

The use of simulation to develop advanced communication skills relevant to psychiatry

Christopher Kowalski,¹ Shivanthi Sathanandan²

¹Barnet, Enfield & Haringey Mental Health Trust, St Ann's Hospital, London, UK
²Camden & Islington NHS Foundation Trust, St Pancras Hospital, London, UK

Correspondence to

Dr Christopher Kowalski, Barnet, Enfield & Haringey Mental Health Trust, St Ann's Hospital, St Ann's Rd, London N15 3TH, UK; kowalskichristopher@hotmail.com

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ABSTRACT

Objective Using simulation, we developed an advanced communication skill training programme with the objective of improving core psychiatry trainees' confidence in managing difficult situations at work.

Design Two simulation courses, comprising six scenarios, were developed for psychiatry core trainees (CTs) on the University College London Partners (UCLP) training scheme. Trainees were divided into small groups. Each trainee undertook two scenarios each. Feedback was delivered by facilitators, peers and the simulated patients. Written feedback was also given.

Setting The courses were delivered in a local postgraduate medical education centre.

Patients Actors were used to simulate adult psychiatric patients and their relatives. Other scenarios involved actors portraying colleagues.

Interventions The simulations offered an opportunity for experiential learning while the debriefs allowed for focused feedback on trainees' communication styles.

Main outcome measures Changes in trainees' perception of their ability to deal with difficult situations at work were measured. Semistructured interviews further explored trainees' experience of the course and its educational impact.

Results 100% (n=39) of the trainees felt that their communication skills had improved after the training. 97% felt more able to defuse an angry/tense situation at work while 92% felt more able to deal with a difficult situation requiring sophisticated communication skills. 97% felt that regular simulation training would be valuable while 100% (n=24) of facilitators agreed that the experience was valuable to the trainees' professional development. Qualitative analysis showed that trainees found the scenarios realistic, that the experience had led to an increased awareness of their communication style and that original improvements in confidence had translated to their clinical work.

Conclusions The programme demonstrates that it is possible to use simulation in a simple, inexpensive and time-effective manner to provide realistic, enjoyable and educationally beneficial advanced communication skill training relevant to psychiatric practice.

INTRODUCTION

In the UK, psychiatric postgraduate training programmes have not traditionally used simulation in the professional development of core trainees, despite there being a wide scope for its use in a variety of settings. Role-play has perhaps featured more significantly due to its low cost and flexibility. This teaching method can, however, be problematic due to both the ethical issues of students portraying disturbed, emotional roles¹ and the reluctance of trainees to engage in the process.² Simulation may

offer an attractive alternative for providing trainees with experience of clinical situations in a safe environment—one that might also achieve better educational outcomes.

Previous use of simulation in psychiatric education can be categorised into two broad groups: (1) to expose trainees to a wider range of diagnoses and psychopathology and (2) to teach advanced communication skills relevant to psychiatry.³ More specifically, simulation has been used to teach: mental state examination;⁴ liaison psychiatry skills;⁵ motivational interviewing skills;⁶ assessment of domestic violence;⁷ psychotherapy skills^{8–9} and the assessment and management of patients seeking benzodiazepines and opiates.¹⁰ It has also been used for less specific clinical skills—for example, to help medical students understand and elicit general psychiatric symptoms.¹¹

Given the nature of psychiatric practice, it seems essential that trainees have the opportunity to develop their communication skills not only with patients and relatives but with colleagues as well. Such opportunities should be relevant to psychiatric clinical work rather than being of a generic nature. There are few studies that assess the impact of simulation on the acquisition of communication skills specifically for psychiatry. Those that do have reported positive student experiences^{12–14} and improvements in students' self-efficacy in psychosocial interviewing¹⁵ and communication skills for dealing with psychiatric dilemmas.¹⁶

Recent changes in many mental health trusts' out-of-hours rota structures mean that trainees may no longer be involved in the initial assessment of acute presentations. This deficit may have a detrimental impact on them achieving a high level of competence in communication skills, particularly in the difficult situations they may face out of hours.

