ARTICLE

Communication skills training in psychiatry

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SUMMARY

Good communication skills are the basis of all effective doctor–patient relationships, and psychiatrists in particular have to manage many types of complex interaction. Research shows the benefits of communication skills training. This article describes strategies for teaching relevant clinical communication skills to trainee psychiatrists on MRCPsych courses and in local centres. The authors set out a sustainable training framework using higher trainees as tutors. There is a need for more widespread teaching of clinical communication skills in psychiatry and at an early stage of specialist training.

LEARNING OBJECTIVES

After reading this article you will be able to:

- recognise the importance of communication skills in psychiatric training
- understand how to deliver clinical communication skills training on exam courses and in local teaching
- provide constructive feedback on clinical communication skills to trainees and medical students, either in groups or individually.

KEYWORDS

Communication skills; communication skills training; MRCPsych courses; interviewing skills; simulation-based education.

> 'The single biggest problem in communication is the illusion that it has taken place.'
>
> Attributed to George Bernard Shaw

Despite the complexity of clinical interactions within psychiatry, the teaching of communication skills appears less widespread than in other specialties, such as general practice and oncology. Psychiatrists also need to be skilled in clinical communication in order to teach and assess trainees effectively.

This article describes a sustainable structure for communication skills training (CST) in psychiatry on the Royal College of Psychiatrists' membership (MRCPsych) examination courses and within local teaching. A course on non-clinical communication skills for higher trainees preparing to become consultants is also outlined as consultants increasingly take on leadership roles.

The CST programme for core trainees (CTs) evolved from S.M.'s work with Professor Peter Maguire on teaching communication skills in oncology. It was then developed within local psychiatry teaching at Northwick Park Hospital, Harrow, and progressed further by S.R.

In 2013, a communication skills tutor post was created to provide communication skills modules on the North West London (NWL) MRCPsych courses. To help run these modules, an integral 'CST train the trainer' course was developed for specialty registrars (SpRs) to become communication skills tutors. In addition, these trained SpRs deliver local CST and, on becoming consultants, have set up their own local training.

Communication skills in medicine

Since the 1980s, there has been extensive research on the impact of communication skills on patient care. In addition, patients have high expectations of doctors to communicate effectively. These have led to a focus on the role of the doctor–patient relationship, patient-centred care and the active involvement of patients in decision-making.

Research identifies significant problems in communication skills, such as doctors not responding to cues (Levinson 2000). Poor communication is also frequently cited in healthcare complaints (Reader 2014).

Box 1 shows research on the benefits of increased patient-centredness. It is often assumed that clinical experience naturally leads to better communication skills, but Maguire & Rutter (1976) showed this not to be the case. More recently, the General Medical Council (GMC) (2012) reported a relationship between time since qualification and a higher proportion of allegations related to communication skills in patient interactions that required investigation.

Studies show that effective communication skills can be taught. Gask et al (1987), for example, found that training improved communication skills of general practitioners (GPs) and Fallowfield et al's (2003) randomised controlled trial showed that improvements in communication skills were maintained after 15 months. Professional medical bodies document the need for good communication

BOX 1 Benefits of improving patient-centred communication

For patients

- Higher satisfaction and better treatment adherence (Maguire 2002)
- Better recovery and emotional health (Stewart 2000)
- A more positive doctor–patient relationship contributes to improved treatment outcomes (Adams 2012).

For clinicians

- The longer a doctor waits before interrupting at the start of a consultation, the more concerns are elicited in the patient (Marvel 1999).
- More accurate identification of the patient's problems (Maguire 2002)
- Reduced malpractice rates in physicians who signposted, checked for understanding, laughed and used humour (Levinson 1997)
- Time efficiency – picking up and responding to cues shortens visits (Levinson 2000)

skills (General Medical Council 2019), with the GMC's generic professional capabilities framework (General Medical Council 2017) including skills of active listening and shared decision-making.

Communication skills models

Clinical communication models describe consultations with respect to stage, tasks and skills. McWhinney's disease–illness model (Levenstein 1986) reflects the two separate agendas of the doctor's 'disease framework' and the patient's 'illness framework'. Bird and Cohen-Cole's three function model (Bird 1990) divides the interview into three components: building the relationship, assessing and understanding the patient's problems, and collaborating to manage these problems.

The widely used Calgary–Cambridge (Silverman 2013) framework divides the consultation into six tasks: initiating the session; gathering information; building the relationship; giving information; explanation and planning; and closing the session. It also includes providing structure and building the relationship as 'continuous threads' throughout the consultation. The NWL CST programme draws heavily on this model, its comprehensive set of evidence-based communication skills (Silverman 2013) and the associated teaching guide (Kurtz 2005).

