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Enclosure:

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What's in a Word: Can Discourse Analysis of the Linguistic Choices Made by Patients Provide Clinicians With Deeper Insights Into Patients' Perspectives?

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Introduction

- To optimize the management of bipolar I disorder (BP-I), **it is important for healthcare professionals (HCPs) to understand the experiences and perspectives of people diagnosed with BP-I**.
  - HCP understanding of a patient's perspective is especially important during the process of shared decision-making when considering treatment options for BP-I, such as switching from an oral to a long-acting injectable (LAI) formulation of an antipsychotic.
- However, **there may be disparities between HCP perceptions and the clinical reality for people diagnosed with BP-I**. For example, it is reported that HCPs underestimate rates of medication non-adherence in patients with bipolar disorder.[1]
  - There is limited evidence to clarify whether such divergences are due to the clinical expertise of HCPs and/or the relative patient listening/engagement acumen of HCPs.
- This study sought to examine this conundrum, to help advance the HCP–patient dialog and shared decision-making processes. **This study collected patient perspectives and examined how HCPs interpreted them, with the aim of evaluating alignment or divergence between the two groups.**
  - To support this aim, a sociolinguistic expert conducted a discourse analysis of the patient perspectives data, to provide insights into language techniques utilized by patients to share their experiences with BP-I.

Research question: Are there differences between HCPs and a sociolinguistic expert in the interpretation of the perspectives of people diagnosed with BP-I, and how might these insights aid patient–HCP communication?

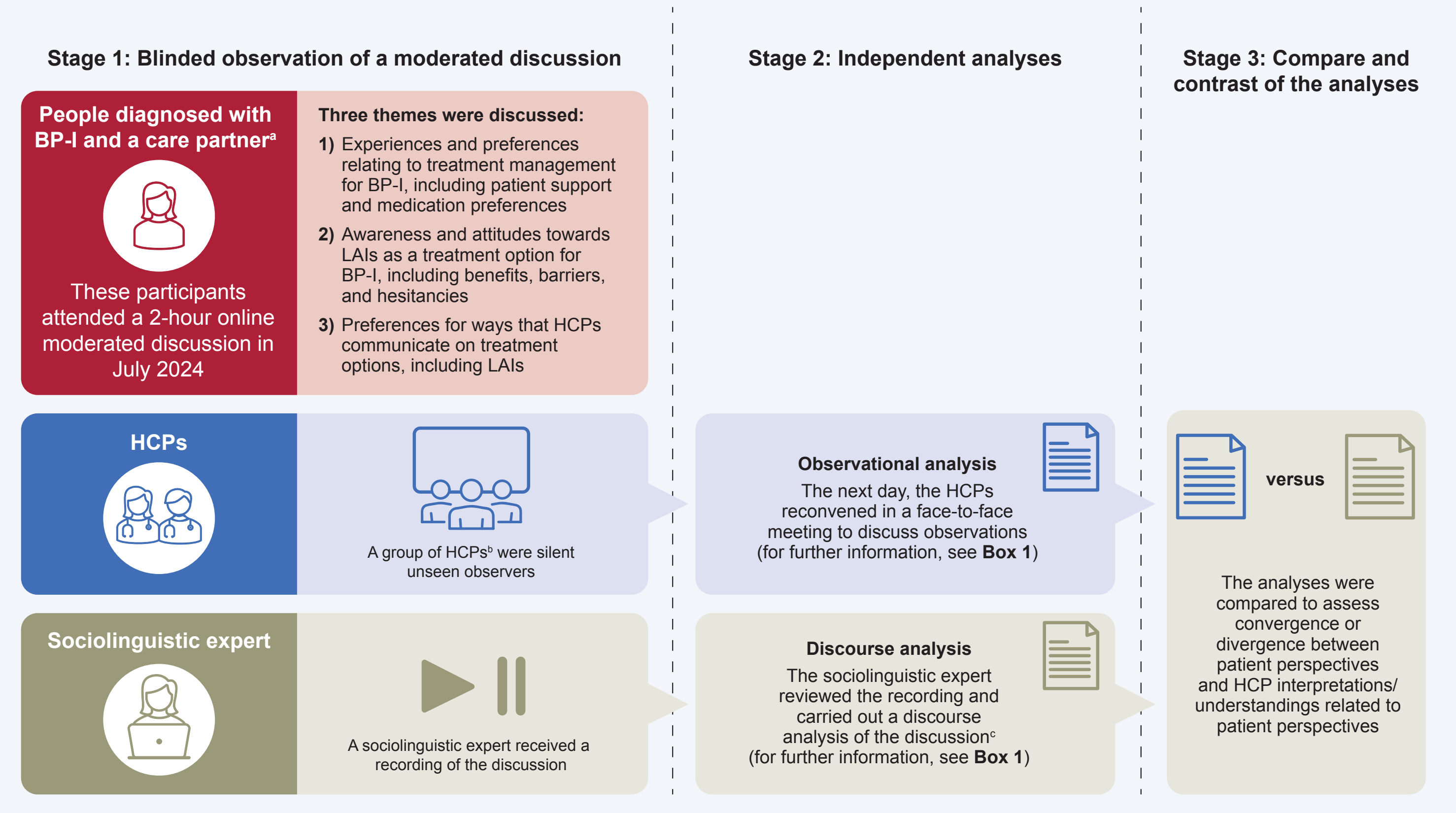
Subquestions further investigated the perspectives of people diagnosed with BP- and care partners:

- What are the main topics and concerns when discussing BP-I treatment, medication preferences, and knowledge, barriers, and concerns around medication options, including LAIs?
- How do they emotionally position themselves in relation to experiences of BP-I and BP-I treatment management?
- What linguistic strategies and techniques, and discursive cues are used to convey thoughts and emotions around BP-I management?

Methods

- This was an observational, non-interventional study. The study design is shown in **Figure 1**.
- Further information about the analyses conducted by the HCPs and sociolinguistic expert is provided in **Box 1**.

Figure 1: Study design



Stage 1: Blinded observation of a moderated discussion

People diagnosed with BP-I and a care partner[a]

These participants attended a 2-hour online moderated discussion in July 2024

Three themes were discussed:

1) Experiences and preferences relating to treatment management for BP-I, including patient support and medication preferences
2) Awareness and attitudes towards LAIs as a treatment option for BP-I, including benefits, barriers, and hesitancies
3) Preferences for ways that HCPs communicate on treatment options, including LAIs

HCPs

A group of HCPs[b] were silent unseen observers

Sociolinguistic expert

A sociolinguistic expert received a recording of the discussion

Stage 2: Independent analyses

Observational analysis

The next day, the HCPs reconvened in a face-to-face meeting to discuss observations (for further information, see **Box 1**)

Discourse analysis

The sociolinguistic expert reviewed the recording and carried out a discourse analysis of the discussion[c] (for further information, see **Box 1**)

Stage 3: Compare and contrast of the analyses

versus

The analyses were compared to assess convergence or divergence between patient perspectives and HCP interpretations/ understandings related to patient perspectives

[a]The people diagnosed with BP-I and the care partner were part of the Otsuka Community Council and were willing to share their experiences with other patients, caregivers, and/or employees at Otsuka. There was no obligation to be receiving an Otsuka medication or have received one in the past. They were ≥18 years old, and had a diagnosis of BP-I or were a care partner to a person diagnosed with BP-I; written informed consent was obtained; [b]The HCPs were in a separate room to the live discussion. There were no specific eligibility criteria for the HCPs, but all HCPs either specialized in BP-I or had a significant proportion of patients with BP-I in their caseload; [c]The discourse analysis was conducted according to Onwuegbuzie et al.[2] within the frame of audience-oriented design.

