Advanced Communication Skills

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1 Introduction

1.1 Welcome

Welcome to the 2015-16 Advanced Communication Skills course, which has been revised from last year’s first edition both for clarity and to take account of new developments in the field.

After the whole day sessions on 3rd, 10th and 17th of September, the course continues with ten half day simulation sessions using actors and video feedback. These sessions are spread over two years. So far as possible, the level of challenge increases sequentially over the two years. We’ve given you some idea what to expect in each session in the notes to the curriculum section of this document on page 7.

The course is designed to be an advanced level course that will give you a good foundation to become expert practitioners in psychiatry. The level of challenge will be high. The scenarios are designed to be true to life but at the most challenging end of what you will see as a psychiatrist. They are not puzzles with magic solutions, rather the aim is to experiment with ways to work with people when they are having difficult times. Most of you will struggle with some of the material at least some of the time, and it is likely that at the beginning you will feel that your skills have actually taken a step back. We would really encourage you to persist, use the sessions to try things out and the actors and facilitators as a resource, and practice skills outside the formal training. Most trainees that attend the whole course greatly benefit from it.

We hope you will enjoy the course and find it productive. Please talk to us as soon as you can if you aren’t getting what you need. Feedback forms are all very well but they can lead to every group getting the course last year’s group wanted, so please, tell us what’s working and what’s not!

GU & HT

1.2 Models of the consultation

Essentially, all models are wrong, but some are useful.

George Box

There are very many models of the medical interview (e.g. Silverman et al. 2005, Pendleton et al. 2003, Neighbour 1987, Cole & Bird 2013). A lot were developed for undergraduates; the majority were developed for and/or by GPs who in many respects have led the way in thinking about consultation models for some years. There is no single model that works well for all psychiatric consultations, though the models do have some obvious overlaps (see Makoul 2001 and de Haes & Bensing 2009 for two attempts at drawing out the commonalities of the various models).

Some of the models distinguish between disease and illness. (e.g. Stewart 2003). The disease framework is that part of the interview that works from a biomedical perspective, focussing on symptoms and signs to elucidate underlying pathology and a differential diagnosis. The disease framework is task centred and if employed alone can be technocratic and depersonalising from the patient’s perspective. The illness framework follows the patient’s perspective, looking at their ideas, concerns and expectations with respect to their illness. The illness framework is patient centred and if used in isolation can miss important treatable disease. Models of the consultation using the disease/illness frameworks emphasise the importance of weaving between doctor and patient centred tasks.

Thinking about the consultation in recent years has increasingly emphasised patient centred consulting styles, with the aim of establishing a clear understanding of the patient’s perspective on his or her problem, and to allow this understanding to inform
both the explanation and planning stages of the consultation’ (Norfolk et al. 2007). This is particularly important in psychiatry both because ‘illness’ may exist in the absence of biomedical ‘disease’ and because some patient groups may be harder to engage than the general population.

Skilful working in a patient centred style is grounded in high levels of empathic accuracy and rapport. Improving these skills means integrating some elements of a counseling approach into general psychiatric practice. One approach that has been influential in this import of counselling skills to medical practice is motivational interviewing (Miller & Rollnick 2012, Rollnick et al. 2008).

1.3 Learning communication skills

Silverman et al (2005) identify a key issue in learning communication skills as a confusion of content with process. Undergraduates are often taught the traditional medical history format (presenting complaint, history of presenting complaint, past medical history etc.) and then use this as a guide to how to organise their interviews: ‘this leads learners to use the framework of the traditional medical history as a process guide, reverting to closed questioning and a tight structure to the interview dictated by the search for medical information’ (Silverman et al. 2005). If communication skills have been taught, these are often not integrated into practice and are treated as a separate skill to day-to-day practice.

Difficulties in distinguishing content (the ‘what’ of the medical consultation or interview) from process (the ‘how’) are exacerbated because process skills are often the skills of the expert practitioner, which experts may find difficult or impossible to articulate themselves: i.e. process skills are often complex, multi-dimensional and tacit (Sadler 1983). Even more frustratingly, it is common for psychiatrists, as for experts in any field, to have incomplete insight into this phenomenon. ‘If one asks an expert for the rules he or she is using, one will, in effect, force the expert to regress to the level of a beginner and state the rules learned in school’ (Dreyfus 2005). Often, trainees are taught the way their trainers were taught, in a way that emphasises content over process — even though the trainers’ observed practice may be very different to what they teach.

Silverman et al (2005) go on to discuss a further confusion: communication skills teaching is sometimes considered to deal solely with process, whereas in fact it also deals with some content, particularly the necessity to explore the patient’s ideas, concerns, needs and values.

1.4 Finding your way

*It takes a long time to sound like yourself.*

Miles Davis

The existence of multiple models of the medical consultation is a sure signal that there is no one ‘right way’ to talk to patients. Although there is some broad agreement on some things that are often helpful in talking to patients, and some things that are often unhelpful, there remains a lot of debate about what constitutes good performance. Trainees invariably receive quite conflicting feedback on aspects of their performance with different trainers responding very differently to what they are doing.

This course is based on three key assumptions:

1 We carry an innate sense of what good communication looks and feels like. It is very easy to tell good, productive or successful interviews from less good ones. Minimally trained lay observers can do it with a high degree of reliability and consistency (Bergus et al. 2009). In role plays, trainees can instantly ‘feel’ whether a consultation is going
well or not.

2 It is much harder to unpick and operationalise the components of good, productive or successful interviews, so as to be able to reliably use good communication techniques and strategies most of the time. This is not a skill most people have innately: however, it can be learned. Key elements are deliberate practice with detailed, descriptive feedback and honing one’s ability to see and describe process skills in others. We also believe that one part of operationalising good communication skills is making trainees aware of the different approaches that have been used to generate quality criteria for communication with their various benefits and disadvantages. Although we use a coding approach, this is not the only technology available (see p48).

3 There are multiple right ways of communicating. One of the tasks of trainees in the course is to find a way that allows them to incorporate what the research says, but also to talk to patients with their own voice or style. Because of the importance we place on finding your own style, the pedagogy in this course is different to what you may have experienced before. We believe that consistent focus on finding what you do well in interviews with patients is likely to be more use to you than finding fault. Medical trainees are often acculturated to receiving harsh, critical feedback to the extent that they see asking for it as crucial to their own development. We don’t believe this to be true and ask that you work at supporting other members of the group by assiduously noticing what they are doing well and basing your feedback on that. If you think what they are doing is particularly good and might work for you, steal it and try it for yourself!

1.5  **Formal learning, day-to-day work and the exam**

The CASC exam looms large for many trainees for obvious reasons. In some respects CASC is a good exam in that it is easier to pass if you have good communication skills and harder if you don’t; however it is also a poor exam in that it requires some specific exam preparation work in itself, in addition to having good communication skills. You may need to approach the CASC in a slightly different way to how you approach day-to-day practice because of the requirement to complete a specific task in a time limited station. Although this is not a CASC preparation course, we will frequently refer to the CASC and try to give examples of when things are particularly relevant to the exam, ideas for ways to approach the challenges of the exam and common pitfalls. Some of the trainers on the course are CASC examiners and can give you a good insight into what is and isn’t received well in the exam. There is also a separate CASC preparation element to the Core Psychiatry course. The primary aim of the Advanced Communication Skills Course is to help you to develop into skilled psychiatrists, practising in the real world.
2 Curriculum for this course

The process of communicating with patients is presented here under four main headings: engagement, structuring the interview, exchanging information and planning.

Not all of the skills will necessarily be used in every interview, and some of the skills appear under more than one of the headings.

Definitions and more detail will be found in the body of the text.

2.1 Engaging

Principles

The task of engagement, or building a therapeutic relationship, is the cornerstone of the psychiatric interview. Engagement tasks are particularly important in the first few moments of meeting a patient, but attention to engagement is important at all phases of the interview process. Skilled clinicians track problems in engagement and prioritise them over task issues throughout the course of the interview.

A key characteristic of good quality engagement process is empathy. Doctors approach the session as an opportunity to learn about the patient and spend time exploring the patient’s opinions and ideas. Empathy is evident when providers show an active interest in understanding what the patient is saying. It can also be apparent when the clinician accurately follows or perceives a complex story or statement by the patient, or probes gently to gain clarity about the patient’s story.

Skills

1. Attends to interview environment (e.g. seating arrangement)

   Considers aspects such as patient comfort, impact on engagement, placement of carers or interpreters, and safety issues.

   Thinks through whether to see the patient alone or with his/her carer, relative or friend, or a combination of the two, with due consideration for the patient’s views on this.

2. Establishes initial rapport

   Does not interrupt patient’s initial account.

   Use of reflective listening to convey empathy, including reflecting not just the superficial content of what is said but also underlying affect, meaning, values or dilemmas.

   Use of summary after initial account of problems.

   Gives special consideration to patients with impaired hearing, sight or verbal communication.

3. Speech is clear, fluent, confident and at an appropriate rate

4. Adjusts to an appropriate educational level and cognitive abilities

   Establishes whether the patient has understood what the doctor is saying by actively checking in. Is wary of the patient who agrees to everything that is said in order to mask difficulties with comprehension. Handles this sensitively, avoiding the patient feeling patronised when possible.
Checks that they have a shared understanding with the patient regarding key terms.

Checks that the patient has an adequate understanding of relevant concepts and has understood the purpose of the meeting and what is going to happen. Remembers that some patients with cognitive difficulties may have limited understanding of concepts such as time, for example tending to say that everything in the past occurred yesterday.

Encourages patient and carer to ask questions and to highlight if things are not making sense.

5. **Makes appropriate cultural adjustments.**

6. **Employs appropriate non-verbal behaviour.**

Uses eye contact appropriately (makes and breaks eye contact, eye contact maintained 50-70% of the time provided patient is making eye contact too).

Facial expressions and posture communicate interest.

Mirroring

Non-verbal vocal cues (uh-huh, hm, etc.).

Avoids distracting hand movements, looking at watch, being overly focused on notes.

Maintains appropriate distance from patient.

Uses silence therapeutically.

7. **The doctor is able to deal sensitively with potentially embarrassing topics without losing focus.**

Remains calm and emotionally containing (communicates a willingness to talk about sensitive topics that mitigates the patient’s embarrassment or shame).

Non-judgemental attitude.

8. **The doctor attends to moment by moment fluctuations in engagement and addresses difficulties around engagement appropriately.**

Able to use de-escalation techniques with angry, agitated, distressed or aggressive patients.

Able to engage with silent or shut down patients.

Employs strategies to engage both the patient and carer in conjoint interviewing.

Has strategies to manage engagement issues when people have sensory impairment, limited verbal communication or cognitive difficulties, or an interpreter is needed.

9. **The doctor uses apology where appropriate for mistakes and failures, e.g. for inadvertently asking an upsetting question or inadvertently crossing boundaries (e.g. lateness).**

10. **The doctor monitors their own reaction to the patient**

The doctor ‘uses his or her emotional response as data’ - i.e. recognises a personal affective response (such as anger, attraction, hatred) but does not act
on it directly, instead reflecting on it and possibly using it as a signal to seek supervision.

11. **The doctor seeks supervision appropriately**

Negative indicator: argues with patient.

## 2.2 Structuring the interview

### Principles

Skilful structuring of the interview blends a predominantly patient centred focus with a task orientated approach: i.e. structure of the interview is determined both by patient needs and by the informational content the doctor is aiming to elicit. Where there is a more medically led, task focussed component of the interview, this should be sandwiched between more patient centred phases. Despite the patient centred focus, the interview is highly directed. The doctor is transparent in his or her focus on the particular problem at hand and helps the patient to return to this topic without doing so in a way that is harsh or authoritarian.

### Skills

1. **Opening the interview.**

   - Introduces self using title, surname and role.
   - Greets patient.
   - Attends to patient comfort.
   - Description of purpose and nature of the interview.
   - Puts interview into context for patient, e.g. referring to a referral letter.

2. **Focussing.**

   - Explicitly negotiates an agenda with the patient (elicits patient’s concerns; with permission adds own concerns if indicated).
   - Prioritises the items on the agenda with the patient.
   - Uses the agenda to structure the interview.
   - Uses the agenda to ‘hold’ areas of discord.
   - Uses the agenda for ‘topic tracking’ to keep the discussion focussed.

3. **Makes the organisation of the interview overt**

   - Appropriate use of signposting, including flexibility in the use of signposting (e.g. making the interview organisation more overt for patients with cognitive impairment or more flexible for upset patients).

   - Uses smooth transitions (transitions that imply a temporal or causal link: ‘with symptom x have you ever had symptom y?’ ‘Some of my patients who have told me x have also told me that y’).

   - Appropriate use of accentuated transitions (‘now I’d like to go on to...’).
Use of selective reflection as a structuring/steering technique.

Where questions are used that may seem strange to the patient, a warning or explanation is given.

Shares thinking on aspects of the interview.

Uses summary as a transitional tool between phases of the interview.

Negative indicator: abrupt transitions.

4. **The doctor uses a following style when appropriate**

   Where the patient is upset or distressed, the doctor uses a looser ‘following’ style for part of the interview and allows the patient to ventilate their feelings.

5. **Using curbing techniques where appropriate e.g. drawing patient back to the negotiated agenda or re-negotiating the agenda.**

6. **The doctor has an understanding of the importance of boundaries in clinical practice.**

   Explains confidentiality and its limits.

   Explains timing and keeps to it.

   Explains purpose of note keeping and communication of the interview with others (e.g. team, GP).

