

Antipsychotic medication, sedation and mental clouding: An observational study of psychiatric consultations[☆]

Clive Seale^{a,*}, Robert Chaplin^b, Paul Lelliott^b, Alan Quirk^b

^a*Brunel University Uxbridge, Middlesex, UK*

^b*Royal College of Psychiatrists' Research Unit, UK*

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Abstract

Sedation and mental clouding are of concern to people on antipsychotic medication and are implicated in social withdrawal but their severity may be underestimated by psychiatrists. Existing studies of communication about adverse effects of medication are based on reports made by doctors or patients. This study is based on audiotapes of 92 outpatient consultations in two UK mental health trusts involving nine consultant psychiatrists where antipsychotic medication was discussed. When interviewed, these doctors and their colleagues had expressed a commitment to 'patient-centred' practice as well as recording concerns about the difficulties involved in the discussion of medication side effects. The study focuses on the ways in which sedation and mental clouding are presented and engaged with. Analysis of audiotape transcripts showed that patients raise these issues more often than doctors, contrasting with other adverse effects (such as blood changes) where doctors are more frequently the initiators of discussion. Sleepiness is sometimes presented by both patients and doctors as a part of normal experience and therefore to be welcomed. When presented as troublesome, patients' reports were sometimes met by doctors offering no response, changing the subject, or disagreeing with the patient's interpretation of the experience. Equally, there were some attempts by doctors to engage with patients' troubles and seek solutions. These could be unsuccessful where they involved challenges to the patients' medication-taking rationale, or more successful where they involved sympathetic and supportive listening. We speculate that the capacity to avoid addressing these problems is linked to the informal conversational style of these consultations, which means that concerns raised by one party can remain unaddressed without offending conversational norms. Doctors in these consultations are able to exercise considerable discretion over whether to define reports of sedation and mental clouding as medication-related problems.

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*Corresponding author.

E-mail addresses: clive.seale@brunel.ac.uk (C. Seale), rchaplin@cru.rcpsych.ac.uk (R. Chaplin), pllelliott@cru.rcpsych.ac.uk (P. Lelliott), aquirk@cru.rcpsych.ac.uk (A. Quirk).

Introduction

Sedation and mental clouding have long been of concern to patients on antipsychotic medications (Estroff, 1981; National Schizophrenia Fellowship, 2001a, 2001b). These experiences are commonly described as feeling ‘tired’, ‘sleepy’ or ‘like a zombie’ and contribute to social withdrawal (Rogers et al., 1998; Usher, 2001). One of the respondents in the study by Rogers et al. (1998) illustrates this:

Well you just sort of, you’re walking around like a zombie and you’re like sort of you can’t join in with things, I wouldn’t be talking to you like what I’m talking now. I know I might seem a bit high, but when you’re on [the antipsychotic drug] you can’t even be bothered holding a conversation you know, you’re just sat there saying yes or no, so I won’t take it I’m sorry but I’m not taking it. (1998: 1317)

Psychiatrists differ from patients in their judgements of the distress caused by adverse effects of antipsychotic medication (Day, Kinderman, & Bentall, 1998; Rettenbacher, Burns, Kemmler, & Fleischhacker, 2004). Psychiatric perspectives on sedation and mental clouding may suffer particularly from this. For example, in their study of the information given by psychiatrists to patients about the side effects of antipsychotic drugs, Smith and Henderson (2000) listed 23 experiences that the authors (both psychiatrists) considered to be common adverse effects of these medications, without including sedation, drowsiness or mental clouding. Yet in a survey of patients reported by the National Schizophrenia Fellowship (2001a) where 2222 respondents were asked ‘What is the worst thing about taking medication for mental illness?’ ‘Sedation and lethargy’ was the most commonly mentioned ‘worst thing’ (22% of respondents).

Other studies indicate that communicating about adverse effects is variable in psychiatric practice (Laugharne, Davies, Arcelus, & Bouman, 2004) with surveys of patients suggesting that insufficient information is given (Mind, 1998; National Schizophrenia Fellowship, 2000; Olofinjana & Taylor, 2005). But all of these studies are based on self-reports, either by doctors or by patients. Such study designs are subject to recall bias. Patients may forget what they have been told. Doctors may be optimistic in their estimates of how much information they provide. Observational studies of communication behaviour in psychiatry are rare. One exception is a study of the extent to which psychiatrists engage with patients who choose to talk about their psychotic symptoms during consultations (McCabe, Heath, Burns, & Priebe, 2002). This study found that doctors exhibited reluctance and discomfort in engaging with these concerns. Thus in this study, when a patient asked ‘why don’t people believe me when I say I’m God’ a psychiatrist responded with a question: ‘what should I say now?’ and laughter. This, the authors argue, is a typical response, although they also warn against generalising from a few selected cases (anecdotalism).

Having searched the published literature we have been unable to discover any studies reporting similar direct observations of how the adverse effects of medication are discussed in psychiatric consultations. We therefore report here a naturalistic observational study of communication about sedation and mental clouding during outpatient consultations in which antipsychotic medications are reviewed. We assess the ways in which psychiatrists either engage with or avoid these issues. We present our data both by means of simple counts (to guard against the charge of anecdotalism) and by means of detailed commentaries on selected extracts.

Method

Nine consultant psychiatrists working in two adult mental health service trusts in the UK agreed to audiotape consultations with consenting patients participating in outpatient consultations where antipsychotic medications were discussed. The psychiatrists had been interviewed about their perceptions of such consultations for an earlier study (Seale, Chaplin, Lelliott, & Quirk, 2006) which had identified the discussion of side effects as an area of particular concern to respondents. Respondents in this earlier study had, in general, expressed a commitment to ‘patient-centred’ practice where possible and they gave accounts of how they had behaved in accordance with this ideal.

