General description form for teaching tools

In order to have a comprehensive general description of the teaching tool, please adhere to this format (fill in table at the end of the document, using the following instructions):

1. The **title.**
    a. It should be descriptive, brief, and always contain
        i. What kind of tool it is (for example, facilitator guide, simulated patient case, etc)
        ii. Which audience it is for
        iii. Which topic it covers
        iv. Which language it is in [in brackets]
    b. Example: Simulated patient case on dental patients with high anxiety for dental students [German]
2. The **language** of the tool.
    a. Describe what language the actual tool you are submitting is in – we welcome tools in all languages.
    b. If the tool is available in other languages, please also indicate this and if possible, submit examples of the tool in each language available.
    c. Example: German (also available in English)
3. For which **audience**?
    a. The audience whom this tool has been used with should be described. We recognize that some tools are for very specific audiences (for example, 2nd year dental students), while others might be used with a broad range of health professional learners (for example, bad news cases for any level of medical learner) This field should contain
        i. Information about profession(s) the tool has been used with (medicine, dentistry, nursing, other)
        ii. Information about level(s) of learner the tool has been used with (undergraduate, postgraduate, other)

iii. Information about preferred size of audience for use of this tool

b. Example: Cardiologists, nurses. Postgraduate. Small group (<10).

4. The **goals and objectives** of the tool (operational).

   a. First, please list the number(s) of the objectives of the Health Profession Core Communication Curriculum this tool addresses (also if the tool is for postgraduates)

   b. Then provide a description of the goals/objectives of the tool, describing the intended purpose of the tool in terms of what learners will be able to do after using it.

   c. If your tool does not fit the Core Curriculum, please make a note.

   d. Example: The tool addresses the Core Curriculum's objective A6. After this session, learners will be able to discuss the consequences of lab tests that indicate an HIV infection.

5. The **type of tool.**

   a. The description should be as brief as possible, yet sufficient to cover what it is.

   b. Possible examples: Lecture notes in powerpoint format, website, facilitator guide, comprehensive model, illustrative video, laminated pocket memory card, etc.

6. General short **description.**

   a. Please limit description to 200 words that includes main features of the tool including (if relevant) more precise description of audience requirements, length of session, etc. Please include important details (e.g. distribution of time on introduction, activation of prior knowledge, role plays, reflection, summaries etc, advantages and pitfalls when using the tool)

   b. Example: This is a set of four teaching sessions using small group work with simulated patients for first year clinical students to practise skills in: basic interviewing, gathering information, adapting their consultation style in different types of consultation, sharing information and discussing treatment, and breaking bad news. The packs include information on the format of the sessions, tutor notes, actor briefing and student handouts. One pitfall is that first year students often feel helpless because of little medical knowledge.

You should use sufficient time on the introduction of the first session to inform the students how to deal with that in these exercises.

7. **Practical** resources such as materials needed, faculty/facilitator needs, preparation needs, etc.
    a. Any information about necessary requirements for the tool needs to be listed here
        i. Necessary human resources (how many people does it take to use the tool in terms of teachers/facilitators, standardized patients (SPs), etc) and capabilities (what special skills do people using the tool need – for example SPs who can cry)
        ii. Necessary facilities and equipment including computers, cameras etc. (Are there any special room requirements, audiovisual equipment such as data projector, flip chart, etc)
        iii. Necessary software, handouts etc. (Does the tool require specific computer programs? Please list any handouts that need to be produced)
8. **Contact** information.
    a. Provide the name and email address of the person submitting the tool. This person should also be the author of the tool. If this is not the case, the authors should be listed and an explanation for why you are submitting the tool instead of them should be provided.
9. **List** of tool files.
    a. We prefer single, amalgated pdf files that include all material, unless this is not feasible.
    b. File names should preferably indicate author_tool type_language_date of submission (YYMMDD).
    c. Example: Gulbrandsen_lecture_note_Norwegian_130530.pdf

We would like to thank you for your contribution! Please follow the progress of our work at www.each.eu