BP-I=bipolar I disorder; HCP=healthcare professional; LAI=long-acting injectable

Box 1: Independent analyses

Observational analysis of HCP discussion

- **Aim:** To capture **HCPs' understanding** and interpretation of the **preferences, concerns, and attitudes of people diagnosed with BP-I**, and care partners, and **how the patients and care partners express those thoughts**
- HCPs were prompted with a series of discussion questions, e.g., '*What did you observe related to patients' feelings about their current BP-I treatment and whether their current treatment addressed their expectations?*'

Discourse analysis by sociolinguistic expert

- **Aim:** To understand how people diagnosed with BP-I, and a care partner, communicate needs and concerns around BP-I disorder treatment
- A pragmatic and conversational analysis focused on the **linguistic and extra-linguistic techniques** that people diagnosed with BP-I and care partners used to **convey thoughts and emotions, whether intentionally or unintentionally**

BP-I=bipolar I disorder; HCP=healthcare professional

Results

- An overview of characteristics for the people diagnosed with BP-I, and HCPs, is provided in **Table 1**.
- Key themes identified from the moderated discussion attended by people diagnosed with BP-I and a care partner are captured in **Table 2**, **Figure 2**, and **Figure 3**, along with insights from the HCPs' observational analysis and the sociolinguistic expert's discourse analysis.
- A summary of the types of insights provided from the discourse analysis, which generally were not discerned by the HCPs, is provided in **Figure 4**, with consideration as to how these insights could inform HCP practice and improve patient–HCP communication.

