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Improving communication in general practice when mental health issues appear: Piloting a set of six evidence-based skills

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ABSTRACT

Objective: To test a communication skills training program teaching general practitioners (GPs) a set of six evidence-based mental health related skills.
Methods: A training program was developed and tested in a pilot test–retest study with 21 GPs. Consultations were videotaped and actors used as patients. A coding scheme was created to assess the effect of training on GP behavior. Relevant utterances were categorized as examples of each of the six specified skills. The GPs' self-perceived learning needs and self-efficacy were measured with questionnaires.
Results: The mean number of GP utterances related to the six skills increased from 13.3 (SD 6.2) utterances before to 23.6 (SD 7.2) utterances after training; an increase of 77.4% ($P < 0.001$). Effect sizes varied from 0.23 to 1.37. Skills exploring emotions, cognitions and resources, and the skill Promote coping, increased significantly. Self-perceived learning needs and self-efficacy did not change significantly.
Conclusion: The results from this pilot test are encouraging. GPs enhanced their use on four out of six mental health related communication skills significantly, and the effects were medium to large.
Practice implications: This training approach appears to be an efficacious approach to mental health related communication skills training in general practice.

1. Introduction

About one-third of patients in general practice present with mental health problems ranging from severe mental disorders to less severe, yet significant, complaints [1]. Most of these patients are treated in general practice and are not referred to secondary health care [2]. Nevertheless, both patients and general practitioners (GPs) report that mental health treatment in general practice needs to be improved. Relatively few patients with mental health problems report that their problems are adequately addressed by their physician [3]. Many GPs also recognize a need for more expertise in treating mental health problems, thus they report learning needs and a wish to improve confidence in their own skills (self-efficacy) [4]. Moreover, studies have found that mental health and psychosocial problems often go unrecognized by GPs [5], or are insufficiently diagnosed [6] and treated [2]. Thus, there appears to be room for improvement in the quality of mental health consultations in general practice.

Several psychological therapies have been applied to improve mental health consultations in general practice, and specific approaches such as reattribution therapy have been designed specifically for general practice. However, these interventions are often conducted by specialized mental health workers and not by the GPs themselves. Moreover, several of these treatment approaches are designed for specific disorders and not for mental health consultations in general. These variations make comparison of effectiveness difficult [6].

However, there is some evidence in the communication skills training literature that physicians' communication behavior might influence a variety of patient outcomes, including effects on mental health outcomes. For instance, Roter and colleagues found that communication skills acquired by physicians after training were associated with decreased emotional distress of their patients [7].

Psychotherapy research has indicated that there are certain components similar in all therapies that together account for most of the outcome of treatment [8]. These components are known as "common factors" such as empathy, understanding of the patient's

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perspective, establishing a therapeutic alliance, and "client factors" such as the patient's personal strengths and motivation [9]. Common factors are similar to evidence-based communication skills emphasized, for example, in the patient-centered approach, which is a strategy for the general practice consultation process [10]. Client factors have been emphasized in more recent research, for instance in an intervention study on communication in general practice [11].

Each of these elements is important for mental health related outcomes. Studies have found that being sensitive and empathic regarding emotions can increase identification of patients' mental health problems, promote the creation of a therapeutic alliance, improve coping, increase satisfaction and self-efficacy, and decrease anxiety and depression [12–14]. Understanding the patient's perspective is important because most patients diagnose their own problems before visiting the physician. By eliciting this explanatory model one can get important knowledge about the patient [15,16], and an opportunity to promote insight and understanding, provide reassurance, reduce worries, and provide a more accurate and acceptable explanatory model [17]. By focusing on patients' strengths and resources one can learn about previous coping strategies, potentially increase awareness of current coping behavior, overcome barriers for change, and empower the patient to improve coping strategies.