Communication skills in psychiatry

The nature of psychiatry requires a high level of competence in communication skills, with symptoms such as depression or delusions having a significant impact on the interviewing process. Patients can be reluctant to disclose concerns and symptoms for fear of the consequences, shame or lack of insight. In addition, psychiatric diagnosis relies far more on history and mental state examination than physical examination and investigations.

Senior psychiatrists assess trainees' work-placed based assessments (WPBAs) and help them prepare for the RCPsych's clinical assessment of skills and competencies (CASC) exam. However, some will not have received CST themselves and may lack confidence in how to provide detailed feedback on communication skills. Furthermore, although communication skills are widely taught in UK medical schools, psychiatry attracts a high proportion of international medical graduate trainees, many of whom have also not received any CST.

GMC data for 2011 showed that psychiatrists attracted 8% of total complaints despite comprising only 3.5% of the medical register (General Medical Council 2012: p. 39). Psychiatry also had the highest proportion of complaints regarding interaction and communication with patients, indicating a need for more CST.

Communication skills training

There have been relatively few studies of the impact of CST within psychiatry, of which we list only a selected minority. According to Wilson (2018) 'Communication skills training is still too often regarded as better suited to physical health consultations than more complex psychiatric interviews'.

Harrison & Goldberg (1993) evaluated a training programme to improve the interviewing skills of psychiatry trainees. Videotaped analysis revealed improvements in responding to verbal cues and establishing the patient's view of their illness. Following a survey of one UK rotation which found that 42.8% of core trainees had no previous CST, Kowalski & Sathanandan (2015) developed an advanced CST programme to improve confidence in managing difficult situations at work. All trainees involved felt that their communication skills had improved.

Evaluation of a communication skills framework found that trainees using it were significantly more confident in communicating a schizophrenia prognosis (Ditton-Phare 2016). McCabe et al (2016) developed a brief CST intervention to work more collaboratively with patients with psychosis. This led to behaviour change and improved therapeutic relationships with patients in routine clinics.

The timing of the RCPsych CASC clinical exam towards the end of core training may discourage trainees from focusing on communication skills earlier on. It is therefore helpful that the RCPsych states that 'all trainees must receive teaching in

interviewing skills in the first year Core Psychiatry Training (CT1). The use of feedback through role-play and/or video is recommended' (Royal College of Psychiatrists 2020, p. 36). In addition, it states that it is essential that trainees attend an MRCPsych course including 'communication and interviewing skills' (p. 37). It identifies communication skills as central to several intended learning outcomes (ILOs) with ILO13 setting out the knowledge, skills and attitudes required (Box 2).

BOX 2 Royal College of Psychiatrists' curriculum for specialist core training in psychiatry

Intended learning outcome ILO13 of the RCPsych's core curriculum is: 'Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances'.

It requires that, within a consultation, trainees must achieve competencies in the following fields:

Knowledge

Demonstrate a knowledge of how to structure the clinical interview to identify the patients' concerns and priorities, their expectations and their understanding

Demonstrate knowledge of how and when to telephone a patient at home

Be aware of limits of your expertise

Skills

Demonstrate interviewing skills, including the appropriate initiation of the interview, the establishment of rapport, the appropriate use of open-ended and closed questions, techniques for asking difficult questions, the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence and summary statements

Solicit and acknowledge expression of the patients' ideas, concerns, questions and feelings

Understand the ways in which patients may communicate that are not directly verbal and have symbolic or unconscious elements

Communicate information to patients in a clear fashion

Appropriately close interviews

Stay within limits of expertise

Communicate both verbally and in writing to patients whose first language may not be English in a manner that they understand

Be able to use interpreters and translators appropriately

Be able to communicate using aids with those who have sensory impairments, e.g. deafness

Avoid jargon and use familiar language

Give clear information and feedback to patients

Share information with relatives and carers when appropriate

Use appropriate Information Technology (IT) skills

Attitudes demonstrated through behaviours

Demonstrate respect, empathy, responsiveness, and concern for patients, their problems and personal characteristics

Demonstrate an understanding of the need for involving patients in decisions, offering choices, respecting patients' views

Ensure that dress and appearance are appropriate to the clinical situation and patients' sensitivity

Demonstrate an understanding of the impact of trauma [...] history on patients (if included)

(After Royal College of Psychiatrists, 2019: pp. 54–55)

Survey of MRCPsych courses

We sent an anonymised survey of CST on MRCPsych courses to 43 UK MRCPsych course directors and 8 (19%) responded. Seven courses provide some CST, of which six deliver it in the first year. Teaching methods vary but all incorporate peer role-play, with five courses using written scenarios. Only two use video recordings of trainees. One includes a formative assessment of communication skills using actors, and another teaches communication skills within CASC or psychotherapy training. The low number of responses suggests a limited provision of CST. Not all respondents were aware of the RCPsych mandate for inclusion of CST in MRCPsych courses. There were requests for more training and resources via the RCPsych.