Ninety-two consultations with consenting patients were taped and transcribed. Psychiatrists’ mean age was 48 (range: 43–52) and 3 were women. All were judged ‘White’ and English was the first language of all but one, whose first language was French. The mean age of patients was 42 (SD: 11.5) with 42 being women. Seventy-six patients were judged ‘White’, 11 Black/Black British, 3 Asian/Asian British and 1 each Chinese or ‘mixed’

ethnicity. Antipsychotic medication can be classified into two types: typical (tending to be older drugs) and atypical (tending to be newer drugs). Atypical antipsychotics are distinguished from typical antipsychotics in that they are better tolerated due to their lower risk of the extra-pyramidal side effects of parkinsonism (stiffness or shakiness), akathisia (restlessness) or dystonia (acute stiffness) and raised levels of the hormone prolactin (leading for example to osteoporosis and sexual dysfunction). In this study 60 patients were currently being prescribed a single atypical antipsychotic; 20 a single typical; 11 were on two antipsychotics and in 1 case the antipsychotic medication the patient was prescribed was not known.

Consultations averaged 17.7 min (SD: 8.2). Initial transcripts produced by transcribers were inspected to identify segments where adverse effects of antipsychotic medication were discussed. These segments were coded using NVIVO qualitative data management software. On retrieving segments thus marked we found that such talk comprised 19.5% of all talk that occurred in the consultations, a statistic produced by an automated letter character count. The content of these retrieved segments was coded according to the type of adverse effect being discussed, the antipsychotic medication(s) said to be involved and whether the issue was raised first by the doctor or the patient.

A wide range of adverse effects was discussed including, for example, sedation, blood changes, diabetes, sleep disturbance, movement disorders, weight gain, sexual capacity, digestive problems and interactions with drugs, alcohol or other medications. The analysis presented here focuses on segments where there were discussions or reports of sedation, lack of energy or feeling mentally clouded or ‘strange’. This focus arose at the data analysis stage when it was noticed that patients raised these issues more often than doctors (see below). At the data collection stage neither investigators nor participants were aware that sedation and mental clouding would be a theme of the study. Discussions coded as being about these things could be about medications prescribed at the time, about experiences of medications in the past, or about medications that were being considered for the future. Examples are shown in [Box 1](#) where all but the first are speech from patients.

The extracts chosen for more detailed analysis were listened to repeatedly and transcribed at a level of detail that went beyond that produced in initial transcripts. These detailed transcripts, shown below in the Results section, use conventions which allow the representation of certain features of speech delivery, such as pauses and overlaps ([Sacks, Schegloff, & Jefferson, 1974](#)). These conventions are explained when they first occur.

Our application of the method of conversation analysis (CA) adopts a sequential approach which, at times, draws on more general interpretive procedures than some CA practitioners have recommended (e.g. [Schegloff, 1997](#)). Our sequential approach focuses initially on who initiates talk about topics (such as the adverse effects of medication), how this is expressed, and how the other then responds. In applying this method we seek to

Box 1

Examples of talk about sedation and mental clouding.

Sedation or lack of energy

‘it could be, well it could be that the Olanzapine is making you sleep more’ (PDP42—doctor’s speech)

‘I’m a lot slower and more sluggish’ (PDP14)

‘I’ve been on sleeping tablets before and taking one does seem very similar to taking a sleeping tablet.’ (PDP75)

Mental clouding or ‘strangeness’

‘my head feels muzzy, you know, not quite so good concentration and things like that, I just feel a bit you know, zombified sometimes.’ (PDP29)

‘I don’t interact with people properly because I’m so stoned out of my head that it just all sort of washes over me’ (PDP89)

‘I felt like I was all over the place in my mind I couldn’t concentrate I was just everywhere.’ (PDP23)

‘it did make me sleep but it’s not only that it also seems to have some other things to it. I can’t really describe what they are but it does make me feel different.’ (PDP69)

make evidence-based inferences about the meaning of utterances that respects the CA position of validating analysts' inferences by examining 'next turn' inferences of speakers (Peräkylä, 1997).

Results

Sedation and mental clouding were raised as topics in 39 of the 92 consultations, more often by patients than by doctors. In relation to typical antipsychotics, patients attributed sedation or mental clouding to the medication 21 times in 14 consultations. A doctor raised the issue independently in relation to typicals on just one occasion (in two others the doctor referred to a past consultation where the patient had complained of this effect). In relation to atypical antipsychotics patients attributed sedation or mental clouding to the medication 32 times in 23 consultations. Doctors raised the issue independently seven times in seven consultations where atypicals were involved, with a further three doctor-initiated renewals of the topic occurring after the patient had raised the issue in an earlier phase of the consultation.

The quantitative predominance of patients' initiations of this topic can be appreciated by comparing these statistics with a similar count of another type of adverse effect: blood changes brought about by antipsychotic medication. Doctors were significantly more likely than patients to raise this as an issue (raised 47 times by doctors but only 16 times by patients across all consultations, $\chi^2 = 47$, d.f. = 1, $p < 0.001$). These included the need to monitor blood changes in general, and specifically to monitor levels of blood sugar, cholesterol or fat, often with regard to concerns about developing diabetes. These were most often discussed in relation to the newer, atypical antipsychotics.

Our qualitative analysis focuses on doctors' responses to patients who raise the topic of sedation and mental clouding. These fall into three main categories, considered in turn below:

- Marking the experience as positive (can be done by either party).
- Denial and avoidance.
- Engaging with patients' concerns.

