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Ramos Ruiz, Juan Andrés; Pérez-Milena, Alejandro; Noguera-Cuenca, Carmen; Rodríguez-Bayón, Antonina; Ruiz-Díaz, Beatriz

DOI: https://doi.org/10.3399/BJGPO.2023.0124

To access the most recent version of this article, please click the DOI URL in the line above.

Received 06 July 2023
Revised 18 September 2023
Accepted 23 October 2023

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Severe Mental Illness patients and their carers’ expectations for general practitioners’ communication skills: a qualitative approach in Spain.

Running head
Communication expectations for GPs in Spain.

Authors:

Corresponding author’s:
Carmen Noguera-Cuenca. Address: s/n Ctra. Sacramento. La Cañada de San Urbano, Facultad de Psicología. (04120, Almería). Telephone: 0034616791881. Email address: cnoguera@ual.es
SEVERE MENTAL ILLNESS PATIENTS AND THEIR CARERS’ EXPECTATIONS FOR GENERAL PRACTITIONERS’ COMMUNICATION SKILLS: A QUALITATIVE APPROACH IN SPAIN.

Ramos-Ruiz Juan Andrés (JR), Pérez-Milena Alejandro (AP), Noguera-Cuenca Carmen (CN), Rodríguez-Bayón Antonina (AR), Ruiz-Díaz Beatriz (BR).

ABSTRACT

Background

Effective Communication with General Practitioners (GPs) provides higher rates of satisfaction and adherence to treatment plans. People with Severe Mental Illness (SMI) and their caregivers present unique characteristics that present difficulties in the GP-carer-patient communication process.

Aim

To explore SMI patients and their caregivers’ expectations for GPs’ Communication Skills (CS) in primary care (PC) consultations.

Design & setting

Face-to-face interviews using focus group methodology surveyed in southern Spain.

Method

42 participants in 21 paired semi-structured interviews with an average duration of 19±7.2 minutes. Information was audio-recorded and transcribed literally. Qualitative content analysis, obtaining a codification in categories by means of triangulation.

Results

The ability of GPs to use a language that was colloquial and adapted to each person was perceived as a determinant of the quality of care provided. An empathetic attitude, low reactivity and efficient time management were the most valued CS. The telephone consultation was perceived as a useful tool to care for people with SMI. Video consultation was valued as a requirement in isolated rural areas. The caregiver was considered by the patients as an allie who improves the clinical interview. Finally, the continuity of care, defined by a low turnover of GPs, determined the quality perceived by those who require care.

Conclusion

Themes emerging from this study suggest that people suffering from SMI require an inclusive, collaborative and personalized approach in the care they receive from the public health system.
Improved communication between general practitioners and patients with SMI is an essential requirement for quality medical care.

**Keywords:**
General practitioners, severe mental illness, caregivers, communication, qualitative research.

**How this fits in:**
The narratives of people who live with SMI are marked by painful experiences of disconnection with the social world that further increase the affliction and adversity of those who suffer from it. Training in communication skills by GPs, makes it possible to offer positive, differentiating care to these people, providing solutions based on collaborative care management between primary and secondary care.

**Introduction**
People with SMI present a set of psychotic or pre-psychotic symptoms that make it difficult for them to understand reality and relate to others. This condition has negative repercussions in different areas of their personal lives (education, employment, social relationships) and can pose a risk to their lives. The health systems of countries that promote comprehensive care offer treatment adapted to the specific needs of these patients and their caregivers, respecting their individual needs and their interdependence.

The underlying idea of this approach is that health services are provided based on the needs of the population, devoting more resources to the health care of those patients with the most serious and needy conditions.

The complexity in managing these conditions, including major depression, bipolar disorder, and schizophrenia, is a challenge for healthcare providers in both urban and rural areas.