Teaching Tool description	
Title	**T**raining to **E**nhance Co**m**munication with **P**atients with Psych**o**sis (TEMPO) [English]
Language	English
Audience	This training is relevant for psychiatrists (higher trainee psychiatrists, Staff and Associate Specialist Psychiatrists and Consultant Psychiatrists), psychiatric nurses, social workers and other mental healthcare professionals. It could also be useful for General Practioners working with patients with psychosis.
Goals/educational objectives Link with Core curriculum	The aim of TEMPO is twofold: firstly, to reflect on patients' experience of psychosis and challenges for patients and professionals communicating about these experiences; and, secondly to enhance communication with patients with psychosis. Participants will have an increased awareness of the patient's experience, which is the springboard for reflecting on and practising skills to enhance communication about psychotic experiences. The training focuses on core communication skills – e.g. exploring symptoms/ feelings/ expectations, active listening skills and responding appropriately, agenda setting, involving patients in decisions – and specific skills for working with positive and negative symptoms of schizophrenia – e.g. collaborative goal setting for patients with negative symptoms, cognitive behaviour therapy techniques for psychotic symptoms, explaining and normalising symptoms. Most elements of the training can also be applied to communication with patients with other mental health problems. After viewing their own interactions with patients, participants will also be able to reflect on their own communication and identify areas to work on with regards to their individual communication style. NB: This tool does not fit the core curriculum.
Type of tool	Facilitator's manual, power point slides for 4 group sessions, video clips of real consultation examples, experiential exercise (simulated hearing voices experience), role-plays in pairs and with actors (with and without) video-recording, individualised feedback session based on video-recorded consultations with patients The facilitator's manual consists of three parts: (i) an introduction to the training development and content (ii) guidance and instructions on how to run the sessions and use the specific training methods, and (iii) the teaching material for all sessions Slides, video clips and supplementary reading are in seperate format
Brief description	The TEMPO training is an evidence-based training programme for mental health professionals that aims to improve communication with patients with psychosis. The programme has been developed by experts in the field of communication, psychosis, medical communication skills, psychiatrists and service-users. The content is based on research conducted over 15 years using real video-recorded psychiatric

