Teaching Clinical Skills in Psychiatry

At the 1980 Annual Meeting (page 194) one of the sessions was devoted to the Teaching of Clinical Skills in Psychiatry. The following articles are based on presentations given at that session.

Teaching Counselling Skills to Undergraduates and Postgraduates

By T. A. BETTS, University of Birmingham

For some years my colleagues and I have been teaching counselling skills to undergraduate medical students and to postgraduate trainees in medicine, social work, nursing, clinical psychology and occupational therapy. We started teaching these skills to postgraduates (particularly family planning clinic doctors and nurses) at the request of the Family Planning Training committee of the West Midlands Regional Health Authority. At first we concentrated on teaching simple psychosexual counselling skills but latterly, as a result of consumer demand, we have extended the number of topics. We have also begun to apply the lessons we have learnt in postgraduate teaching to the teaching of medical undergraduates.

In the light of our experience we feel that counselling can be taught and learnt with benefit by all health professionals (whether students or trained). Continual evaluation of our courses has led to the following conclusions about what should be taught and how.

Firstly, what do we mean by counselling? There are, of course, many schools of counselling, each with its proponents and areas of usefulness. Both teachers and trainees on our courses come from different disciplines, with different theoretical concepts. On what kind of common basis can we teach?

Our basic model, which suits all health service professionals and which requires little theoretical knowledge to understand, is a simple non-directive reflective one; it is designed to elicit information and feelings from the client and to enable the counsellor to discover the factual information he needs to give so that the client can reach a considered decision about a particular problem (e.g. choice of contraceptive or whether to seek termination of pregnancy). When therapy is needed (as in sexual or marital counselling) a simple behavioural model is taught. We do not try to teach psychotherapeutic skills, although counsellors are taught how to facilitate the expression of feelings (as in bereavement counselling).

This choice of model does not imply that alternative ones are not equally useful, but we have found that novices need a model which makes sense and does not require a long theoretical training before it can be put to use. Trainees can grasp this simple model readily. Their own theoretical background, previous training, personality and preferred style of work determine how they will modify the model in the light of experience.

Many non-medical health professionals who would make excellent counsellors are inhibited from giving simple counselling in their work because they believe they need extensive training before they can counsel effectively. We try to demonstrate that principles of counselling are fairly simple and common sense, and we encourage them to 'get their feet wet'.

We have experimented with both single and multidisciplinary courses. Both have their advantages. Certainly, if too many different professions participate in one course, members of a particularly assertive group can swamp the learning experience of others: but a combination, say, of health visitors and social workers can be most valuable, as can a mixture of medical students and social workers or medical students and nurses.

Whatever the participants' theoretical background and previous experience, we feel that teaching principles of counselling proceeds along distinct stages, and depends to some extent on whether the trainee already has clients and wishes to learn to counsel them better, or whether he is seeking opportunities for counselling experience as well. Stages of training are best illustrated by our programme in psychosexual counselling.

Stage 1: Basic Knowledge and Interviewing Skills

We first teach interviewing skills, using the model developed by Maguire and others in Manchester; in addition we focus on aspects, such as dealing with embarrassment and avoiding jargon, which are pertinent to psychosexual counselling.

The trainee requires a certain knowledge of the anatomy, physiology and psychology of human sexuality to be able to counsel effectively; this does not mean an esoteric acquaintance with the Kama Sutra, but he should learn enough about current scientific knowledge of human sexuality to give non-judgemental and factually correct answers to clients' common questions, and to distinguish between normal, if somewhat unusual, phenomena and pathology. The counsellor is taught to recognize common patterns of sexual difficulty which he will face. Next follows instruction on assessment of sexual problems in terms of necessary

https://doi.org/10.1192/S0140078900014632 Published online by Cambridge University Press

background information needed to implement treatment. The final component of stage 1 is the teaching of the basic counselling skills that are used to treat common psychosexual problems.

These areas: (1) interviewing (2) technical information (3) problem recognition (4) assessment, and (5) simple counselling are usually taught in a three-day course. After this, participants decide whether they have learnt enough (and experience has taught us that most participants on such a course have learnt enough to be able to give simple advice in, for instance, family planning clinics) or whether they wish to receive further training.

Stage 2: Role Play and Feedback

Trainees who seek further training attend a second course (usually lasting two days) in which more intensive instruction is given in interviewing and counselling skills and in a 'Masters and Johnson' behavioural programme. The trainees, fewer than on the first course, receive feedback of their performance and skills, using role play. The role players are usually staff members who portray clients they have counselled in the past.

Stage 3: Supervised Clinical Experience

Students now form a closed seminar training group which meets fortnightly over a year. Co-therapy pairs treat three patient couples with sexual problems under the supervision of an experienced therapist. Co-therapy works if both trainees have similar levels of competence, as each gives the other support. In the week when no seminar is held they see their clients; they report their progress to the seminar group in the other week.

Stage 4: Further Experiences

With three couples treated, trainees can receive additional supervision over a year, in which, no longer in pairs, they treat another six couples.

There has been much discussion about whether some kind of assessment of suitability for training should be instituted, perhaps between stages 2 and 3 or between stages 3 and 4; we are currently experimenting with different forms of assessment.

The above programme is obviously modified for the other forms of counselling, although the model is basically the same. We offer instruction in the following: psychosexual counselling; marital counselling; pregnancy/abortion counselling; counselling of the dying and the bereaved; and contraception/sterilization counselling. Courses on counselling the handicapped and the alcoholic are planned. Basic information for some of these courses can be taught together in the same programme, and we have developed 'Introduction to Counselling' courses in which basic interviewing and counselling skills are described and demonstrated and the various aspects of specific counselling areas are outlined. Participants can then choose a particular training course, starting at stage 1.