The current health reality, both in the public and private spheres, imposes certain limits that condition care for people with SMI: efficient management, waiting times, number of people treated, biomedical response based on pharmacological treatment as well as absence of physical places for communication and sociability. It would be advisable to make these limits more flexible, in order to offer a more immediate and personalized treatment and closer to the expectations of each patient.

In this context it is necessary to use CS that allow GPs to create a climate of trust and provide effective support to patients. There are specific CS related to each phase of the clinical interview: initiation (quality and respectful reception), information gathering (open questions and verbal
facilitation techniques), explanatory phase (concretion and negotiation techniques), resolution phase (agreement on problems and their solutions), and closure (check compression and take precautions for future appointments). Both verbal and non-verbal communication are important in this doctor-patient relationship 9.

Effective communication increases the satisfaction of professionals and users, adherence to treatment and clinical efficiency (fewer complementary tests and referrals to secondary care) 10. It has also been shown to reduce the hyperutilization of primary care consultations 11. We can therefore affirm that CS during the care interaction between doctor and patient are an essential tool 12. These skills acquire special relevance when the patient suffers from SMI 13.

A new aspect to study is the skills necessary for telephone care for these patients, which is on the rise after the COVID-19 pandemic and which has contributed to overall inequity of psychiatric service provision 14. This remote attention could improve medical accessibility but hinders the relationship by suppressing non-verbal communication.

In a complementary way, the biopsychosocial approach that characterizes family medicine facilitates a comprehensive therapeutic approach to the patient with SMI. This model of clinical care allows us to understand how suffering, illness and disease are affected by multiple levels of organization, from the social to the molecular. On a practical level, it is a way of understanding the subjective experience of the patient as an essential factor for accurate diagnosis, health outcomes and humanitarian care 15.

There are previous studies that explore those desirable PC quality indicators to provide health care to people with SMI 16. In our country, the experiences of relatives who live with people suffering from SMI have been explored 17. Our research team has investigated the influence of the companion in PC consultations and communication skills of GPs 18.

However, the expectations of this group regarding communication processes with the medical professionals who care for them have not yet been sufficiently investigated. This study proposes to obtain information through qualitative techniques on the perspectives and needs of the patient with SMI and the person who cares for them during the clinical interview with GPs.

METHODS

-Design and setting

Qualitative methodology with semi-structured interviews was used to explore the expectations of patients with SMI and their informal caregivers about the communication process during medical consultation. This methodology is suitable for this study due to the exploratory nature of the
research questions, which seek to reveal expectations and perceived needs on communication skills for GPs.

This article conforms to appropriate qualitative reporting guidelines\textsuperscript{19}.

-Participants and recruitment

People with SMI and their caregivers participated. 21 paired semi-structured interviews, using focus group discussion, were conducted to explore the communication expectations of people who request health care around the SMI in PC. Participants were recruited from January 2021 to June 2022. The study was carried out in the province of Jaén, in southern Spain. Purposive and convenience sampling was carried out by key informants (physicians, psychologists or social workers who knew the patients and caregivers), in urban and rural areas.

-Data collection

Face-to-face interviews by patient-caregiver pairs were carried out by JR and BR, with experience in semi-structured clinical interviews and following the agreed topic guide (Supplementary Figure 1) designed by three members of the research team (AP, BR and JR), according to the aim of the study. Interviewers had no prior professional contact with the people interviewed by him. These interviews began with a framing, introductory sentence and an open-ended question asking participants to express their experiences and expectations regarding the communication abilities of GPs who provide their health care.

-Qualitative analysis

All interviews were audio-recorded and transcribed verbatim with the prior consent of the patients and their caregivers. A content analysis of them was carried out, complying with the 7 stages of Framework Approach described by Ritchie and Spencer and Gale et al.\textsuperscript{19,20} and in accordance with the Standards for Reporting Qualitative Research (SRQR) recommended by O’Brien et al\textsuperscript{21} (Supplementary Box 2).