Teaching on MRPsych courses

The NWL MRCPsych course has CST sessions on both the first- (Paper A) and second-year (Paper B) courses. Each consists of five half-day sessions on specific topics. As psychiatry trainees join with different levels of communication skills proficiency, the aim of Paper A is to ensure a minimum standard of communication skills. For Paper B, the aim is to develop these skills further and to prepare trainees for the CASC exam. Additional benefits include discussion on descriptive psychopathology.

Course feedback is consistently positive. Approximately 80% of trainees rate the items of 'content relevant to my learning needs' and 'stimulating interest in the subject' as 'very good'. Trainees specifically comment on the relevance to exams and clinical practice, and the usefulness of role-playing clinical scenarios (data available from S.M. on request).

Core communication skills

The introductory session on Paper A summarises the core communication skills as applied to psychiatry.

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It is important to discuss previous CST experience at the outset, including trainees' preconceptions and concerns. Evidence of the consequences of poor clinical communication skills and the benefits of effective communication skills are outlined.

It is important to create a safe space to encourage trainees to participate fully. Ground rules are set out, including confidentiality, mobile phone etiquette and allowing equal contributions from everyone. We use the phrase 'no idea is a bad idea' to encourage free flow of ideas.

Tasks for different stages of the psychiatric interview are then outlined (Box 3). At the start, psychiatrists must listen attentively, without interrupting, allowing patients to describe presenting concerns in their own words. The use of non-verbal skills (posture, gestures, facial expression, eye contact, touch and positioning) is discussed. Verbal skills used in information gathering (Box 4) are explored in detail, such as how open questions allow the patient to tell their story and the interviewer to obtain more information.

As the interview progresses, there is a move to specific open and then closed questions to obtain finer details (Silverman 2013). These active listening skills allow trainees to develop an interview style that is responsive, as opposed to one we term 'machine-gun fire' (firing multiple questions from the doctor's agenda without responding to patients' cues). Basic history taking is also reviewed; we find this is not always applied as rigorously to psychiatric symptomatology, such as delusional content, as to physical symptoms.

Trainees are taught to build rapport through actively showing interest, curiosity and empathy. A distinction is made between cognitive empathy and affective empathy. Cognitive empathy involves gaining a genuine understanding of the patient's condition whereas affective empathy is the ability to reflect on a patient's experienced emotions (feeling with) (Cox 2012).

When expressing empathy, trainees can rely on clichés, especially 'That must be very distressing for you'. If also delivered in a neutral manner, this comes across as robotic and patronising, which we term 'empty empathy'. To highlight this, trainees are asked to think about how a friend might react to their responses in a similar situation. They are encouraged instead to use more natural sounding phrases ('That must have been really tough for you') and to match the level of empathy to the specific situation. Trainees report that role-playing the patient enhances their understanding of patients' symptoms and difficulties.

Dealing with sensitive subjects, especially risk and substance misuse, requires specific techniques, such

BOX 3 Tasks for stages of a clinical interview

Beginning

- 'Greeting and seating'
- Introducing oneself
- Purpose of the interview
- Time available
- Putting the patient at ease
- Establishing rapport
- Mentioning note-taking
- Addressing confidentiality

Middle

- Gathering information
- Building rapport
- Being flexible in structure
- Maintaining control

Ending

- Screening questions
- Explanation and planning
- 'Safety-netting' for subsequent difficulties
- Summarising
- Checking understanding (on both sides)

BOX 4 Information-gathering skills

- Listens attentively
- Facilitates patient disclosures both verbally and non-verbally
- Tone of voice – uses appropriately
- Acknowledges concerns
- Paraphrases important points
- Expresses empathy – both verbally and non-verbally
- Open to closed style of questioning
- Leading and compound questions avoided
- Picks up and responds to cues – verbal and non-verbal
- Clarifies for more detail or if patient is unclear
- Signposts for change of topic and to prepare for questions on sensitive areas
- Avoids medical jargon
- Summarises frequently to check for accuracy and facilitation
- Screens for additional information
- Timelines – progression of the disorder
- Curious attitude
- Encourages expression of feelings
- Ideas, concerns and expectations are enquired about
- Impact on life is explored

(Adapted from Silverman et al, 2013)

as a graduated approach to questioning. 'Empathic linking '('That sounds really tough – do you sometimes find you use drink to cope?') and 'normalising statements' (We often find that people in your situation also feel/do … ') are useful (Carlat 2016).