Marking the experience as positive

Feeling sleepy is not only a part of normal experience but, for people with a diagnosis of schizophrenia, it may represent either an unwelcome experience of day time, drug-induced drowsiness or a positive restoration of sleep deprivation in the recovery from acute psychosis. Both doctors and patients therefore sometimes interpreted sleepiness as a positive experience, as shown in Extract 1, one of three occasions in which the doctor initiates an interpretation of the experience as positive. The patient (lines 1–2) reports an experience of tiredness which appears evaluatively neutral but, as the 1.3 second pause and the subsequent invitational 'y' know' suggests, requires a response from the doctor. The doctor (line 3) treats the patient's report as positive, saying that the tablet 'must help'. The doctor's 'I guess' (line 4) is responded to by the patient as an invitation to align herself with the doctor's evaluation. The patient (line 5) duly echoes this positive evaluation with 'it helps me to sleep yeah'.

*Extract 1**

- 1 Patient: like that makes me tired (0.8) So I'll go to bed I go to bed quite
2 early (1.3) [y'know
3 Doctor: [take your tablet then and you slee- you it must help
4 you sleep a bit I guess
5 Patient: I go to bed yeah and it helps me to sleep yeah
(PDP03 – Risperidone)

* In this and other extracts overlaps are shown with square brackets and pauses in seconds are shown in round brackets

In six other consultations the patient reported the experience in a way that either discounted the seriousness of the effect, or which provided the doctor with a cue to reinforce a positive interpretation with a reformulation. Extract 2 begins after the doctor had asked the patient ‘of the medication that you’re on do you think there’s anything that’s particularly helpful?’ After a report of difficulties sleeping when on another drug, the patient begins at line 1 with a positive evaluation of Olanzapine, an evaluation repeated at lines 8 and 10 after the doctor has responded to the initial report with tokens of sympathetic listening (lines 3, 7, and 9). The extract is then notable for the reformulation offered by the doctor at line 11, announced with a ‘so’ that prepares the ground for a summary statement. The patient is then invited to agree with the view that ‘trust’ characterises his attitude to the medication. Line 12 shows him indicating agreement.

*Extract 2**

- 1 Patient: The Olanzapine helps me sleep because if I don’t take them
 2 then I don’t sleep until the early hours of the morning
 3 Doctor: mmm
 4 Patient: or sometimes I don’t sleep [at a:ll
 5 Doctor: [so so if you take that
 6 Patient: because of this trouble with my breathing
 7 Doctor: aha
 8 Patient: it helps me sleep it helps me sleep
 9 Doctor: aha
 10 Patient: so that’s good
 11 Doctor: so it sounds like you trust the the the medication qui quite a lot
 12 Patient yeh
 13 Doctor: yeh yeh yeh
 (PDP80 – Olanzapine)

** a colon within a word (eg: line 4) indicates an extended vowel sound. An underlined word indicates emphasis by the speaker (eg: line 11)*

Denial and avoidance

Denial and avoidance, at their most simple, were achieved by offering no response to the patient’s report (four instances) or by changing the subject (six instances). A variation of this (five instances) involved the patient raising sedation or mental clouding as one of two or more issues and the doctor responding to other issues on the list. In further three cases the doctor questioned whether medication was causing a problem or disagreed with the patient’s interpretation of their experience.

Extract 3 shows the first of these: a doctor offering no response. The patient had been angry and upset about a variety of things, to which the doctor had been responding in a quiet and non-challenging manner. The extract opens with the doctor continuing a list of questions with ‘and do you take it at night as well’ (line 1). This is met instantaneously with an angry denial from the patient: ‘no I do not’ (line 2) to which the doctor responds with pauses and utterances indicating that he is collecting his thoughts while acknowledging receipt of this information (lines 3–4). The patient (lines 5–7) uses the pause that this involves to express her complaint about being drugged up ‘like some zombie’ at lines 5–7 with considerable emotional emphasis. Line 8, though, shows the doctor apparently not engaging with this complaint but continuing (denoted by the introductory ‘and’) with his question list. This effectively quiets the patient who responds with the requested information which is then received by the doctor’s ‘right’ at line 10, and is followed by a lengthy silence at line 11. The doctor then continues (lines 12–13) with a further ‘list’ question: ‘are you going out socially, are you meeting people’ without having responded to the patient’s attempt to topicalise the feeling of being ‘like some zombie’.

Heritage and Sorjonen (1994) have found such ‘and-prefacing’ to be a notable feature of talk in institutional settings. They are often used strategically by professionals to indicate that questions have ‘a routine or agenda-based character’ (1994: 1), whereby a focus is maintained on the official business of the encounter. Here, it

appears that the doctor is using this to distance himself from the obligation to respond directly to the challenges posed by the patient.

*Extract 3**

- 1 Doctor: and do you take it at night as well no=
 2 Patient: =no I do not
 3 Doctor: just (0.2) okay
 4 (2.6)
 5 Patient: you're not drugging me up doctor (1.5) I'm not stupid with
 6 them you know I'm not (1.7) (*sniff*) you're not drugging me
 7 up (0.7) like some zombie
 8 Doctor: and are you taking the iron tablets
 9 Patient: yes every morning
 10 Doctor: right
 11 (9.5)
 12 Doctor: .hhh are you going out socially are you meeting
 13 [people
 14 Patient: [yes
 (PDP11 – Olanzapine)

** an equals sign (=) at the end of one line and the start of another indicates that the second turn follows instantly from the first turn*

In a conversational exchange, where someone uses his turn to raise several issues the next speaker is able to choose just one of them for further comment, ignoring the others unless the first speaker raises them again or insists on an answer. This often happens, for example, in news interviews with politicians on radio or television. This capacity to respond to just one thing from a list of two or more items was used in avoiding the issue of sedation or mental clouding. An example is shown in Extract 4 where the patient is explaining how the adverse effects of Modecate appear when he takes less than six tablets of the Orphenadrine which is prescribed to counteract Modecate's extra-pyramidal effects (stiffness in the case of the patient in Extract 4).