   Only uses self disclosure if helpful to the patient and within appropriate limits.

   Only uses physical touch if helpful to the patient and within appropriate limits.

7. **Modifying the structure of the interview when it is a conjoint interview**

   Ensures that both the patient and carer(s) have opportunity to express their views.

   Checks-in regularly with both parties to ensure shared understanding.

   Balances the need to ensure that the carer’s perspective is heard against the potential negative impact of the patient listening to critical comments and loss of engagement with the patient.

   Considers whether seeing the patient and carer separately might be appropriate, in order to ensure they are both able to speak openly, particularly where there may be safeguarding concerns.

   Has strategies to manage conflict or disagreement between the patient and carer, or one dominating the interview.

8. **Closing the interview**

   Closes down highly emotional areas (e.g. by returning to more neutral areas of conversation).

   Checks how the patient is feeling now if appropriate.

   Gives opportunity for the patient (and carer if appropriate) to ask questions.
Links the interview with further contact (e.g. arranging to see the patient again, making provision for emergency contact ('safety netting')).

Says goodbye and thanks the patient if appropriate.

Negative indicators: dominates the interview, imposes an agenda, allows the interview to drift in an unfocussed way. Ends the interview with patient upset, angry or closed down.

2.3 Eliciting information

Principles

There are two interwoven tasks in the psychiatric interview, of understanding the biomedical perspective and the patient’s perspective. The biomedical perspective is disease centred and focussed on a sequence of events, symptom analysis and relevant symptom review, with the aim of accurate and complete diagnosis on which to base treatment. The patient perspective is based on ideas, concerns, expectations, values, meanings, strengths and goals. Both strands are important and should feature in the assessment.

Skills

9. Questioning style

Uses predominantly open questions.

Uses an open to closed question cone.

Able to use questions to clarify understanding (e.g. asking for an example, exploring links the patient has made, probing to get to a core problem, asking patient to expand or clarify).

Able to use questions to expand understanding (e.g. asking for third party perspectives, asking about the best and worst things, asking about ‘two futures’).

Bayesian reasoning (in pursuing a diagnosis, lines of questioning are informed by likelihood and are not uninformed, standardised data collection routines).

Avoids complex sentence structures and esoteric questions in people with cognitive impairment, limited understanding of English or who are highly emotionally aroused or thought disordered. For example, avoiding double negatives, long sentences, tag questions or complex metaphors.

Avoids volleys of questions without allowing the patient time to answer and questions which have multiple parts, for example: ‘have you ever tried smoking, alcohol or drugs?’

Negative indicator: leading questions, loaded questions.

10. Able to use reflective listening statements.

11. Uses non verbal listening behaviour to encourage the patient to continue.

12. Uses summary to clarify information.

13. Takes small therapeutic opportunities as they arise.

e.g. in summarising a patient’s psychotic experience does so in a way that
grounds the experience more in reality; where a patient gives reason for positive change such as stopping drinking follows this up with an invitation to expand or go on; in summarising a muddled and disjointed account, creates sense and meaning that the patient recognises as an accurate picture of their experience.

14. **Elicits patient ideas, concerns and expectations about their problem.**

15. **Elicits patient values and strengths.**

16. **Elicits information about patient goals and preferences.**

17. **Uses silence appropriately.**

18. **Elicits an appropriately detailed and comprehensive history.**

Able to use heuristics and Bayesian inference to perform rapid and effective assessments in acute situations.

Does not fall into the ‘assessment trap’ of gaining information at the cost of engagement.

19. **Performs a mental state examination**

Including cognitive assessment and insight.

Able to perform a detailed mental state examination in a range of patient groups, including: people with learning disability; children; older adults and those with psychotic experiences.

20. **Performs a risk assessment.**

Able to perform a detailed risk assessment in a range of patient groups including adults, older people, children and people with learning disabilities.

Able to prioritise obtaining key information in urgent situations.

Checks for safeguarding issues sensitively.

21. **Assessment of capacity**

Able to assess capacity based on a structured framework, for a variety of different decisions, including in patients with cognitive impairment.

Avoids the traps of conflating ability to speak fluently on a topic with understanding it, or the compliant patient who will just agree and repeat back verbatim without understanding.

22. **Elicits a collateral history**

Able to obtain collateral information sensitively both in the presence and absence of the patient.

Responds appropriately to carer distress.

Manages conjoint interviews including children and people with learning disabilities whilst being mindful of how the interview is experienced by both the patient and relative or carer. Is vigilant to the patient feeling disempowered or either party feeling ignored.
Considers whether attempts should also be made to speak to the patient and carer separately (e.g. to check for any safeguarding concerns). If so request this in a sensitive manner.

Obtain a collateral history when the patient has not given permission for information sharing i.e. when the doctor may listen but not provide information. Discuss the reasons for not providing information in a sensitive manner.

23. **Information giving**

The patient or carer’s understanding is elicited before any information (e.g. a diagnosis, test results or treatment options) is given and the patient’s understanding is checked (ask-tell-ask model).

A ‘chunk and check’ approach is used for information provision. Checking must be explicit and detailed in those with cognitive impairment.

Consideration is given to motivation for treatment before offering information.

Consideration is given to the patient’s preferences for information (amount, format etc.).

Provides a diagnosis in a sensitive, individualised manner.

Provides a model of the patient experience that makes sense to him or her (e.g. simple cognitive models of anxiety, depression, somatisation).

Provides information about treatment options.

The patient’s reaction, understanding and views are elicited after information is given, piece by piece.

The patient’s family are involved where indicated; sensitive and appropriate information giving for the patient’s family, educational approaches to parents (e.g. information on psychosis for parents of newly diagnosed children).

Negative indicator: the ‘information dump’; use of jargon or technical language without explanation, failing to check understanding and emotional response to information given.

24. **Aware of common sources of cognitive bias in medical practice**

A basic awareness of reasoning strategies in diagnosis and problem solving and the biases and errors associated with them.

Employs de-biasing strategies appropriately.

25. **Performs a joint assessment with another health or social care professional**

Discusses with the other professional beforehand, identifies important agenda items for the assessment, whether one of the professionals will lead all or part of the assessment, and how decisions will be made and discussed with the patient.

Performs an assessment where both professionals are able to participate without either feeling overruled by the other, or the patient feeling they are being interrogated.
Has strategies for managing disagreements with other health or social care professionals.

2.4 Planning and treatment

Principles

In planning treatment with a patient, skilled practitioners are highly collaborative, actively fostering power sharing in a way that the patient’s ideas can substantially influence the outcome of the treatment plan. In order to achieve this, they ‘hold the reins’ on their own expertise, using it strategically when the patient is ready to hear it and most likely to act on it.

Skills

1. Treatment planning

Planning treatment using ‘three treatment trajectories’ model (goals for this session; goals for this episode of care; longer term goals)

The session is structured and goal directed.

There is an overarching plan for the illness episode. A session to session treatment plan is negotiated with the patient and revisited periodically.

There is a sense of the illness career of the patient and of timing particular interventions correctly at particular times (e.g. some therapeutic tasks may be deferred in the current illness episode).

Treatment planning flexibly uses hierarchical approaches (e.g. dealing with life threatening issues or criminogenic issues first) or patient centred approaches (encouraging the patient to set or negotiate an agenda).

Involves patients who lack capacity with regard to the treatment decision, as much as possible. Continues to consider patient perspectives and how they may perceive management decisions, even if they are not able to make the decision themself.

2. Decision making

Decision making is shared in so far as possible.

Patient preferences are elicited for information/treatment.

Patient motivation is assessed for treatment.

The doctor is able to communicate clinical equipoise where indicated.

Able to guide patient to a particular course of action when not in equipoise.

Information is given in a way that supports patient autonomy and emphasises patient choice.

Planning of treatment is done in a collaborative manner that expresses a realistic optimism about the future.

Negative indicator: uses coercion, threats or persuasion to attempt to influence a patient toward a particular course of action; missing engagement problems re-appearing in planning treatment and/or failing to address these appropriately, dogmatic approaches, providing unrealistic hope or lying.
3. **Breaking bad news**

- Giving a ‘warning shot’.
- Knowing when to stop because more information is not being taken in (‘shut down’).
- Controlling the pace of information provision depending on the patient or carer’s responses.
- Ensuring adequate opportunities for asking questions.
- Making follow-up arrangements, including arrangements to see other professionals, speak to relatives and asking questions that the patient may have later on.
- Breaking bad news to a relative, including responding to his/her emotional needs.
- Apologising when appropriate.
- Providing information regarding complaints procedures when appropriate.

4. **Planning for relapse prevention**

- Working collaboratively with the patient and if appropriate carer, to identify warning signs and actions to be taken.
- Simple cognitive model of relapse.

5. **Communication with other professionals**

- Ward rounds, care programme meetings and discharge planning
- Writing letters and reports to patients and other professionals/other agencies
- Taking a system view of the patient’s care when it is provided by multiple agencies and individuals.
- Signposting to other agencies.

6. **Returning to work**

7. **Common problems in the treatment of psychiatric patients and strategies to address them**

- Ambivalence.
- Medication non-concordance.
- Avoidance.
- Anxiety.
- Emotional extremes and lability.
- Impulsivity and dysexecutive problems.
- Splitting.
Pessimism and low self esteem.

Anger and hostility.

Trust and intimacy difficulties.

Third party distress and high expressed emotion.

Uncertainty.

Search for a medical cure for social difficulties.

Impaired insight.

Lack of emotional language.

Perceived stigma.

Cultural issues.

Unconventional lifestyle choices versus mental disorder.

8. Complaints

Handling complaints in a sensitive way.

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3 Process, content, structure, skills...

The content of the traditional history and mental state is not the same as the process and structure of the interview (see page 5). Particularly for interviews focused on information gathering and diagnosis, the content is often quite well defined (the traditional headings of the history and mental state examination). There are however multiple ways of approaching an interview depending on the circumstances. There isn’t a single right way: some ways work better in some situations; some ways work better for some people, and sometimes more than one approach will be needed even in a single interview. This section presents three ways or modalities for thinking about the consultation.

3.1 Doctor centred

The history and mental state are performed in textbook order, aiming for accurate and complete data collection. At the end of the process, the information gathered is used to make a diagnosis and formulation, a process with which the patient may have limited or no involvement.

In doctor centred interviews, the routine of data collection varies little from patient to patient. Although the structure of the interview is clear to the doctor, it may be much less clear to the patient, who can experience the interview as jumping from topic to topic. The patient may also struggle to find a chance to impart information they believe or know to be important, which can lead to frustration and disengagement. Although beginners using this technique generally gather the important information to make a correct diagnosis and formulation, they can be swamped by a large amount of information that can be difficult to sort into a meaningful diagnosis and formulation, leading to over-diagnosis of rarities. They may also miss something important to the patient if that item is not on their routine data collection routine.

This strategy is associated with particular techniques:

- funnelling: the cone of open to closed questions
- predominant use of closed questions
- abrupt transitions

Good for:

- Beginners (medical students) who need to learn about the content of the interview
- More experienced practitioners when trying to ensure complete data collection with patients or carers who can give a coherent history e.g. medicolegal reports, diagnostic assessments for autism spectrum disorders.
- As a fall back position when you don’t know what you’re looking for e.g. when aspects of the presentation don’t make sense and you are consciously ‘broadening the search strategy’ (this is sometimes conceptualised following Kahneman (2012) as a switch from fast, intuitive ‘system 1’ thinking to slow, deliberative ‘system 2’ thinking.)

Less good for:

- Time limited situations
- Upset or paranoid patients
- Understanding important patient perspectives - which can limit its utility in complex problems.
- Patients with limited attention spans.
- Patients who do not understand why they are being assessed or cannot provide the answers to many of the questions and then may experience this as if they are failing.
3.2 Patient centred

This strategy collects essentially the same data as a more doctor centred approach but does so in a way that aims to allow the information to emerge in a way that makes sense to the patient. In doing so, other information around the patient’s subjective experience is more likely to emerge in addition.

Because the order of data collection is determined more by the patient, the routine of data collection varies from patient to patient. The doctor uses the interview to begin to work psychotherapeutically right from the outset, exploring connections the patient has made and structuring interventions so that aspects of experience that are puzzling or troubling to the patient begin to make more sense or seem more manageable. At the end of the interview there is a shared understanding of the way forward.

This strategy is associated with particular techniques:

- predominant use of open questions
- use of selective reflection to guide the interview
- use of smooth transitions (transitions that imply a temporal or causal link: e.g. ‘with symptom x, some of my patients have experienced symptom y’)
- transparent structure (use of accentuated transitions)
- exploration of patients’ values, ideas, concerns, expectations and strengths
- the doctor sharing his/her thinking processes in the course of the interview

Good for:

- much day-to-day psychiatric practice, including upset or patients with paranoia
- complex problems

Less good for:

- time limited or urgent situations
- as a sole paradigm in forensic settings where patients may be motivated to avoid certain crucial areas unless directed to them/asked about them specifically

3.3 Task centred: Bayesian inference

Bayesian statistics update the probability of particular hypotheses with each new piece of information. Expert reasoning (in many fields including medicine) tends to use Bayesian reasoning. The doctor makes a differential diagnosis very early in the interview (often even before the interview starts on the basis of the referral). The search for information and questioning strategy is guided by the differential diagnosis and the probabilities attached to each diagnosis, with each question (or test) aiming to increase or decrease the likelihood of a particular diagnosis. Lines of enquiry that don’t alter probabilities are not used. Bayesian reasoning relies on having a bank of (often implicit) knowledge about the likelihood of particular diagnoses. This implicit knowledge is based in pattern recognition and may include ‘soft’ and local amendments to probability (e.g. an urgent referral from a GP whom you know to be very competent with mental health issues who hardly ever refers vs. an urgent referral from a GP whose strengths lay away from psychiatry).