Training programmes in psychosexual, marital and pregnancy counselling take place at present in the West Midlands Health region and are proving successful. Some trainees have access to clients and need only supervised experience following a basic training; for other trainees we provide clients from a counselling clinic run jointly by the Departments of Psychiatry and of Obstetrics and Gynaecology of Birmingham University. Pregnancy counselling is provided separately in one of Birmingham's main family planning clinics.

Counselling courses are run for medical students as an option while they are having ten weeks' training in psychiatry in their final year. Some students continue to counsel patients during the rest of the final year and join a training group. A recent innovation has been the development of a specific two-month elective in counselling offered in the students' fifth year. Some students attend a three-day basic course (stage 1 or 2) during their psychiatric clerkship.

Use of videotape

We use videotape extensively in the above training. As Maguire and others have shown, video is an excellent tool in teaching interviewing skills, as it provides both a model of methods the trainee should aim for and feedback to him of his actual performance.

In stage 1 video is used to provide models of, and information about interviewing. Basic technical knowledge is also transmitted through video, as are patterns of the presentations of problems, a model of assessment, and models of counselling.

We have found that the best method of teaching is a combination of teacher and video. (Although our tapes are designed for self-teaching and impart as much information as a teacher plus video, students prefer the combination.) We have shown in an unpublished study that a teacher without video is significantly less effective, in terms of the information trainees retain.

In the stage 2 course video models are also used, and video feedback of the trainees' performance in role play is incorporated. In stage 3, video is applied again to introduce various models of interaction with clients and to provide trainees with feedback of their work with actual clients.

Over the years we have made a large number of training and modelling tapes (these are widely used in other centres). Details of these tapes, which are available for use, can be obtained from the author. These tapes have been made in cooperation with the Television and Film Unit of the University of Birmingham. Our own studio is used for video feedback training, and to make tapes for our own consumption.*

* [At the first festival of the Inter-University Working Group for Audiovisual Programmers on Psychology held in 1980, the only award granted was won by Dr Betts for his series on "Psychosexual counselling".—Ed.]

https://doi.org/10.1192/S0140078900014632 Published online by Cambridge University Press

Evaluation by the trainees of our courses has always been carried out, and we have much modified them in the light of comments received. Trainees have consistently reported the use of videotape as being invaluable as a training procedure, and as a means of gaining a great deal of information which could not be acquired in any other way. Without videotape providing information, models and feedback we could not run the courses in the economical way that we do, and they would not be so successful.

Teaching Medical Students to Interview Psychiatric Patients

By PETER MAGUIRE, Withington Hospital, Manchester

If medical students are to be effective in clinical practice they must acquire the skills needed to put patients with psychiatric problems at ease, to promote trust and confidence, and to elicit an accurate and relevant history. Unfortunately, there is considerable evidence that traditional methods of medical training fail to equip them with these essential skills.

To assess their skills, 50 medical students about to take final examinations were each asked to interview a cooperative psychiatric patient. They were given 15 minutes to obtain a history of the presenting complaints. The interviews were videotaped, and the interviewing techniques rated on a 5-point scale. The information obtained was also rated according to category and completeness.

This analysis revealed serious deficiencies in history-taking skills (Maguire and Rutter, 1976). Eighty per cent of the students avoided personal aspects such as the patient's relationships, sexual adjustment, feelings about his illness, and the possibility of suicidal ideas. They (86 per cent) made little effort to date key events in the patient's history or to determine what treatments he had received. While all the patients gave clear verbal clues about their problems, most students (74 per cent) failed to pick up more than a fraction of these. Even when they established the key complaints they commonly (62 per cent) failed to clarify their true nature and extent. The students obtained only a third of the relevant data that were judged to be 'easily obtainable' within the time allowed.

These deficiencies are not remedied by later clinical training and are equally evident in general practitioners, general physicians and surgeons (Sanson-Fisher and Maguire, 1980). Moreover, Goldberg and his colleagues have established a strong link between this lack of skills and the failure of general practitioners to recognize and treat much psychiatric illness which presents to them (Goldberg *et al*, in press; 1980). It is important, therefore, to consider why students and doctors lack these skills and how they can better acquire them.

Most undergraduate teaching is based on the apprenticeship method. When attached to a psychiatric firm students are given a handout which simply lists the questions they should ask when taking a history. As clinical clerks they then interview both new and old patients. Their ability to take a history is judged on the histories they write up and present. Such a judgement takes no account of how the student actually conducted his interview or of what the patient thought of the student. Like the initial handout it focuses on content, and is inevitably misleading. So both teacher and student remain unaware of any deficiencies. Most teachers were taught by using a similar method and are unaware of its shortcomings or reluctant to admit them.

The development of more effective methods

History-taking skills could be acquired more easily if the training programme included the following components: the provision of handouts detailing questions to be asked and the techniques to be used; a chance to practise under conditions of direct observation within a strict time limit, and feedback about performance.

To evaluate such a programme, 24 medical students were randomly allocated to routine clinical training (control) or to routine training plus the training programme (experimental) (Rutter and Maguire, 1976). Students in both groups conducted a short practice interview which was videotaped. The experimental students were then given a handout, watched their taped interview and received individual feedback about their performance. A week later both groups of students conducted a second practice interview. The experimental students obtained nearly three times as much accurate and relevant information as the control students.

A second study was conducted to see if videotape feedback was a crucial component of training. Students were randomly allocated to training by practice, presentation of a handout and video feedback, or to training by practice and handout alone. No differences were found between the groups in the amount of data they obtained. Provision of a clear model of what and how to ask questions coupled with practice under strict conditions led, it seemed, to students obtaining more accurate histories.

This encouraged us to prepare videotapes more clearly demonstrating history-taking methods. Students who viewed these tapes in conjunction with the handouts and practised

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