Advanced Communication Skills

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1. Introduction

1 WELCOME

Welcome to the 2014-15 Communications skills course, which has been revised this year with the production of this handbook for the first time, which we hope will give a clearer overview of the whole of the course and how it fits together from the outset.

After the whole day sessions on 4th, 11th and 18th September, the course continues with nine 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 4.

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. 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 and to 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!

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2 MODELS OF THE CONSULTATION

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 for one attempt at drawing out the commonalities of the various models).

Some of the models distinguish between disease and illness (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 illness. 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 counselling 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)).

3 LEARNING COMMUNICATION SKILLS

Silverman *et al* (2005) identify a key issue in learning communication skills, 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.

4 FINDING YOUR WAY

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 practice with detailed, descriptive feedback and honing one's ability to see and describe process skills in others.

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.

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.

2. Curriculum for this course

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

I ENGAGING

1. 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.

2. Skills

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

Considers aspects such as patient comfort, impact on engagement, placement of carers 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, for example: time concepts; and has understood the purpose of the meeting and what is going to happen.

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 sensitively but without losing focus.

Remains calm and emotionally containing.

Non-judgemental attitude.

8. The doctor attends to moment by moment fluctuations in engagement and addresses difficulties around engagement appropriately[1].

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

Able to engage with silent or shut down patients.

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

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 his/her own reaction to the patient

The doctor 'uses his or her emotional response as data' - i.e. recognises a personal affective response 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.

1. Simulation session 4 on 5th March 2015 is primarily based around an angry and hard to engage patient.

2 STRUCTURING THE INTERVIEW

3. 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.

4. 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 cognitively impaired patients 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.[2]

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).
Uses self disclosure appropriately.
Uses physical touch appropriately.

2. Simulation session 5 on 26th March 2015 covers a psychotherapy assessment in which there are multiple boundary issues.

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

Ensures that both the patients and carer 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.

3 ELICITING INFORMATION

1. 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.

2. Skills[3]

3. The first three days of the communication skills course largely focus on skills in this section. Simulation session 8 in the second year is an opportunity to revise the skills, particularly the skills of motivational interviewing, in a patient with addiction problems.

1. 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 tag questions in people with learning disability.

Negative indicator: leading questions, loaded questions.

2. Able to use reflective listening statements.
3. Uses non verbal listening behaviour to encourage the patient to continue.
4. Uses summary to clarify information.
5. 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.
6. Elicits patient ideas, concerns and expectations about their problem.
7. Elicits patient values and strengths.
8. Elicits information about patient goals and preferences.
9. Uses silence appropriately.
10. 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.
11. Performs a mental state examination
Including cognitive assessment.
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.
12. Performs a risk assessment[4].
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.
Check for safeguarding issues sensitively.
13. Assessment of capacity
Able to assess capacity based on a structured framework, for a variety of different decisions, including in patients with cognitive impairment.
14. Elicits a collateral history[5]
Able to obtain collateral information sensitively both in the presence and absence of the patient.
Respond appropriately to carer distress.
Manage conjoint interviews including children[6] and people with learning disabilities[7] whilst being mindful of how the interview is experienced by both the patient and relative or carer. Be vigilant to the patient feeling disempowered or either party feeling ignored.
Consider whether attempts should also be made to speak to the patient without the carer present (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.
15. 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.
16. 3.16 Performs a joint assessment with another health or social care professional
Discuss with the other professional beforehand, identify 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.
Perform 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

4. Simulation session 7 in the second year covers risk assessment in detail.

5. Simulation ssession 2 on the 6th November 2014 covers interviewing a carer of an older adult.

6. Simulation session 9 in the second year is a conjoint interview of a mother and child with an eating disorder.

7. Simulation session 6 in the second year covers a conjoint interview with an adult with learning difficulties and a professional carer.

professionals.

4 PLANNING AND TREATMENT

1. 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.

2. Skills

1. Treatment planning

Planning treatment using 'three treatment trajectories' model:
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. Information giving[8]

The patient or carer's understanding is elicited before any information e.g. a diagnosis, test results or treatment options, is given.
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).
Providing information about treatment options.
The patient's reaction, understanding and views are elicited after information is given.
The patient's family are involved where indicated; sensitive and appropriate information giving for 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.

3. Decision making[9]

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 way 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, providing unrealistic hope.

4. Breaking bad news

8. Simulation session 1 on the 2nd October 2014 covers information giving and decision making in a session based around telling a patient about Lithium (supplementary material will be distributed prior to the day). This is a relatively simple skill that sometimes trips up trainees in the CASC.

9. Simulation session 3 on 27th November is a difficult interview with a challenging situation of shared decision making in a depressed woman.

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.
Interviewing with a relative when giving bad news.
Apologising when appropriate.
Providing information regarding complaints procedures when appropriate.

5. Planning for relapse prevention

Warning signs and actions to be taken.
Simple cognitive model of relapse.

6. 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.

7. Returning to work

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

Ambivalence.
Medication non-concordance.
Avoidance.
Anxiety
Emotional extremes.
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.

