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Training matters

Interview skills training

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The importance of interview skills in psychiatry cannot be underestimated, and the acquisition of adequate interview skills must be one of the foremost aims of training. The College requirement that MRCPsych candidates must interview the patient in front of the examiners (in both parts I and II) rightly stresses the fundamental importance of interview skills in clinical practice. Maguire (1982) has questioned the adequacy of standard methods of training psychiatrists (usually reporting and discussing interview findings with a senior colleague) in interview skills. In a study of medical students, he has shown that audio/videotaped observation of interviews with feedback is superior to traditional methods (Maguire *et al*, 1978). Gask *et al* (1988) demonstrated that use of group video feedback training was effective in improving psychiatric skills in a group of general practitioners. Rutter & Cox (1981) published a series of studies examining the effects of interview style on the quality of factual information obtained and the emotional response elicited. Such work has generated interest in interview skills training and specialised courses are now run in some centres.

This survey reports the recent experience of interview skills training of a group of psychiatric trainees. An important aim was to establish the frequency with which the trainees had been observed by senior staff and given feedback on their performance. Their satisfaction with the training they received was investigated and they were asked to suggest changes they would make when in consultant posts to ensure that their junior staff obtained adequate training. Interview skills need to be modified when working with particular patient groups, e.g. children or the mentally impaired, and specialised skills are also needed to use psychotherapy techniques successfully. The survey therefore examined the proportion of trainees who had experience and training in these areas.

The study

A brief 14-item questionnaire was constructed to obtain information about interview skills training. Due to restrictions in the scope of this study, it was not possible to distribute a questionnaire to each trainee nationwide. To obtain information from trainees in as many training schemes as possible, copies of the questionnaire were distributed to all clinical tutors in England, who were then asked to pass them on to their trainees; 750 questionnaires were distributed and a return envelope was provided with each one.

The trainees were asked how often and in what settings they had been observed by a senior colleague while interviewing a patient. Other items related to the types and usefulness of other methods of interview-skills training received. Trainees were asked to record their satisfaction with their training and what changes they would make when in consultant posts. They were also asked to record if they had experience and training in any of the following areas: behaviour therapy, cognitive therapy, psychodynamic psychotherapy, child psychiatry, and mental impairment.

Findings

Two hundred and thirty (31%) questionnaires were completed and returned; the trainees concerned came from 23 training schemes. Posts held and years in training are shown in Table I.

One hundred and seventy-two (75%) trainees had been observed interviewing by a senior colleague, while 58 (25%) trainees had not. This training had been provided by consultants in 87 (38%) cases, by senior registrars in 22 (10%) and 58 (25%) had been observed by both. In most cases, this observation and feedback took place in specific teaching sessions (117, 51%), while 56 (24%) had been observed in

TABLE I
Clinical experience of trainees (N = 230)

(i) *Year commenced training*										
	1988	1987	1986	1985	1984	1983	1982	1981	1979	1975
N	40	50	59	39	12	12	11	4	2	1

(ii) *Post held*			
	SHO	Registrar	Senior registrar/Research post
N	58	140	32

ward rounds, 55 (24%) in out-patient clinics, and 66 (29%) had been observed in more than one setting. Of the 40 (17%) trainees in their first year of training, 23 had never been observed. Of the 81 (35%) who were in the fourth or later years of training, 13 had never been directly observed and a further four had been observed in child psychiatry but never in general psychiatry.

There were wide variations in the frequency of observation, from those who had been observed once only to some who had been seen regularly throughout their training. In some cases this observation had only been provided in 'pre-exam' tutorials. Several other methods of interview skills training had been experienced; 156 (68%) had read about interview skills, 134 (58%) had attended seminars/lectures, 175 (76%) had seen videos of others interviewing and 217 (94%) had directly observed their colleagues. Of these methods, direct observation of others was rated the most useful by 139 (60%), seminars by seven (3%); 170 trainees (74%) wanted more interview skills training, while 26 (14%) were satisfied with the training they had received (34 failed to reply to this question). Of those 81 trainees in fourth or later years of training, 64 would have liked further training, while seven were satisfied with their experience (ten did not reply to the question). Of those wanting more training, the most popular request (from 123, 85%) was for more observation and feedback on their performance, either direct observation or by use of video, one-way screen or role-play.