When note-taking by hand or electronically, it can be helpful to mention this at the start and to look up periodically. At significant moments, the equivalent of 'putting down the pen' emphasises giving full attention.

The acronym ICE (ideas, concerns, expectations), widely used in undergraduate and general practice CST, is especially relevant in psychiatry, where patients are often reluctant to disclose sensitive topics: 'Balancing a patient's agenda, ideas, concerns, and expectations with the clinician's is a tricky but skilful task. Done well, it flows like a guided conversation; done badly it is stilted and jars' (Wilson 2012: p 11).

We find that certain difficulties with communication skills frequently occur, especially talking excessively, using multiple closed questions, and failing to clarify symptoms and concerns. Additionally, trainees do not always enquire adequately about the impact of symptoms on various aspects of patients' lives. S.M. therefore created the acronym TOE as an aide-mémoire: 'Talk less, listen more; Open to closed questions; Explore cues'. Other common problems include the understandable urge to provide premature reassurances and solutions.

We based a light-hearted teaching strategy on the interviewing style of the popular 1970s television detective Columbo. Like detectives, psychiatrists can also have reluctant interviewees and require sensitivity in encouraging opening up. Trainees are asked to think of communication skills common to both situations, beginning with the letter C. These include: curiosity, checking, clues/cues and appearing confused (i.e. not blaming the interviewee when they are unclear or when carefully challenging discrepancies). A subsequent interviewer question might be 'I'm sorry, I don't quite follow why you did that. Could you tell me a bit more?'

Teaching on clinical topics

Paper A includes sessions on depression, psychosis and assessing risk to self and others. Paper B includes sessions on substance misuse, providing explanations and eating disorders. Communication skills as applied to other subspecialties, such as older adult, child and adolescent, and intellectual (learning) disability psychiatry, should also be covered during general core training. During the early stages of the COVID-19 pandemic, CST was adapted for online teaching by using pre-recorded undergraduate teaching videos with professional actors.

Sessions commence with an informal, half-hour interactive presentation on a specific clinical topic. Each includes challenges of interviewing, review of relevant symptoms and phrasing of questions, plus disorder-specific communication skills strategies (the last two often lacking in postgraduate psychiatry textbooks). In our experience, this overview also enhances the trainees' confidence to engage more fully in the role-plays.

Certain disorders require more detailed attention. Interviewing patients with psychosis can be extremely challenging owing to the influence of psychotic symptoms on patients' ability to communicate and develop trust. Clarifying delusions requires sensitive questioning: for example, assessing insight using challenging questions too early on can risk alienating the patient. The interviewer also needs to be careful about the use of too much silence and of personal space, as these can increase paranoid thinking. Silverman et al (2013) mention the difficult challenge of empathising with the patient but not colluding. Hamelijnk et al (2012) highlight the importance of flexibility, empathy, signposting and summarising, as well as building rapport by exploring 'external' problems before 'internal symptoms'.

Providing explanations

Research reveals inadequate information-giving skills of doctors (Maguire 1986a, 1986b) and poor recall of information by patients (Ley 1998). An important skill is 'chunking and checking', in which information is provided in bite-size pieces and understanding is then checked. Others include: assessing a patient's starting point, categorising information, the use of signposting, repetition and summarising (Silverman 2013).

Additional areas

Advanced techniques for use in other situations are covered, including motivational interviewing for substance misuse (Rollnick 2010) and the chronological assessment of suicide events (CASE) framework (Shea 1998). Especially in risk-related scenarios, trainees are repeatedly reminded not to ignore their 'gut instinct'.

Role-play

Small-group role-play followed by feedback is facilitated by specifically trained SpR communication skills tutors. Box 5 summarises the tasks involved in organising and facilitating a role-play. Role-play allows trainees to safely practise their communication skills with presentations of various psychiatric

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BOX 5 Facilitating a role-play

- Discuss any concerns
- Decide on prepared scenario or real-life example
- Prepare patient role-player separately
- Prepare interviewer
- Encourage observers to take detailed verbatim notes
- Negotiate duration
- Feedback

disorders and commonly arising difficult situations, such as encountering anger, suspiciousness and being asked difficult personal questions.

Some trainees are very apprehensive of role-play, having had adverse experiences as undergraduates of role-playing communication skills in too large a group and/or receiving harsh feedback. It is therefore important to enquire about any anxieties and to create an informal and encouraging atmosphere with an emphasis on peer learning and the use of appropriate feedback techniques.

The number of participants in each role-play group is preferably limited to around six, including the two role-players. There is often reluctance to volunteer to be the interviewer and an effective strategy is to leave briefly to allow the group to decide. The facilitator then carefully prepares the interviewer, patient role-player and observers.