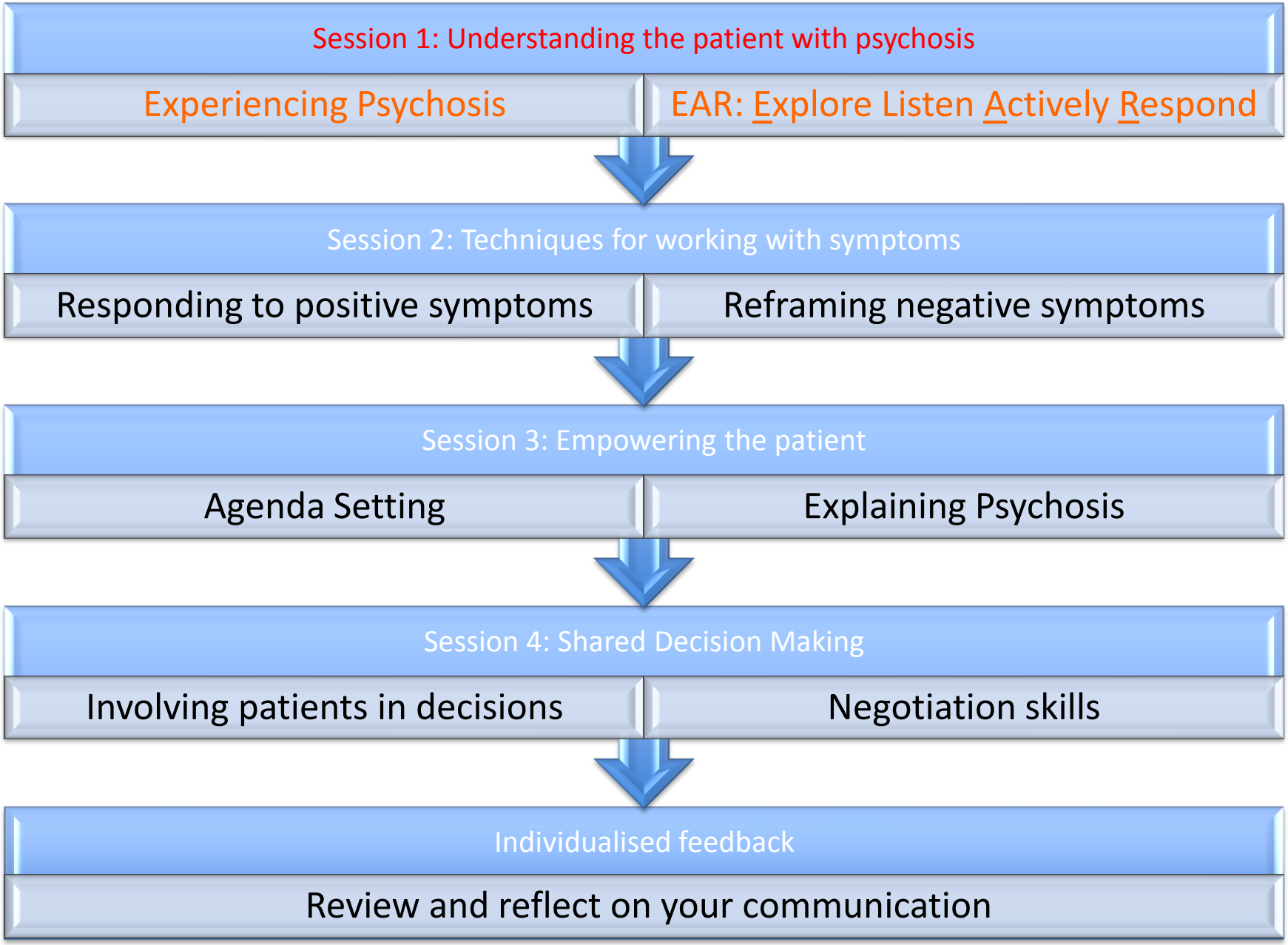
	consultations. The approach promoted in the training is to develop core communication skills, which can be applied to issues specific to psychosis and other areas in psychiatry. The training consists of four (3 hour) group sessions and one (1.5 to 2.5 hour) individualised feedback session. The focus of the four group sessions is: 1. Understanding the patient with psychosis 2. Techniques for working with symptoms 3. Empowering the patient 4. Involving the patient in decisions A range of training methods are combined, including experiential exercises, video-recorded role-play with simulated patients, reflecting on examples of real video-recorded psychiatric consultations and individualised feedback on one's own routine consultations with patients. The training can be adapted to suit the needs of participants. In a Randomised Controlled Trial, the training has been found to improve: professional communication in routine consultations; professional and patient views of the quality of their relationship; and, treatment satisfaction. Please contact us below if you would like further details on the trial.
Practical resources	The TEMPO training can be delivered in a number of different ways. It is possible to pick and mix elements of the training and adapt these according to your course requirements and learners' needs. Facilitators: Ideally, two facilitators should run the sessions. Between them, they should have an understanding of psychosis and communication. A combination of a communication skills facilitator and an experienced psychiatrist who is interested in communication works well. In order to ensure continuity, at least one facilitator should be the same across all of the sessions. It is optional to involve more facilitators who can deliver aspects of the training programme relevant to their expertise. However, a second co-facilitator is required for session 3 and 4 to run the role-plays in sub-groups. The minimum equipment needed is: • Overhead projector with screen • Flipcharts and pens • A laptop computer with PowerPoint is needed to access the material • MP3 players/device with headphones are required for the hearing voices exercise in session 1 • Two video-cameras and usb-connecting cables are required to film and enable video-feedback for role-plays in session 3 and 4 Optional: • Professional actors for role-plays in session 3 and 4