Seventy-seven (34%) had some experience using behaviour therapy, 43 (19%) cognitive therapy and 147 (64%) psychodynamic psychotherapy; 91 (40%) had experience of child psychiatry and 40 (17%) in mental impairment. Of the trainees, 209 (91%) would make changes in interview skills training when they reached consultant status, while one would make no alterations (20 did not answer the question). One hundred and fifty-one (66%) suggested more observation and feedback of their trainees, and 47 (20%) would provide more opportunities to observe senior colleagues. Other suggestions included more early training and more regular training with periodical assessment. The instigation of formal courses, mock examinations, video libraries and patient feedback were also suggested. Twenty-five (11%) trainees particularly suggested that more observation and feedback should take place in clinical settings, either out-patients or ward rounds. Some suggested that particular problems should be emphasised – e.g. interviewing the violent patient or interviewing transcultural cases. A number of trainees suggested that their general psychiatry training would have benefited from the use of the type of interview skills training found in child psychiatry or general practice.

Comments on training were frequent: "I feel that what I have had has been very helpful". "Not as often as would be beneficial and varied widely between units and consultants." "Registrar/senior registrar should have more time to teach trainee, rather than trainee being left to get on with it."

Comment

This study describes the experience of interview skills training of 230 psychiatric trainees. Sending the questionnaire to every trainee in the country was beyond the scope of the study. Responses from 230 trainees from 23 training schemes do, however, form a substantial experience of training, and the results are worthy of preliminary consideration.

Our findings suggest that direct observation with feedback of trainees' interviewing technique is a valued part of training and more of this type of input would be welcomed by many. In some training centres this occurs regularly and trainees are very satisfied. In other cases the end of training has been reached without any observation, and it is debatable whether such trainees are adequately prepared to move on to senior posts, where they will be responsible for the training of juniors.

Many were in their first years of training when this survey was carried out and were likely to be observed interviewing patients at later stages. However, it

could be argued that some sessions of direct observation and feedback should be carried out at the beginning of training and that reliance on interview skills training carried out at undergraduate level is unsatisfactory.

Many trainees wished to have more regular observation; on some training courses there appeared to be marked variation between posts – some trainees were regularly observed while others were not. In some cases all the training had occurred in one post and the rest of the rotation had been completed with no further feedback. For some trainees, the only observation of their interview skills was carried out in preparation for the MRCPsych examination, which undervalues the relevance of interview skills to clinical practice. The majority was carried out in special teaching sessions and rather less in clinical settings. As time and resources are scarce, it may be that out-patient clinics and other clinical settings could be better utilised. More input from consultants would be valued, and it appears from these results that senior registrars could become more involved in training of their juniors. Several trainees suggested that their senior colleagues would benefit from interview skills training. Maguire (1982) has pointed out the dangers of observation of those whose skills are themselves deficient.

Of the other types of interview skills training offered, observation of others was seen as being much more useful than seminars or lectures. It may be better to suggest reading to enable trainees to learn theoretical points and lecture time could then be replaced by practical work with feedback. Child psychiatry training is highly regarded, trainees are regularly observed and several wished that they had had the same experience in general psychiatry. A few trainees were opposed to observation and feedback. In a trial of such methods, Zimmer *et al* (1983) encountered similar resistance in some colleagues. In this survey, these trainees felt that the experience would be nerve-racking and their interview skills inhibited. Senior staff should be prepared to invite feedback on their own techniques and hence encourage trainees to overcome these anxieties.

While most trainees had experience of psychodynamic psychotherapy, most had not used behaviour therapy or cognitive therapy. Similarly, not every trainee had interviewed children and very few had experience with the mentally impaired. It is possible that increased instruction in specialised interview skills may encourage trainees to gain experience in these areas. In this sample, direct observation with feedback is a valued method of learning interview skills and its importance seems to be recognised in most of the training schemes concerned. We suggest that such training should begin as early as possible during the rotation and a short introductory course may be the most satisfactory way of achieving this. Training can be very patchy, even within rotation schemes, and more regular training is necessary so that trainees can evaluate their progress and work on problem areas. This could perhaps be carried out by each consultant at the beginning and end of each placement. Such an arrangement might be beneficial to consultants who often have to rely on their trainee's evaluation of a patient when making management decisions. If possible some training in interviewing problematic patients, such as the violent, suicidal or psychotic could be considered.

Obviously replies from a larger number of trainees would have been preferable; however, the information obtained in this survey suggests that the provision of interview skills training needs further examination. In psychiatry our competence depends on our ability to conduct a satisfactory interview. We support Maguire's view (1989) that a more systematic approach to postgraduate training and assessment of competence should be considered. A comprehensive survey of the quality of interview skills training is indicated.

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