AP and JR had previous experience in qualitative research studies\textsuperscript{22}. CN, due to her role as a Psychology professor at the University of Almeria, was aware of the need to explore expectations within this group. AR contributed her expertise as an established researcher in Communication and Health. BR had previous experience in conducting and transcribing clinical interviews. All the interviews were read in full by three members of the research team (AP, CN and JR), who independently subjected them to preliminary coding using the triangulation technique. In subsequent meetings, the coding was refined and the final designation of the definitive topics was agreed upon.
Patients who were decompensated or with some acute discomfort did not participate. To guarantee the ability of the people with SMI who participated in the study to understand and construct their own narrative, the World Health Organisation Disability Assessment Schedule (WHODAS 2.0) was administered to all patients. The questionnaire measures the degree of health and disability, and allows the clinician to think of the individual's disability. In this study, disability is considered in people with SMI from a moderate to extreme degree (≥1.5 points).

Segmentation criteria were chosen to collect all possible opinions, using heterogeneity criteria to select different profiles of patients and caregivers. The heterogeneity criteria used were gender, diagnosis, disability moderate to severe assessed with the WHODAS 2.0 questionnaire, Apgar test to measure family function, and Zarit test to measure burden of the carers.

**Results**

21 patient/caregiver paired interviews were carried out with a total of 42 participants and a mean duration of 19 minutes (± SD 7.2) (range 5-33 minutes). The patients had diagnoses of schizophrenia (38%), bipolar disorder (31%) and major depression (31%), with a mean age of 58.8 years (± SD 13.1), 63% were women, 32% were disabled and 25% had family dysfunction. The caregivers were first-degree family members (50% spouses, 31% sons and/or daughters, 13% siblings and 6% parents), 53% were men and the mean age was 52.9 years (±DS 16.9), 60% showed caregiving burden and 32% perceived family dysfunction. The characteristics according to an urban or a rural area are shown in Supplementary Table 1. The data collected is presented in four categories and ten subcategories (Supplementary Box 1) corresponding to the topics of the interview script, the hypotheses generated and the explanatory framework.

Following the framework approach, four main themes emerged from the analysis:

- **Interviewer communication characteristics**
  - **Language understandable and adapted to patients and carers**

Both patients and caregivers positively valued the application of a culture of care based on dialogue, where the effort by GPs who care for them to adapt the scientific language to more colloquial language, is appreciated. The use of simple, clear and friendly speech with the person suffering from SMI becomes a basic need:
“Sometimes, you miss that the person who gives you that information, that is, the family doctor, uses a language adapted to us. Because many times we leave the medical center saying: what has this man told me?” (56-year-old woman, caregiver of a patient with major depression, intense overload and family dysfunction, rural environment).

“I tell him: explain it to me better, I don’t understand. Because doctors have a special way of speaking and sometimes, we don’t understand them and other times we do.” (59-year-old woman with bipolar disorder and disability, urban environment).

“When my GP asks me: ‘how’s the run-run going?’ I know he’s referring to the intrusive and repetitive thoughts that sometimes pop up in my head. However, when foreign GPs come in, they don’t understand this terminology.” (49-year-old woman with major depression, rural environment).

- **Empathetic attitude and low reactivity**

Empathy and low reactivity, are two essential characteristics of a good clinical interviewer. The empathetic professional is capable of not only putting himself in the place of the person who is reporting a problem, but also of making that person feel heard and understood. On the other hand, the low reactivity of GPs in consultation allows listening to the experiential story of the patients, without premature interruptions and paying full attention.

People with SMI reported perceiving a higher degree of empathy and low reactivity from those GPs they know. In the same way, they denote that these qualities are less present in sporadic consultations, such as those in emergency services.

“My family doctor talks to me as if I didn’t have a disability. I feel that he understands me and listens to me like he does with his other patients. Because, when my illness is under control, I am a normal person”. (47-year-old woman with bipolar disorder, urban environment). (47-year-old woman with bipolar disorder, urban environment).