	• Video-recording of a consultation between the participant and a patient for individualised feedback sessions
Contact (name and email)	Prof Rose McCabe University of Exeter, Medical School R.McCabe@exeter.ac.uk
List of tool files	TEMPO_Training manual.pdf Slides session 1.pptx Slides session 2.pptx Slides session 3.pptx Slides session 4.pptx Hearing-voices-simulation.mp3 Supplementary reading: Session 1 - McCabe et al. (2008).pdf Session 1 - McCabe et al. (2002).pdf Session 2 - Kingdon et al. (2006).pdf Session 3 - Thomson et al. (2010).pdf Session 3 - Mitchell et al. (2007).pdf Session 4 - McCabe et al. (2013).pdf Session 4 - Torrey et al. (2010).pdf Video clips: Session 1 - EAR Skills 1.mp4 Session 1 - EAR Skills 2.mp4 Session 3 - Agenda Setting 1.mp4 Session 3 - Agenda Setting 2.mp4 Session 3 - Explaining Psychosis.mp4 Session 4 – Double-sided reflection.mp4 Session 4 – Options.mp4 Session 4 – Stop meds.mp4 Session 4 – Disagreement Service-user.mp4 Session 4 – Language Service-user.mp4 Session 4 – SDM Service-user.mp4

TEMPO – **T**raining to **E**nhance Com**m**unication with **P**atients with Psych**o**sis

Session 1

Understanding the patient with psychosis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Involving patients in decisions
Negotiation skills
Individualised feedback
Review and reflect on your communication

Key communication skills and how to acquire them

Peter Maguire, Carolyn Pitceathly

Summary points

- Doctors with good communication skills identify patients' problems more accurately
- Their patients adjust better psychologically and are more satisfied with their care
- Doctors with good communication skills have greater job satisfaction and less work stress
- Effective methods of communication skills training are available
- The opportunity to practise key skills and receive constructive feedback of performance is essential

Cancer Research UK Psychological Medicine Group, Christie Hospital NHS Trust, Manchester M20 4BX

Peter Maguire
director

Carolyn Pitceathly
research fellow

Correspondence to:
P Maguire
peter.maguire@man.ac.uk

BMJ 2002;325:697–700

Challenges

In pairs discuss…

- What issues have you faced when working with patients experiencing psychosis?
- What might the issues be for patients?

Group discussion…

- Feedback to group.

BMJ. 2002 November 16; 325(7373): 1148–1151. PMCID: PMC133454

Engagement of patients with psychosis in the consultation: conversation analytic study

Rosemarie McCabe, *senior research fellow*,[a] Christian Heath, *professor of work and organisations*,[b] Tom Burns, *professor of community psychiatry*,[c] and Stefan Priebe, *professor*[a]

[a]Unit for Social and Community Psychiatry, Barts and the London School of Medicine, Newham Centre for Mental Health, London E13 8SP, [b]Management Centre, King's College London, Franklin-Wilkins Building, London SE1 8WA, [c]Department of Psychiatry, St George's Hospital Medical School, London SW17 0RE

Contributed by

Contributors: RM was involved in the conception and design of the study, collection, analysis, and interpretation of the data, writing the article, and approval of the final manuscript; she will act as guarantor for the paper. CH contributed to the design of the study, interpretation of the data, and revision and approval of the final manuscript. TB contributed to the design of the study, collection and interpretation of the data, and revision and approval of the final manuscript. SP was involved in the conception and design of the study, interpretation of data, critical revision of the article, and approval of the final manuscript.

Correspondence to: R McCabe r.mccabe@qmul.ac.uk

Transcript

Mother: Okay three months time

Dr: So

Patient: Why don't people believe me doctor when I say I'm God? Why don't they believe me, cos everyone knows I am?

Dr: What shall I say now?

Mother: ha-ha

Dr: Well you are free to believe it but people are free not to believe you.

Communicating about psychotic experiences

- Avoidance – fear of disagreement
- Patients don't feel understood
- Patients 'confront'
- Disagreement between psychiatrist & patient
- Not a good basis for treatment engagement & adherence
- Qualitatively different experience
- Not a good basis for negotiating about treatment

- McCabe et al. (2002) Engagement of patients with psychosis in the consultation: conversation analytic study, British Medical Journal, 325: 1148-51.

