Author's response to reviews

Title: 'Understanding the explanatory model of the patient on their medically unexplained symptoms and it's implication on treatment development research: a Sri Lanka Study'.

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Author's response to reviews: see over
Review 1

Prof Michael King

Thank you for your valuable comments

Major compulsory revisions

Comment 1
It is unusual in a qualitative study to write down the interviews verbatim. Could the authors say whether this limited the pace of the interviews? Was it possible to record every word or were only summaries or key phrases of the patients' responses recorded?

Response and clarification
Actually this was not a separate qualitative study by itself but a semi-structured assessment carried out as the assessment part of an intervention in the pilot RCT. Therefore the information elicited through the interview had to be noted then and there, to be used in the intervention than transcribing it later. This pilot trial using CBT was also done in an out patients’ clinic in Sri Lanka, The interview and note keeping also had to be done to keep it as close to a routine practice. On the other hand as mentioned in the paper audio recordings the interviews was a culturally sensitive issue that could have lead to a considerable numbers not wanting to participate in the CBT trial.
In fact this SEMI assessment itself turned out to be having a therapeutic effect and this fact is discussed in my PhD as well as in the second larger trial now accepted for publication in BJPsych.
During the interview, for each question some patients provided single word answers and some others elaborated. However, generally the answers were reasonably short so that they would be recorded verbatim exactly as the patient mentioned. This did not limit the pace of the interview because the questions we short and structured, therefore the answers too were short. Only after recording one question the next one was posed. Each interview on average took between 10 -15 minutes.
To my knowledge the studies that have used SEMI noted down the responses verbatim than audio recording.

Revision

Accordingly we have inserted this paragraph under data collection to clarify the issues raised by the reviewer.
SEMI was carried out as the assessment part of the intervention. Therefore the information elicited through the interview was noted then and there to be used in the intervention, rather than transcribing it later. The reason being for most patients the first session was conducted on the same day after assessment. However, because
the questions were short and structured, and the answers short it was possible to accurately record verbatim without limiting the pace of the interview. For each question some patients provided single worded replies while some others elaborated their answers. The answers to each question was recorded, after which the next question was posed. Each interview took 15 minutes on average.

Comment 2
The analysis section is too brief to be able to judge it properly. How were themes identified and a consensus between raters achieved? It seems a coding manual associated with the SEMI was used. But was any other thematic analysis undertaken and if so, what was the process?

Response
The coding manual for SEMI is quite detailed and explicit with instructions so that the information elicited can be categorized using the existing codes. There is also ‘any other’ category to fit in the information that cannot be easily assigned to any existing code. Therefore the consensus was based on whether both raters had categorized the response to the same code. If and when there was a discrepancy the two raters discussed and agreed on the appropriate code. But most of the coding was straightforward. In fact there was certain information that did not fit into any existing codes. These were initially assigned to any other category (ex table 2 another category 13). We analysed such information by hand after the study was concluded. Accordingly the coding manual was revised to accommodate such responses for the second larger study. (I will attach these files for your information)

We did not carry out any other thematic analyses for the data presented in this paper.

I should also note that the adapted version of the SEMI was piloted among 10 patients before using it in the study.

Revision
1. under The Short Explanatory Model Interview (SEMI)[33]

We have included this paragraph.

Each section of the interview is designed to stand-alone which allows flexibility in the order of questioning and the interviewer can omit parts of the SEMI according to the study objectives.

We have deleted the section below as it gives a wrong impression that we used the option of probing the participant after their response.
‘Probes are employed to confirm beliefs and to explore areas not volunteered initially by participants. Respondents are encouraged to talk about their attitudes and experience of the illness, with the aim of eliciting their beliefs’.

2. Under data collection we added this paragraph.
All un-coded data (ex, symptoms) and coded data (ex, perceived causes – internal, external etc) were entered into a SPSS spreadsheet.

And also amended the following paragraph by inserting the highlighted text
AS and SH coded the SEMI scripts independently, using the coding manual after each interview. Subsequently the coding by AS and SH carried out on the individual responses documented in the scripts were compared for agreement. Disagreements were discussed and re-coded. This was repeated for all 68 patients.