The patient indicates that 'I just don't have any mental energy to get to communicate with people' (lines 3–4). This report continues as the doctor issues tokens of sympathetic listening ('ri:ght', 'a:h hah'). This report is reminiscent of the respondent to the study by Rogers et al. (1998) quoted at the start of this paper who indicated the effect that sedation and mental clouding had on social withdrawal. At line 10 the patient continues his complaint with a report of feeling 'stiff around place'. It is possible, of course, that 'stiffness' might be intended to refer to social stiffness in the sense of feeling awkward or tense in social situations, but the doctor's response at lines 11–12 (and eventually at line 31) clearly shows an interpretation of the stiffness as a physical or bodily experience (such bodily stiffness is a recognised side effect of some antipsychotic medications). The doctor's speech at lines 11–12 is, in the light of this, hearable as an inquiry into whether this is a physical sensation. However, the patient's response at line 13 is somewhat ambiguous, confirming the doctor's conjecture with a 'yes' but also referring once again to 'enough energy'. Lines 17 and 19–20 show the patient continuing alternately to present feeling stiff and lacking energy as problems to which the doctor responds with tokens of sympathetic listening.

At line 22 the patient initiates a sequence in which he provides a metacommentary (Bateson, 1972) on how adequately he might be explaining himself in the doctor's eyes, to which the doctor responds with encouragement (line 23). As this sequence reaches a summary point as the patient tries to encapsulate his generalised feeling of not feeling 'okay at all' (line 28) the doctor uses 'mm no' (line 27) and 'right' (lines 29 and 31) to announce a change of footing (Goffman, 1974) in which elicitation and sympathetic listening or encouragement is replaced with more business like orientation of an inquiry made for medical diagnostic purposes at line 31 ('where does the stiffness affect you'). At this point it is clear that the doctor has decided to focus on physical stiffness and the issue of mental energy and its consequences for social interaction has been dropped.

Extract 4*

- 1 Patient: if I don't take the Orphenadrine
 2 Doctor: yeh
 3 Patient: I feel like uh:m (1.1) I just don't have any mental energy to get
 4 to communicate with people
 5 Doctor: ri:ght
 6 Patient: have enough mental energy (0.8) to () free and communicate
 7 Doctor: a:h hah
 8 Patient: and be happy and mix with people
 9 Doctor: Ri[ght
 10 Patient: [just tend to be like feel stiff around place [I
 11 Doctor: [d'you do you
 12 actually (0.7) feel stiff
 13 Patient: yes () enough energy
 14 Doctor: right
 15 Patient: on all the times I've tried to stop taking six
 16 Doctor: yeh
 17 Patient: I just feel so stiff you know
 18 Doctor: ri:ght
 19 Patient: and then I just feel like I haven't got any (0.3) energy to be
 20 [happy you know
 21 Doctor: [yeh yeh yep
 22 Patient: I don't know if I can explain it properly though
 23 Doctor: oh well you [are
 24 Patient: [its hard to explain how [I feel
 25 Doctor: [()
 26 Patient: I'm trying to [trying my best
 27 Doctor: [mm no
 28 Patient: () I just don't feel okay at all
 29 Doctor: right
 30 Patient: I don't feel okay at all
 31 Doctor: right yes yeh wh- where does the stiffness affect you
 (PDP36 – Modecate)

* an empty bracket () indicates unclear speech

Finally, doctors sometimes disagreed with the validity of patients' interpretations of sedation or mental clouding and their causes. This was made possible because consultations were opportunities for doctors to speak from a position of medical expertise about the nature of mental illness and the effects of medication. Patients often supported this position by asking doctors whether an adverse experience might be caused by medication. For example, a doctor hearing a patient wondering whether his low testosterone and 'sexual appetite' was caused by medication responded 'although the drug you're on can affect a hormone called Prolactin I don't think it normally affects testosterone' (PDP30). Sometimes, too, doctors would offer comments spontaneously about whether something was caused by medication. For example, on hearing a patient's view that 'falling out of bed' might have 'something to do with the medication' a doctor responded 'I have to say I haven't heard of falling out of bed as a side effect with medication' (PDP92). This asymmetry in the distribution of medical expertise was also involved when doctors contradicted the patient's interpretation of the effects being experienced.

This last is shown in Extract 5, a consultation involving the patient's wife as well, which begins after the doctor has been stressing the need to take Olanzapine regularly. The patient (lines 1–7) begins talking about how ceasing to take it has meant an increase in mental clarity: 'when I've missed them that's when I think to myself oh it it feels like oh they've been hiding the truth all the time'. It is arguable as to whether, at this point, the report might be considered to be about 'sedation and mental clouding'. It is reminiscent of the examples described by McCabe et al. (2002) where patients attempted to initiate talk about their psychotic experiences

(which doctors in that study generally avoided). There is evidence at an early stage in the doctor's contributions that the doctor experiences this topic as unwelcome: line 3 ('yeh bu- but') appears to be an attempted announcement of disagreement, but the patient continues, overlapping this speech with a continuation of the report. The doctor's 'no I see' (lines 8–9) occurs at a point where the patient is winding up his complaint with (at line 10) an attempt to align the doctor with his point of view ('you know').