It was with these considerations in mind that we set about developing and implementing a simulation-based advanced communication skills training programme for CT1s and CT2s on the University College London Partners (UCLP) core psychiatry training scheme. **Box 1** shows the expected benefits of the programme.

METHOD

In setting out to develop the programme, we first assessed both the need and the desire for communication skill training among psychiatry CTs on the UCLP rotation. A survey carried out (n=42) showed that 14.2% felt poorly equipped to deal with clinical situations at work. In total, 42.8% had no previous communication skill training at all and 100% felt that some form of simulation training on communication skills would be beneficial to them.



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Box 1 Expected benefits of the training programme

1. Improved communication skills for psychiatric practice
2. Improved confidence in managing difficult clinical situations
3. Enjoyable training experience
4. Improved postgraduate clinical examination outcomes
5. Improved patient experience
6. Reduced patient complaints about CTs

Having obtained funding to run pilots of the course for both CT1s and CT2s, we set about devising scenarios and designing the intervention itself. The scenarios were written by the authors following a focus group held with the CTs (box 2). Scenarios in the CT2 year were written with a higher level of complexity to account for trainees' increased level of experience. Particular consideration was paid to achieve the correct accent of reality when writing the scenarios. There are inherent limitations with using actors to portray patients with mental health needs.¹⁷ These include concerns about the depiction of emotionally realistic individuals and the ability of actors' portrayals to evoke a realistic empathic response in participants.¹⁴ We attempted to moderate for this by working closely with the actors prior to the sessions and creating detailed backstories as a real patient might have. In particular, conscious and unconscious conflicts were specified for the actor to draw from and thereby create a more realistic character.

Additionally, in practice, patients often come with agendas that may dominate a clinical encounter. Contrary to this, simulation tends to privilege the clinician's own agendas, for example,

Box 2 Scenarios used in the training programme

CT1 scenarios

1. Dealing with a patient with emotionally unstable personality disorder demanding an admission to hospital
2. Liaising with an A&E specialist registrar regarding a complex patient with physical issues
3. Informing a relative that their child has attempted suicide while on the ward
4. Addressing your concerns with a colleague who appears to be struggling
5. Attempting to take a mental state examination from an extremely manic and disinhibited patient
6. Discussing your concerns with a relative who wishes to take their child off section

CT2 scenarios

1. Assessing an elderly patient's capacity to refuse social care interventions at the time of hospital discharge
2. Negotiating a plan with your consultant regarding overwhelming clinical workload
3. Discussing a disclosure of sexual assault with the parent of a young female inpatient
4. Conveying your team's decision not to support discharge of a vulnerable patient to his parent's care
5. Assessing suicidal risk in a non-communicative adolescent patient
6. Managing a difficult interview between a community patient and their care coordinator

engagement, information-gathering and diagnosis.¹⁷ We therefore deliberately engineered scenarios so that participants had to negotiate the patient or relative's agenda in order to add further realism.

The training for the CT1s was delivered once they had been in post for 6 months in order to allow them to acclimatise to their specialty training. CT2s had their training 2 months following a change of training post. Delivery coincided with the time slot during which trainees would normally attend academic teaching in order to minimise disruption to clinical services, since this time was usually anticipated for by the services in which trainees were in post.

Each year's course followed the same format—six scenarios taking place over one afternoon. In order to facilitate learning and promote a safe environment, trainees were split into small groups of three to four trainees. Each group had two facilitators trained in giving feedback: a consultant and a higher trainee (ST4-6). Each of the six scenarios involved one actor, with the actors rotating around each of the small groups over the course of the afternoon. Trainees undertook at least two scenarios each. Each scenario lasted 10 min with a 15 min debrief during which feedback was given by the facilitators, peers and actors.