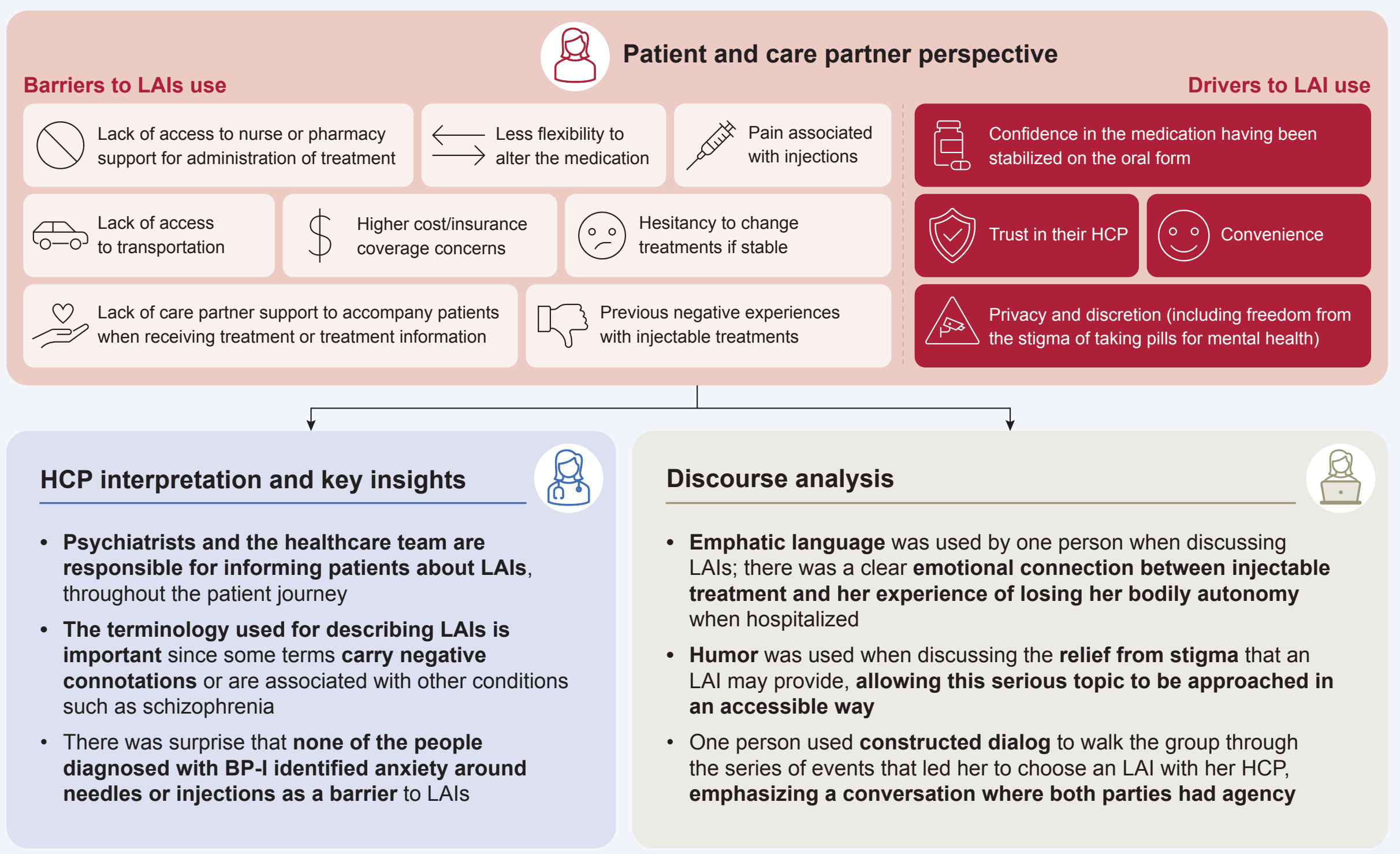
Table 1: Participant characteristics

People diagnosed with BP-I (n=5)[a]	
Age:	23–50 years
Sex:	Female (n=5)
Ethnicity:	Caucasian (n=3) | Hispanic/Latino (n=1) | Caucasian/Hispanic/Latino (n=1)
Employment status:	Employed (n=4) | Unemployed (n=1)
Average time since diagnosis:	21.4 years (range: 4–34 years)
No. of previous hospitalizations:	1–3
Comorbidities:	Schizoaffective disorder (n=1) | Schizoaffective disorder, PTSD, ADHD, BPD, depression/anxiety (n=1)
Current medication:	LAI antipsychotic + oral antipsychotic + antidepressant (n=1) | Oral antipsychotic + sleep aid (n=1) | Oral antipsychotic + antidepressant + mood stabilizer + benzodiazepine (n=1) | LAI antipsychotic only (n=1) | Oral antipsychotic + alpha-2a agonist + NMDA receptor antagonist (n=1)
HCPs (n=8)	
Primary job role/ speciality:[b]	Physician (n=5) | Nurse Practitioner (n=3)
Average time working in clinical practice:	17 years (range: 7–34 years)

[a]The care partner was the mother of one of the people diagnosed with BP-I. She was aged 65 years, Caucasian, and employed; [b]HCPs worked in a variety of settings, including specialist mental health clinics, community outpatient care, private practice, and research

ADHD=attention deficit hyperactivity disorder; BPD=borderline personality disorder; BP-I=bipolar I disorder; LAI=long-acting injectable; NMDA=N-methyl-D-aspartate; PTSD=post-traumatic stress disorder

Figure 2: Barriers and drivers to LAI use perceived by people diagnosed with BP-I and a care partner



Patient and care partner perspective

Barriers to LAIs use

- Lack of access to nurse or pharmacy support for administration of treatment
- Less flexibility to alter the medication
- Pain associated with injections
- Lack of access to transportation
- Higher cost/insurance coverage concerns
- Hesitancy to change treatments if stable
- Lack of care partner support to accompany patients when receiving treatment or treatment information
- Previous negative experiences with injectable treatments

Drivers to LAI use

- Confidence in the medication having been stabilized on the oral form
- Trust in their HCP
- Convenience
- Privacy and discretion (including freedom from the stigma of taking pills for mental health)

HCP interpretation and key insights

- **Psychiatrists and the healthcare team are responsible for informing patients about LAIs**, throughout the patient journey
- **The terminology used for describing LAIs is important** since some terms **carry negative connotations** or are associated with other conditions such as schizophrenia
- There was surprise that **none of the people diagnosed with BP-I identified anxiety around needles or injections as a barrier** to LAIs

Discourse analysis

- **Emphatic language** was used by one person when discussing LAIs; there was a clear **emotional connection between injectable treatment and her experience of losing her bodily autonomy** when hospitalized
- **Humor** was used when discussing the **relief from stigma** that an LAI may provide, **allowing this serious topic to be approached in an accessible way**
- One person used **constructed dialog** to walk the group through the series of events that led her to choose an LAI with her HCP, **emphasizing a conversation where both parties had agency**

BP-I=bipolar I disorder; HCP=healthcare professional; LAI=long-acting injectable

Table 2: Key themes from the moderated discussion attended by people diagnosed with BP-I and a care partner