To train yourself to use Bayesian reasoning, make a differential diagnosis on the basis of a referral call or letter. Make sure you include the rare but ‘can’t miss’ diagnoses (high mortality/high morbidity). Rank the diagnoses in order of likelihood. Focus your questioning strategy on questions that will move diagnoses up or down the likelihood ranking. What is the minimum number of questions you could ask to reach a diagnosis with a high degree of confidence in that diagnosis?

Good for:

- time limited situations where a rapid diagnosis and action plan is needed
• expert supplementation of a more junior colleague’s work where that colleague is using a doctor centred approach

Less good for:
• complex problems that can’t be simply put into a medical model framework.

3.4 Blended approaches

In practice, a clinical interview will nearly always use a mixture of these approaches. One common way that they are used together is to sequence them, sometimes called the ‘sandwich technique’. After introductions, an interview might start with a patient centred component, then shift into a more doctor centred component. (‘OK, I have this assessment paperwork I need to fill in with you to get some background’) before finishing with a more patient centred component again (See also the Calgary Cambridge model of Silverman et al. 2005, p.19).

Skilled use of the different approaches also relies on some use of metacognition – recognising which approach you are using and why, and understanding its limits. Many experts combine a Bayesian approach with a forced ‘checking’ or de-biasing of their fast intuitive response by explicitly asking themselves ‘is this the answer I expected? Could anything else be going on here?’
4 Spirit and techniques

4.1 A definition of motivational interviewing

Much of this chapter is derived from motivational interviewing (MI), itself derived in part from Rogerian counselling.

**A short definition:** Motivational interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change.

**A technical definition:** Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.

It originated in the drug and alcohol field but has found many other applications including eating disorders and treatment adherence.

4.2 The underlying spirit and approach

Rogerian counselling (Rogers 2012) is grounded in a belief that a key motive for all people is to self-actualise – to fulfil one’s potential – and that people will flourish if their environment is good enough. Rogerian psychotherapy is based on three key concepts: genuineness, empathy and unconditional regard.

**Genuineness:** having access to one’s own internal experiences, attitudes and moods; to present oneself transparently.

**Empathy** means continually working to understand the patient’s experience from his or her point of view, and to communicate that experience accurately to the patient/client. The way this understanding is communicated matches the client’s mood and content. Empathy is one element of the relational dimension to patient care (sometimes denigrated as a non-specific factor in psychotherapy research) very strongly associated with outcome in some areas of practice (e.g. Moyers & Miller 2013). Note that empathy is not just ‘imagining what it is like to be in someone’s shoes’: it is an active process of communicating one’s perception back to the patient – including not just what has been explicitly stated but what the patient means but has not yet said.

**Unconditional positive regard:** an attitude of basic acceptance of a person whatever he says or does so long as he/she is not causing significant harm. Even if you don’t like the patient or have radically different values, he or she is ‘prized’.

Motivational Interviewing has clear Rogerian roots but lays a slightly different stress (Miller & Rollnick 2012):

**Partnership:** MI is a partnership in which the patient’s experiences, perspectives and expertise are respected. The practitioner provides an atmosphere that is conducive rather than coercive for change. In practical terms, this means a very active power sharing stance with the patient, acknowledging their expertise and seeking to build consensus on tasks or goals.

**Acceptance:** the practitioner acknowledges the patient’s right to self determination and facilitates informed choice. This includes being disinterested (not uninterested) in the outcome for the patient. In practical terms, one aspect of this is that the practitioner specifically supports the patient’s autonomy, highlighting areas where the patient
has a sense of control, freedom of choice or personal autonomy. Conversely, confrontation and persuasion are avoided.

Compassion

Evocation: change is a naturally occurring process; most people make changes in their lives without professional help. MI presumes that the resources and motivation for change lie within the patient.

The general approach is one of quiet, respectful curiosity as to how the patient has got to where they are now. This usually involves paying careful attention to the patient’s values so that they can be supported to live a life closer to those values. This can occasionally be quite challenging when the patient’s values are radically different to the doctors. In Rollnick et al. (2008), this is also described in terms of style: MI uses predominantly a ‘guiding’ style, as opposed to a ‘following’ style (careful, sympathetic listening without providing any answers) or a ‘directing’ (offering advice, suggestions or prescription, maybe even telling someone what to do) style. A guiding style ‘goes down the middle between the other two, combining some of the better qualities of both’ (Rollnick et al. 2008). In this model a competent healthcare professional will use predominantly a guiding style but will switch to following or directing when appropriate.

For more on the importance of the therapeutic alliance and the importance of the quality of therapeutic relationships, see Norcross (2011).

4.3 The core skills: OARS

The core skills of MI are summarised in the mnemonic OARS: Open questions; Affirmations; Reflective listening; Summaries. These are common skills to all client centred counselling styles and are used to a greater or lesser extent in many psychotherapies.

Open questions

Open questions invite answers from the patient that are more than a single word or short phrase.

Explore disadvantages of the status quo: ‘What worries you about your current situation?; ‘In what ways does this concern you?; ‘What do you think will happen if you don’t change anything?.

Elicit advantages of change: ‘How would you like things to be different?; ‘What would be the advantages of making a change?; ‘What would you like your life to look like in five years time?’

Express optimism about change: ‘What makes you think if you decided to make a change you could do it?; ‘Tell me about the people that could help you with this; ‘When else in your life have you made a significant change? How did you do it?’

Seek intention to change: ‘What would you be willing to try?; ‘What do you make of these different options?; ‘What do you think you might do?’

Affirmations

Direct affirmations recognise and prize something in the patient. They may note a trait, an attribution, a strength, effort or worth. They validate the patient’s experience, build rapport and encourage the patient to use the strengths recognised. Good affirmations lock into the patient’s value system rather than the therapist’s: that is, they aren’t generic compliments, praise or cheerleading but highly specific interventions tailored to the patient in front of you (note that agreeing is also different from affirming, be-
cause there is a step away from the patient’s ideas towards the therapist’s ideas).

Aim to affirm ‘away from the problem area’: e.g., noting a patient’s achievements as a parent (in spite of difficulties with alcohol) to build self-efficacy.

**Reflective listening**

Reflective listening is a difficult skill to master. Good reflective listening is empathic and gives the patient the sense of being heard at a deep level. However, the different varieties of reflections can (in skilled hands) simultaneously be used to steer the interview in a particular direction. In MI, the therapist will have a change goal in mind and will tend to prefer reflections that move the patient in that direction (see Strategy: change talk and sustain talk on p24)

**Simple reflection** repeats back what the patient has just said using their own word or a paraphrase. This should be more than parroting back to the patient; the response should ‘pass through you’ and be changed in some way. An example might be ‘if I gave up smoking, it would really benefit my health’ leading to the reflection ‘you see some real advantages in stopping smoking’.

**Selective reflection** repeats back some of what the patient has said. Typically this should be what you perceive as the core issues (earlier on in the process) or change talk (later in the process). Use of selective reflection in this way is an important way of balancing being patient centred but also steering the interview in a particular direction, usually in the direction of the interview’s focus: e.g. ‘I went out last night and had a really good time, we saw a couple of bands and when I got home I just forgot to take my medication’ might be met with ‘it sounds like it’s been a struggle to remember your medication sometimes this week’. The doctor focuses on the issue (here medication concordance) and leaves elements of the utterance that aren’t relevant to it.

**Double sided reflection** reflects the last statement and a previous, contradictory statement the patient has made. You may be able to recast this in terms of a dilemma or ambivalence the patient is experiencing, or build discrepancy by reflecting a value with a behaviour. ‘I think about stopping drinking, but then I think about what my life would be like. What would I do? All my life is based round the pub, my friends that all drink, the darts team…’ Leads to the reflection ‘giving up drinking might mean making some difficult changes for you – and yet it’s still something you’re seriously considering’.

‘Continuing the paragraph’ echoes the last statement and ventures a hunch as to where it is headed. When you’re off the mark the patient will tell you, and this should be respected. ‘My husband is a decent man, he works so hard and always provides for me and the kids, and he’s never hit me or anything…’ could have the reply ‘he’s a good man in very many ways, and yet a part of you still has some doubts’.

**Amplified reflection** (also known as overshooting) repeats back something the patient says in a slightly exaggerated way: e.g. ‘I can’t see myself giving up cannabis’ might produce the response ‘You see yourself using cannabis for the rest of your life’. Use amplified reflection when you hear sustain talk, to invite the patient to correct you to a more understated version of what they just said.

**Undershooting** reflect back something the patient has said in an understated way. Reflections should in general often understate. Use undershooting to invite a response that amplifies the original statement. So a statement such as ‘I didn’t want to come to see you today doctor, but my wife is worried about my drinking’ could lead to a response such as ‘so you don’t think you need to be here – there isn’t a problem with your drinking at all’.

**Complex reflection** involves reflecting back something more than just the words: typically affect but also meaning, values, strengths or direction. As a general rule, aim for accuracy but err on the side of slightly understating the emotional content when
The core skills: OARS

you reflect it; if you overstate the patient may back off and refute the affect. To re-use
the example in the previous paragraph, a complex reflection might be ‘it sounds like
your drinking is becoming a bone of contention between the two of you, and you want
to do something about that’ or ‘so you’re here to keep the peace’.

A tip for trainees for whom English is a second language: for key affects (e.g. anger or
sadness), collect as many synonyms as you can (including informal and slang terms)
and try to place them on a scale of one to ten for the intensity of the feeling. This may
help you find accurate synonyms (including slight over- and under-shoots) when you
need them with patients.

Metaphorical reflections are a particular type of complex reflection that demonstrate
understanding, but may allow a different way of thinking about something that can
allow a patient to feel comfortable with making a shift in how they think e.g. ‘the wind
has changed and you think you may need to change tack’.

Reframing is a skilled type of reflection that relies on the fact that the stories people
tell about themselves often don’t have a completely closed meaning. Meaning can be
opened up by reflecting back with a negative connotation removed or downplayed and
a positive connotation added: e.g. ‘because of my past experiences, I can’t trust people’
could be reflected back as ‘you’ve learned to be cautious in relationships’. The reframe
tacitly switches the frame from damaging traumatic experiences to painful learning
experiences; tacitly opens up the possibility of relationships, rather foreclosed in the
original, universalising, statement; and explicitly substitutes a virtue (caution) for a
problem (lack of trust). A key part of reframing is spotting strengths that might not
have been spotted by the speaker. These strengths may lie in the domains of insight,
creativity, independence, ethical behaviour, initiative, humour or conduct in relations-
ships.

<table>
<thead>
<tr>
<th>Reflection stem</th>
<th>Rephrased version</th>
</tr>
</thead>
<tbody>
<tr>
<td>It sounds like...</td>
<td>You’re not terribly excited about...</td>
</tr>
<tr>
<td>This has been totally... for you</td>
<td>You’re not much concerned about...</td>
</tr>
<tr>
<td>Almost as if...</td>
<td>The thing that bothers you is...</td>
</tr>
<tr>
<td>Like a….</td>
<td>The important thing as you see it is...</td>
</tr>
<tr>
<td>Sounds as if you...</td>
<td>You must be...</td>
</tr>
<tr>
<td>For you, it’s a matter of...</td>
<td>You are...</td>
</tr>
<tr>
<td>From your perspective,...</td>
<td>You... It sounds like...</td>
</tr>
<tr>
<td>Must be...</td>
<td>Sounds like...</td>
</tr>
<tr>
<td>Through your eyes,...</td>
<td>So you’re saying that...</td>
</tr>
<tr>
<td>Your belief/concern/fear is that...</td>
<td>You’re feeling like...</td>
</tr>
<tr>
<td>It seems to you that...</td>
<td></td>
</tr>
</tbody>
</table>

Box 1: Reflection stems

Summary

Use an accentuated transition to announce that you are going to summarise where you
have got to, e.g. ‘let me see if I’ve got this right’. Go on to invite corrections/ additions
(open question), then perhaps use another open ended question, e.g. ‘so; where do we
go from here?’

The skill in summary is choosing what to put into the summary and what to leave out.
Remember that summaries need to be briefer with patients with difficulties with sus-
tained attention. Summary is also a great technique to use when you don’t know what
to say next or think you may have forgotten to ask something vital!
5 Strategy, structure and tactics

5.1 Strategy: change talk and sustain talk

Ambivalence

Ambivalence is the coexistence in a person of two competing urges, wishes, values, beliefs or aspirations. It is sometimes called the ‘conceptual anchor of MI’.

Ambivalence is a normal part of human existence and in particular is often present in the early stages of contemplating change before the person is ready to make a change: for example someone who is drinking but has signed up to talk to an alcohol counsellor, or someone that is contemplating leaving a job but has not yet done anything about it. Typically, people feel stuck between two courses of action and often feel unsettled or uncomfortable about this. Ambivalence can paralyse behaviour or cause repeated oscillations (throwing cigarettes away at 8 o’clock in the morning, sorting through the bin to find them that evening).

There is a ‘self correcting’ element to the human psyche so that (for an ambivalent person) if you provide the arguments for change, they will respond with the arguments for the status quo. The more unfortunate patients find themselves labelled ‘resistant’ for exhibiting this kind of behaviour.