Experiencing psychosis

What do psychotic symptoms feel like?

- Hearing voices simulation exercise

- Feedback experience to group

Break!

EAR Skills

Patients want to feel heard and understood

- Explore
- Listen Actively
- Respond

EAR Skills

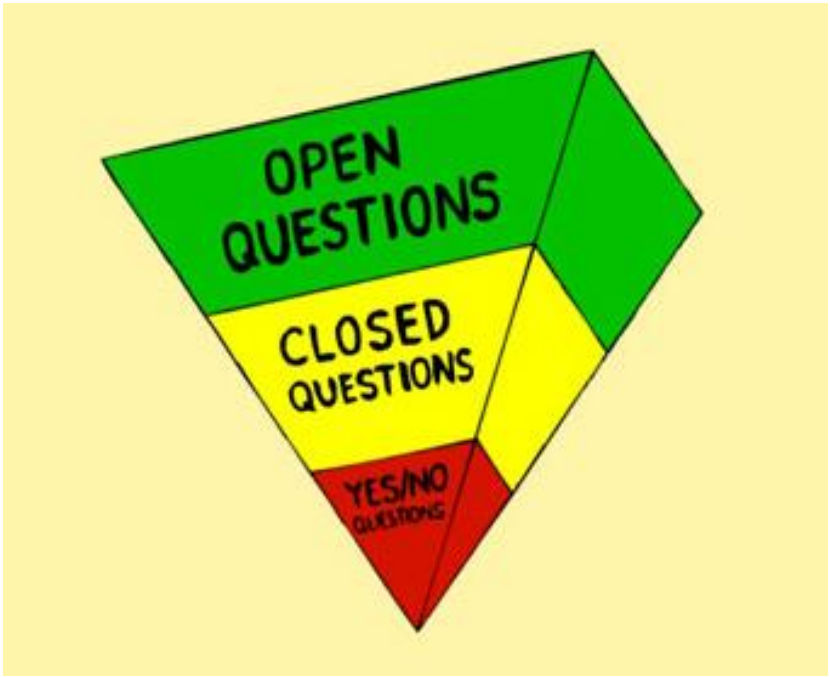
- Explore What?

Explore

- Explore:

  - Symptoms, Experience, Ideas, Feelings:
    - How are you in yourself?
    - How does it make you feel?
    - How do you cope with it when it happens?
    - What's your understanding of that?
    - How are things at home?
  - Worries, Concerns
    - What are you worried about?
  - Expectations
    - What were you wanting to talk about today?

Explore: Open to closed vs. closed questions



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Explore

- Avoid leading questions & presumptions
  - Real consultation examples:
    - ‘The voices don’t bother you do they?’
    - ‘You weren’t suffering from any paranoia?’
    - ‘No side-effects at all?’

Listen Actively

- What makes you feel listened to?
- Skills that help the patient to talk

  Wait:

  - Give patient time to think before answering
  - Allow patient to complete statements without interruption

  Non-verbal behaviour:

  - posture, gaze, nodding

- Summarize periodically, invite patient to revise

  Can I check that I have understood? What you have told me is…

  So from what you have said …… Have I got that right?

Respond

- Specific follow-up questions (depends on topic)
- VALIDATION
  - If patient is expressing or reporting difficulties: Acknowledge patients' feelings, concerns BUT not empty empathy ("I understand", "That must be very difficult")
    - You seem (frustrated, worried, sad).....
    - It sounds like that is very hard/distressing etc.....
  - If patient is expressing, reporting positives:

    Reinforce how the patient manages and positive steps they have taken
    - It sounds like you are dealing with it very well...
    - I can see you are feeling pleased with how things are.....

