for patient to ask questions[25].

Conclusion and Recommendations

In this paper, the nurse-patient interaction has been analyzed using conversation analysis in terms of turn-taking and adjacency pairs. The analytic focus of conversation analysis provides the readers with insights into how nurses talk, advise, or care for the patients during home visits through interaction. However, limitations of the study are that the interactions were small in number and context-bound; therefore, the specifics of how these nurses interacted may not be able to be generalized. These results could have implications for healthcare providers in terms of the need to receive training, to reinforce communication strategies, and to fully engage with patients in their care. Further research is necessary to understand the interaction between nurses and patients along with clinical outcomes.

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