Extract 5

- 1 Patient: but but (0.4) when I've missed them I- tha- that's when I think
 2 to myself oh it it feels like oh they've been hiding the truth all
 3 Doctor: [yeh bu- but
 4 Patient: [the time you know somebody's hiding the truth from me and
 5 tha- and that
 6 Doctor: yeh [yeh
 7 Patient: [you're stopping me seeing what's go- really going on [like
 8 Doctor: [no
 9 I see
 10 Patient: you know that's what it feels like
 11 Doctor: mm cos of course the way (0.6) I would see it [()
 12 Wife: [yeh
 13 Doctor: is that (0.9) when you stop the Olanzapine you actually become
 14 more unwell] and more paran[oid]
 15 Wife: [mm
 16 Doctor: and therefore start being suspicious (1.2)
 17 Wife: mm
 18 Doctor: so it's it's because you're not having the beneficial effect that
 19 the Olanza[pine
 20 Patient: [it feels as though you can see ev[erything clearly
 21 Doctor: [but you feel it you
 22 Wife: [you feel
 23 Doctor: you feel you [can see it more clearly
 24 Patient: [you feel you
 25 Wife: [you feel
 26 Patient can see things clearly [more yeh
 27 Doctor: [and we see I- I would think that
 28 you're seeing it (0.2) less clearly
 (PDP21 – Olanzapine)

The doctor's response to this attempted alignment is to issue a minimal acknowledgement token ('mm' at line 11) and to begin announcing her alternative version. At this point the patient's wife begins to interject in support of the doctor's viewpoint (line 12). Charles, Gafni, and Whelan (1997) review studies showing that the presence of third parties in consultations often results in 'coalitions' between two of the three, aligning themselves against the third and this is evidently what is going on here. In her turns at lines 13–19 the doctor outlines her alternative version, explaining how she disagrees with the patient's views. Her emphasis on how 'I would see it' initially invokes a possibly purely personal view, but it becomes clear, from her use of the medical term 'paranoid' (line 14) that she considers herself to speak from a position of expertise. Acknowledgements from the patient's wife (lines 15 and 17) further identify her as aligned with the doctor's version. The patient's interjections at lines 20, 24 and 26 are further attempts to get across his perception of seeing things more clearly when off the drug. There is considerable overlapping speech between all three between lines 20 and 27, reflecting competition between each party in the disagreement to hold the floor. The sequence ends, however, with the doctor reasserting the fact that she takes the opposite view to the patient on this issue (lines 27–28). At issue is the patient's view that medication obstructs clarity of thought and the psychiatrist's view that this 'clarity' is delusional and therefore undesirable.

Engaging with patients' concerns

Doctors in these consultations were often concerned to accommodate patients' preferences. In all, 20 of the 92 consultations, for example, involved reductions or stoppages of an antipsychotic drug, of which 13 were purely at the instigation of the patient and 2 more involved some initiative from the patient. Given that doctors involved in this study had stated that they wanted to be 'patient-centred' (Seale et al., 2006) we searched the 92 transcripts for examples of them trying to engage with patients' concerns about sedation and mental clouding. We found three, one of which was not very successful, the other two being judged successful. We begin with the unsuccessful attempt and then describe one of the successful attempts.

Extract 6 begins with the doctor attempting to elicit the patient's concerns with an inquiry as to whether the drug is causing 'any problem' or whether he has any concerns about it (lines 1–3). The patient, though initially replying with a downplaying of any problems ('not really no') at line 4, then proceeds to raise one: the problem of feeling drowsy during the day, which the patient links with his taking the tablets during the day. The doctor's response to this report at line 10 takes the form of a challenge to the patient's behaviour: 'so why do you take it during the day if it makes you drowsy'.

Extract 6

- 1 Doctor: any problem with it er:: any [any
 2 Patient: [er
 3 Doctor: concerns about it
 4 Patient: not really no no I mean I do feel er (0.3) quite a lot a lot er quite
 5 drowsy on the tablets (0.5) they're very drowsy and that you
 6 know bec=
 7 Doctor: =during the day
 8 Patient: during the day when I'm taking them it lasts (0.4) it takes about
 9 an hour to work and then when it works I'm drowsy=
 10 Doctor: =so why do you take it during the day if it makes you drowsy
 11 (0.8)
 12 Patient: cos I'm u- well the reason why I take it during ten in ten in the
 13 morning and ten at night cos I'm used to used to it I've been
 14 taking it for years
 15 Doctor: Ri[ght: but
 16 Patient: [if I take two two before I go to bed I get frightened I might
 17 get too agitated during er (0.4) er you know cos er ten in the
 18 morning I get drowsy and lay down .hh and the day's alright
 19 and then I take it [at
 20 Doctor: [yeh
 21 Patient: night and then go to sleep and I sleep through the effects you
 22 see so
 23 Doctor: right now I was thinking in terms of what you are saying if you
 24 go out and have to cross the roads it it doesn't affect your
 25 concentration does it
 26 Patient: oh no no
 27 Doctor: no okay
 28 Patient: no I mean it was worse like I keep saying earlier when I was
 29 smoking cannabis it was totally [different
 30 Doctor: [oh yeh
 (PDP39 – Olanzapine)

The patient's response to this then indicates perturbation in various ways. First, there is a 0.8 s pause (line 11). Silences of roughly 1 s have been noted by Jefferson (1988a) to be commonly implicated in interactionally difficult moments, as where a speaker pauses when trying to recollect a name, has delivered news designed to be a 'surprise', or where (as in this case) a challenge is received. When the patient's response is delivered (line 12) it is characterised by an abandoned phrase ('cos I'm u') an attempted re-start with an explicit attempt to

make the challenged behaviour accountable ('well the reason why') and stammering ('ten in ten in the'). The stammering continues at line 13 ('used to used to it') and line 16 ('two two'). In lines 12–21 the patient produces an extended justification for taking a pill in the day, successfully proceeding past an attempted interruption from the doctor (line 15), so that by lines 19 and 21 the initial 'problem' (reported at line 1) is no longer a problem: 'the day's alright' (line 18). The doctor then initiates a discussion of road safety issues, having failed to engage, for example, with the reported fears of night time agitation (lines 16–17) that the patient claims to be behind his pill taking regime.