Pre-prepared scenarios are used on the MRCPsych course. The facilitator prepares the patient role-player separately (Box 6). Although it is preferable to use actors as simulated patients (see below), for practical reasons, trainees generally act the role of patient or carer. The success of a role-play partly depends on the interviewee's script having adequate details, including background, concerns and symptoms. CASC exam scenarios often include cues to crucial information, which we call 'golden nuggets', for example an impending court appearance.

Scripts should also mention pointers on how to behave and especially how much and what information to give in response to questions (Dudley 2012). Occasionally trainees can get 'carried away' and overact, so we use a Goldilocks analogy, i.e. playing it 'just right', not too easy and not too difficult.

The rest of the group, including the trainee interviewer, are given a brief outline of the patient's demographics, the setting and the tasks. The interviewer is offered the option to call time out (in our experience seldom used). During the role-play, the rest of the trainees complete an observer sheet which includes prompts to identify specific communication skills: body language, open questions, facilitation, responding to cues (verbal and non-verbal), clarifying/checking, ICE, avoiding jargon, signposting, summarising and empathy. They are strongly encouraged to note down verbatim examples. The role-play can either be timed or allowed to run its course, usually 10–15 min. In Paper B, trainees often prefer to be given a time limit, in preparation for the CASC. If it is clear that a role-play is going badly, the tutor should stop and restart rather than carry on regardless.

Trainees may bring up concerns about CST itself. Some view it as unrelated to CASC preparation, to which we relate our experience as CASC examiners that poor communication skills are a common reason for failure. Another is that CST will lead to lengthier interviews, but there is evidence to the contrary; for example Levinson et al (2000) showed that picking up and responding to patient cues actually shortens medical consultations.

Occasionally, trainees negate personal critical feedback by labelling role-play as contrived and not reflective of their true skills in real-life situations. It is important to acknowledge some validity to this view, while also pointing out that role-play likely reflects aspects of trainees' communication skills. There is a body of research on observations of recorded consultations with real patients that can be called upon. One interesting example is how using 'so' to preface declarative questions ('So, you feel a bit anxious?') when interviewing patients with psychosis may enhance alliance and adherence (Thompson 2016).

BOX 6 Preparing the patient role-player

Trainee reads the script, then the trainer asks for thoughts/questions/clarifications and offers key tips for the trainee:

- decide on an opening gambit, e.g. 'I just want to leave'
- provide information piecemeal – in response to effective communication skills
- give verbal and non-verbal cues, e.g. 'family problems', avoiding eye contact
- repeat important cues, especially if the interviewer struggling
- play it for real – respond as any patient/carer would
- no Oscar performances – Goldilocks principle
- improvise – within reason
- provide cues to 'hidden nuggets'

Trainee re-reads script

Simulated patients

Simulated patients played by specially trained actors are widely used in CST. This allows for

repeated rehearsal of skills and improvisation. Actors are also less likely than medically trained learners to overlook the patient's perspective (Kurtz 2005).

Most training schemes hold mock CASC exams, but these are often too late to make a significant impact. We piloted 'Coaching CASC' mock exams at the end of Paper A, using actors. Trainees received direct feedback after each scenario, so that it could be immediately incorporated. Trainee and examiner feedback was highly positive on both improving communication skills and future CASC success. As resources for paid actors are limited, we are beginning a pilot with a local university to train drama students.

Feedback

Effective feedback is crucial to successful CST. Our approach to feedback is based primarily on the recommendations of key researchers, namely King, Pendleton, Kurtz and Silverman.

King (1999) states that the purpose of feedback is neither to judge nor evaluate but to provide insight. Pendleton's rules of feedback in medical education were devised (in 1984) as an alternative to 'teaching by humiliation' (see Pendleton 2003). Pendleton advocates a two-stage enquiry: 'What was done well?' Then 'What could be done differently?' Feedback is solicited in a specific order: learner first, then group, followed by the facilitator. Box 7 summarises both sets of guidelines.

Kurtz et al (2005) describes potential difficulties of the conventional Pendleton feedback rules, including a sense of artificiality, late discovery of the learner's agenda, and too much time spent on the good with too little for constructive focus on difficulties. Pendleton et al (2003: pp 77–78) responded that the original guidelines should be seen as principles and that most of these points 'reflected over-zealous application'.

As an alternative focused feedback approach, Silverman et al (1996) developed agenda-led outcome-based analysis (ALOBA). By starting with the learner's agenda (e.g. aware of asking too many closed questions) it 'gets learners quickly to the nub of the problem'. Learners then identify desired outcomes. Interviewers are also encouraged to solve problems themselves before the group attempts to do so.

Feedback in practice

Drawing on the approaches described, we use various strategies to facilitate constructive feedback. These contribute to making the sessions interactive and engaging and promote useful learning. Box 8 lists tutors' tasks for facilitating feedback.