Theme 1: Experiences and preferences relating to treatment management for BP-I, including patient support and medication preferences

	Patient and care partner perspective	HCP interpretation and insights	Discourse analysis
Positive impact of current treatment	• **More positive mood with consistent treatment** • Improvements in cognition, ability to manage triggers and stressful circumstances, and social engagement	• Patients demonstrated a high level of comfort in sharing their experiences • HCPs **wondered how patients closer to a manic or depressive episode would communicate their experience**	• **Confident and straightforward language indicated** an **ease and comfort** when talking about the benefits of treatment
Challenges with current treatment	• **Side effects**, particularly weight gain and sleep disturbances • However, benefits of symptom control outweighed the impact of side effects, as illustrated by one person who said, "*I would rather be happy and chubby than skinny and suicidal*"	• **Sleep disturbance** – need for better patient education • **Weight gain** – importance of informing patients about potential weight gain so they can try to manage it with exercise or diet • **Comorbidities** – few patients mentioned comorbidities, but comorbidities must be considered when discussing treatment challenges as dissatisfaction may be the result of comorbid conditions not being addressed sufficiently	• Various techniques were used when discussing challenges and negative impacts of treatment options, including: – **Humor, hedging and softening language** – **Emotional language** when expressing frustration – **Aligning with the audience** through use of impersonal pronouns ('you', rather than 'I') – **Seeking affirmation and building camaraderie** when discussing personal experiences
An ideal treatment	• **Stability and predictability** in treatment regimens, with minimal visible side effects (weight gain), to ease their daily lives	• **Patients had realistic treatment expectations** – wishing for a stable life, rather than a perfect life	
Understanding of treatments/ information needs	• **Concern about their limited understanding of BP-I medications** • Wanted a good understanding of common side effects and long-term impact of treatment over life stages	• **Care partner presence at appointments is beneficial** for retaining information when the person living with BP-I has a diminished capacity to take-in and process information	• **Softening language** was used to talk about a lack of knowledge, revealing a **discomfort about their level of understanding**
Care partner support	• Most people reported a **lack of formalized care partner** support		

Theme 2: Awareness and attitudes towards LAIs as a treatment option for BP-I, including benefits, barriers, and hesitancies

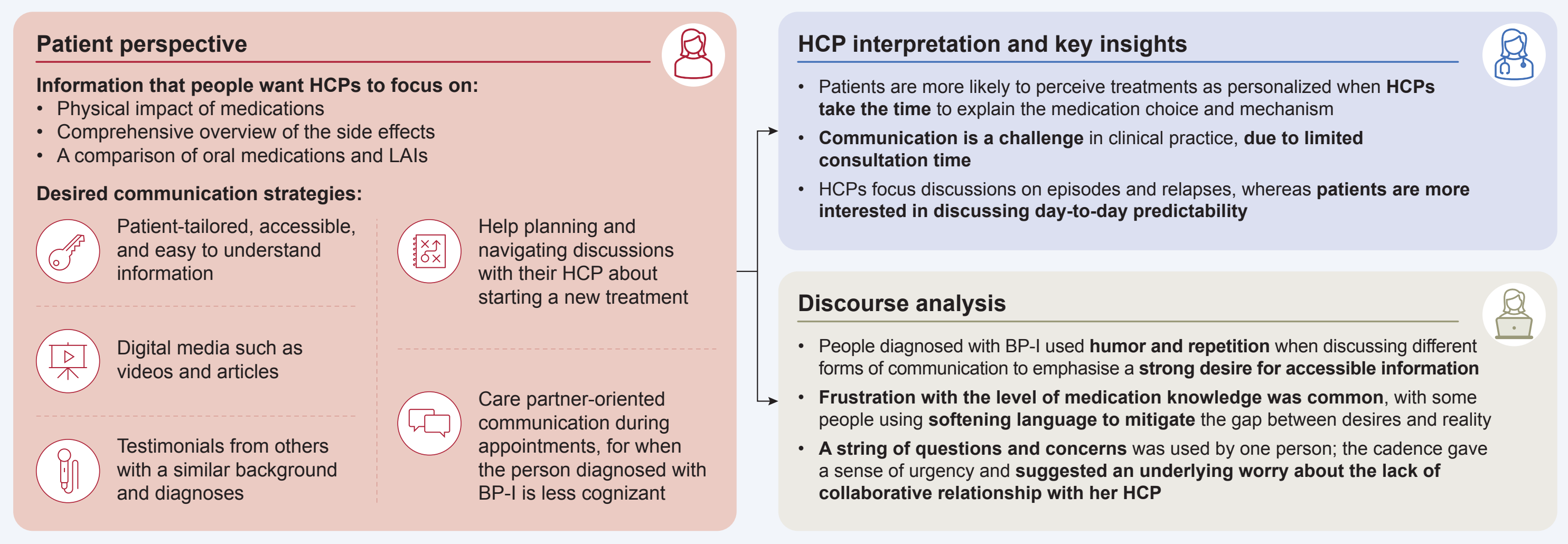
	Patient and care partner perspective	HCP interpretation and insights	Discourse analysis
Sources of information about LAIs	• Never heard of LAIs (n=1) • Introduced to LAIs by their HCP (n=1) • Introduced to LAIs by online social groups for patients, or patients they know personally (n=2)	• **Patients may not be adequately informed about their treatment options**, including LAIs • **Information shared on social media may not be comprehensive or accurate**; despite this, repeated exposure may lead patients to perceive such information as credible	• **Constructed dialog** was used by one person to communicate their experiences of HCP interactions related to LAIs • One person had a collaborative relationship with their HCP and was satisfied, whereas the other did not and was frustrated
Barriers and drivers to LAI use	***See Figure 2***		