“My GP gives me enough time to express myself; I don’t feel like she’s in a hurry. However, I believe that in the Emergency Department, this doesn’t happen because the doctors don’t know me well enough. (51-year-old man with major depression, rural environment). (51-year-old man with major depression, rural environment).”.

- **Time management**
Generosity of time spent by GPs takes on a leading role: without space or time, professionals cannot listen attentively and, therefore, therapeutic work is at risk. Caregivers positioned themselves as observers of the clinical interview between GP and patient and often manifested the need for more time allotment for these consultations:

“After waiting a long time, we go in for a consultation and they only spend five or six minutes... The doctor needs to be attentive, check the medication carefully, chat a little and let you tell your doubts.” (48-year-old man, caregiver of person with major depression, moderate overload, urban environment).

“The waiting times in the emergency room are distressing, I get nervous, I have to go out into the street. You spend hours in the waiting room and the doctors don’t call you. And then, when you enter, you don’t have time to explain everything you need.” (65-year-old man with bipolar disorder and disability, urban environment).

2ª. Telemedicine: telephone consultation and video consultation:

- Telephone consultation during the Covid pandemic
  During the months of the Covid pandemic in which face-to-face consultation was not possible, both patients and caregivers adapted to the telephone consultation on most occasions. The degree of satisfaction with them was high. Its problem-solving capacity and the reduction of waiting times stood out.

  “The last appointment, due to the Covid pandemic, was not in person. It was by phone... And she answered the questions that her family doctor asked her... There was no need for her to be face-to-face either... because she was calm and well”. (62-year-old man, caregiver of person with bipolar disorder, poor family function, urban environment).

- Useful aspects of telephone consultation
  They chose telephone assistance as the preferred consultation modality in specific situations: mild or moderate relapses, treatment adjustments and as a guarantee of access to check-ups in those patients from rural areas.

  “It would be very useful for decompensations or doubts, if we had prompt attention, on the same day, a telephone to speak directly with our family doctor, and many doubts could be resolved and we would avoid going to the emergency service.” (47-year-old woman with bipolar disorder, urban environment).
However, for situations considered urgent or serious, face-to-face interview becomes a necessity.

“If the reason for consultation was not serious, the telephone method was useful. But when we are really unbalanced, we need to have someone to looks you at the eyes, to knows you, and to explains things to you face to face.” (49-year-old woman with major depression, rural environment).

- Video consultation with Psychiatrist

In rural areas, far from the consultation with Psychiatry (secondary health), the demand for video calls emerged as a useful communication tool for annual check-ups. With this method, patients and caregivers could share their narratives and came face to face with their psychiatrist.

For this video consultation, they proposed the GP as a moderator. Agility, ease of access and the guarantee of continuity of care were some of the aspects that make video consultation attractive.

“We live in a rural mountain area, more than 100 kilometers from the Psychiatry service... Most of the annual check-ups with Psychiatry could be carried out by videoconference and our GP could be present to help resolve doubts. Also, just as the telephone consultation works, why can’t the video consultation work?” (54-year-old man, major depression, rural environment).

3º. The role of the caregiver during the clinical interview:

In most settings, the caregiver stood as an ally during the clinician-patient interview. It offered bidirectional support that helps both GPs and the patient himself to improve the exchange of information and, therefore, mutual understanding.

- Facilitating attitude of the caregiver during the interview

A patient told how her sister and main caregiver helped her to express herself and remembered the stories about the evolution of her condition when she was in front of her GP:

“Sometimes I haven’t slept well, I’m tired or I get nervous when my doctor is in front of me. If it weren’t for my sister accompanying me, I wouldn’t be able to remember the things I want to tell my GP and she helps me remember them.” (56-year-old woman with borderline personality disorder and major depression, urban environment).