The two consultations in which engagement appeared successful both involved the same doctor. These were characterised by careful listening to the patients' concerns and provision of advice about, or reinforcement for, strategies that the patient might take to cope with sedating effects. The first consultation, for example, contained the advice to take the medication 'at night because some people do find these helpful making sure you get to sleep and it can still do all its anti-psychotic work as well'. Speech from the second consultation is shown in Extract 7. The patient has been telling the doctor about the time when he was required to be witnessed taking Olanzapine and other medications. This is marked as a delicate issue in the doctor's first turn (lines 1–2) where 'I', 'we' and finally a more neutral 'somebody' are identified as having implemented this

Extract 7

- 1 Doctor: cos w- cos what had been happening before that I- we had been
2 delivering [somebody had been delivering your medication
3 Patient: [half past three
4 Doctor: every day
5 Patient: half past three every afternoon
6 Doctor: every [day
7 Patient: [Monday to Saturday yes a:nd I had to take it in front of
8 them (0.3)
9 Doctor: yes
10 Patient: and then I was wrecked goi- an hour later it kicked in and I was
11 wrecked for the rest of the evening [I
12 Doctor: [yes
13 Patient: just go to sleep
14 Doctor: yes and that had been going on for how long
15 Patient: oh about three or four years
16 Doctor: so that's a long time [ter
17 Patient: [that's a long time yes
18 Doctor: to have that pattern established
19 Patient: yes
20 Doctor: yeh yeh .hh an- and during that time (1.1) umm and I hear what
21 you're saying your actual day was pretty wrecked by
22 Patient: yeh
23 Doctor: by that um were there (0.5) any other things that happened
24 during that time
(material untranscribed here)
25 Doctor: I mean generally umm wh- when there have been changes and
26 I mean in your case is it's changes around the time
27 Patient: yeh
28 Doctor: that you take your medication
29 Patient: yeh
30 Doctor: i-it
31 Patient: so I'm still wrecked in the mornings in the mornings don't last
32 I mean I only get [myself
33 Doctor: [ah
34 Patient: back together by noon
35 Doctor: mm yeh

36 Patient: I can't get- my my good time my quality time is from .hh
 37 round about half past three onwards now
 38 Doctor: right
 39 Patient: you [know
 40 Doctor: [right
 41 Patient: I have time to do what I want to [()
 42 Doctor: [yes because you were saying
 43 you're more of a night owl really
 44 Patient: yeh
 45 Doctor: yeh yeh yeh (0.3) okay (0.5)
 46 Patient: okay
 47 Doctor: .hh okay so I mean th- (2.0) what was I saying um (0.3) I mean
 48 the the change from it being (0.3) you- your meds in the
 49 afternoon always observed every day half past three that's it
 50 which i- interfered enormously with the day .hh umm to (0.8)
 51 you taking responsibility for it and and er so on were you
 52 saying you're still wrecked in the morning
 53 Patient: yeh I ta-
 54 Doctor: would you be able to take it any earlier in the evening do you
 55 think
 56 Patient: no I don't think I want to I think it's best to ()
 57 Doctor: midnight
 58 Patient: yeh
 (PDP82 – Olanzapine)

coercive approach. The patient begins his complaint of being 'wrecked' at line 10, continuing with an elaboration of this at line 13 with 'just go to sleep'.

The doctor's response is to acknowledge receipt of this news ('yes' at line 14) and ask for further details with 'and that had been going on for how long'. The patient responds with this information ('three or four years') which the doctor receives (lines 16–18) with a sympathetic evaluation about the lengthy period this trouble has been experienced, to which the patient responds with confirming echoes 'that's a long time yes... yes' (lines 17 and 19). The doctor then makes an explicit metacomment about her level of attention to what the patient is saying 'I hear what you're saying' (lines 20–21) and further emphasises her attendance to his concerns by echoing them emphatically with 'your actual day was pretty wrecked' (line 21).

Although this first half of the extract appears, in general, to indicate a stance of careful and sympathetic listening by the doctor, the formulation at lines 16 and 18 ('that's a long time to have that pattern established') can also be heard as the psychiatric equivalent of 'online commentary' (Heritage & Stivers, 1999). This is the talk produced by doctors when they comment on the physical appearance of body parts (for example, an inflamed tonsil) during physical examinations. Clearly, in psychiatry the physical examination is replaced, largely, with listening to patients' 'troubles talk' (Jefferson, 1988b) which is constituted as the raw material on which diagnostic and treatment decisions are made. Online commentary has an implicit evaluative component and is often produced by doctors as a way of warranting summary expert evaluations or diagnoses ('this is tonsillitis') and treatment recommendations ('you need/don't need antibiotics'). The comment about it being 'a long time to have that pattern established' is similar, in that it marks a verbalisation of a train of thinking about the influence of the time at which medication is taken which is returned to later in the consultation.