Feedback was delivered using Pendleton's rules.¹⁸ This model was chosen due to our anticipation that trainees would display a strong desire to receive specific feedback and suggestions for improvement from the training. Furthermore, we anticipated that trainees would not yet have achieved competence in some of the communication skills so that debriefs would require an emphasis on technique. Owing to the limited time available, a more in-depth debriefing model would have been difficult to accommodate. However, where appropriate, facilitators were encouraged to discuss both the non-technical factors and the psychotherapeutic factors at play during the scenarios. Along with oral feedback, trainees were given written feedback so that they might further reflect on their experience after the event.

Pre-session and post-session questionnaires were devised to assess trainees' experience of the simulated scenarios and the small group debriefs. These also assessed change in trainees' perception of their ability to deal with difficult and challenging situations. The questionnaires comprised a mixture of Likert scales and free-text boxes to allow both a quantitative and a qualitative perspective on the training. Facilitator feedback on the experience was also requested.

Individual interviews of participants (n=4) on the CT1 course were conducted 2–3 months after the course. Using a semistructured questionnaire, trainees' experiences of the course and its educational impact were explored. Interviews were transcribed and analysed for themes. These themes were correlated with the qualitative data collected in the post-course questionnaires and cross-checked for validity by both authors.

RESULTS

Box 3 summarises the feedback collated from the post-course evaluation questionnaires.

Thematic analysis of the participant interviews and the free-text questionnaire answers elucidated the following themes:

- ▶ *Scenarios*—these were reported to be highly realistic while the opportunity to practise challenging scenarios was appreciated.
- ▶ *Feedback*—trainees appreciated receiving feedback from multiple sources. Written feedback was reported as 'very powerful'. The style of oral feedback was felt to be *honest* and *helpful*, although one trainee found it to be too general in nature. The manner in which feedback was delivered appeared important with one trainee appreciating the employment of Pendleton's rules:

Box 3 Trainee and facilitator feedback from the training programme

Trainees (n=39)

- ▶ 100% agreed that learning in small groups was useful
- ▶ 95% felt that simulation training was a good use of training time
- ▶ 100% felt that their communication skills had improved
- ▶ 97% felt more able to defuse an angry/tense situation at work
- ▶ 92% felt more able to deal with a complicated situation requiring sophisticated communication skills
- ▶ 97% felt that regular simulation training would be valuable

Facilitator results (n=24)

- ▶ 100% felt that the group sizes worked well
- ▶ 100% agreed that the training was valuable to the trainees' professional development
- ▶ 100% felt that the training provided a realistic experience of clinical situations
- ▶ 96% felt that the training was conducted in an environment conducive to learning

It's the difference between you feeling really rubbish about yourself and actually feeling good but learning stuff...

Facilitators also welcomed the opportunity to contribute to the trainees' professional development by giving feedback after the scenarios.

- ▶ *Small groups*—these allowed for an *informal* and *comfortable* setting. Group size was *ideal*, although one trainee reported feeling nervous in groups. Trainees particularly appreciated the opportunity to observe how their peers dealt with situations.
- ▶ *Self-awareness*—this was a significant theme with trainees demonstrating rather poor self-awareness going into the training:

I didn't really know if what I was doing was the right thing.

This was complemented with the idea that the training had helped improve trainees' awareness of their communication style.

- ▶ *Educational impact*—trainees reported improvements in their confidence which later seemed to have translated to their clinical work. Indeed, immediately after the courses, some trainees reported the intent to adapt their communication styles on return to clinical work.
- ▶ *Exams*—the experience was felt to be a useful introduction to how undertaking the postgraduate clinical examination might feel.
- ▶ *Benefits of simulation*—simulation was identified as an opportunity to experiment—one that the trainees had not yet experienced in psychiatric training. This reflected the validity of the educational need initially identified.

DISCUSSION

While the pilots ran well and ongoing support for the programme continues, we encountered many difficulties in setting up and delivering the training.