Tutors initiate feedback with open questions, then enquire about specific communication skills, such as the use of questions, empathy and signposting to promote discussion of overlooked points. Socratic questioning (a series of focused, open-ended questions to encourage reflection), along with increasingly specific prompts, helps trainees to identify difficulties and find their own solutions. Questions from trainees are initially redirected back to the group to provide answers. Tutors can also ask specific probing questions to highlight the impact of a particular communication skill, for example 'What was the key question that opened everything up?' Exploring the reasoning behind interviewers'

BOX 7 Feedback guidelines

King (1999):

- Be descriptive
- Be specific rather than general
- Be sensitive to the needs of the receiver as well as the giver
- Direct feedback towards behaviour that can be changed
- Feedback should be timely (given as close to the event as possible)
- Be selective (address one or two key issues)

Pendleton 1984 (see Pendleton et al, 2003):

- Briefly clarify any matters of fact
- Encourage the learner to go first
- Consider what has been done well first
- Make recommendations rather than state weaknesses

BOX 8 Facilitating feedback

- Ask for the interviewer's agenda and desired outcomes
- The interviewer always provides feedback first
- Next, the observers and patient role-player give feedback
- Feedback should be balanced – what went well/what could be done differently
- Order of feedback may be flexible
- Feedback should be specific, non-judgemental and descriptive
- Use increasing prompts/redirect questions
- Involve the whole group
- Elicit alternative suggestions
- Rehearse suggestions using role-play
- Check back with the interviewer
- Identify learning points

(Adapted from Kurtz et al, 2005)

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unhelpful behaviours can reveal important points. In one example, a reluctance to clarify crucial aspects of a suicide attempt uncovered underlying fears of 'upsetting' patients. Sample feedback questions for tutors are shown in Box 9. Dudley (2012: pp 153–154) provides a more comprehensive list.

Observers are encouraged to give feedback directly to the interviewer and for it to be specific and non-judgemental ('effective or not', instead of 'good or bad'). For example, 'You explained clearly who you were and why the patient's family were concerned', rather than 'You did a very nice introduction'. Descriptive feedback using verbatim examples is key and often requires prompting. As Kurtz et al (2005: p 126) emphasise, 'By describing exactly what you saw in the interview, you will almost always produce non-evaluative specific feedback'.

Flexibility in the order of feedback can sometimes be useful, especially if during an initial discussion of what went well an issue arises that would be better explored there and then. This is especially so in the second year of the MRCPsych course, when trainees are more experienced and familiar with each other.

An important tutor role is to get the whole trainee group involved in discussions. This is achieved by the use of eye contact, verbal invitation and sensitively managing dominating participants. Responding encouragingly by finding value in almost all answers also helps promote interaction. Trainee interviewers can be overly self-critical, requiring prompting to recognise what they did well. Conversely, observer peers' feedback can be overly positive. We find that interviewers accept constructive criticism more readily from their peers, underlining the importance of ensuring trainees deliver much of the feedback.

Feedback from the trainee playing the patient is particularly influential in providing the patient's perspective. In one instance, the group perceived an interviewer as empathic but the 'patient' disagreed as no empathic statements were expressed. Feedback can be in role, out of role or in a neutral role (in character but without strong emotions). We follow Dudley's (2012) recommendation of allowing both in-role and out-of-role feedback.

Following feedback, the interviewer is given an opportunity to put the learning into practice by rehearsing (replaying) part of the interview. Even a brief replay, for example illustrating the positive difference of responding to a previously ignored cue, can provide effective teaching points and also leave the interviewer with a sense of achievement. Finally, the tutor asks the group to identify take-away points both for the interviewer and for the rest of the group.

Individual assessment of communication skills

The usefulness of WPBAs has been questioned. A survey of trainers and trainees highlighted problems and negative attitudes (Menon 2009). Many of the feedback strategies described above can also be applied successfully in one-to-one situations such as WPBAs and when assessing medical students.

Videotaped feedback

Video recording and feedback are utilised extensively in undergraduate CST using simulated patients. There are many advantages: trainees can view their non-verbal behaviour, more accurate descriptive feedback can be given and the recording can be paused at key points. Disadvantages include trainees' anxiety at being recorded and difficulty rehearsing suggestions arising from the feedback.

Communication skills training in local teaching

CST occurs in many of our trust's teaching centres with each one led by a designated local consultant and/or trained SpR communication skills tutors. The inclusion of GP trainees and Foundation doctors requires some flexibility, however, trainees from non-psychiatry backgrounds contribute different insights, for example GP trainees highlight the importance of family and physical illness factors.