- The caregiver as a guarantee of therapeutic compliance
A caregiver described how she accompanied her brother to the consultation to listen to the explanation of his GP and, once at home, to remind him of the medication administration and dosage plan:

“His doctor already knows me as well as he knows him and he thanks me for accompanying him to the consultation, because that way I can find out more about the changes that he indicates in the medication. There are times when my brother is compensated and he understands it easily, but there are other times when he needs me to be aware of what his doctor explains to him”. (54-year-old woman, caregiver of a person with schizophrenia, rural environment).

4ª. Perceived barriers and facilitators during the clinical interview:

- The high turnover of professionals as a barrier to communication

The instability of medical staff in rural areas made it difficult for patients to perceived that they were aware of their experiences and, therefore, feel understood. GPs who don’t knew patients often transmitted insecurity and mistrust during the clinical interview.

“In the public system consultation, each time a different doctor sees you, and no one knows you. That is the reason to go to a private doctor. Because, in the private clinic, the same doctor always sees you and he already knows my sister. Sometimes, before telling him anything, he already knows what is happening to her”. (57-year-old woman, caregiver of a person with schizophrenia, rural environment).

- The figure of Nursing as a facilitator of communication

Sometimes, when the high turnover of general practitioners meant that patients with SMI do not perceived that they are known, the figure of the nurse stood as a facilitator in the doctor-patient clinical interview.

“I am lucky that my nurse has known me all my life. If I ever come in and my doctor is not there, she tells the substitute doctor my whole story. Because she has known me forever and knows how to understand what is happening to me”. (55-year-old man, schizophrenia, disability, urban environment).

“We need a GP who listen to us and know us to be able to tell him how we sometimes feel, feelings and very personal thoughts... When our doctor is not there, our nurse comforts us” (48 years-old woman, major depression, intense overload, rural environment).
DISCUSSION

-Summary

This study was conducted to find what SMI patients and their carers felt during the communication process with general practitioners. The results of the research show that a majority of patients with SMI want collaborative healthcare between their family members, their social environment and the healthcare system itself, where the GP is the main focus.

SMI patients and their caregivers demand a collaborative communication model with the clinicians who care for them. The results obtained emphasize the role of the family doctor in promoting an adequate relationship with that population subgroup. Both patients and caregivers have high expectations in the quality of the communication they establish with their doctor. Communication training of health professionals is essential to promote a fluid transmission of information between patients, caregivers and GPs.

The use of colloquial language, close and even enriched with the expressions of each geographical area (localisms) provides greater therapeutic power to the discourse of the attending physician. Feeling listened to, being able to relate their experiences without fear of being prejudged and receiving cordial and empathetic treatment are the most valued communication characteristics of general practitioners. On the contrary, the high reactivity in the speech of those who care for them, which is usually related to less time spent during the clinical visit to active listening of the patient's reports, is the main factor for improvement that they review.

Thus, the most valued communication skills of GPs by this group are: mastery and use of a language adapted to the person suffering from SMI, empathy and low reactivity during the clinical interview, and efficient time management. Secondly, the video consultation appears as an expectation of care improvement for those people who live in rural and isolated environments.

On the other hand, the caregiver is positioned as an ally in the clinical act, facilitating the flow of information between doctor and patient. Finally, the high turnover of professionals in PC is identified as the main perceived barrier during the clinical encounter. The nursing professional fulfills a facilitating function of communication.

In this study, patients propose communication spaces that generate a safe context and away from impositions. They request that their honest opinion be taken into account and that their decision be respected, maintaining a horizontal transmission of information between sender and receiver. This reinforces some of the previous conclusions published by the team of Pattyn et al. in 2013.

In the same way, they request that their narratives of affliction, suffering, overload or hopelessness are exposed.
In relation to the caregivers of people with SMI, we have detected that they are concerned in the first instance about the perceived helplessness in situations that require a more immediate approach (review before relapses, consultations on pharmacological treatment adjustments) and propose the use of telephone consulting as an effective and desired communication alternative.

Video consultation appears as a desirable option, especially in rural settings where check-ups with a specialist involve traveling many kilometers away, in line with previous research such as that of Monica Cassey.