3. Analysis
Data entered into SPSS files were analysed using descriptive statistics. Some of the qualitative data was categorised and analysed by hand. No other specific qualitative data analysis software was used. This was a semi structured interview with detailed coding manuals. Due to the specific nature of the interview and coding, we did not have to carry out any additional thematic analyses either.

Comment 3
Table 2 is somewhat haphazard in its presentation – some themes have accompanying examples/quotes and others do not. This is a similar problem with some of the sections. Why (given it is a very common issue – 97% of patients) is emotional representation presented so briefly (page 13)?

Response/clarification
An internal reviewer suggested including more details in the categories which were not straight forwards to clarify what the responses were under these themes (coding). Therefore under debilitation and ageing, natural world, wrong action by professionals, discrimination we left out without giving the actual response as the coding covered the theme directly. For an example ageing, the response was ageing.

Re emotional representation basically these responses were such without any wide variations, when they were coded 33% reported fear of death, 20% fear of paralysis, 13% fear of developing cancer and the rest unspecified incurable illness.
Those who were categorised under fear of death basically responded to say they were worried that they were going to die. Similar was with paralyses. The responses in sinhala if translated may be ‘I am going to die’, ‘I may die’. Similarly in paralyses, ‘I will be paralysed, ‘I am going to get paralysis’, ‘a stroke’. Although
the direct translation of there response may have slight variation in English what they said was that they are frightened of death, paralyses or incurable illness. When asked ‘what do you fear most about these problems (symptoms)’? to elicit emotional representation their responses were brief and spot-on. However during consequence domain they elaborated and this information is presented in consequence domain. So we did not want to be repetitive.

Some examples are

'I may get bed-ridden'

'I will die and if so what will happen to the children’?

‘It may be a cancer, because doctors are saying nothing is wrong and the symptoms continue

Will I suffer hemiplegia/stroke because my mother also died of a stroke and I may not be able to walk?’

‘Won't live much longer’

‘It may be a cancer, because doctors are saying nothing is wrong and the symptoms are not responding to treatment. My mother also died of cancer’

Revision

No specific revision undertaken as it is clarified here

Comment 4

In the section Patient’s perceptions and interpretation on the encounter with the doctors (page 15) the questions concerned what patients expected or hoped to get from their doctors, but only the doctors’ explanations or instructions are given as results

Response

This information has got lost in the text during editing even though part of this was in the abstract. We have now included that paragraph back.

A majority, 34 (50%) specifically wanted the doctors to make them better, 9 (13%) wanted advice and explanation, 8 (12%) medication, 6 (9%) a diagnosis while another 6 (9%) expected further investigations. However, none had expected a referral to a specialist.
Comment 5

A further limitation is the nature of the interviewer, in this case a psychiatrist. Patients might express themselves differently depending on what they know about the interviewer and the setting in which the study is conducted.

Response

Although the interviewer was a psychiatrist (AS) he is also a qualified primary care physician who was in charge of the primary care setting where the study was conducted before he came to UK. Due to this reason and the fact that the study was conducted in this primary care out patients’ facility, it is unlikely that during the initial assessment this factor significantly affected the study. However after the CBT sessions and latter part of the study some became aware that AS was a psychiatrist and we guess some of the drop out during the follow up was likely be due to that fact.

We have included the following paragraph under the weaknesses.

Revision

It could be argued that a further limitation is the nature of the interviewer; in this case a psychiatrist, patients might express themselves differently depending on what they know about the interviewer and the environment in which the study is conducted. Although the interviewer was a psychiatrist (AS) he was also a qualified primary care physician who was previously in charge of the primary care setting where the study was conducted. Due to this reason and the fact that the study was conducted in this primary care out patients’ facility, it is unlikely that during the initial assessment this factor significantly affected the study. However after the CBT sessions and latter part of the study, some became aware that AS was a psychiatrist and we guess some of the drop out during the follow up was likely be due to this factor.

Comment 6

It might make the paper more useful to a general (particularly clinical) readership if the authors could describe how GP encounters with these patients might elicit such views and how they might use them in ordinary consultations to reduce patients’ (and doctors’) anxieties.

Response

This is an important comment given the fact that eliciting such information; patents explanatory model it self could be therapeutic. We have now included the fowling paragraph.
Implications for clinicians

Even during a routine clinical practice the doctor could elicit patients' views and interpretation of their symptoms by asking what the patient’s thought about their symptoms, the potential consequences, resulting fears and what they expect from the clinician.