For the practitioner, this means that issues associated with ambivalence need to be handled with particular care. Typically, if the doctor provides arguments for change, the patient will respond with arguments for not changing, from which it is a short step to arguing with the patient. A better outcome is when the patient provides the arguments for change themselves, as people are generally better persuaded by the arguments they make themselves: so MI suggests that the doctor’s task is to help the patient to articulate and strengthen the arguments that work in favour of change. This is at the heart of the difference between Motivational Interviewing and other forms of counselling: it is overtly directional. The directionality comes from the response to change talk, talk that favours change in a particular direction. This means that in MI one must have a clear idea of a focus that is the topic for conversation.

In linguistic terms ambivalence can be thought of as an utterance with a mixture of change talk and sustain talk. There are different strategies for responding to both of these.

Change talk

The patient expresses disadvantages of the status quo, advantages of change, optimism for change or intention to change.

There are five main types of change talk, summarised in the acronym DARN-CAT: Desire, Ability, Reasons, Need, Commitment, Activation, Taking steps. Activation is preparatory steps towards changing (not necessarily yet embodying change); taking steps is experimentation with making a change without actually committing to it.

Some research (Amrhein et al. 2003.) suggests that commitment language predicts change more than anything else. However, encouraging ‘DARN’ is important because it shifts people towards commitment.
Change talk often arises naturally in conversation with the patient, typically mixed in with a lot of sustain talk.

When you hear change talk, don’t let it go by! Respond by:

- Asking for elaboration and examples: ‘What…?’, ‘How…?’, ‘Tell me about that’

Follow your curiosity.

- Affirm change talk: ‘I can see you’ve thought carefully about this’. Affirmation may be the single most important intervention in eliciting more change talk (Apodaca & Longabaugh 2009).

- Reflect change talk. This should be selective.

- Summarise change talk: your summary might include things the patient has said, the affect with which it was said, objective evidence of a problem (e.g. liver damage in a drinker).

Where change talk does not arise spontaneously, direct what you say at eliciting it: ask evocative questions such as ‘In what way does that concern you?’, ‘What might you do about that problem?’ Look for problems with the target behaviours, concerns, willingness and optimism.

Desire: ‘I really want to stop drinking’
Ability: ‘I can do this... it is possible’
Reasons: ‘Whenever I stop taking my medication, I end up in hospital’
Need: ‘I need to stop going on benders, it’s wrecking my marriage’
Commitment: ‘I am definitely going to stop drinking’
Activation: ‘I’ve joined a gym’
Taking steps: ‘I had a day last week when I didn’t drink’

Box 2: Change Talk (DARN CAT)

SUSTAIN TALK

The patient lists the advantages of the status quo or the disadvantages of change; or expresses intention not to change or pessimism about the possibility of change. In some research, sustain talk is more predictive of (lack of) change than change talk (Magill et al. 2014), suggesting that it is particularly important not to elicit sustain talk unnecessarily (e.g. by asking about obstacles to change).

Motivational interviewing suggests moderating change talk when it occurs and being cautious about eliciting sustain talk.

- Use reflective listening statements
- Emphasise personal choice
- Agree with a twist: reflection with a reframe.

As a general rule, aim not to elicit or reflect sustain talk. There are, however, times when working with sustain talk is necessary. A typical example is working with a very suicidal patient where it may be necessary to talk about suicidality in order to ‘come alongside’ the patient. Think of this as working on the engagement between you and the patient: reflect some sustain talk in the service of building and maintaining a relationship. When you have a relationship, then try to open up choices for the patient again. Often, the way back to change talk is through picking up on a paradox or discrepancy in what the patient has said and using this as a route back to change talk.

Unless you find a way to empathise with something other than sustain talk, it is easy to get trapped in a spiral of negativity. Short runs focussing on sustain talk are ok; longer runs will invariably be problematic.
Neutrality

Neutrality is a conscious decision by the therapist not to influence ambivalence one way or another - that is, not to try to influence the patient’s choice in a particular direction. MI originated as a strategic intervention to move a patient towards a particular goal (e.g. stopping drinking), but can be used in situations where the therapist may intentionally stay neutral (e.g. a woman deciding whether to have children). In this situation, the decisional balance tool can be a helpful approach (page 35).

Strategy: discord (resistance)

Sustain talk is part of the patient’s ambivalence, and it isn’t necessarily interpersonal. If things aren’t going well, sustain talk can shift into dissonance, which is interpersonal: resistance has been called ‘ambivalence under pressure’. Note that the term ‘resistance’ was replaced by ‘dissonance’ in the third edition of Miller and Rollnick. The reason for this is that ‘resistance’ located the problem in the patient, which is both inaccurate and unhelpful: dissonance locates the problem in the relationship, which is both more accurate and a better guide to responding to it. Dissonance indicates an absence of collaboration between doctor and patient: arguments, disagreements, friction, minimising (‘there is no problem’). Dissonance represents and predicts movement away from change. It is related to the concept of high Expressed Emotion which has been repeatedly shown to be associated with poor outcome in a range of diagnoses.

Dissonance often conceals feelings of embarrassment, shame, guilt, or loss, and with that assumptions about how you fit into the patient’s relational schema. Behind patient anger is often fear of judgement, labelling, loss of freedom - i.e. worries about your response to their situation.

When dissonance arises, change approach and ‘roll with it’:

- Use reflective listening statements (especially complex reflections: ‘follow the affect’)
- Shift focus: move to safer ground
- Apologise if appropriate
- Emphasise personal choice
- Reframe
- Align with the status quo (paradox)
- Agree with a twist: reflection with a reframe.

The key message is that when dissonance arises, it is a signal for you, not the patient, to do something different. Pushing against resistance entrenches it (note that although ‘rolling with resistance’ was dropped as a term by Miller and Rollnick, the college haven’t caught up with this as yet: it still sometimes appears in the exam!).

Dissonance can be triggered by some practitioner behaviours. In the Motivational Interviewing Treatment Integrity (MITI) (Moyers et al. 2014) schedule, MI non-adherent behaviours are defined as persuading and confronting:

**Persuading** occurs ‘when the clinician makes overt attempts to change the client’s opinions, attitudes or behaviour using such tools as logic, compelling arguments, self disclosure or facts (and the explicit linkage of these tools with an overt message to change...[also] if the clinician gives biased information, advice, suggestions, tips, opinion, or solutions to problems without an explicit statement or strong contextual cue emphasising the client’s autonomy in receiving the recommendation’ (note that persuading with permission is coded differently in the MITI 4.2: see Moyers et al. 2014).

**Confronting** includes ‘directly and unambiguously disagreeing, arguing, correcting, shaming, blaming, criticising, labelling, warning, moralising or questioning the client’s
honesty. Such interactions will have the quality of uneven power sharing, accompanied by disapproval or negativity.

Research tends to suggest that patients of clinicians using these types of behaviours have worse outcomes.

**A good apology can save a therapeutic relationship and build trust.**
1. Express regret
2. Admit responsibility (empathise: demonstrate an understanding of how the other person feels)
3. Make amends (including how you will make sure it won’t happen again)

From Allan et al. 2015

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**5.2 Structure: four processes**

Motivational interviewing conceives of four overlapping processes, engaging, focussing, evoking and planning. The processes are ‘somewhat linear’ in that engaging necessarily comes first and focussing (identifying a change goal) is a prerequisite for evoking. Planning is a logically later step. Yet they are also recursive in that engaging and re-engaging continue throughout the process. Sometimes engagement can happen very quickly and it can seem like the conversation moves rapidly to evoking or planning.

**Engaging**

Establish a working relationship in order to create the psychological safety the patient needs for help. The first task within this may be resolving ambivalence about the helper. The first meeting with a patient can be difficult because process tasks are dressed up as content tasks. Although one asks about the presenting complaint, the real task for the patient is often addressing the patient’s first unspoken dilemma: is this person safe enough for me to trust with my problem? Often, this dilemma appears as ambivalence about the helper.

In a sense, although the content at this stage may be about change or ‘getting a history’, the task is particularly process focussed: in getting to know the patient be artfully vague and treat avoidances and ellipses on the patient’s part as legitimate ways of protecting their sensitivities. If people are pushed for specifics too early, they sometimes protect themselves by misrepresenting themselves, which can then be hard to back track from later.

Skills to use include the typical day (see p31) asking permission, giving a menu of options.

**Focussing**

The focussing phase is about finding a clear direction and goal when it might not be clear from the outset. What is the particular goal for change in this patient? For some patients, it may take many weeks to get to this point: for some, you will be there in the first minute of the first session. Negotiating a goal so that there is consensus between doctor and patient, and then keeping the patient on task in talking about the goal (without eliciting dissonance) is predictive of a good outcome.

There is something of a continuum in this stage: there may be a single clear topic of focus from the outset; there may be multiple issues that need prioritising through agenda setting; or the issue may be unclear, in which case the first task is to clarify
what the issue or issues are.

One of the skills of focussing is making the organisation of the interview overt for the patient (‘signposting’), so he or she feels safely guided through the process. At times this will be more overt, at other times it can be more implied: a patient with cognitive impairment or one with autism may need you to provide more overt structure, a cognitively intact but very upset patient may need you to be more flexible and free form.

9. Clear focus

If a patient has decided they need help, and has some ideas about what this might be, exploring ambivalence can be actively harmful: move rapidly to evoking. Occasionally, there may be less clarity than is first apparent and you may sometimes need to shift to clarification.

10. Agenda setting

See page 30.

11. Clarifying

Sometimes, a change goal isn’t immediately apparent. It is helpful to think of clarifying as a two stage process, starting with neutral exploration and moving on to expanding understanding.

In neutral exploration, the task is to explore the client’s view, without changing anything, so as to create a common understanding of the starting point for any change effort. The key interventions are simple reflections. In someone with a very polarised worldview, this may take some time: use lots of summaries and reflections (two simple for every one complex) before attempting anything like a reframe. If there is dissonance, drop back to the task of establishing a working relationship. Other skills to use include typical day, and good things and less good things.

When expanding understanding, the task is to gently introduce alternative viewpoints. Discrepancy, ambivalence and dissonance may all be part of the interaction with the client at this stage because the client’s perspective is challenged. Listen hard for the DARN-CAT statements pointing to change goals. Often people get stuck because of a restricted understanding of the situation or a narrow repertoire of solutions. Use complex and metaphorical reflections. Use reframes, e.g. reflect ambivalence as an ability to see things in more than one way. Use information exchange. Prepare the ground for those not ready to change.

When expanding understanding, if you hit dissonance, drop back to neutral exploration.

Skills to use include good things and less good things/decisional balance, looking backwards and forwards, using third party perspectives (e.g. ‘what does your wife make of all this?’) talking about other patients (‘Other patients I’ve known in your position have thought about x. How would you feel about that?’).

**Evoking**

This phase is where the strategic focus comes to the fore for you as therapist as you focus down and guide the patient to the particular goal identified in the focussing stage. Summarise the patient’s perception of the problem, perhaps acknowledging ambivalence and including acknowledgement of the positives in the status quo.

Motivation is driven by a discrepancy between a person’s goals and his/her present state. Clear goals are an important part of instigating change. Patients’ core values may feed into both sides of their ambivalence, e.g. a clash between loyalty to drinking
friends and loyalty to family. Nevertheless, explicitly recognising the value at stake can help people move towards change. If these goals surprise you or seem misguided, stick with the patient’s goals as much as possible. Try to relate the proximal goals to the patient’s broader life goals and guiding values. If the goal seems unrealistic (e.g. for someone with a ten year cocaine habit and few social resources to ‘just stop’), consider using open questions to explore the possible consequences of a given course of action. What might be good and what might be less good, about achieving this goal? Aim to support the patient towards a more realistic plan consonant with their values.

At this stage, the strategic and directional parts of MI really come into play: selective eliciting, selective responding and selective summaries. Elicit and reflect change talk (‘DARN-CAT’). ‘You said…What does that mean to you?’ ‘How would you like things to turn out for you now, ideally?’ ‘What happens next?’

Other skills to use: good things and less good things/decisional balance, looking backwards and forwards, inviting third party perspectives, two futures (‘what would your life be like in five years time if you made this change? If you didn’t?’), importance and confidence rulers, miracle question (or the three wishes/winning the lottery questions). Now can be a good time to normalise ambivalence. Perhaps use a summary and invite the patient to step outside him/herself: when you look at yourself, what do you see? If you were giving yourself advice right now, what would you say?

Planning

Generate choices with the patient. One way to do this is to brainstorm; this process should quite explicitly include outlandish ideas. The aim is to generate a good list of possibilities without prematurely evaluating them. If an option elicits a resistant response, reflect this and reiterate that this is only a creative list of options. Draw on the patient’s own, natural resources and supports in making the list. Respond with reflective listening, emphasising change talk, personal responsibility, freedom, choice. You may want to use a decisional balance exercise about different options. You can do this with your patient or give it as homework.

Identify potentially useful choices with the patient. Skills to use include:

- working with a menu of possible solutions with good and bad points rather than working towards a perfect solution, so that the patient chooses options rather than refutes suggestions.
- Give information, particularly around any evidence in respect to the choices.
- Consider the change options.

Summarise the patient’s plans; consider drawing up a written change plan with bullet points of actions to be taken.

Try to elicit the patient’s commitment. Having drawn up the plan ask the patient if this is what they want to do. If they are cagey or ambivalent, you may have some more work to do first. Don’t press for commitment if it isn’t there. Commitment can be enhanced by making it public or shared, e.g. with a spouse (this is a less good strategy in families with high levels of expressed emotion).

