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## Communication skills in psychiatry training

Type of manuscript: Comment on training as it relates to mental health and mental health services.

## Communication skills in psychiatry training

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### Abstract

**OBJECTIVE:** Mental health clinicians can experience problems communicating distressing diagnostic information to patients and their families, especially about severe mental illnesses such as schizophrenia.<sup>1, 2</sup> Evidence suggests that interpersonal communication skills can be effectively taught<sup>3</sup>, as has been demonstrated in the specialty of oncology.<sup>4-6</sup> However, very little literature exists with respect to interpersonal communication skills training for psychiatry. This paper provides an overview of the communication skills training literature.

**CONCLUSIONS:** The report reveals significant gaps exist and highlights the need for advanced communication skills training for mental health clinicians, particularly about communicating a diagnosis and/or prognosis of schizophrenia. A new communication skills training framework for psychiatry is described, based on that used in oncology as a model. This model promotes applied skills and processes that are easily adapted for use in psychiatry, providing an effective platform for the development of similar training programs for psychiatric clinical practice.

Communication skills training (CST) is an integral part of undergraduate medical teaching and has become an increasingly important component of postgraduate training programs, particularly in fields such as oncology.<sup>4-6</sup> Such programs are uncommon in psychiatry, despite communication being a key therapeutic tool. Ineffective clinical communication practices have been linked to poorer patient mental health outcomes and experiences.<sup>7</sup> However, little is known about what CST programs currently exist and how they are applied to psychiatry. Following is a brief report on the role of CST in psychiatric education, examining existing frameworks for developing CST programs specific to psychiatry and the Australian postgraduate teaching context.

Communication between patients and clinicians is a simultaneous two-way, interpersonal experience<sup>8</sup>, where effective communication results in better outcomes for both patients and clinicians. Enhanced outcomes for patients include higher satisfaction, improved insight, and better treatment adherence; and for clinicians, more accurate identification of patient problems, improved wellbeing, confidence, and reduced distress.<sup>3,9</sup> Despite the apparent necessity for effective communication between clinicians and patients, skill deficiencies have been observed across several clinical fields<sup>3</sup>, including psychiatry.<sup>1</sup> Of particular difficulty in psychiatry is the communication of potentially distressing diagnostic and prognostic information

associated with severe and debilitating mental illnesses such as schizophrenia. Although relevant treatment guidelines raise the importance of this issue (e.g., National Institute for Health and Care Excellence guideline<sup>10</sup>), fewer than half of psychiatrists explicitly inform patients of a schizophrenia diagnosis,<sup>11-14</sup> while some 40% of patients reported receiving insufficient information about their condition<sup>15</sup>.

In a recent series of studies by our group, the perceptions and experience of communicating a schizophrenia diagnosis in psychiatry were examined. Mental health clinicians, patients with schizophrenia, and carers were interviewed. Over half the clinicians (56%) agreed that patients should be informed about a schizophrenia diagnosis, but most gave multiple reasons for not doing so in practice, including diagnostic uncertainty, patient distress, and stigma<sup>14</sup>. Many cited a lack of health system resources and time constraints that prevented them from discussing distressing news<sup>16</sup>. Patients and carers, on the other hand, reported significant unmet need for information, preferring a named diagnosis, as opposed to the uncertainty of not knowing<sup>1, 2</sup>, and were unanimous that the positive aspects of receiving a diagnosis far outweighed the negatives.

Communication skills can be taught<sup>4, 5</sup>. At the undergraduate level, medical schools usually teach core communication skills such as active listening, questioning, and appraising cues and barriers to communication<sup>6</sup>, while training programs in

postgraduate specialties focus on advanced skills relevant to that discipline and illness specificity. A meta-analysis of 13 studies<sup>5</sup> reported a moderate effect size (Cohen's  $d = 0.54$ ) of CST for improving the communication skills of oncology clinicians.

Advances in CST have largely occurred within the medical speciality of oncology.

Arguably one of the most effective and professional postgraduate training programs is that provided by the Comskil Training Program (Memorial Sloan Kettering Cancer Center, New York; <http://www.mskcc.org/research/psychiatry-behavioral-sciences/communication-skills-research>), which teaches advanced topics such as breaking bad news, responding to emotions, and running a family meeting<sup>17</sup>. The Comskil model consists of five components: goals, strategies, skills, process tasks, and cognitive appraisals<sup>18</sup>. Communication *goals* (e.g., breaking bad news) are the desired outcome of the consultation, achieved by utilising communication *strategies*, *skills*, *process tasks*, and *cognitive appraisals*. Strategies are the *a priori* planned steps that are followed sequentially to achieve goals, and strategies are accomplished by the combination of skills (verbal utterances), tasks (nonverbal behaviours) and appraisals (monitoring the process).