EAR-skills

EAR-skills

Active Listening Role-play

- In pairs assign psychiatrist and patient role
  - Patient presents concern
  - Psychiatrist to listen actively using EAR skills
  - Psychiatrist to then respond – acknowledge*
- Now swap roles…
- Feedback in group

*NB – do not give advice or explain yet

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan

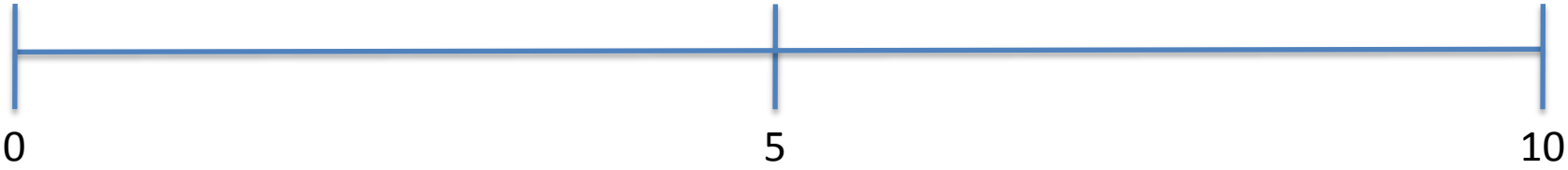
Action planning

- Choose 2 of the EAR-skills you think would benefit your practice this week.

1.

2.

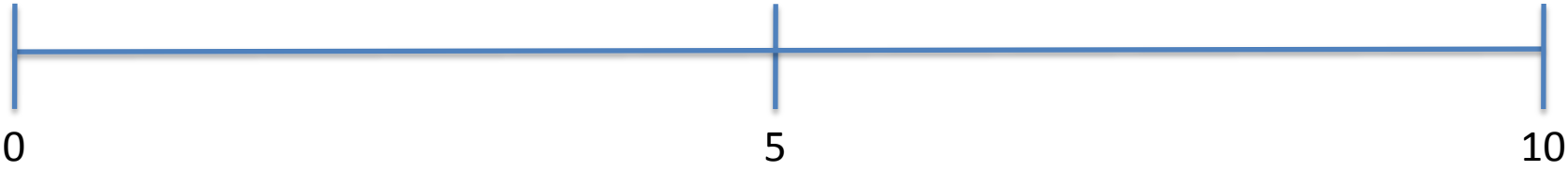
How important is it to you to use this in your practice in the next week?



Not important at all

Extremely important

How confident are you that you will use it in your practice in the next week?