Valuing small changes is important at this stage. Some patients may come out with a plan to cut down drinking, start going to AA and begin taking their antidepressants regularly. Others may only be able to commit to thinking about change and coming back to talk some more. Both are positive steps warranting affirmation. Even a restricted, limited short term plan can help the patient avoid high risk situations; and change tends to produce more change.

The planning stage is often the time to incorporate other skills that you may have, such as pharmacotherapy or CBT, into your work with your patient. It is also the time that
the patient should be encouraged to use your knowledge and for you to give advice.

In planning with the patient, in your own mind have three ‘treatment trajectories’ in mind:

- This session
- The patient’s current contact with services or treatment episode
- The patient’s ‘lifetime career’ with services

This model can help you prioritise your treatment goals for the patient. In particular, use the three trajectories model to consciously consider what you want to address and what you want to ‘park’ for the next session (days or weeks away) or even for another treatment episode. For example, when admitting a patient at 2am with whom you have no ongoing contact, your session goals are likely to be different from admitting a patient for your own team at 2pm. It is quite legitimate and probably preferable at 2am to do the minimum to keep staff and patient safe and to defer (for example) a detailed history of abuse. This can be picked up by the patient’s own team and can be dealt with carefully, quietly and sensitively over time when both patient and doctor are rested.

5.3 The short form tactics (structured therapeutic tasks)

The short form tactics are various ways to help you keep track of a therapeutic conversation, to structure it and keep it focussed on the therapeutic goal. They tend to be helpful when time is short or the objective is clear.

**Agenda setting**

Agenda setting is a structured conversation in which a number of different discussion topics are identified before a conversational focus is agreed. Agenda setting allows a collaborative process for identifying the focus of conversation; it avoids the dangers of premature focus on the first topic raised; and enhances the efficacy of the clinical encounter (Gobat et al. 2015).

The traditional skill of agenda setting is probably better thought of as a two stage process of agenda mapping and agenda navigation. Guiding (p21) is involved in both of these processes: i.e. your expertise is put at the service of the client’s own interests, goals and values. When focussing on individual topics, it is important to stay focussed ('topic tracking') and not drift to a different topic before the one under discussion is resolved.

1. **Agenda Mapping**

First, map an agenda with the client by eliciting all the concerns they may wish to discuss, without beginning to discuss the individual items. A good question to start with might be: ‘how should we use our time today?’ List the items, or arrange them in blobs drawn on a piece of paper. Try to draw out all of the patient’s concerns (‘what else would you like us to cover?’). Demonstrate understanding by reflective listening. Ask for a brief elaboration on each agenda item raised. If possible, try to reframe ideas located in the person’s character to locate them in their behaviour e.g. ‘I started drinking again. I’m such a failure’ becomes ‘you’ve really struggled with staying dry this week’.

If necessary (and with permission), add one or two items that you perceive as being important or that have come up in previous sessions.

Second, consider exploring the agenda in broad general terms, particularly looking for the client’s ideas about how the different items relate. Some useful questions are:
'What thoughts have you had on what these different concerns have in common? What themes have you noticed? If you were to say one thing was the root cause of all these different concerns, what ideas come to mind? If someone who really cares about you was describing you, how might they explain the connection between these different concerns? This may help begin the process of winnowing down a large set of problems into one fundamental source. Try to keep an attitude of open minded curiosity about how issues relate.

2. Agenda Navigation

Once you have generated a shared agenda (list of items), work towards establishing a shared focus. Explicitly consider options with the patient using reflective listening and asking specific questions.

Use the agenda document as a framework and plan for this and future treatment sessions. You may need to help the client prioritise multiple goals. Sometimes it is worth encouraging the client towards a lesser but achievable goal first rather than a more important but challenging goal. The agenda document can also be used this way both as a method of parking and holding disagreements and as a 'container' for anxiety around difficult issues, e.g. 'OK, so we’ll spend today looking at your housing as that’s clearly your number one priority, and we’ll leave looking at your drug use for another time'.

Skilled navigation round the agenda using a guiding style can foreground issues that are clearly important (e.g. drug use) even when these are not initially prioritised by the client. Navigation round the agenda can be an iterative process as the client comes to trust you (and may be prepared to talk more about issues initially rejected). In time, you may also see the sense in some of the client’s priorities that you had initially not appreciated. Using agenda navigation in this way can help both you and your client ‘sit with’ uncertainty about aspects of their problems that can’t be resolved immediately.

3. Topic tracking

Within the session, use the agenda to maintain focus on the identified topics. Mauksch et al. (2008) suggest that there are three skills in topic tracking: summarisation, process transparency (describing the interaction) and goal alignment (confirming agreement on the topic focus).

Typical day

The ‘typical day’ technique was developed for practitioners that are often given a long assessment schedule to complete in a relatively short space of time. In this situation, practitioners often feel a conflict between the needs of the organisation and their wish to work in a client centred style. Using this technique often allows the capture of a lot of information in a fairly client centred way, by focussing on a typical day rather than on a typical episode or problem. It works best by staying curious and resisting the urge to investigate. It also relies on the practitioner knowing their assessment schedule very well, to allow the assessment to be fitted into the interview and not the other way round.

1. Set the scene clearly

E.g. ‘I have a lot of questions to get through here, but it often works better if I put all those to one side and we spend five or ten minutes talking through a recent typical day in your life. I’ll probably have to go back to the form to fill in the gaps at the end and maybe ask you a bit more about your drinking. Is that OK?’

2. Locate a day

‘Can you think of a recent day that was fairly typical for you, an average sort of day?’
Use this to ‘hold’ the conversation if the client drifts off topic.

3. **Go through a ‘typical day’**

Use reflections and summaries to guide and to speed up or slow down the progress through the day if the account is too detailed or too general. In your reflections and questions, focus on both behaviour (‘what happened then?’) and feelings (‘that sounds hard’).

4. **Check if the client wishes to add anything**

5. **Ask any questions of your own.**

6. **Go back to the assessment schedule**

Fill in the gaps, or do it later on.

**Importance and confidence**

People change when they feel the change they have to make is important and that they themselves are confident to make it. People can feel a change is very important (but lack confidence in making it); or they can be very confident in the possibility of change (but not feel that changing is important); or they can feel the change is both unimportant and that they lack the ability to make the change.

It is important to focus on the dimension of change that is low e.g. there is no point asking about importance if it is already high but confidence is low.

Ask the client to rate their confidence in making a change on a scale of 1 to 10 (or use a visual scale on paper). Then explore below the number: ‘why are you a five and not (say) a four or a three?’. This question typically elicits self affirmations, strengths or stories of past obstacles overcome. Lastly explore above the number: ‘what would it take to lift your confidence to maybe a six or seven?’ At this stage, keep the number only one or two above the value the client offered. This question typically elicits change talk.

The exact form of the questions is important. Ask why a five and not a six and you will elicit negative self evaluations. Ask what it would take to move from a five to a four and you will elicit sustain talk.

A similar set of questions is used for importance.

Change talk rulers can give you a rough and ready guide to one aspect of navigating your session with a patient. 15mins from the end of a 50 minute session, if both importance and confidence are >5, move to trying to elicit a change plan. If not, focus on building importance and confidence.

**Information giving (ask tell ask)**

When giving information first ask the patient: ‘what do you know about...’; then ask permission to add more information; then give the information; and lastly check what sense the patient has made of it. Do this by explicitly asking an open question or asking the patient to repeat back what they understood. ‘Have you got all that’ will invariably be answered ‘yes’ whether the patient has understood or not. You may wish to consider the ‘teach back’ technique where the patient is asked to ‘teach’ the information back to you.

Some rules of thumb:

- Try to elicit everything the client knows before giving information.
• Establish the patient’s preferences for information (amount, format)
• Always try to ask for permission before giving information. This means being prepared to be rebuffed if the client says no. For times when you really must give the information and don’t want to ask permission (e.g. if the information is safety critical or if you are required by law to give it), don’t ask for permission: give the information but give the client permission to disregard it, e.g. ‘I have to tell you about what the law says about drinking and driving. It’s up to you what you do with the information I give you, and you may choose to ignore me altogether, but I have to tell you’.
• Give information in small chunks only. One to two sentences at a time is often enough, then check in again, before providing more.

**Two futures**

Invite the client to consider two possible futures, one in which the target behaviour continues, one in which the behaviour stops or moderates. ‘Let’s look forward five years. Where do you see yourself if you carry on drinking? And if you’ve stopped it?’

**Best and worst things**

‘What are the best things that might happen if you make this change? What are the worst things that might happen if you didn’t?’

**Decisional balance**

In older accounts of MI, the decisional balance exercise was commonly recommended. Current best practice suggests restricting the use of the decisional balance tool to situations where the practitioner is neutral about the outcome of the discussion (therapeutic equipoise or neutrality) – i.e. where there is no behavioural goal (Miller & Rose 2013). The disadvantage of using a decisional balance tool when there is a clear change goal is that it elicits sustain talk in two of the four quadrants. This is likely to be unhelpful.

The decisional balance exercise essentially invites the patient to consider the pros and cons of continuing the target behaviour and the pros and cons of stopping it. There are different ways of doing it: One can use two columns for the two courses of actions. Some people use a two by two grid with advantages and disadvantages on one axis, and different courses of action along the other.

It can be useful to ask the patient to mark the most important reasons in each column.

Remember that it is normal for some of the most powerful arguments to be strictly speaking irrational. It can be helpful to be explicit regarding that as some patients feel they are going mad when they are expressing strong, clearly contradictory feelings.

The decisional balance is potentially harmful when...

• The patient has already made a decision.
• When the clinician has a clear goal (e.g. reducing alcohol consumption) in mind and the exercise could elicit sustain talk.
• When the person has no choice or no alternative.
• When the person needs to minimise a dilemma to cope with a difficult situation.
• When exploring ambivalence might lead to overwhelming emotion.

**MI sandwich**

Some practitioners worry that it is difficult to combine a patient centred, MI consistent approach with tasks in their job that require them to be extremely directive, such as dealing with a mental health act assessment that will lead to a compulsory admission.
This is a very legitimate worry: the two facets of the role are hard (but not impossible) to combine fluently.

The MI sandwich is a simple model of integration of the two aspects of the practitioner’s role. The practitioner starts with an MI consistent approach; clearly switches into a more directive mode; and then switches back into a more MI consistent phase again. For example, the practitioner might ask about the offence that has led to the recall; inform the client that this has led to a recall; ask the client how the practitioner can help best at this point.

6 Beyond the basics

6.1 Some rules of thumb

Rules of thumb function as useful guides to practice for beginners, as safety net for the intermediate practice and as a bridge to expert practice. These rules of thumb can be used as fall back techniques in situations that may feel difficult and they work a lot of the time. There is no compulsion to use them, and indeed, you may well consciously choose not to use them as you get more confident. If the interaction with the patient is getting sticky or not moving the way you want, they may help.

If you come up with other good rules of thumb, please share them.

I don’t know what to say next!

Try a summary (by the time you’ve finished, you’ll know what to say next or the patient will), or simply ask ‘what else?’.

The patient is ambivalent and I don’t know where to go with it

Sometimes it’s ok to tread water and not try to move things forward. Be content with some simple reflections before you start swimming again and trust the patient to work it out.

This change talk sounds fake!

Sometimes patients know what they are expected to say and come up with pseudo change talk that doesn’t have the ring of truth. Sometimes change talk is profoundly unrealistic, almost to the extent of being a fantasy. This is very difficult to handle. Be careful not to be judgemental or challenging. It may be helpful to build a reflection around values as a way of nudging the patient to speak from the heart.

Sometimes pseudo change talk reflects some anxiety about the conversation and in particular about how the patient thinks you are going to react to something.

This feels really stuck!

It’s often helpful to treat this as counter-transference: you are getting a taste of how the patient is feeling (and maybe has been feeling for months or years). Make a reflection based on this. Another way of thinking about it is to think that arousal levels are too high and you’ve got into cognitions too quickly, so making an intervention on the basis of how the patient is feeling rather than what they are thinking may be more productive.
I really need to say something clever here…maybe a values based double sided complex reflection…making sure the change talk is second…

For some people (not all), a self-imposed pressure to try to be clever is one to monitor. Sometimes it means that things are getting too technical and it’s a signal to re-connect with the patient on a relational level.

Responding differentially to change talk (CT) and sustain talk (ST)

One simple rule is to respond to ST with a simple reflection and CT with a simple reflection followed up by a complex reflection.

Mirroring

Mirroring refers to matching one’s own body language to that of the patient. Many people do this unconsciously, and it is certainly something you will spot skilled communicators doing. For those who are consciously trying to incorporate mirroring into their practice, one rule of thumb is ‘match for empathy, mismatch for change’. If a patient is highly aroused and pacing round the room, this isn’t an opportunity to mirror! Instead, try to lead in being more calm, more still and perhaps even smaller than the patient.

When in doubt…

…try to ‘see the person’.

6.2 Boundaries

Professional boundaries include the following dimensions (Gabbard & Crisp-Han 2010):

- Location
- Time (length of the session)
- Confidentiality
- Gifts and donations
- Professional role (the psychiatrist is not a friend, lover, parent or business partner)
- Clothing and language—provocative or too casual clothing, just like crude language, may cause the doctor to appear unprofessional
- Physical contact—hugs and/or kisses can be interpreted as sexual even if the doctor’s intent is otherwise
- Prohibition of any sexual contact whatsoever
- Avoidance of dual roles—one must avoid business relationships or other complications so that one is only the patient’s psychiatrist and nothing more
- Excessive self-disclosure (see below).