Based on the Comskil model and with the aim of developing a detailed, consensus-driven, and testable CST framework specific to psychiatry, Levin et al.<sup>19</sup> conducted an e-list survey of psychiatrists to facilitate an in-depth online discussion of issues

concerning communicating a schizophrenia diagnosis.<sup>19</sup> The e-survey results recommended the inclusion in postgraduate CST of stigma reduction and adherence maximisation goals, a timeframe for initiating diagnostic discussions with a patient (e.g., within two weeks from the date of admission), when to include family involvement, the use of a symptom checklist, using formulation to link the patient's perception of their illness to prognosis, and the use of the 'best, worst, and most likely outcome' strategy for discussing prognosis. The resulting CST program, called ComPsych<sup>20</sup>, includes five higher order categories from the Comskil model<sup>18</sup> (e.g., agenda setting, checking, questioning, information organisation, and empathy), that contains 20 core communication skills. ComPsych CST includes a didactic introductory session that outlines the communication skills being taught and provides exemplary videos specific to discussing either a schizophrenia diagnosis or prognosis. This is followed by facilitated small group role-play sessions that allow trainees to practice communication skills with a simulated patient specifically trained for the session. Feedback to trainees includes video playback and facilitator led peer discussion. Because trainee psychiatrists are treating patients with schizophrenia on a daily basis, they are well placed to immediately transfer the communications skills learnt in training to the workplace and hone skills in practice.

Traditional models for evaluating the communication skills of clinicians generally encompass the apprenticeship model<sup>21</sup> and pre/post evaluation designs<sup>18</sup>. In the apprenticeship model, a supervisor observes a trainee during actual or recorded patient interviews to provide feedback<sup>21</sup>, but standards of effective communication might not be articulated. Trainees learn an informal curriculum from their supervisor (that is taught outside the set curriculum), but a ‘hidden curriculum’ may also exist, whereby the trainee learns whatever their supervisor deems appropriate, or what is current practice for that institution, and poor modelling can occur<sup>6</sup>. Pre-test/post-test methodologies, on the other hand, are often used to evaluate the efficacy of interventions in CST.<sup>18</sup> However, there is a paucity of research about the teaching and evaluation of communication skills in psychiatry.

An objective and well-established model for evaluating CST programs is that developed by Kirkpatrick<sup>22</sup>. This model has been adapted for CST<sup>23</sup>, and developed and applied by Comskil<sup>6</sup>, and later ComPsych<sup>20</sup>. Level 1 evaluation measures trainees’ perceived communication self-efficacy. Level 2 evaluates the trainees’ learning in an objective, quantitative design. Level 3 compares trainees’ work-based performance before and after training, while Level 4 measures whether training impacts patient outcomes<sup>24</sup>. Improving clinical communication and real world patient outcomes, and demonstrating the durability of these changes over time is paramount. Kissane et al.<sup>6</sup> noted that there is



a paucity of research investigating whether training dose, such as booster or consolidation CST improve the impact of CST over time.

Several studies have used Kirkpatrick's model to evaluate their programs. Examining the first level of evaluation, Brown et al.<sup>25</sup> found that participants who undertook Comskil CST reported increased confidence post-training in utilising new communication skills, providing quality clinical care, and discussing a prognosis with patients. In a related study evaluating all nine Comskil oncology modules, participants reported significant increases in communication skill self-efficacy post-training<sup>24</sup>.

Comparable findings have also been observed for ComPsych, with Loughland et al.<sup>20</sup> reporting that trainees completing ComPsych CST were significantly more confident communicating schizophrenia prognosis post-training.

One second-level evaluation of the Comskil model has been published. Bylund et al.<sup>17</sup>, using a pre/post-test design, compared coded video-recordings of oncologists' interactions with patients pre- and post-training. Participants significantly increased their communication skill usage, particularly in establishing a consultation framework (agenda setting) and checking skills (e.g., patient understanding). Dose of training was divided into those participants who attended 2-3 modules and those that attended 4-5 modules; no differential effect of dose on skills uptake was observed.

To the best of our knowledge, systematic evaluations of CST that examines the impact on actual clinical practice (levels three and four) are yet to be reported. In psychiatry, it remains to be seen if CST differentially improves the use of particular communication skills as it does in other medical specialties, whether communication skills learned are transferable to the workplace, and whether patient outcomes are improved by CST.

**Disclosure**

The authors have no conflicts of interest to report.

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