Communicating to connect with patients

Abstract

Michaelson and Rahim describe a very welcome sustainable training framework for teaching clinical communication skills to trainees on MRCPsych courses. Specific challenges arise in psychiatry and further work is required to identify these in real consultations along with the impact of effective communication on patient experience and outcomes. While psychiatrists need to be skilled interviewers, they also need to be skilled listeners to develop rapport and trust, the foundations of a good therapeutic relationship. Rapport appears to be more difficult to establish in telemental healthcare. Nonverbal communication – in particular gaze and voice quality – is central in establishing rapport, which increases disclosure of sensitive information. Exactly how questions are asked also impacts on disclosure and is particularly important in risk assessment. Extending videorecording role plays in training to routine (remote) clinical consultations and involving people with lived experience will be key to identifying communication that has a positive impact on patient experience and outcomes.

Communication is central to psychiatric practice. However, as Michaelson and Rahim note, it is relatively neglected compared to other specialties. Psychiatrists frequently highlight the key role of communication in establishing and maintaining a therapeutic relationship with people, many of whom do not voluntarily seek treatment. The authors welcome the RCPsych's recommendation that all trainees receive teaching in interviewing skills. It is exciting to see how the authors have developed and constantly sought to enhance their communication skills training programme. They describe a sustainable training framework that can be used to teach clinical communication skills to trainee psychiatrists on MRCPsych Courses.

Listening to develop trust and rapport

As the authors note, psychiatrists need to be skilled interviewers to elicit relevant information. An interview focuses on one person asking and another person answering questions. Given that psychiatrists routinely engage in delicate and emotional conversations, they also need to be skilled listeners as described by Michaelson and Rahim. Listening can be difficult when the focus is on interviewing or assessing mental state. In a typical question-answer interview structure, there is no conversational slot for listener feedback: information is received in a passive way. However, listening is important for developing trust and rapport and is also associated with patient satisfaction. Listening may sound trivial but 'really listening' requires a lot of effort and skill. Often, it is easier to keep asking questions or to start giving advice prematurely than to really listen to what people are saying. Analysis of video-recorded doctor-patient interactions shows that speakers monitor listeners continuously to check if they are really listening, with patients becoming dysfluent when the doctor is not listening, and particularly when doctors are attending to written or electronic records (Ruusuvuori 2001).

The authors and the Royal College of Psychiatrists core curriculum highlight trust and rapport. Rapport and trust are essential for developing and maintaining a therapeutic relationship, which is not only necessary for assessment, diagnosis and engaging people in treatment but is also a curative element in its own right (Freeth 2017). People with lived experience say it is the most important factor in good care (Johannson and Eklund 2003). Developing trust and rapport can be more challenging in remote mental health communication: while there are considerable advantages (e.g., fewer 'no shows' and greater understanding of the person's social context), psychiatrists also find it more difficult to detect subtle changes in tone of voice, inflection, affect and gaze and also harder to develop rapport (Chen et al. 2020). Evidence suggests that therapeutic relationships are difficult to establish in remote first appointments but can be sustained if there is a pre-existing relationship (Schlief et al. in press).

Disclosing sensitive information

Given that communication in psychiatry involves asking people about sensitive, stigmatized and socially undesirable information, rapport takes on extra significance. Goffman and others have shown that there is a strong preference for 'saving face' and not disclosing negative information about oneself in social interaction. However, people are more likely to disclose sensitive personal information when there is good interpersonal rapport. Nonverbal communication is an important channel for rapport and empath: it is not 'what' we say but 'how' we say it. Gaze (Brugel et al. 2015) and voice quality (Simon-Thomas et al. 2009) are associated with perceived empathy. In our busy day to day work, when we are tired and distracted, it takes extra conscious effort to convey empathy through posture, gaze, facial expression and tone of voice.

The authors advise not ignoring one's 'gut instinct' when assessing risk. Psychiatrist nonverbal communication may be diagnostic in its own right. When assessing and predicting whether patients would re-attempt suicide after attending the emergency department, Haynal-Reymond et al. (2005) found that psychiatrists' written predictions of future suicide attempts were correct in 22.7% cases. However, when their nonverbal behaviour was analysed, they found that frowning and gazing at the patient for longer, predicted around 90% of future suicide attempts. This suggests a perception of risk, of which doctors are not consciously aware, that is overridden by verbal communication. What is happening in an interaction when trainees and psychiatrists have a 'gut instinct' about risk could be further explored in training and practice.

Studies also show that exactly *how* clinicians ask sensitive questions influences the patient's response (McCabe et al. 2017). Clinicians tend to ask closed yes/no questions such as "Have you had any thoughts of ending your life?" or "Do you feel like life is not worth living?". Most communication skills programmes advocate non-leading questions. However, all closed questions expect or invite either a yes or a no response. They do this through the presence or absence of negative/positive polarity items. Common negative polarity items are 'ever/any/at all' and 'some' is the most common positive polarity item. Psychiatrists and other professionals in outpatient settings are more likely to invite patients to say no (McCabe et al. 2017). When they ask questions about suicidality or other embarrassing or stigmatized feelings, thoughts and behaviour with 'ever/any/at all', patients are more likely to say no, compared to when they are asked questions with 'some'. In addition to enhancing the validity of risk assessment, when people are struggling with highly distressing thoughts, being asked

in way that invites them to say yes makes an enormous difference in conveying acceptance of these thoughts and the possibility of a conversation that instils hope.

Videorecording communication

The programme designed by the authors involves videorecording and sensitive feedback to trainees, allowing for more accurate descriptive feedback on nonverbal behaviour. Most research on communication has emerged in other specialties such as primary care and oncology. As the authors describe, communication in psychiatry is affected by peoples' symptoms (e.g., delusions, depression), which changes the interaction. Often there are carers present. also altering the dynamics of the interaction. When videorecording trainees and consultants in previous studies, they have commented on how little opportunity they have to observe and reflect on their communication and how to overcome specific challenges that arise in psychiatry, e.g. being interested and engaged when they first meet people with psychosis but losing motivation over time when working with people with negative symptoms (McCabe et al. 2017). This highlights the need for ongoing reflection and supervision on communication for trainees and more senior psychiatrists.

Involving people with lived experience in communication skills training

People with lived experience and carers are increasingly involved in training mental health professionals. This could also be implemented in communication skills training for trainees. They offer a first-person perspective, which is particularly effective in tuning in to the aspects of communication that matter from a patient perspective (feeling understood, being listened to and validating distress) and supporting clinicians to develop empathy that is experienced as genuine rather than tokenistic. They share practical advice on what helped them at different points in their illness along with positive examples of how to manage complex issues such as sharing information with carers.

Finally, many of the concepts that are central to effective communication such as warmth, empathy and rapport can seem rather nebulous. However, when observers watch role plays and video-recordings of practice, there is typically strong agreement on when an interaction is warm, empathetic and there is good rapport. The authors are to be lauded on their communication skills programme and calls for further research to identify effective communication. Collecting video-recordings across different presenting problems and treatment settings (e.g., tamh.co.uk) would further enhance our understanding of positive practice within the constraints of everyday busy clinical practice to equip trainees with these skills as they embark on their careers.

Declaration of Interest

Rose McCabe is an Editorial Board Member of BJPsych Advances.

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