Gabbard describes the twin perils of boundaries as thinking that boundary violations only happen to other people, but also acknowledging that flexibility is essential in psychotherapy. There is often a difficult judgement call to be made, which is why supervision is essential. Gabbard also provides the useful heuristic that anything the supervisee is tempted not to take to supervision or conceal from his or her supervisor is probably the thing that most needs to be taken to supervision.

Gutheil’s (2011) distinction between boundary crossing and boundary violation is very helpful in capturing one aspect of the difficult distinction between permissible and harmful transgressions of boundaries. A boundary crossing is a departure from the...
usual norms of therapy in a way that is ‘harmless, [...] non-exploitative and may even support or advance the therapy’. These are contrasted with boundary violations which are typically exploitative or done for the therapist’s benefit and have the potential to do harm.

6.3 Self disclosure

A historic perspective on self disclosure

Traditionally, many therapists urged restraint in self disclosure, typically promoting therapist neutrality and arguing that the therapist who answers personal questions ‘robs the client of an opportunity to explore the feelings and fantasies that gave rise to the question’ (Kahn 1997 pp148-9). Psychoanalytic psychotherapy in particular taught that the more a client knew about his or her therapist, the less ‘pure’ the transference.

This began to change in the last part of the twentieth century, particularly following the influence of humanistic therapists. The traditional psychoanalytic ‘blank screen’ was seen both as an impossible ideal and as actually being rather unhelpful. Self disclosure and transparency were seen as being a component of the therapist’s real human presence and genuineness.

Disclosures of immediacy

A useful distinction is between disclosures of immediacy and more factual/historic disclosures about the therapist’s life. Disclosures of immediacy (also known as therapeutic impact disclosure) focus on the here and now process of the therapy, on the therapists feelings or thinking in the moment. As a general rule, these are safer disclosures to use. In particular, they can make very effective lead-ins to questions:

Disclosing uncertainty: ‘I’m puzzled by your reaction. Can you help me understand what you mean?’

Disclosing different perspective: ‘I suppose I do see things slightly differently. What has led you to your conclusions?’

Disclosing confusion: ‘I’m having difficulty following this. Can you tell me more about...’

Disclosures of immediacy include admission of error. If you realise you have made an error (e.g. interrupting, criticising or failing to follow the patient’s lead), it is almost always worth admitting the error.

Factual/historic disclosures are often harder (but not impossible) to use. ‘I also had weight problems. I went to weight watchers and lost three stone! Might that work for you?’ risks belittling the patient’s own struggle and setting yourself up as an expert source of answers and solutions, perhaps to be refuted with ‘yes, but’.

Guidelines for factual/historic forms of self disclosure

1. Overarching principles

Self disclosure can be a powerful technique and should be part of your repertoire. It must be used with the patient’s interests firmly in mind, and it should be used sparingly (perhaps 1% or less of interventions). Some authors consider its potency as an intervention to be related to its infrequent use: therapists who over use it can be perceived as having tenuous boundaries and too frequently to be shifting the focus of the therapy away from the patient. Conversely, therapists who never use it can come across as cold, distant or withholding.
2. **Timing for the therapist**

Beginners often feel cautious or even nervous about self disclosure. This is legitimate: if you don’t yet feel comfortable about self disclosure, don’t do it. One important timing issue is to restrict self disclosure to resolved personal issues and to avoid issues that are ‘live’ for you in your personal life. In these areas, you may lack the objectivity to be truly helpful to the patient.

3. **Safety for the therapist**

Although doctors have a duty of confidentiality to their patients, this isn’t reciprocal. What might the patient do with the information you share with them? Once you tell, you have lost control of that information. Are you happy to have what you tell your patient passed on to other patients? Or that they join a club/gym/church where you are a member? There are appropriate boundaries to your personal history and safety aspects must be considered if the patient might attempt to contact you outside work.

Be particularly cautious around issues such as your own drug or alcohol use as some answers could have GMC implications. This is one question it is worth anticipating and having a prepared stock response to, as many drug and alcohol clients will ask. Some options:

- **Reflection:** ‘it seems important to you to talk to someone with first hand experience of drug use’.
- **Evocative questions:** ‘if I used cannabis, how would you answer? And if I didn’t, how then?’
- **Statement of boundaries:** ‘I’ve learned the need to keep aspects of my work life separate from my personal life, and I’m afraid the answer to that question lies firmly in my personal life’.

There may be times that a degree of self disclosure is inevitable and may invite questions from the therapist - pregnancy is one example, a non-UK accent or obvious physical incapacity are others. Again, it is worth anticipating and preparing a response.

4. **Timing for the patient**

Beginnings and endings can be more appropriate times for self disclosure. The patient may have legitimate questions at the beginning of an episode of care around professional issues, qualifications and experience. Similarly, close to discharge, it may be appropriate to use self disclosure to facilitate termination and to shift your relationship to allow the patient to view you as a ‘real’ other person and not simply their doctor.

5. **Ask yourself: what do I hope to achieve?**

Some possible strategic goals in self disclosure are: to provide information, to enhance the perceived similarity between therapist and client, to model behaviour, to offer patients different ways to think and act, to strengthen the therapeutic alliance, to normalise and validate patient experiences, or to meet clients’ desires that therapists disclose (Knox & Hill 2003).

As a general rule, when considering whether to use self disclosure, it is worth thinking about whether your goals could be achieved with a different intervention, and if so, to use that. Hinkle (n.d.) suggests thinking in terms of a limited self disclosure allowance that you spend carefully and wisely.
6. **The three second rule**

Generally, after making a self disclosure, return quickly to a patient focus. Hinkle (n.d.) uses a basketball analogy: ‘a player who steps into the marked area closest to his/her basket can only stay there for three seconds at a time. Make your move in the shortest time possible, and get out. Get the focus back where it belongs: on the client’.

7. **Alarm bells**

Consider the patient’s likely response. Might they respond with admiration, jealousy, approval or increased respect for you? Might this response be gratifying to you? Or is your response there to demonstrate how genuine and congruent you are? These are signs that self disclosure might not be the best approach to use.

If you find yourself wanting to make a self disclosure but thinking it is something that you might pass over in supervision or not note in the patient’s records, this is a signal that it probably isn’t the intervention to use.

8. **Keep it light**

Although self disclosure is an intervention to be used sparingly, try not to ‘make a fetish of not talking’ about yourself (Kahn 1997, p.150). Some enquiries really are just polite conversation. Sometimes (e.g. beginnings and ends of a session) a brief enquiry as to whether you enjoyed your holiday or that your cold is better may be perfectly appropriate on the patient’s part and merits a brief polite response before getting down to work. Refusing to answer such questions can anger and frustrate a client, not least as it unnecessarily reinforces the unequal nature of the power balance of the conversation.

For an alternative view on self disclosure, see (Yalom 2013).

6.4 **Silence and pauses**

**Theory**

The use of silence in communicating with patients is a difficult skill to master and often creates anxiety in beginners. Curiously, there is little literature on how to use silence well and beginners are often caught between discomfort with silence and using it too much as a way of managing anxiety (Hill et al. 2003). Such theoretical literature as there is gives conflicting advice and is often based on psychoanalytic theories rather than empirical evidence (e.g. (Lane et al. 2002). What does seem certain is that psychotherapeutic speech is different to ‘normal’ speech, where, in English at least, there is an intolerance for sustained gaps between speakers. When one speaker finishes, the other normally considers this an invitation to speak, and there are various ways of accepting the invitation that fill the silence even when reaching for something to say (‘ummmm…’).

Summerson Carr (2013) distinguishes the pauses that a therapist may make in his or her own speech with those that come between speakers and regards them as typical of the ‘poetics’ of motivational interviewing, particularly identifying pauses that practitioners use such as ‘post infinitives’ (‘to…understand’), after ‘and’ and before subordinate clauses.

Levitt (2001) used a grounded theory approach to divide silences into three categories (productive, neutral and obstructive) with a number of subcategories in each. For example, productive silence might be emotional (accessing or experiencing emotion), expressive (e.g. articulating ideas) or reflectively (e.g. Making connections, or gaining insights). Obstructive silence includes both disengaged silence (avoiding emotion or withdrawing) and interactional silence (e.g. uncertainty about the task or comment).
When to pause

Don’t be afraid to take a little time to think what to say, even if this feels a little unnatural to begin with. It almost certainly feels longer to you than it does to the patient.

Well done, ‘evocative empathy’ allows patients to talk even without questions. If the patient pauses, don’t rush to fill the silence with a question: let it hang for a moment. Sometimes the patient is using the silence to think or explore or assimilate something, and your need to keep the chatter going will stop these processes’ (Martin 2011, p.29). View periods of silence as ‘active moments’ rather than awkward gaps and try to feel your way in to what is happening for the patient. Sometimes this kind of pause is easier to do when you have a decent relational foundation with the patient.

Sometimes it is worth pausing after a reflection (particularly a complex reflection) to let the patient digest it for a moment.

Ending an awkward pause

Try reflecting the process. ‘Finding the right words is hard’ or ‘it sounds like you’re drawing a blank on where to go next’.

It’s important to try to keep these responses calm and benevolent: silence can sometimes feel a little persecutory for the practitioner too, and that feeling is not one to put into the reflection.

Ask the patient what is going on for them, especially if you sense the pause is driven by disengagement or avoidance of difficult emotion.

Sometimes a patient generated pause will be born from shame: the patient is worried about the practitioner’s response to something that is at the front of their mind that is shaming. If you sense this, it is sometimes possible to reflect it: e.g. ‘there’s part of you that doesn’t want to talk about this right now’ or ‘this isn’t something you want to talk about at the moment’ or even ‘you’d really like a simple answer’.

The patient may be feeling awkward at the length of the pause, but you may sense that it is a ‘productive pause’. Sometimes giving permission can be helpful: ‘take your time’.

When not to pause

Pauses should be used with caution in early sessions before there is a sound therapeutic alliance because the patient may feel persecuted and may not yet know the ‘rules of the game’.

Silence should be used with caution in psychotic patients with persecutory ideas or ideas of thought control.

If the pause is because you’ve lost concentration and are daydreaming/otherwise not present (if this is the case: check in with yourself to see what this feeling might mean, or just apologise to the patient for losing track and ask to go back a moment or two).

Deliberately to increase patient anxiety.

6.5 Modifications to skills and tactics for particular situations

Cognitive deficits

In psychiatry we often work with patients with specific or global cognitive difficulties, which may be temporary or permanent. Diagnostic groups include not only those tra-
ditionally recognised as having learning difficulties or cognitive impairments but other groups as well. Psychosis is increasingly recognised as being grounded in cognitive deficits (Wykes et al. 2011). Patients with autism spectrum disorders (ASD) may have deficits that vary from very obvious to subtle and easily missed. Patients with ASD and without it, may lack emotional language or the ability to recognise and name their own emotional states. Therefore, there is often a need to adapt techniques for the individual patient’s needs, particularly as these patients are more likely to lack insight into their difficulties as perceived by others, or in fact why they have to see a psychiatrist at all.

There is no ‘one size fits all’ when working with patients with additional needs such as these. However, two basic principles are helpful to remember. Firstly, start simply and only build up the level of language sophistication and complexity when you are sure the patient will understand this; and secondly, check understanding explicitly and frequently.

Think about the patient’s attention span, particularly if they have active psychotic symptoms, manic symptoms, ADHD, dementia or learning disability. Keep sentences short, emphasising one or two key words only. Be aware that lengthy summaries may not be taken on board by the patient, but he or she may agree in the correct places and not alert you that they tuned out some time ago. Use simple reflections initially, and then consider once you have been talking to the patient whether complex reflections may be helpful or not. In general, use of metaphor tends to be less helpful with people with learning disability and autism spectrum disorders. Double negatives are confusing, as are tag questions (questions converted from statements by an appended interrogative e.g. ‘You saw the man, didn’t you?’) which may encourage the patient to just say ‘yes’ without that being meaningful. These are particularly unhelpful if the patient is highly suggestible, as the format means that they hear the statement as though it is a fact they have been given, rather than the first part of a question. Do not be afraid to reverse sentence structures or ask the same question in two different ways if you think the patient is just saying ‘yes’ or that their answers are echolalic.

Questions starting with ‘why’ often carry an accusatory or interrogative undertone in English (less so in some other languages). In general day-to-day practice, we suggest trying to recast ‘why’ questions using other stems (e.g. ‘what’) to avoid this problem. In patients with cognitive impairments, ‘why’ questions may be harder than simple ‘what’ questions as they require a developmentally higher level with a basic understanding of causality, so should be used with even more care. It is much easier to understand and answer the question: ‘what happened before she hit you?’ than ‘why did she hit you?’.

Many patients with learning disability and/or autism spectrum disorders will struggle with abstract concepts, including emotions. They may also have developed techniques for answering questions they do not understand to try to mask these difficulties. To know if you are getting a meaningful answer to the question ‘how have you been feeling?’, you would need to know whether the patient has a reasonable understanding of the different emotional states in theory and whether they can identify what they themselves are feeling. Visual aids may help with this.

Open questions are still a good start for patients like these, but if unsuccessful you may need to use a higher closed: open question ratio than usual. If you are needing to use lots of closed questions, try to use menu-based questions when possible to increase the patient’s options when answering. To minimise the interview feeling like an interrogation, think about using a highly transparent structure, making every question count and dropping back to talking about things the patient wants to talk about every few minutes (this may include things that have little or no bearing on your assessment, such as football or soap operas). When possible use terms that are meaningful to the patient, for example a referral for ‘angry outbursts’ may make no sense to the patient, but he or she may be able to talk about the times when they get really upset.