Fortunately, we had considerable support when we embarked on the initiative and, despite economically difficult times, the medical education boards in the mental health trusts involved

were forthcoming with funding. However, we did encounter some difficulty in finding venues with suitable space as several breakout rooms are required for the small group work. Enlisting enough facilitators was also at times time-consuming.

With regard to the running of the training sessions themselves, unanticipated non-attendance of students affected group sizes with some having only two trainees. This inevitably affected the dynamics of the group and could have affected trainees' experience despite preplanning to avoid such eventualities. Another unanticipated issue was the need to establish a protocol for reporting concerns over trainees' competence. This happened on one occasion and no clear pathway had been established.

The data we collected were limited due to the inherent difficulties in measuring individuals' perception of their ability. There is high variability in self-concept and we did not account for this in our data analysis. This may not therefore be the best way to measure educational impact. Rather, observation of particular communication skills developed during the training in the clinical environment may provide a better demonstration of learning.

Furthermore, the use of Likert scales, while allowing for simplistic quantitative data, resulted in a lack of specifics in the data. For example, our data could not answer *why* the course was a good use of training time.

It is likely that there was a significant response bias in the questionnaires as the trainees were aware that the training was an undertaking of goodwill and therefore may not have reported negative experiences. An anonymised feedback questionnaire at a later date may have resulted in less bias. Furthermore, the gathering of reactionary feedback failed to give any accurate information on whether or not the training had had a lasting impact on trainees' practice. It would be important to measure educational impact in a longitudinal way while ensuring the scientific rigour of the data collection methods.

The interviews were conducted and analysed by the authors. This also led to significant response and analysis bias. While an effort to triangulate the data was made by using the post-course questionnaires, a more appropriate method of attempting this could have been to assess the supervisor's perceptions of trainees' change in confidence pre-course and post-course.

On course delivery days, it was clear that there were significant variations in facilitator feedback style which could have impacted on trainees' learning. A more thorough briefing and training of facilitators in feedback methods would help to account for this.

Finally, when designing the intervention initially, we had hoped to videotape the scenarios in order to give the trainees the opportunity to watch themselves back and to allow facilitators to give more focused feedback. Existing literature demonstrates that videotape analysis, when coupled with simulation and feedback, is of added benefit in improving communication skills.^{12 15 19} Unfortunately, we did not have the technical facilities available to us to implement this intervention.

CONCLUSION

Despite the limitations, our training programme demonstrates that it is possible to use simulation to provide realistic, enjoyable and educationally beneficial advanced communication skills training relevant to psychiatric practice.

Trainees valued the opportunity to experience difficult situations involving patients and relatives in a controlled

environment while facilitators appreciated the opportunity to contribute to trainees' professional development. Furthermore, trainees appeared to experience an improvement in their confidence in managing difficult interactions along with an increased awareness of their particular communication style.

Changing roles in modern healthcare provision may threaten core psychiatry trainees' exposure to first-line assessments. Simulation training may, in part, compensate for this while also helping trainees to gain more confidence in their abilities. Our programme is a relatively simple, inexpensive and time-effective intervention that can be easily replicated in other postgraduate psychiatry trainings both in the UK and beyond.

The question of whether such simulation courses can be used as a formative or indeed summative assessment of an individual trainee needs consideration. The implications of using simulation for the assessment of psychiatric skills has previously been discussed.¹⁷ While its use in objective structured clinical examinations (OSCEs) is appropriate when assessing a discrete skill, for example, eliciting the core features of a depressive episode, the standardisation of concepts such as empathy, interpersonal skills and communication skills is problematic. In adopting such an approach, the implication is that there is a 'correct' way of communicating with patients. For our course, we wanted to foster what was already good about trainees' individual styles and support them in reflecting on possible alternative approaches to their interactions with patients and relatives. To us, this negates the option of our particular course being used for assessment. However, this concept is one that would benefit from further consideration, and there are numerous novel ways in which simulation might be developed for use in psychiatric education in the future. The area is an exciting one to explore.

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