Not confident at all

Extremely confident

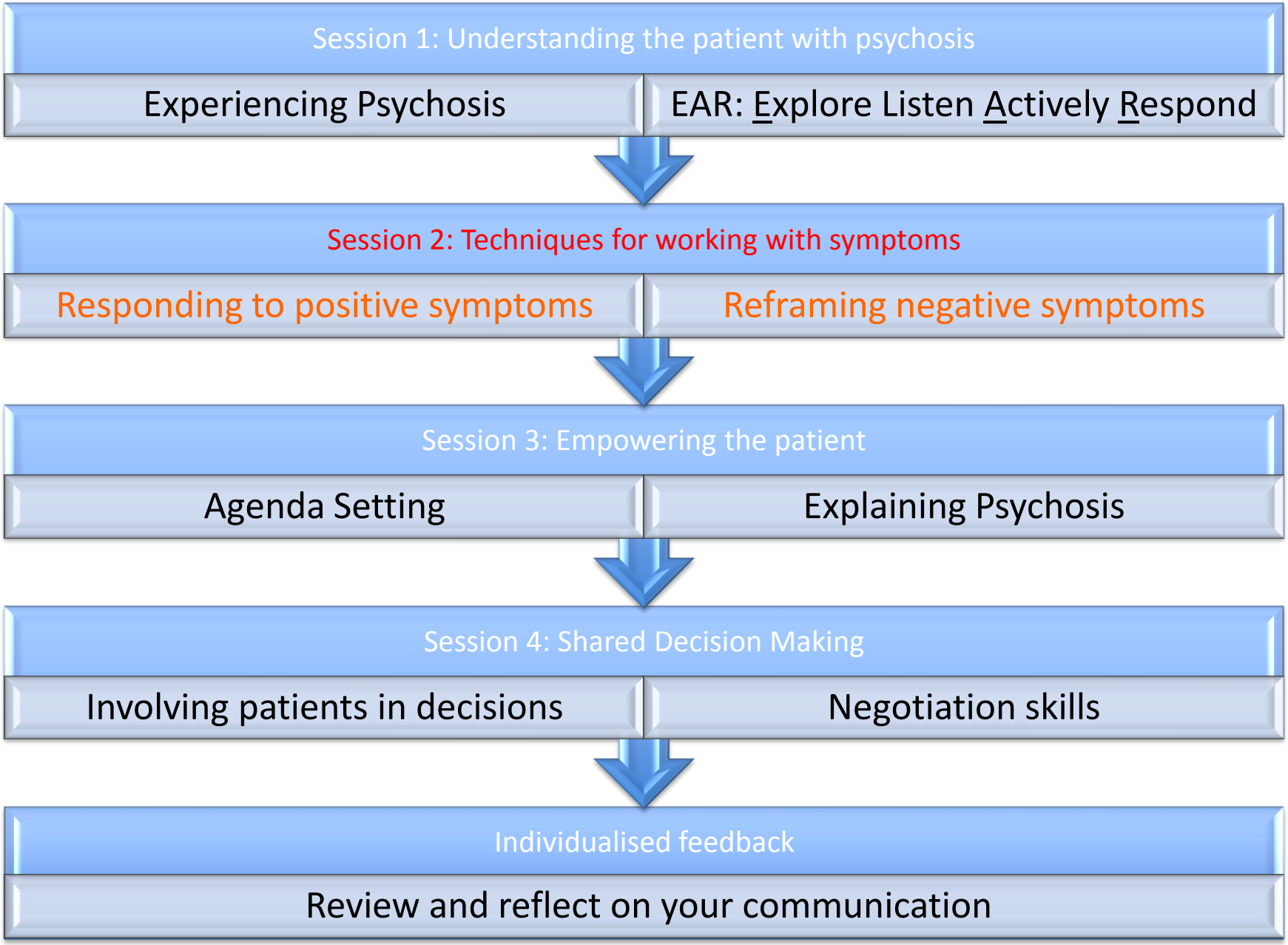
TEMPO

Session 2

Techniques for working with symptoms

Action planning - recap

- What 2 skills did you try?
- What success did you enjoy?
- What challenges arose?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Introduction

- CBT is effective for treatment of psychosis
- CBT session: 50 minutes over the course of multiple weeks but psychiatrists only have approx. 15 minutes
- However, some of the techniques are still very useful in psychiatric practice
- Work with patients along side other mental health professionals

Introduction

- What is the function of an outpatient psychiatric consultation?

Introduction

Essential tasks in any consultation:

- **Engagement**
- Assessment
- Formulation

Facilitating patient engagement

- Work on building up a therapeutic relationship
- Therapeutic relationship → Engagement → Adherence
- Develop therapeutic relationship:
  - Show that you're interested – in a non-critical way
  - Not about right or wrong
  - Patient to feel listened to
- You're the expert but patient is expert in their own life
  - work alongside each other and show understanding and respect

Positive symptoms: Working with strong beliefs

- How do you feel about discussing strong beliefs with your patients?
- How do you talk to the patient about it?

How to talk about strong beliefs

- Previous research shows: patients are talking about something really important to them and psychiatrist responds with e.g. are you taking your meds?

  → Psychiatrists tend to avoid the discussion because it may lead to disagreement
- Focus on listening, understanding, exploring, i.e. working on the relationship!