Explicit consistent boundaries are key with patients who lack an awareness of socially
appropriate behaviour or are disinhibited and overfamiliar. The interview can also provide an opportunity to model appropriate social behaviour.

Think about the duration of sessions. Sometimes longer is needed to complete an assessment or explain treatment options, because concepts need to be broken down in more detail and the patient may have a slower processing speed, however, can the individual patient cope with a longer interview? What is his or her attention span like (particularly if it is not a topic of interest to them)? You may need to have several brief sessions rather than one longer one.

Use of visual media in conjunction with verbal communication may be helpful for some patients, but if using written information ensure you have checked how much the patient can read meaningfully, being aware that some people with autism spectrum disorders can read high level texts accurately but not with comprehension. Sequencing and time concepts are often difficult as well and it is imperative to check the patient’s understanding of these, in order to avoid misunderstandings.

Use of silence needs careful thought with people with limited attention spans, impairments of social interaction (as seen in ASD) or those who are used to being talked at rather than to. Be aware of the challenges and observe what happens when there are silences. If you are working with a patient with ASD who takes every possible opportunity to talk about their special interest in paint colour charts, you may decide to avoid leaving too many long pauses and to be very clear about the purpose and format of the interview. For example: ‘this meeting is to talk about your seizures, I need to ask three more questions about them, and then we can talk about the charts again’. Having a clear structure does not preclude the patient being enabled to make choices when appropriate.

Working with patients with memory impairments due to dementia or brain injury, may also require different uses of silence, as the pause may lead to them forgetting the previous information. Similarly a patient with a very limited attention span due to ADHD or mania, may lose track of the conversation and need steering back to that topic if there are lengthy pauses.

Patients with more severe communication difficulties, including those who cannot communicate verbally, are likely to benefit from communication profiling by speech and language therapists. They may use a variety of techniques to communicate including: facial expressions; eye pointing; signs (often idiosyncratic); vocalisations; use of picture, photo or symbol cards and gesture. Carers may be a mine of useful information regarding how the individual patient communicates with them, how they know if he or she is happy or distressed and how he or she makes choices. Speech and language therapists may also be able to help ascertain how the patient’s comprehension of verbal language differs from their expressive language abilities.

You may also need to adapt your techniques for patients with sensory impairments. For those with significant hearing impairment think about the environment, including lighting levels and line of sight to aid lip-reading. If at all possible, do not rely on lip-reading which is highly inaccurate and exhausting even for an expert. If you are consulting with another health or social care professional, think about one professional taking the lead and the need for the patient’s attention to be drawn to each speaker prior to starting talking. When possible, acknowledge the sensory impairment and ask the patient how to make the consultation as easy as possible for them, and give them permission to ask you to repeat yourself or modify your communication style.

For patients who use sign language as a primary means of communication, you need to check which language or form they use. British Sign Language is not a direct translation of English; it is a language in its own right and has its own grammatical structures. Some concepts are difficult to translate and are affected by the visual nature of the language, for example the sign for ‘suicide’ looks like a particular method of suicide.
One can then be left not knowing if the patient has denied any thoughts of suicide, or just thoughts of that method.

Allow at least 50% extra time if your consultation involves a BSL interpreter and remember that the interpreter will need regular breaks. The interpreter should be able to give you guidance regarding seating arrangements. As with all sessions involving an interpreter, talk to the patient not the interpreter and pause frequently for your words to be interpreted. It is always helpful to allow a few minutes to brief the interpreter beforehand regarding the objectives of the session, and courteous to also allow time to debrief the interpreter if the content of the session may have been distressing for them.

**Psychosis**

Psychotic patients often need some of the same kinds of modifications as people with cognitive deficits. Formal thought disorder can be unhelpfully elicited by open questions. It sometimes makes more sense to use closed questions with much checking back, reflection and summary. Try to anchor reflections into reality where possible without either confronting or colluding with the psychosis. Reflecting the affect rather than the content can be a good approach, for example the fear of being attacked rather than the fixation on assassins. A useful attitude to take when talking with psychotic patients is that even the craziest seeming idea probably has some kernel of truth in it, if you and the patient can find it together. This attitude of respectful curiosity can develop into the ‘collaborative empiricism’ that is sometimes recommended by CBT therapists as a basis for testing the evidence for (and utility of) different beliefs later on in the relationship ((Kingdon & Turkington 2005), (Turkington & Kingdon 2014)).

Agenda setting may have to be done more slowly and flexibly than with non-psychotic patients: agendas may have to be more implicit and develop slowly over time.

Psychotic patients with theory of mind deficits can find complex reflections invasive or even akin to mind reading (particularly if they have delusions around thought control or thought alienation), so these should be used with care. Patients with persecutory ideas may become suspicious if the structure of your interview is not apparent to them: be careful to signpost what you are doing to make links for them, e.g. ‘other patients of mine who have been troubled by voices have sometimes felt that their thoughts weren’t their own. Is this something you have ever experienced?’ Avoiding discord (‘Rolling with resistance’: p26) is a particularly important skill for psychotic patients who are likely to retreat deeper into psychosis if they feel criticised, disrespected or disbelieved. Sometimes when the patient seems to be retreating into psychosis, it is a signal for you to ‘tactically withdraw’ and change the tack of the interview.

**Emotionally unstable personality disorder**

1. **The issues**

Patients with emotionally unstable personality disorder can be challenging to work with and require a knowledge and skill base beyond the scope of this handbook but Dialectical Behaviour Therapy (Linehan 1993; Linehan & Wilks 2015) provides a useful and practical approach even in situations where a complete DBT package is unavailable. The DBT skills training manual (Linehan 2014) is particularly helpful.

Linehan says that ‘in a nutshell, DBT is very simple. The therapist creates a context of validating rather than blaming the patient, and within that context, the therapist blocks or extinguishes bad behaviours, drags good behaviours out of the client and figures out a way of making the good behaviours so reinforcing that the patient continues the good ones and stops the bad ones.’

In practice, this often means keeping a very keen eye on the emotional experience of the patient (and responding to that) even when the behaviour (which can be dramat-
ic) is demanding attention. The behaviour (e.g. cutting) is often a solution to another problem (unbearable affect).

Validating the patient can be difficult. This group may have had repeated experiences of their feelings and thinking being invalidated, and are likely to be very sensitive to invalidation happening again.

Because of this we recommend a few modifications of technique.

2. **Taking small risks**

When trying to learn to make better reflective listening statements, trainees are often encouraged to ‘take small risks’. Generally, when you are wrong, patients will correct you and not much is lost, particularly if you are communicating that you are really trying hard to understand. For patients with EUPD, it is generally better not to take risks in making reflective listening statements because of the potential for the patient to experience this as invalidating if you are wide of the mark. Keep on safe ground: reflect what you are sure is going on for the patient. If you aren’t confident, consider making a more generic reflection than you otherwise might: ‘that sounds difficult’ for example. Generic reflections should be a last resort when you haven’t got anything else to say!

3. **Reflecting with first person stems**

As a general rule, reflective listening statements work better when they don’t start with ‘I’. This can shift focus on to the doctor in an unhelpful way and point up differences in opinion or perspective, when what is needed is a closer focus on the patient alone.

In working with patient with EUPD, this isn’t always the case. It is sometimes the case that in aiming to make reflective listening statements that are accurate, supportive and containing one is treading a thin line between statements that are invalidating by being only slightly inaccurate and statements that are accurate to the point they are experienced as intrusive. In this scenario, it is sometimes preferable to use reflections starting with ‘I’ as a way of explicitly labelling one’s own fallible perceptions as just that: your flawed take on what might be happening for the patient. So for example ‘you’re very angry’ might be recast as ‘I guess you’re very angry’.

This technique can also be framed in terms of a continuum with the active therapeutic approach of mentalisation. Patients that struggle to ‘see’ other minds may not always realise your guesses about their mental experience are the product of your own mentalisation process. Being explicit about how you come to your conclusions about what your patient is feeling (and how this can be wrong) can be therapeutic for the patient (Bateman & Fonagy 2010). In this case, the reflection might become ‘I guess from your face you’re very angry’.

4. **Giving permission to disregard**

One way of keeping reflections tentative (and encouraging mentalisation) is to give permission to disregard: ‘I may have got thing all wrong, but what I’m seeing...’ or ‘This may not make a lot of sense to you, so tell me if it doesn’t, but...’

5. **Using disclosures of immediacy**

If you do make a mistake, apologise, back up and try to work out with the patient why you made the mistake. Use a disclosure of immediacy (p36) to help the patient mentalise. ‘I’m sorry, when you said you partner had left you, I made an assumption about how you felt about it that was wrong. My mistake. Can we back up and try again?’
6.6  Interviewing with another health professional

Interviewing with another health or social care professional is a key skill in mental health care and can be extremely helpful when done well. Working with a colleague you know well allows you both to develop ways of working where you can support each other and enhance the therapeutic value of the interview. Often nurses may have a better grasp of local services than doctors new in post (Boyd et al. 2013). It is often easier to observe the patient and their responses when you are not having to also think about what questions to ask and avenues to pursue.

However, interviewing with a professional you do not know can be a significant challenge. This is often eased by taking a few minutes together, before meeting the patient, in order to clarify objective and roles. Is one of you going to lead? Do you have the same agenda? How are decisions going to be made? With crisis assessments when a decision whether to admit needs to be made at the time, it may be helpful to agree beforehand that you will gather information, then step outside to discuss your opinions before sharing any ideas on management with the patient and/or carer.

During the interview, be aware of the risk of splitting phenomena and the importance of providing consistent messages to the patient. Keep disagreements outside the interview room and endeavour to support your colleague at all times. Also discuss beforehand what you will do if the patient asks to see one of you alone. If there are safety issues, it is entirely appropriate to decline to see the patient alone, and much better if you have both agreed this ahead of time.

When you are more familiar with your co-worker and have a degree of trust, more options become open to you, chiefly around using versions of circular questioning. When leading the interview, you can ask your co-worker what he or she thinks about what the patient has said. This can then be offered to the patient for comment: ‘what do you make of what my colleague just said?’ This can be helpful on several levels: patients can learn how they are experienced by others, and can be encouraged to reflect on this. The co-worker who is following the interview may be more free to say challenging things than the person leading the interview, who can then explore the challenge without owning it: this can make it easier for the patient to reject the challenge without rejecting the primary interviewer.

6.7  Interviewing dyads and families

In psychiatry it is not unusual to see patients with their family members or paid carers, particularly in child and adolescent, learning disability and older adult services. Too often, considerations of confidentiality are perceived as barriers to talking to families, which is a common source of complaint for families. However, it is important to engage family members as a resource for patient care. Even when you don’t have permission to talk to a family member, you can listen and support if appropriate, and they may be able to provide you with crucial information.

Interviewing two or more members of the family together brings its own challenges. You may need to explicitly ask the patient at the start of the interview whether they wish to be seen alone, with their carer present throughout the interview or a bit of both. However, this may not be appropriate if the patient lacks capacity to understand this decision or for example is a very young child, and the carer is needed in order to make the consultation have value. Some people may not wish to state their wish to be seen alone in front of their significant other and at times it is worth setting up the opportunity to speak alone without offering a choice. Vulnerable patients should be seen alone, even if only briefly, at some point. There is obviously an art to achieving this. Paid carers should expect this and it is certainly advised in the post-Winterbourne View documents. With family members and patients who do not want to be seen alone, it is much more challenging: with children and teenagers with LD, appointments in a school setting can make this easier. With teenagers without LD, most parents understand that their presence may inhibit responses, however one then has
the dilemma of what to do if the teenager tells you something risky without the parent present. Ideally parents and carers should also be seen without the patient as they may also be holding things back. A parent or carer who refused to allow a vulnerable patient to be seen for a few minutes without them present would ring serious alarm bells. Sometimes it is worth deferring this one or two sessions to build up some trust. One can also normalise if helpful: ‘whenever we see young people here, we find it helpful to have some parts of the sessions all together and some parts separately. What order shall we do that in today?’.

Think about the set up of the room. If the patient is likely to get bored whilst the carer is explaining the difficulties, are there any activities available for them? Would having two professionals in the consultation be helpful, so that one can focus on the patient’s needs and the other on the carer’s needs?

The art for the Psychiatrist is to find ways to ensure both the patient and carer are able to get their thoughts aired without the patient becoming distressed or losing interest whilst their carer talks. Collaborative agenda setting and some clear limit setting (e.g. about the time available) can be useful. It is not helpful for a vulnerable patient to have to listen to their carer give a lengthy list of everything they think is bad about the patient’s behaviour. The Psychiatrist will need to control the interview sufficiently to avoid this or other inappropriate discussion, for example two parents arguing or discussing explicit sexual material in front of their child. It may be necessary to provide explicit boundaries and offer separate carer only sessions to address these aspects of the case.

A general rule of thumb is to introduce yourself to everyone but start addressing your questions to the patient first, before focusing on the carer. However, not all patients will be confident enough to talk first and many may encourage you to speak to their carers rather than them. If that is the case, encourage the patient to let you know if he or she does not agree with anything that is said, and check in with the patient for his or her views regularly. You may need to explain to carers how important it is that the patient actually answers questions themselves when possible, particularly if you are trying to assess capacity or cognition. Again a transparent interview structure can be helpful here with a negotiated agenda, with both the patient and carer putting items onto this.