9. Complaints

Handling complaints in a sensitive way.

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 page 4). 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.

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.

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. 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 they have difficulty sorting into a meaningful diagnosis and formulation, which can lead 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, autism assessments.
- 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'.

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.

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 patients' 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')
- 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 paranoid patients
- complex problems

Less good for:

- time limited 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 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.

4 BLENDED APPROACHES

In practice, a clinical interview will nearly always use a mixture of these approaches. One common way that they are used 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 (Silverman et al. 2005, p.19)).

4. Spirit and techniques

1. MOTIVATIONAL INTERVIEWING DEFINED

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.

5 THE UNDERLYING SPIRIT AND APPROACH

Rogerian counselling is grounded in three key concepts: genuineness, empathy and unconditional regard.

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

2 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. The way this understanding is communicated matches the client's mood and content.

3 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):

1 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.

2 Acceptance: the practitioner acknowledges the patient's right to self determination and facilitates informed choice. This includes a disinterest (not uninterested) in the outcome for the patient.

3 Compassion

4 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. In Rollnick, Miller and Butler (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, p.13).

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

6 THE CORE SKILLS: 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.

1. Open questions

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?"; "Who could offer you help making this change?"; "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?"; "Of the options I've mentioned, which sounds like the most appealing for you?"; "What do you think you might do?"

2. Affirmations

Direct affirmations recognise achievements and acknowledge difficulties. They may note a trait, an attribution or strength; they may simply recognise a struggle the patient is having. 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, but highly specific interventions tailored to the patient in front of you (note that agreeing is also different from affirming, because 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.

3. Reflective listening

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.

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).

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. Double sided reflections are a useful technique for steering the interview in a particular direction while continuing to be patient centred.

'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.

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. Use undershooting to invite a response that amplifies the original statement.

Complex reflection involves reflecting back something more than just the words: typically affect but also meaning, values or direction. This can be simply a statement ("you look very happy when you talk about your wife") but can be more sophisticated, for example by linking feelings to experiences and behaviours: *you feel* [accurately name the patients feeling] *when* [accurately name the experiences and behaviour that gave rise to the feeling]. This is a very formulaic approach! Once you've got used to the idea of linking feelings with behaviour and experiences, use your own words. As a general rule, err on the side of understating the emotional content when you reflect it; if you overstate the patient may back off and refute the affect.

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 relationships.

Box 1: some reflection stems

It sounds like…	You're not terribly excited about…
This has been totally… for you	You're not much concerned about…
Almost as if…	The thing that bothers you is…
Like a….	The important thing as you see it is…
Sounds as if you…	You must be…
For you, it's a matter of….	You are…
From your point of view,…	You… It sounds like…
Must be…	Sounds like…
Through your eyes,…	So you're saying that…
Your belief/concern/fear is that…	You're feeling like…
It seems to you that…	

4. 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 sustained attention.

Summary is also a great technique to use when you don't know what to say next!

5. Strategy, structure, tactics

I STRATEGY: CHANGE TALK AND SUSTAIN TALK

1. 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 practitioner 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 practitioner'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.

2. 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. n.d.) suggests that commitment language predicts change more than anything else. However, encouraging 'DARN' is important because it shifts people towards commitment.

Box 2 Change talk: DARN-CAT

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 doing this".
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".

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 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, concerns, willingness and optimism.

3. 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).

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.

4. 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 31).

5. 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'. 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.

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.

1. 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 p29) asking permission, giving a menu of options.

2. 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.

There is something of a continuum in this stage:

Clear focus	Agenda setting	Clarifying
Single topic: get down to work!	Several possible foci. Use a menu of options	Unclear focus. The initial task is to clarify.

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 cognitively impaired patient 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.

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.

Agenda setting

See page page 21.

Clarifying

Sometimes, a change goal isn't immediately apparent. Clarifying sometimes is a two stage process, starting with neutral exploration and moving on to expand understanding.

In **neutral exploration**, the task is to explore the patient'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 patient at this stage because the patient'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?).

3. 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. Use summary again to draw phase 1 to a close. 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, 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?

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?"

4. 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 sug-

gestions. 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 (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.

3 THE SHORT FORM TACTICS

1. Agenda setting

The traditional skill of agenda setting is probably better thought of as a two stage process of agenda mapping and agenda navigation. Guiding (see page 14) is involved in both of these processes: i.e., your expertise is put at the service of the patient'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.

Agenda Mapping

First, map an agenda with the patient by eliciting all the concerns they may wish to discuss, without beginning to discuss the individual items. A good question to start with is often something like: how should we use our time today? List the items, or arrange them in blobs drawn on a piece of paper. If necessary (and with permission), add one or two items that you perceive as being important. Use reflective listening and 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".

Second, explore the agenda in broad general terms, particularly looking for the patient'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.

Agenda Navigation

Use the agenda document as a framework and plan for this and future treatment sessions. You may need to help the patient prioritise multiple goals. Sometimes it is worth encouraging the patient 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. "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".