BOX 9 Feedback questions

Patient role-player

- How did it feel as the patient?
- How did you feel when the doctor asked X?
- How might the interviewer have:
  - got more information?
  - got you to be more cooperative?

Interviewer and observers

- What were your thoughts?
- What else might you want to find out about?
- How could that be achieved?
- Any other symptoms to enquire about?
- If you were the patient how might you feel being asked that?
- Was there a point when things changed?
- Was there something else going on here?
- What might be the outcome if it was left like that?
- What are the take-home messages?

Local CST consists of six hour-long monthly sessions during each 6-month trainee rotation. Following the introductory session, subsequent sessions involve role-play, simulation of recent problematic clinical encounters, most commonly challenging patients, suicide risk assessment and psychosis. The trainee bringing the case role-plays the patient or carer. Role-play facilitation and feedback, including rehearsal, are as described above. At the conclusion of each session, participants complete a 'sticky note' of techniques to try out. In the final session, common themes from previous weeks' cases are identified, plus learning points for future use.

Specific circumstances

Cultural differences

Silverman et al (2013) list common issues and barriers in cross-cultural communication relating to language, non-verbal communications and cultural beliefs, and where relevant, CST tutors introduce discussions on the influence of cultural factors on both clinical presentation and on the interviewing process itself.

Use of interpreters

Interpreters play an important role in psychiatric interviews. Wherever possible, especially if not an emergency, an impartial professional interpreter should be used rather than family, carers or acqaintances. It is crucial that the correct information is relayed to the interviewer without distortion. Raval & Tribe (2014) make a number of recommendations: holding a pre-consultation meeting between the interpreter and the health professional; translating speech verbatim (to avoid missing important aspects such as thought disorder and swearing); and for the interviewer to talk to the patient and not the interpreter.

Interviewing informants

Some of the role-play scenarios involve interviewing family/carers, for example explaining a diagnosis of schizophrenia or a treatment such as electroconvulsive therapy. Other related points can be brought up and explored during teaching. One important example is of trainees feeling uncomfortable in asking carers to 'wait outside' while they interview the patient, not fully realising how vital, sensitive information could easily be missed.

Joint interviewing

Clinical assessments are increasingly carried out with other members of the multidisciplinary team. It is important to discuss beforehand who will take the lead and how they will collaborate throughout the interview. We recommend that, following joint assessments, trainees ask their colleagues for informal feedback on their communication skills. According to Poole & Higgo (2017), the lead interviewer should periodically invite the other interviewer's observations or comments; breaks can allow discussion of difficult decisions (such as legal detention) and planing in case the patient reacts badly.

It can also be useful to run interprofessional CST sessions. S.M. set up the Communication and Assessment Skills Training (CAST) project for ward-based and community mental health teams (CMHTs). Involvement of different disciplines brought a useful range of different professional perspectives.

Telephone interviews

Since the advent of COVID-19, CMHTs have increasingly used telephone interviews. The absence of visual cues has a negative impact on developing rapport and on eliciting adequate information and can generate misunderstandings. There is therefore a much greater emphasis on verbal facilitation, which should be enhanced. Silverman et al (2013) advocate careful active listening, the crucial importance of discovering the patient's ICE and frequently checking for understanding. To simulate telephone consultations during CST, we ask the interviewer and patient role-player to interact while seated back-to-back. Observers can also be similarly 'masked'.

Remote interviewing using video

The use of video consultation in medical practice is also increasing, especially since COVID-19. Johns et al (2020) outline a step-by-step guide for clinicians on using video consultations in mental healthcare, for which there is a growing evidence base demonstrating suitability, acceptability and satisfaction. They list key considerations such as 'legal and ethical issues, such as defining and documenting patient's suitability and the role of the clinician, risk assessments and contingency planning, privacy, confidentiality, security and consent'.

Although preferable to telephone interviews, disadvantages remain. Technology can be a challenge for some patients, owing to either ability or availability. Some patients find it acutely uncomfortable to see their own faces on screen. For others, the use of cameras may compound persecutory ideation. In addition, as cameras usually only show a patient's face, other non-verbal cues may be missed. S.M. ran a Supported Return to Training Course in which psychiatry trainees assessed simulated

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patients in video consultations and reported this experience to be very useful in increasing their confidence.

Training communication skills tutors

The RCPsych (2019) recommends that SpRs be encouraged to teach on MRCPsych courses. An advantage of having SpRs rather than consultants facilitate in CST is that core trainees appear more comfortable in acknowledging their difficulties with them. Having a large number of available facilitators also allows for smaller, less daunting, role-play groups.

The NWL communication skills tutor course trains SpRs over two half-days on skills in small-group teaching, role-play, facilitation and feedback. Common problems that can arise during CST from either tutors or trainees are shown in Box 10. Strategies for preventing and managing these are described above.