Carers can be extremely helpful in facilitating interviews, sometimes suggesting ways to rephrase your questions if the patient does not understand, providing prompts and encouragement, highlighting if they think the patient has not understood, and being able to reiterate key information to the patient afterwards. They may need some guidance on what is and is not helpful and of course may have their own emotional responses to the content of the consultation which may need addressing. They may also be worried about upsetting the patient if they talk about difficulties, or even be frightened of them. This is another reason why seeing patients and carers separately at some point in the course of treatment is useful, so that safeguarding issues can be covered, both where the patient or carer may be a victim of abuse.

Interviews with a patient and a family member can provoke disagreement or even arguments. (Cole & Bird 2013) suggest being ‘a benevolent traffic cop’ and politely but assertively curbing more dominant members of the family to allow other members to speak. Circular questioning can again be a helpful technique: ask one member of the family what they made of what the other member of the family just said. Members of the family don’t need to be physically present to use circular questioning: e.g. in interviewing a mother-daughter dyad, ask about how the husband/father perceives the situation (and explore the differences in perspective that may be presented).

Skills that you have learned in making good complex reflections transfer well to scaffolding circular questions: if you can spot the underlying affect, strength or value in what one member of the family has said, offer a précis that incorporates that observa-
tion to the other member of the family for comment.

Family members can be particularly useful in consolidating motivation to change. Sometimes, negotiating a treatment plan with patient and spouse can be more successful than negotiating just with the patient – both because of the dimension of public commitment to change but also because of the practical considerations for the plan (e.g. a dietary change is likely to be more successful in the case that the spouse that does the cooking and shopping becomes involved in the change plan).
7 Improving practice

7.1 Introduction to simulation and coding

Three ways to analyse practitioner discourse

1. Discourse analysis

Discourse analysis uses a fine grained and detailed examination of what are typically fairly small samples of doctor-patient interaction. It looks at how people do things with language (achieve a particular social outcome), typically examining how things are constructed through language, how interpersonal goals are achieved through language and the social effects that result from these constructions. It is technical and time consuming to do but can achieve a greater insight into the inner workings of a consultation.

2. Computer assisted text analysis (CATA)

If discourse analysis is a microscope, computer assisted text analysis is an aerial view. It tends to provide more general data on how language is used in consultations, often using a large body of material, for example looking at word frequencies in transcripts. It has found some use in analysis of consultations (e.g. (Atkins et al. 2014)) but is not extensively used.

3. Coding

The coding approach falls somewhere between discourse analysis and CATA. It is the predominant research approach to analysing consultations in psychotherapy. In developing this course we have been strongly influenced by the motivational interviewing literature. Coding in MI uses the MITI (Motivational Interviewing Treatment Integrity) (Moyers et al. 2014), itself derived from a much longer coding instrument, the MISC (The Motivational Interviewing Skills Code), which was in turn very influenced by the Psychotherapy Process Code ((Chamberlain et al. 1986)). The MITI was generated by using factor analysis to pick out which of the 43 codes were responsible for most of the variance in the MISC to reduce the codes to 18.

Coding is valuable for quality control and coaching. However, what it gains in reliability it can lose in validity compared to discourse analysis. For example, some questions that are in the strict sense 'closed' clearly function to invite the patient to talk freely (e.g. 'can you tell me more about that?'). Despite its limits, coding provides a useful basis for skills coaching.

Moyers (personal communication) refers to the MITI as a 'torch shining into the dark cavern of human communication'. It is important to remember that the tools that are available for analysing communication are not flawless. We believe it is important for skilled practitioners to have at least a beginning acquaintance with these tools and their limits in order to more fully engage with thinking about quality criteria as they apply to their own practice.

7.2 Simulation

Standardisation or simulation?

Standardised patient scenarios are very tightly scripted and may have particular cues to be hit at particular points. The scenario is usually designed to run within strict time parameters. These types of scenarios are often associated with assessment of one type or another, for example exams or appointment interviews. They tend to run to the end whatever happens. In these kinds of situations reproducibility is important so that each candidate is getting a very similar experience, in order that the assessment is fair.
These types of scenarios can sometimes lose some realism in the service of standardisation.

Simulated patient scenarios are less tightly scripted. Improvisation within the bounds of the script is permissible or encouraged. In this kind of scenario, realism is more important than standardisation. The encounter is not about assessment: experimentation and mistakes are encouraged, with the aim of the training being for the trainee to maximise their learning.

**KEEPING IT SAFE**

Performing in front of a video, your colleagues and a consultant is stressful and can feel exposing. If you want to stop, you can call for a time out or just to ‘back up 30 seconds’; if you want to stop and ‘ask the audience’ you are free to do so.

We suggest trainees try things out, without expecting them to work every time. It’s better for something to go wrong in a simulation (when we can stop, discuss and rewind) than it is with a real patient.

Ask for what you want to practise. Ask the actor to do something different – their brief and their skill usually allows a wide margin of flexibility.

**HOW LONG?**

Working on shorter segments of the interview – maybe five to ten minutes – often seems to work best. It is less stressful, it rotates the roles and it keeps the debrief focussed on one or two key issues.

## 7.3 Live coding using StudioCode

StudioCode is a proprietary software package used for video analysis of sports. It is also used for analysis of other activities including in the medical field, though the Severn course is unique in using it for communication skills training.

During a simulation, one trainee works with the actor and a second ‘codes’, by clicking on buttons on a ‘code window’. The buttons capture an event immediately before the button is pressed: so for example, clicking on ‘open question’ captures the seven seconds before the button is pressed and one second after. The coder must wait for the end of the utterance and then make a very quick assessment of what it was.

Coding outputs include video of particular types of coded utterance (e.g. a review of all simple reflections in a simulation); behaviour counts, allowing calculation of ratios such as reflection: question ratios; uploading of coded videos for later review at home.

Live coding is difficult and requires concentration. It is also very effective at sharpening the ability of the coder to subsequently monitor their own practice.

The coding schemes we are currently using are provisional and we encourage trainees to experiment to improve them (what aspects of good practice are we not currently capturing?). It is easy to change the code window in sessions. Interested trainees can read the StudioCode manual (StudioCode 2013).

## 7.4 Feedback

This course provides a variety of different sources of feedback on your clinical practice: from the actors in the simulation, directly from the video, from coding approaches, from your peers and from the trainees. Some of these forms of feedback may be more useful to you than others, but we encourage you to try to use all the modalities available to help you reflect on and develop your practice.
In receiving feedback, work towards:

- Taking responsibility for the feedback you want at any point in time. Ask for the kind of feedback you want on the kinds of issues that are concerning you.
- Being more open to feedback.
- Listening to the feedback all the way through without jumping to a defensive response.
- Respond to the feedback you get as data: the feedback you get is how one other person perceives you. It isn’t the whole truth. Don’t try to excuse or explain away – or at least, monitor this tendency in yourself.
- Reflecting on the feedback and consider whether it might be useful to you. If it isn’t, that’s fine.
- Noticing where the feedback you get from different people or different modalities is inconsistent and trying to work out what this means.

In giving feedback, focus on what the colleague you are observing has asked you to look for. There may be other feedback that you would like to give when you have noticed something important. Ask for permission to give it.

Feedback on something as individual as communication skills risks being personal and hard to hear. If given insensitively, it can drain your colleagues’ motivation to improve and/or provoke them to discount what you have said. So the spirit in which feedback and advice is given also has to be right: before you give advice check that you have (a) elicited your colleague’s views on the subject (b) considered the impact of what you are going to say on their motivation. Although we suggest being both supportive and rigorous in helping each other develop, we have found that medical trainees sometimes need more support and less challenge than they ask for.

Give feedback following the mnemonic CORBS: Clear, Owned, Regular, Balanced and Specific.

- Clear: be clear in your own mind what the feedback is you want to give.
- Owned: the feedback you give is your opinion/your perception: it isn’t the whole truth. If you can state or imply this in the feedback, it can help the listener, e.g. ‘when you [name behaviour] I feel [name feeling]’ rather than ‘you are...’
- Regular: regular feedback is better than saving up problems to be delivered in a package; similarly, for skills based learning, try to give the feedback as soon as possible after the event.
- Balanced: try to balance negative and positive over time.
- Specific: focus on particular examples of behaviour. Focus on the task/behaviour and not the person.

Much feedback in medicine is crudely norm referenced to a variety of norms, e.g. the observer implicitly compares practice to themselves (‘is that what I do?’) or to peers (‘is that what other CT 1s would do?’) (Kogan et al. 2011). This is less helpful for development of skills than careful behavioral feedback. Watching colleagues and learning how to accurately describe what you see in behavioural terms, whether using coding or direct verbal feedback is one of the most useful ways of developing your own skills.
8 Bibliography

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Appendix: worksheets

**Structure, task, skill exercise**

**Emergency Department assessment – task:**

It is 1am and you are the on call doctor for Psychiatry. You are called to see a patient in the local emergency department who took an overdose of paracetamol. Her paracetamol level is below the treatment line and she is now sober. The emergency department doctor wants you to assess whether she can go home. The crisis team are at a Mental Health Act assessment and ask you to go alone. Unfortunately there are two other patients waiting for assessment after this one.

The patient’s name is Anna Smith and she is 28. Her Emergency Department notes are brief but include that she says she took 32 paracetamol at 6pm with 2 bottles of Smirnoff Ice and wanted to die. Her psychiatric history in the notes consists of the single line: ‘Psych history positive’ and there is no mental state examination or social history documented. She is described as ‘generally fit and well’.

**Inpatient admission – task:**

You are working as a Psychiatry CT1 on an older adults ward. Eric Bennett is a 72 year old who is being admitted under your team following a Mental Health Act assessment in the community. He has been detained under section 2 and his section papers say that he is failing to care for himself, eating and drinking poorly and saying he is dead. The concern is that he has depression with psychotic symptoms, namely nihilistic delusions and auditory hallucinations. He has no known psychiatric history and was referred by his GP who was concerned about his welfare. The GP summary says that he nursed his wife until her death from pancreatic cancer 6 months ago and his mental state has deteriorated since. He has hypertension and benign prostatic hypertrophy. His regular medication was amlodipine 5mg once daily and aspirin 75mg once daily, although it is unclear whether he has been taking this.

Your task is to clerk him into the ward. It is daytime on a weekday and you are likely to be the ward doctor caring for him for the foreseeable future.

**New patient assessment in the community – task:**

You are a Psychiatry CT1 working in a community mental health team. You have a new patient booked in for assessment. You have up to 90 minutes allocated for this initial appointment. The patient is Eleanor Thomas who is 35. She has been referred by her GP regarding her longstanding anxiety. The referral is brief but notes that she is motivated to address her anxieties now as she has a 9 month old baby and is worried about the effect on her. She has had no contact with secondary mental health care before. She previously had input from the primary care psychological therapies service but found the anxiety management group very anxiety provoking. Citalopram was also tried but the patient stopped it because of nausea and dry mouth. She has no significant physical health problems and is not taking medication.

**Inpatient assessment for section 5(2) – task:**

You are on call for psychiatry. You are called to an adults of working age inpatient ward you do not know well, to see a patient you have never met before, to assess whether they should be detained under section 5(2). It is 23.45 on Friday. The ward is staffed by bank nurses who do not know the patients well and are busy dealing with a manic patient you keeps trying to run naked down the ward.

You have been asked to see Jared Turner, a 23 year old man who was admitted to the ward informally 3 days ago. He had apparently been behaving oddly in the community, talking about snakes and the CIA, and had nowhere to stay. Today he left the ward at lunchtime saying he was popping over to the hospital shop. He did not return until half an hour ago, and when he returned he smelt strongly of cannabis. The nurses asked to check his pockets and bag. He then became agitated and said he wanted to leave again and the nurse phoned you to ask for a 5(2) assessment.

A quick look at the psychiatric notes tells you that he was not previously known to mental health services, and that his own team are wondering whether he is psychotic or whether it is ‘behavioural’. They also want to find out what role drugs and alcohol may play in his presentation. They have not provided any guidance on what they think should happen if he was to try to leave.

He had a basic physical examination, blood tests and ECG on admission which were all unremarkable. He is yet to provide a urine sample. Prior to going out today he has kept a low profile on the ward, mostly staying quietly in his room. There have been no other incidents. He is not taking any medication.
Observing practice: reflection worksheet

What was the situation? Who were you observing?

What did you notice them do?

What were the effects?

What have you tried yourself?

What could you incorporate into your own practice?
1.1 OARS Observation sheet

Open Question OQ
Count:

Closed Question CQ
Count:

Reflection (simple) SR
Count:

Reflection (complex) CR
Count:

MIA (Asking permission, affirming, autonomy support)
Count:

MINA (Advice without permission, confront, direct)
Count:

% Complex reflections (=CR/CR+SR): Target:>50%

% Open questions (=OQ/(OQ+CQ): Target:> 70%

Reflections: Questions (= (CR+SR):(CQ+OQ)): Target>2

% MIA (=MIA/MIA+MINA): Target 100%
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<tbody>
<tr>
<td>Open Question OQ</td>
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<td>Closed Question CQ</td>
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<td>Reflection (simple) SR</td>
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<td>Reflection (complex) CR</td>
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<tr>
<td>MIA (Asking permission, affirming, autonomy support)</td>
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<tr>
<td>MINA (Advice without permission, confront, direct)</td>
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% Complex reflections (=CR/CR+SR): Target: >50%
% Open questions (=OQ/(OQ+CQ): Target: >70%
Reflections: Questions (=CR+SR):(CQ+OQ)): Target: >2
% MIA (=MIA/MIA+MINA): Target: 100%