They propose health policies that integrate effective efforts to maintain a consistent staff of professionals who care for them, especially in rural areas with difficult coverage.

-Strengths and limitations

This project has explored, for the first time in Spain, the perspectives of patients with SMI and their caregivers regarding the communication barriers of the GPs who care for them. Their expectations for improvement are useful for generating future health programs that help transform health systems. The results illustrate the importance of the GP in the comprehensive care of patients with SMI and their caregivers. The skills to communicate closely and directly with these patients allow a greater degree of satisfaction for them.

Patients could potentially modify their stories to avoid being especially critical with the healthcare system or their general practitioners. However, the fact that the semi-structured interview was carried out by a health professional with experience in it was a desirable factor. Taking these last two aspects into account, we decided that the interviews should be carried out by a healthcare professional with experience in qualitative methodology and close to the environment of the interviewed patients and caregivers.

In accordance with the idiosyncrasy of qualitative methodology, the findings of this study cannot be extrapolated to populations that differ from the reference population. However, this study makes it possible to lay the foundations for improving healthcare in environments with similar characteristics. We propose to replicate this research in other populations, in order to compare and improve the specific communication qualities required for the healthcare of people with SMI and their informal caregivers.

-Comparison with existing literature

To the authors' knowledge, this is the first Spanish study that is interested in the influence of GPs communication skills on the quality of care perceived by people with SMI and their caregivers.
The desire to be informed correctly is a common feature in most patients. Domenico et al. assessed the desire of people with severe mental illness for information on their treatment and whether the desire for information is associated with therapeutic relationship and symptom severity\textsuperscript{15}.

In another line of research, Aoki Y.\textsuperscript{36} has been interested in the shared decision making (SDM) for adults with severe mental illness. SDM is a communication process that may overcome traditional power imbalance and encourage changes among both users and professionals and is defined by five phases: goal sharing, information sharing, deliberation, mutual agreement and follow-up.

Previously, several authors have explored the relationship between severe mental illness (SMI) and physical health\textsuperscript{37,38}. For example, it is known that there is a higher mortality rate in people with SMI due to cardiovascular diseases than in the general population\textsuperscript{39}. However, few previous investigations have been interested in learning about the CS of GPs who work with people who suffer from SMI\textsuperscript{13}.

In a broader context, we can assert that there is a dissonance between clinical and patient conceptions of ideal care. In this study, the experiences and expectations of patients and their caregivers have been examined to understand the perception of quality of care. Nevertheless, further investigation is needed to identify how different physician-patient interaction styles influence the perceived quality of care and the time required to provide such care\textsuperscript{40}.

- Implications for research and practice

Qualitative studies that reveal the expectations of the patients themselves and their caregivers regarding the characteristics of health care should be the starting point for designing, building, and improving the structure of future health systems. Many investigations have shown how approaches that neglect communication and quality social relationships only contribute to a worsening and stagnation of the situation of patients. Authors such as Jaakko Seikkula\textsuperscript{41}, regarding the Finnish model of the Open Dialogue, place the question of communication as the central axis of healthcare.

The qualitative approach to the experiences of the people who have participated in this study and to know their positions and knowledge, has allowed us to reflect and propose some action strategies around the issue of communication\textsuperscript{15}. Health systems should promote holistic care for the population, especially the population with SMI, taking into account the context, culture, meaning and subjective internal experience, including the strengths and deepest fears of the person. This change could be seen in medical care models such as the Co-Work-Care model\textsuperscript{42}, in order to improve communication and facilitating active dialogues between general practitioners, psychiatrists, caregivers and the patients themselves.
-Funding
This work was financially supported by two grants from the call for Research and Innovation Projects in the field of Primary Care of the Andalusian Health Service (file numbers: AP-0207-2019 and A2-0026-2020).