After discussion of some other matters, in which it becomes clear that the patient now takes his medication before bed, the matter of the timing of medications in relation to being 'wrecked' is returned to (line 25) with the doctor offering an interpretive generalisation to link the time of taking medication to the experience of feeling 'wrecked in the mornings' (line 31). After a continuation of the patient's account of his troubles with morning sedation the doctor begins to lay the groundwork for a proposed solution (line 47 onwards) that is based on their jointly established understanding of the relationship between the timing of medication intake and the sedation problem. This proposed solution is prefaced by considerable reference to what has gone before ('what I was saying' (line 47) and the summary of what went before between lines 48–50). At line 51 the doctor produces a secondary formulation about the patient's medication behaviour in general as involving 'taking responsibility for it' which is a mixture of support and exhortation. There is an exchange about the

nature of the trouble (lines 51–53) in which the patient is asked yet again to confirm the nature of the problem, which he does (line 53).

The doctor only then delivers a potential solution (lines 54–55) in the form of a proposal which the patient rejects with ‘no I don’t think I want to’ (line 56). Notably, there is no practical outcome or commitment to change arising from this discussion, but it is clearly one in which the doctor both empathises with and listens closely to the patient’s concerns. There is no avoidance of the issue by, for example, offering no response, changing the subject or denying the patient’s concerns or their link with medication. Nor is there any attempt to reformulate the experience with a positive evaluation of sleepiness. Considerable care is taken, too, to respond in a way that does not challenge the logic of what the patient is doing, thus supporting the doctor’s explicit attempt to characterise the patient as now ‘taking responsibility’ for his medications.

Discussion

In these consultations patients initiate discussion of sedation and mental clouding quite frequently and do so more often than doctors. By marking the experience of sleepiness and lethargy as positive both doctors and patients are responding to the ambiguous status of sleepiness, in that it can be understood as part of normal experience rather than a medical condition. This can contribute to a lack of ‘hearability’ of the issue as a complaint and stands in marked contrast to evidence from patient surveys ([National Schizophrenia Fellowship, 2001a](#)) and qualitative studies ([Rogers et al., 1998](#); [Usher, 2001](#)) which indicate that sedation and mental clouding are experienced as unwanted consequences of antipsychotic medication.

Doctors were shown to be more concerned to discuss and monitor blood changes than sedation and mental clouding. This may reflect a perception by doctors that newer antipsychotic drugs, which are now more frequently prescribed, are less likely to be associated with sedation than older kinds. There is also recently increased official concern about the effects of atypicals on blood, including the possibility of weight gain and diabetes, with influential guidelines for psychiatrists stressing the need to monitor blood indicators ([Taylor, Kerwin, & Paton, 2005](#)). Patients showed an opposite pattern of concern, with blood monitoring being infrequently and sedation frequently raised. This suggests patients respond more to immediate illness experience than potential indicators of ‘disease’, to use [Eisenberg’s \(1977\)](#) terms.

The findings remind us that those who participate in these consultations are often pursuing a number of different conversational goals simultaneously. Extract 3, for example, suggests that the avoidance of confrontation with an angry patient may have been an overriding concern for the doctor, meaning that the patient’s concerns about mental clouding were not taken up. Because consultations in part follow everyday conversational rules rather than, for example, being governed by a checklist, it is possible for doctors to engage with some concerns but pass over others without either party experiencing this as disruptive or anomalous. Structurally, this allows doctors to focus on apparently preferred topics rather than sedation or mental clouding (Extract 4). Additionally, the ambiguity in the meaning of some words (such as the word ‘stiff’ in Extract 4) means that conversation can sometimes be steered away from engagement with these experiences without either party really noticing that it is happening.

One of the tensions revealed by these doctors and some of their colleagues when they were interviewed about their experiences of such consultations ([Seale et al., 2006](#)) is that they maintain a self-image as being engaged in ‘patient-centred’ practice. Yet our findings show that attempts at engagement with patients’ concerns about sedation and mental clouding met with mixed success. Extract 6, for example, demonstrates how easily an intervention can come across as confrontational, leading the patient to downplay concerns that might otherwise have been addressed more fully.

The example of sympathetic and supportive engagement shown in Extract 7 demonstrates that it is not always necessary to be able to solve patients’ problems in order to attend to their concerns. Here the doctor listens sympathetically and elicits further information about the patient’s experience of medication-induced lethargy, seeking to understand how the patient is trying to structure his days around this experience. Notably the doctor’s suggested ‘solution’ towards the end of the extract is rejected by the patient without reducing the sense that the patient’s concerns have been heard.

Clearly this is a study based on outpatient consultations only, and the practice of just nine consultant psychiatrists. An observational study which included more doctors, different grades of doctor and more varied

psychiatric care settings might reveal a different pattern of engagement. We have no data to report on whether the avoidance/engagement variable is linked to adherence to recommended medication regimes but note that one of the most robust predictors of non-adherence is a poor therapeutic alliance and there is a link between the subjective experience of side effects and a negative attitude toward treatment (Lacro, Dunn, Dolder, Leckband, & Jeste, 2002). Day et al. (2005) provide further evidence linking the quality of patient–doctor relationships in psychiatry to attitudes towards medication. From a psychiatric point of view greater engagement with patients describing sedation and mental clouding would therefore be desirable and, unlike statistical studies which do not provide detailed accounts of interaction, this paper (through the example shown in Extract 7) suggests some ways in which such engagement might be achieved.