Three good principles for agenda navigation are:

- Change should be simple because changing is not
- Look for change that is a good 'next step' and a stepping stone to future change

- Change that builds self worth (e.g. 'quick wins') or a stronger network of supportive relationships will increase capacity for future change.

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 patient. Navigation round the agenda can be an iterative process as the patient 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 patient's priorities that you had initially not appreciated. Using agenda navigation in this way can help both you and your patient 'sit with' uncertainty about aspects of their problems that can't be resolved immediately.

Topic tracking

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

2. 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 patient centred style. Using this technique often allows the capture of a lot of information in a fairly patient 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.

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 though 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?"

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 patient drifts off topic.

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').

Check if the patient wishes to add anything

Ask any questions of your own.

Go back to the assessment schedule

Fill in the gaps, or do it later on.

3. 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 patient 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 patient 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.

4. 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.

Some rules of thumb:

- Try to elicit everything the patient 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 patient 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 patient 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'.

5. Two futures

Invite the patient 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?"

6. 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?"

7. Decisional balance

In older versions of MI, the decisional balance exercise was commonly recommended. It invited 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 the decisional balance exercise. 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.

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. 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.

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

Remember that some of the most powerful arguments aren't rational, and that's normal. It can be helpful to be explicit about that as some patients feel they are going mad 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.

8. MI sandwich

Some practitioners worry that it is difficult to combine a patent 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 patient that this has led to a recall; ask the patient how the practitioner can help best at this point.

6. Beyond the basics

1 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 and Brodsky'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.

2 SELF DISCLOSURE

1. 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, p148-9). 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.

2. 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. As a general rule, these are safer disclosures to use. In particular, they can make very effective lead-ins to questions:

I'm puzzled by your reaction. Can you help me understand what you mean?

I suppose I do see things slightly differently. What has led you to your conclusions?

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.

3. Guidelines for other forms of self disclosure

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.

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.

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 patients 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.

Timing for the patient

Beginnings and endings can be 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 than simply their doctor.

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 patient, 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 patients' 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 (2012) suggests thinking in terms of a limited self disclosure allowance that you spend carefully and wisely.

The three second rule

Generally, after making a self disclosure, return quickly to a patient focus. (Hinkle 2012) 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".

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.

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 patient, not least as it unnecessarily reinforces the unequal nature of the power balance of the conversation.

3 MODIFICATIONS TO SKILLS AND TACTICS FOR PARTICULAR SITUATIONS

In psychiatry we often work with patients with specific or global cognitive difficulties, which may be temporary or permanent. Other patients 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 to start simply and only build up the level of language sophistication and complexity when you are sure the patient will understand this; and secondly to 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 which may encourage the patient to just say 'yes' without that being meaningful. 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.

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.

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. 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 social-

ly 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.

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. 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.

4 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. However, interviewing with a professional you do not know can be a significant challenge. This is often eased by taking a few minutes 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 be-

forehand 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.

5 INTERVIEWING DYADS

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. This may mean interviewing a pair or more at a time which 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.

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 are activities available for them?

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. 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. hey 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.

7. Improving practice

I SIMULATION AND CODING

1. Three ways to analyse practitioner discourse

Discourse analysis

Discourse analysis uses a fine grained and detailed examination at (typically) fairly small samples of doctor patient analysis. 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 to the inner workings of a consultation.

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. It has found some use in analysis of consultations (e.g. Atkins et al. 2014) but is not extensively used.

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 (Moyers et al. 2010).

Coding is valuable for quality control and coaching. However, what it gains in reliability it can lose in validity compared to discourse analysis.

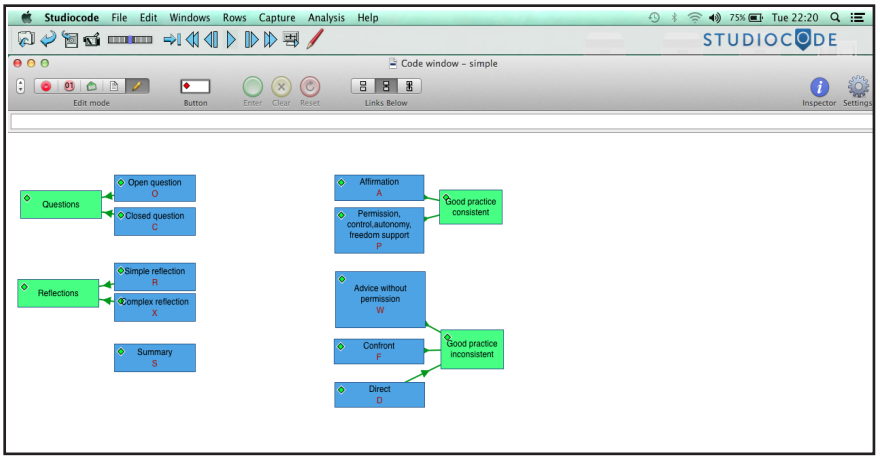
2. Simulation

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.

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)***.

2 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 trainers. 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.

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[10].

10. 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 CT1s would do?') (Kogan et al. 2011). This is less helpful for development of skills than careful behavioral feedback.

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