-Ethical approval
Ethical approval was previously obtained by means of a review provided by the Research Ethics Committee of the Andalusian Healthcare Service (TMG01 protocol, 2019/03/28; Jaén provincial committee, Spain) with reference to ethical principles of The Helsinki Declaration. Participants were reminded that their participation was completely voluntary and were requested to sign informed consent forms. Audio recordings were deleted according the ICC/ESOMAR International Code.

-Data
The verbatims with the expectations of the interviewees have been exposed in the "results" section preserving the privacy of the participants. It would be inappropriate to publish the personal data on which the conclusions of this research are based, as this would be outside the terms of the informed consent to participate.

-Provenance
Freely submitted; externally peer reviewed.

-Acknowledgements
To the participants (patients and their carers) who gave us their time to make this research work possible. To the Biosanitary Research Foundation of Eastern Andalusia "Alejandro Otero" for his methodological help. To Andrew Buchmann for his grammar review.

-Declaration of interest
The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Table 1. Characteristics of Study Sites and Participants

<table>
<thead>
<tr>
<th></th>
<th>Interview duration (minutes)</th>
<th>Sex (female)</th>
<th>Mean age (years)</th>
<th>Family Dysfunction</th>
<th>Disability</th>
<th>Caregiving burden</th>
</tr>
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<tbody>
<tr>
<td><strong>Rural Zone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Patient</td>
<td>21,8±2,5</td>
<td>57,1%</td>
<td>62,7±9,6</td>
<td>42,9%</td>
<td>28,6%</td>
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<tr>
<td>Caregiver</td>
<td></td>
<td>66,7%</td>
<td>52,5±15,4</td>
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<td>83,3%</td>
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<tr>
<td><strong>Urban Zone</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>16,8±9,7</td>
<td>66,7%</td>
<td>55,8±15,1</td>
<td>11,1%</td>
<td>33,3%</td>
<td>--</td>
</tr>
<tr>
<td>Caregiver</td>
<td></td>
<td>33,3%</td>
<td>53,2±18,9</td>
<td>22,2%</td>
<td>--</td>
<td>44,4%</td>
</tr>
</tbody>
</table>
Table 2. Categories and subcategories.

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUBCATEGORIES</th>
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<tbody>
<tr>
<td>1. Interviewer communication characteristics</td>
<td>1.1. Language understandable and adapted to patients and carers</td>
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<td>1.2. Empathetic attitude and low reactivity</td>
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<td></td>
<td>1.3. Time management</td>
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<td>2. Telemedicine: telephone consultation and</td>
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<td>3. The role of the caregiver during de clinical</td>
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<td>interview</td>
<td>3.2. The caregiver as a guarantee of therapeutic compliance</td>
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<td>4. Perceived barriers and facilitators during</td>
<td>4.1. The high turnover of professionals as a barrier to communication</td>
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<tr>
<td>the clinical interview</td>
<td>4.2. The figure of Nursing as a facilitator of communication</td>
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</table>


Figure 1. Flowchart of the qualitative study according to SRQR recommendations.

<table>
<thead>
<tr>
<th>FOCUS GROUP</th>
</tr>
</thead>
</table>
| • Audio recordings  
  • Patients/caregivers pairs | • 11 paired groups in rural area  
  • 10 paired groups in urban area |

<table>
<thead>
<tr>
<th>PATIENTS WITH SEVERE MENTAL ILLNESS SELECTION</th>
</tr>
</thead>
</table>
| • Key informants recruitment  
  • Purposive sampling | • 18 years, 2 years evolution  
  • With functional deterioration |

<table>
<thead>
<tr>
<th>CONTENT ANALYSIS USING FRAMEWORK METHOD</th>
</tr>
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</table>
| • STAGE 1: Transcription  
  • STAGE 2: Familiarisation with the interview  
  • STAGE 3: Coding  
  • STAGE 4: Developing a working analytical framework  
  • STAGE 5: Applying the analytical framework  
  • STAGE 6: Charting data into the framework matrix  
  • STAGE 7: Interpreting the data |