More broadly, we believe the presentation of this detailed observational material sheds light on why patients often complain of not being told enough about side effects (Mind, 1998; National Schizophrenia Fellowship, 2000; Olofinjana & Taylor, 2005). Clearly, it is possible for inadequate engagement (for which read ‘not being told enough’) to happen even in an environment where psychiatrists profess to an orientation towards ‘patient-centred’ practice (Seale et al., 2006). This is partly because of the rather friendly and ‘conversational’ style adopted by parties to these consultations which allows topics to be variably addressed according to speakers’ preferences and partly, we suggest, because of an asymmetrical distribution of medical expertise. This asymmetry means that doctors are relatively free from challenges when they issue judgements about, for example, whether drowsiness is caused by medication or whether a patient’s preferred mental state is instead a marker of abnormality or mental illness. This is possibly an inevitable limitation of the degree to which consultations can be ‘patient centred’.

References

- Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. Chicago, IL: University of Chicago Press.
- Charles, C. A., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science & Medicine*, 44(5), 681–692.
- Day, J. C., Bentall, R. P., Roberts, C., Randall, F., Rogers, A., Cattell, D., et al. (2005). Attitudes toward antipsychotic medication: The impact of clinical variables and relationships with health professionals. *Archives of General Psychiatry*, 62, 717–724.
- Day, J. C., Kinderman, P., & Bentall, R. (1998). A comparison of patients’ and prescribers’ beliefs about neuroleptic side-effects: Prevalence, distress and causation. *Acta Psychiatrica Scandinavica*, 97(1), 93–97.
- Eisenberg, L. (1977). Disease and illness: distinctions between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry*, 1, 9–23.
- Estoff, S. E. (1981). *Making it crazy: An ethnography of psychiatric clients in an American community*. California: University of California Press.
- Goffman, E. (1974). *Frame analysis: An essay on the organisation of experience*. New York: Harper and Row.
- Heritage, J., & Sorjonen, M.-L. (1994). Constituting and maintaining activities across sequences: And-prefacing as a feature of question design. *Language in Society*, 23, 1–29.
- Heritage, J., & Stivers, T. (1999). Online commentary in acute medical visits: A method of shaping patient expectations. *Social Science & Medicine*, 49(11), 1501–1517.
- Jefferson, G. (1988a). Preliminary notes on a possible metric which provides for a ‘standard maximum’ silence of approximately one second in conversation. In D. Roger, & P. Bull (Eds.), *Conversation: An interdisciplinary perspective* (pp. 166–196). Clevedon and Philadelphia: Multilingual Matters.
- Jefferson, G. (1988b). On the sequential organization of troubles talk in ordinary conversation. *Social Problems*, 35, 418–441.
- Lacro, J. P., Dunn, L. B., Dolder, C. R., Leckband, S. G., & Jeste, D. V. (2002). Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: A comprehensive review of recent literature. *Journal of Clinical Psychiatry*, 63, 892–909.
- Laugharne, J., Davies, A., Arcelus, J., & Bouman, W. P. (2004). Informing patients about tardive dyskinesia: A survey of clinicians’ attitudes in three countries. *International Journal of Law and Psychiatry*, 27(1), 101–108.
- McCabe, R., Heath, C., Burns, T., & Priebe, S. (2002). Engagement of patients with psychosis in the consultation. *British Medical Journal*, 325, 1148–1151.
- Mind. (1998). *Psychiatric drugs: Users’ experience and current policy and practice*. London: Mind.
- National Schizophrenia Fellowship. (2000). *A question of choice*. London: National Schizophrenia Fellowship.
- National Schizophrenia Fellowship. (2001a). *Doesn’t it make you sick?*. London: National Schizophrenia Fellowship.
- National Schizophrenia Fellowship. (2001b). *That’s just typical*. London: National Schizophrenia Fellowship.
- Olofinjana, B., & Taylor, D. (2005). Antipsychotic drugs—Information and choice: A patient survey. *Psychiatric Bulletin*, 29, 369–371.
- Peräkylä, A. (1997). Reliability and validity in research based on tapes and transcripts. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (pp. 201–220). London: Sage.

- Rettenbacher, M. A., Burns, T., Kemmler, G., & Fleischhacker, W. W. (2004). Schizophrenia: Attitudes of patient and professional carers towards the illness and antipsychotic medication. *Pharmacopsychiatry*, 37(3), 103–109.
- Rogers, A., Day, J. C., Williams, B., Randall, F., Wood, P., Healy, D., et al. (1998). The meaning and management of neuroleptic medication: A study of patients with a diagnosis of schizophrenia. *Social Science & Medicine*, 47(9), 1313–1323.
- Sacks, H., Schegloff, E., & Jefferson, G. (1974). A simplest systematics for the organisation of turn-taking in conversation. *Language*, 50, 696–735.
- Schegloff, E. A. (1997). Whose text? Whose context? *Discourse and Society*, 8(2), 165–187.
- Seale, C., Chaplin, R., Lelliott, P., & Quirk, A. (2006). Sharing decisions in consultations involving anti-psychotic medication: A qualitative study of psychiatrists' experiences. *Social Science & Medicine*, 62, 2861–2873.
- Smith, S., & Henderson, M. (2000). What you don't know won't hurt you: Information given to patients about the side-effects of anti-psychotic drugs. *Psychiatric Bulletin*, 24, 172–174.
- Taylor, D., Kerwin, R., & Paton, C. (2005). *The Maudsley 2005 prescribing guidelines* (8th ed). London: Taylor & Francis.
- Usher, K. (2001). Taking neuroleptic medications as the treatment for schizophrenia: A phenomenological study. *Australian and New Zealand Journal of Mental Health Nursing*, 19(3), 145–155.