However, a defined set of such evidence-based skills has seldom been presented as a potential approach for handling various mental health problems in general practice. Although many of these skills are taught in medical school and continuing medical education it is most often as a means to obtain rapport and secure an efficient and hopefully patient-centered exchange of information in the consultation, while emphasis on communication behavior as therapeutic strategies in and of themselves is less prominent. Furthermore, few approaches highlight how outcomes might be influenced by the exploration of different patient domains. This could explain why many GPs do not use these skills in practice [18]. We suggest that teaching GPs how to apply a limited set of core communication skills that previously have been found related to mental health outcomes might be a fruitful alternative for several types of mental health problems in general practice.

With this background, we have designed a communication skills training module with a set of six skills, for GPs to apply in potential mental health consultations. The aim of this paper was to assess GPs' use of the six skills before and after completing the communication skills training program. Previous studies on communication skills training have repeatedly found behavioral changes among physicians (in terms of the increased use of required communication skills) [7,19]. Therefore, our hypothesis was that GPs would use more of the six skills in a mental health consultation after this training program than before. Self-efficacy has been found previously to influence the learning and application of skills [20]. Therefore, we examined the GPs' perceived learning needs and self-efficacy before training, and evaluated whether these changed after training.

2. Methods

2.1. Research design, approach and strategy

The design was a test–retest intervention study without a control group. The assessment of GPs' communication behavior was based on video recordings of consultations with simulated patients before and after training. In addition, participants answered questionnaires about their self-perceptions. A quantitative approach was used to analyze data.

2.1.1. Participants

The communication skills training program was advertised on the Norwegian Medical Association's website. Participation gave Continuing Medical Education-points, and there was a participation fee, similar to other courses. All participants were GPs working in Oslo or Akershus County, Norway. Fifteen (71%) were males and 6 females.

2.1.2. Content of intervention

The training program was developed by three of the authors (TLS, TAM, and AF). It was based on findings from psychotherapy and communication skills training research outlined in the Introduction. The main content is a set of six skills (Table 1). Three of the skills are explorative, as follows: *#1 Be sensitive to and explore patients' hints, concerns and emotions*, *#3 Explore the patient's perspective and understanding* and *#5 Assess the patient's resources and strengths*. The other three are therapeutic skills elaborating on patients' responses to the explorations; *#2 Be explicitly empathic to emotional content*, *#4 Provide insight into possible cause-effect relations of the problem*, and *#6 Promote empowerment by focusing on resources, strengths and coping strategies*. All six skills have potential treatment objectives. Communicative strategies and examples of utterances are presented in Table 1, in addition to shortened labels for each skill #1–6 (used hereafter).

2.1.3. Intervention procedures

Two identical courses were conducted. Training was given over four afternoons for a total of 20 h.

On the first day of the course, before training started, all participants filled out two questionnaires and conducted a consultation with a simulated patient, which was video recorded. The participants were told to act as if in a normal setting, but without performing physical examinations. The simulated patients were seven professional actors, carefully trained in two specific patient cases. The cases were designed to exemplify common patients with mental health problems in general practice. One patient presented with abdominal pain and other somatic complaints which turned out to be symptoms of social anxiety. The other patient presented with a bad headache and fear of having a brain tumor, which appeared in a context of work-home stress. Participants on the first course got the pain/anxiety case before and the headache case after training, while participants on the second course got the headache case first and the pain/anxiety case second. We varied the case sequence to avoid results indicating behavioral changes caused by possible differences in the two case histories.

To give all participants equal opportunity to perform, we trained the actors to give specific verbal hints in each consultation. One such hint was a vague expression of fearing a serious disease. In addition, all actors/patients requested approval for sick leave from the GP. GPs' use of sick leave before and after training will be addressed in another paper.

After the first video recording, training started with a presentation of content and teaching strategies. Each skill was explained in short lectures, which gave an evidence base of how and why each was effective, as well as examples of exactly what to say (Table 1). These included demonstrations of specific skills. Modeling as well as other strategies used in the training (e.g. role-plays and feedback) have been highlighted previously as important in communication skills training [21,22].

The group of participants was then divided into smaller groups of four to six participants, each led by a physician or a psychologist. Role-plays were conducted in the small groups, and the participants discussed relevant experiences and challenges from their practice. Patient cases prepared in advance and GPs' own