Discussing patient’s views will enable a clinician to appreciate the patient’s response to illness,, to develop an empathic relationship and to communicate his explanation and recommendations for treatment more effectively. By recognising areas where the patient’s and the health care providers understanding of the problem are different, the clinician can address these differences. This may result in negotiating a shared model but if the differences are irreconcilable, the clinician can acknowledge them and work with the patient in a manner so as to avoid conflicts and thus maximise the chances of compliance to the clinician’s treatment. Empirical evidence suggests that patients are most satisfied where their therapists share their model of understanding distress and treatment [57].
Review 2
Prof Javier Escobar
Thank you for your valuable comments

Major compulsory revisions

Comment 1
Paper is unnecessarily long. It should be tightened and condensed with particular attention to the terms and concepts used. There is need for more clarity for the use of terms. Examples are "lay illness beliefs" (page 1, 3, etc.), "emotional domains" (page 2), "lifelessness" (table 1) "internal world", "debilitation", "self abuse" (Table 2) and several others. These should be spelled out more clearly. For example "originating in the body or mind" would be a better way to define internal world, "fatigue" may be better understood than "debilitation" and "substance use" would be more precise than self abuse.

Response and clarification
We have tightened and condensed the paper with particular attention to the terms. Some terms such as emotional representation was retained because it is a term used for description of the original CSM model (please see reference 26 of the manuscript). Others are changed or explained.

Revision
"Lay illness beliefs" (abstract and body of the paper), we have dropped the word ‘lay’ and clarified. "Lifelessness" (table 1) and “fatigue” were combined under “fatigue”, "Internal world" the original wording of the instrument was supplemented with "originating in the body or mind", "Debilitation" was also changed to “fatigue”. "Self abuse" was changed to "substance use" (Table 2)

Comment 2-
In some areas, the paper still looks like a draft (bottom of Table 2, Supernatural? (a better word than magic?........).

**Response and clarification**

Apologies this anomaly is now corrected

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**Comment 3-**

Because the paper is entirely focused on the SEMI, this instrument should be included in the title and possibly in an appendix since it is not well known in other countries.

**Response and clarification**

As it is difficult to include the name or the instrument in the title we included what is being detected through the instrument. We have also clarified in the introduction that even though varying names such as illness perception model, self-regularity model, parallel process model, explanatory model have been used, all these are derived from the Common Sense Model (CSM) by Leventhal [26]. It describes how an individual constructs an internal representation of what is happening when they experience physical or psychological symptoms [26].

Therefore we have changed the title to 'Understanding the explanatory model of patients with medically unexplained symptoms by using SEMI and it's implication on treatment development'. We have attached SEMI and its coding manual as an appendix.

**Revision**

Title changed to ‘Understanding the explanatory model of patients with medically unexplained symptoms by using SEMI and it’s implication on treatment development’.

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**Comment 4-**

It is important to contrast the observations in this Sri-Lankan population to those of studies in the UK to examine cross-cultural differences or similarities.
Response
To our knowledge there are no studies carried out in the UK using SEMI specifically on patients with medically unexplained symptoms. However the original validation study was on common mental disorders and we have included the following paragraph in the discussion.

Revision
To our knowledge there are no studies carried out in the UK using SEMI on patients exclusively with medically unexplained symptoms. However, the original validation study among patients with common mental disorders, presenting complaints was mostly non-specific physical symptoms [57]. Even though none of the patients in our study volunteered psychological symptoms in contrast 13.9% of Indo-Asians, 6.7% of white British, 8.9% of Afro-Caribbean in the above [57]. Although most patients (58.8%) in our study were unable to give a specific biomedical diagnostic label for their complaints it was only 30.6% among Indo Asians, 19.7% Afro-Caribbeans in UK, 13.3% White British [57] Significantly, relation to the super-natural world is a particularly interesting one from a cross-cultural point of view as 11.2% Asians in London believed in spells and black magic/obai.

Comment 5-
It needs to be spelled out more clearly how the information from the SEMI influenced was incorporated into the intervention.

Response
It was described already under ‘Implications of the findings on refining CBT intervention’ but we have now edited it.

Revision
Implications of the findings on refining CBT intervention is now revised