Theme 3: Preferences for ways that HCPs communicate on treatment options, including LAIs

	Patient and care partner perspective	HCP interpretation and insights	Discourse analysis
Wish for open communication/HCP awareness of patient concerns	• **Felt a disconnect from psychiatrists**, and wished for more time to be invested in building the patient-doctor relationship, and for HCPs being more attuned to their concerns	• **Dissatisfaction** – patients were more vocal about their HCPs than medications • **Shared decision-making** – patients did not feel a sense of dialog with their doctor, and experienced an inability to have a shared decision-making process • **Loss of insight** – patients did not acknowledge potential loss of insight and decision-making capacity during acute manic or depressive episodes, or early in their treatment journey	• **Softening or mitigating language** was used when discussing their needs from HCPs, while simultaneously taking a strong stance on priority issues including **expressing frustration around wanting more empathetic support from their psychiatrist** • **Given the politeness strategies used, it is possible these people would be reticent to express concerns directly to their doctor**
Shared decision-making	• Wished for **more opportunity to advocate** for themselves and to be more involved in decisions regarding their treatment		
Information needs and preferred modes of communication	***See Figure 3***		

BP-I=bipolar I disorder; HCP=healthcare professional; LAI=long-acting injectable

Figure 3: Information needs and preferred modes of communication for people diagnosed with BP-I



Patient perspective

Information that people want HCPs to focus on:

- Physical impact of medications
- Comprehensive overview of the side effects
- A comparison of oral medications and LAIs

Desired communication strategies:

- Patient-tailored, accessible, and easy to understand information
- Digital media such as videos and articles
- Testimonials from others with a similar background and diagnoses
- Help planning and navigating discussions with their HCP about starting a new treatment
- Care partner-oriented communication during appointments, for when the person diagnosed with BP-I is less cognizant

HCP interpretation and key insights

- Patients are more likely to perceive treatments as personalized when **HCPs take the time** to explain the medication choice and mechanism
- **Communication is a challenge** in clinical practice, **due to limited consultation time**
- HCPs focus discussions on episodes and relapses, whereas **patients are more interested in discussing day-to-day predictability**

Discourse analysis

- People diagnosed with BP-I used **humor and repetition** when discussing different forms of communication to emphasise a **strong desire for accessible information**
- **Frustration with the level of medication knowledge was common**, with some people using **softening language to mitigate** the gap between desires and reality
- **A string of questions and concerns** was used by one person; the cadence gave a sense of urgency and **suggested an underlying worry about the lack of collaborative relationship with her HCP**

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Figure 4: Applying insights from the sociolinguistic expert's discourse analysis in clinical practice

So, were there differences in what the HCPs observed and what the sociolinguistic expert perceived?

