



## COMMENTARY

# Communicating to connect with patients<sup>†</sup>

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**SUMMARY**

Michaelson & Rahim describe a very welcome sustainable training framework for teaching clinical communication skills to trainees on MRCPsych courses. This commentary expands on their article, noting how psychiatrists listen and ask questions affects the therapeutic relationship and patients' willingness or ability to disclose sensitive information, which is particularly important in risk assessment. Extending videorecording role-plays in training to routine (including remote) clinical consultations and involving patients and carers in training will be key to identifying communication that has a positive impact on patient experience and outcomes.

**KEYWORDS**

Education and training; communication; therapeutic relationship; non-verbal communication; disclosure.

Communication is central to psychiatric practice. However, as Michaelson & Rahim note (Michaelson 2022), it is relatively neglected in psychiatry training compared with training in other specialties. Nevertheless, psychiatrists frequently highlight the key role of communication in establishing and maintaining a therapeutic relationship with people, many of whom do not voluntarily seek treatment. The authors welcome the Royal College of Psychiatrists' recommendation that all trainees receive teaching in interviewing skills. It is exciting to see how the authors have developed and constantly sought to enhance their communication skills training programme. They describe a sustainable training framework that can be used to teach clinical communication skills to trainee psychiatrists on MRCPsych courses.

**Listening to develop trust and rapport**

As the authors note, psychiatrists need to be skilled interviewers to elicit relevant information. An interview focuses on one person asking and another person answering questions. Given that psychiatrists routinely engage in delicate and emotional conversations, they also need to be skilled listeners as described

by Michaelson & Rahim. Listening can be difficult when the focus is on interviewing or assessing mental state. In a typical question–answer interview structure, there is no conversational slot for listener feedback: information is received in a passive way. However, listening is important for developing trust and rapport and is also associated with patient satisfaction. Listening may sound trivial but 'really listening' requires a lot of effort and skill. Often, it is easier to keep asking questions or to start giving advice prematurely than to really listen to what people are saying. Analysis of videorecorded doctor–patient interactions shows that speakers monitor listeners continuously to check if they are really listening, with patients becoming dysfluent when the doctor is not listening and particularly when doctors are attending to written or electronic records (Ruusuvuori 2001).

Michaelson & Rahim and the Royal College of Psychiatrists' core curriculum highlight trust and rapport. Rapport and trust are essential for developing and maintaining a therapeutic relationship, which is not only necessary for assessment, diagnosis and engaging people in treatment but is also a curative element in its own right (Freeth 2017). Patients say it is the most important factor in good care (Johansson 2003). Developing trust and rapport can be more challenging in remote mental health communication: although there are considerable advantages to telepsychiatry (e.g. fewer 'no shows' and greater understanding of the person's social context), psychiatrists also find it more difficult to detect subtle changes in tone of voice, inflection, affect and gaze and also harder to develop rapport (Chen 2020). Evidence suggests that therapeutic relationships are difficult to establish in remote first appointments but can be sustained if there is a pre-existing relationship (Schlief 2022).

**Disclosing sensitive information**

Given that communication in psychiatry involves asking people about sensitive, stigmatised and socially undesirable information, rapport takes on extra significance. Goffman (1955) and others have shown that there is a strong preference for 'saving face' and not disclosing negative information about oneself in social interaction. However, people are more likely to disclose sensitive personal

information when there is good interpersonal rapport. Non-verbal communication is an important channel for rapport and empathy: it is not 'what' we say but 'how' we say it. Gaze (Brugel 2015) and voice quality (Simon-Thomas 2009) are associated with perceived empathy. In our busy day-to-day work, when we are tired and distracted, it takes extra conscious effort to convey empathy through posture, gaze, facial expression and tone of voice.

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

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

### Videorecording communication

The programme designed by Michaelson & Rahim involves videorecording and sensitive feedback to trainees, allowing for more accurate descriptive feedback on non-verbal behaviour. Most research on

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

### Involving people with lived experience in communication skills training

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

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

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