Tutors need to use excellent communication skills to maximise trainees' engagement and learning. Parallels are drawn between the teacher–learner relationship and the doctor–patient relationship: both involve careful questioning, reflecting, paraphrasing, clarifying, recognising and exploring cues, summarising and being genuinely curious. The oft-used phrase 'let the group do the work' highlights how learning is maximised when trainees discover their own solutions. We also often find that the judicious use of humour helps to create an informal atmosphere and to defuse tensions.

As a prerequisite of attendance on the tutor course, SpRs commit to facilitating at least three MRCPsych sessions, during which the consultant communication skills tutor will provide assessments of teaching (AoTs). As well as useful feedback, the expectation of AoTs appears to enhance motivation to become tutors. SpRs also apply course learning to the assessment of communication skills in WPBAs and undergraduate assessments.

BOX 10 Common problems arising during feedback

Tutor

- Poor planning and set up
- Talking too much
- Lecturing, not guiding
- Excessively critical
- Not involving all trainees

Trainees

- Avoiding taking part/discussing
- Only talking to the tutor
- Dominating
- Overly positive peer feedback
- Scepticism

Undergraduate teaching

As early as the 1970s, it was shown that undergraduates' communication skills tend to worsen as they progress through medical school (Maguire 1976). Following initial preclinical CST, undergraduates have had little subsequent exposure apart from during general practice. Medical schools, though, are now starting to integrate CST vertically throughout the curriculum. Psychiatrists in particular can play an important role in reinforcing core communication skills such as empathy and how best to communicate with patients presenting with psychiatric disorders (Michaelson 2009).

Non-clinical communication skills for higher trainees

Consultant psychiatrists require a high level of non-clinical communication skills not always taught comprehensively during specialist training. The RCPsych curriculum (2019) includes negotiating, mediation/conflict resolution and teaching skills. The NWL Regional Higher Training Course was set up to prepare higher trainees for the variety of roles and responsibilities required as consultants and includes strands of advanced communication skills and leadership. In addition to the above-mentioned competencies, other session topics include supervision, coaching, teamwork and maintaining professional boundaries. The interactive teaching sessions frequently involve role-play.

Conclusions

The nature of psychiatry requires sophisticated communication skills. Research shows that communication skills can be improved by training and lead to many benefits in the doctor–patient relationship. This article details the skills involved in effective interviewing and outlines a structure and recommendations for organising and delivering CST on MRCPsych courses and in local centres.

The most effective way to improve communication skills is by role-play followed by constructive feedback. Careful preparation and facilitation are essential. Impact can be enhanced by using actors as simulated patients and videotaped feedback. Using specifically trained specialty registrars as facilitators makes it sustainable. As psychiatric interviews are increasingly conducted jointly or remotely, training on these special situations can be incorporated.

The RCPsych mandates that CST forms part of MRCPsych courses. Our survey of course directors

MCQ answers
1 b 2 e 3 a 4 c 5 c

indicates limited provision and a desire for more support from the RCPsych. CST needs to be more widespread within psychiatry and at an early stage of training. Additionally, courses on non-clinical communication skills for higher trainees can help prepare them for the consultant role. Further research on CST in psychiatry is needed to identify the most effective methods and their impact on clinical practice.

Data availability

The data that support the findings of this study are available from the corresponding author on reasonable request.

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Author contributions

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Declaration of interest

None.

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MCQs

Select the single best option for each question stem

1 Communication skills:
- a always improve with clinical experience
- b can be taught and make a difference to patient outcomes
- c result in longer consultations
- d are not included in the MRCPsych curriculum for core trainees
- e tend to be naturally better in psychiatrists.

2 Feedback should be:
- a descriptive and specific
- b non-judgemental
- c targeted at behaviours that can be changed
- d delivered as close to the event as possible
- e all of the above.

3 Clinical communication models such as the Calgary–Cambridge model:
- a often structure the interview into distinct stages
- b are rigidly prescriptive and must be strictly adhered to
- c are too complex to use in everyday practice
- d are outdated and no longer required in modern practice
- e can only be used in certain medical specialties.

4 Clinical communication skills training in psychiatry is best delivered:
- a in lecture format
- b via online interactive modules
- c in small groups, using some form of simulation
- d in the later stages of psychiatric training
- e just before the CASC exam.

5 When conducting assessments in psychiatry:
- a it is impossible to employ good communication skills over the telephone
- b video assessments are better than face-to-face as people tend to open up more
- c if using interpreters, it is important that they translate speech verbatim
- d when doing joint assessments, the doctor must always lead
- e it is vital to always have an informant in the room with the patient.