Of course, the answer is yes!

HCPs will, naturally, make empirical, descriptive interpretations of what patients say from a medical point of view; however, greater awareness of linguistic subtleties will allow for a more compassionate and comprehensive approach to care, where patient experiences are fully acknowledged and addressed

What sort of linguistic nuances should HCPs look out for (or listen out for!) in patient conversations?

Use of constructed dialog

- Constructing their identity through representations of real or hypothetical conversations may indicate information that the speaker considers important to an understanding of themselves

Use of softening and mitigating language

- This politeness strategy may be used to protect the speaker from being seen as a complainer, and may be a flag for topics that the patient feels uncomfortable talking about in a straightforward manner

Aligning towards the audience

- Using language to shift the focus from self/personal experience to a collective group identity may flag a bid for affirmation around a topic that the speaker feels insecure about

What are the implications of these strategies for HCPs?

HCPs should investigate further when these strategies are used as they may be indications of a deeper importance or potentially uncomfortable topics, allowing for patient experiences to be more fully acknowledged and addressed

HCPs could use shared decision-making to help implement learnings from the discourse analysis

- **Ask more questions**, **actively listen**, and **validate the experiences** of people diagnosed with BP-I to **build trust and foster a collaborative environment** where patients feel comfortable expressing preferences and concerns
- Create a **personalized and adaptive treatment plan** based on evolving needs over time

BP-I=bipolar I disorder; HCP=healthcare professional

Limitations

- The small sample size, and the lack of sample diversity (participants were not selected based on demographics or other criteria) may limit generalizability, including to people with characteristics different to those included in the study.
- Results should be interpreted in context (group discussion with a moderator) as the method of data production determines the scope of language and discourse possible, e.g., small groups facilitate group identification. Consequently, results may not be translatable to other settings such as one-on-one HCP-patient interactions.
- As only one focus group was held, it is not possible to identify concordance in results between different groups.
- The use of a discussion guide and a moderator may have impacted the group dialogue, potentially stimulating theme and language in a particular direction.
- The use of video technology rather than an in-person discussion may have impacted the sociolinguistic expert's ability to interpret non-verbal cues.

Conclusions

- People living with BP-I, and the care partner, desired more comprehensive information on treatment options, open and involved communication with HCPs, and discussed factors to overcome barriers to LAI use
- The sociolinguistic discourse analysis provided deeper insights into language used by people living with BP-I, which may facilitate understanding of difficult, negative, or frustrating experiences
- Use of strategies such as shared decision-making can help patients to feel more comfortable expressing their preferences, and may facilitate improved HCP–patient communication
- These results indicate some of the current barriers and potential strategies around BP-I management and the use of LAIs; improving HCP communication will ensure people diagnosed with BP-I have access to all available treatment options that may enhance their quality of life, as indicated by previous research[3]

References

1. Baldessarini et al. Hum Psychopharmacol 2008; 23 (2): 95–105
2. Onwuegbuzie et al. Int J Qual Methods 2009; 8 (3): 1–21
3. Renes et al. Soc Psychiatry Psychiatr Epidemiol 2024; doi: 10.1007/s00127-024-02761-8

Disclosures

John Adeniji is a full-time employee at Inland Psychiatric Medical Group Redlands and is on the Speaker Bureau for Otsuka and Biogen.

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Mauricio Tohen was an employee of Lilly (1997–2008) and has received honoraria from or consulted for Abbott, AbbVie, Alkermes, AstraZeneca, Atai Life Sciences, Biohaven Pharmaceuticals, Bristol Myers Squibb, Elan, Intra-Cellular Therapies, Johnson & Johnson, Lilly, Lundbeck, Merck, Minerva, Neurocrine Biosciences, NeuroRX, NoemaPharma, Otsuka, Pfizer, Rapport Neurosciences, Roche, Sunovion, and Teva; his spouse was a full-time employee at Lilly (1998–2013).

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Key contributors

All authors were involved in data interpretation and reviewed and approved the content for poster presentation.

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