Explore strong beliefs

- Initial assessment

  (History of Presenting Complaint)

  – trace origins of belief: ‘listen to their story’
  – build a picture of prodromal period
    - identify *significant* life events & circumstances
    - identify relevant perceptions & thoughts
  – explore content of belief

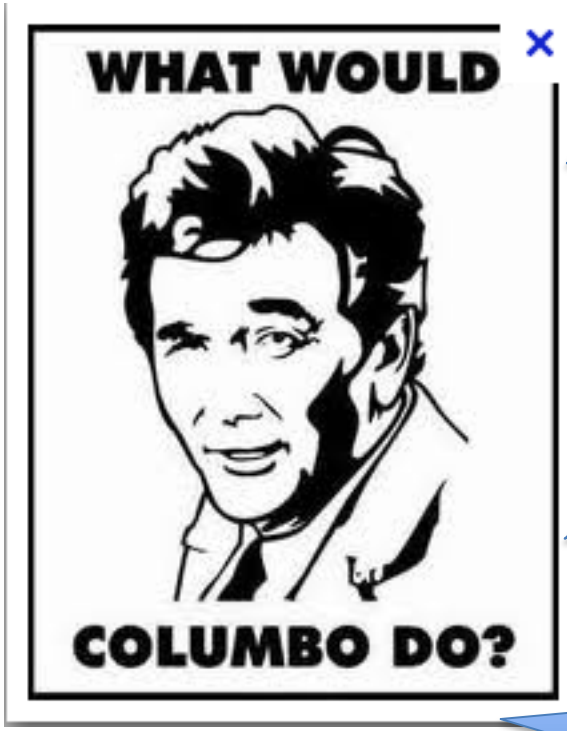
Explore patient's story

- Draw out the person's story surrounding the belief
  - 3 objectives:
    - You know the story
    - Patients knows you know the story
    - Patient understands the story and begins to process it
  - Process over course of 2 or 3 sessions
  - Go back to why they came to conclusions (belief) and what reinforced it
  - Exploring and listening to story helps building up rapport and patient engagement

Helpful phrases

When did it start?

What was happening at the time?



I'd like to understand why you believe this…

What made you believe this at the time?

It's given me some understanding of how you've become concerned

Tips

- Get across that you're interested. Not to demonstrate they're wrong. Not in a critical way, in an exploratory way.
  - I'd like to understand why you believe this….I'm really interested.
  - Can you keep going with the story? It's giving me some understanding of how you've become concerned.
- If patient is becoming distressed, step back
  - We can leave this for now, and come back to it.

Debate strong beliefs

- Establish nature of evidence for the belief
  - discuss significant others' opinions
    - Why do you think others think that..
  - elicit alternatives: prompt only if necessary
    - If someone said that to you, how would you respond?
    - What about...? do you think just possibly..?
    - Explore doubts about belief: even the tiniest wink of doubt is extremely helpful in the future
  - exploration/investigation
    - Simple tasks – find information or test out (e.g. use audio-recorder to test if voices are really there)

Opening and closing session

- Opening session:
  - trace origins & prodrome – sometimes this is only in notes!
  - explore current concerns
  - empathise/discuss

- Terminating sessions
  - agree to continue discussion – next time
  - agree to set up opportunity for further discussions
  - It's been very helpful to discuss this and we will continue our discussion

How do you respond…

- When the patient asks: ‘You don’t believe me –do you?’

How do you respond…

- Suggested responses:
  - Whether I believe you or not, it's important to talk about this. What you've told me at the moment, I'm not fully convinced. I think we need to talk about this more. I think I can see how you came to believe this. Is there anything you can do over the next few months that would help us in this discussion?
  - Can we set this aside for the moment and go back a bit to help me understand?

Positive symptoms: EAR skills

EAR-skills	Responding to positive symptoms: strong beliefs
Explore	Explore: patient's story of belief and individuality of perception & origin Discuss phenomena
Listen Actively	Show understanding & interest Check understanding
Respond	Normalize *most people…* Debate coping

Delusions Role-play

- In pairs assign psychiatrist and patient role
  - Patient describes current concern
  - Psychiatrist draws out their story using prompts and questions
    - by exploring how strong beliefs began
    - how they have developed
    - how they affect them now
  - Agree a way forward
- Now swap roles…

Break

Working with voices

- **Goal:**
  - Patient understand that you understand they are hearing voices
  - Ideally, the long-term aim is to develop patient awareness that voices may be something to do with them. This is key for interventions, medication, coping strategies, which are not relevant if nothing to do with them.

Explore voices

- Discuss the experience:

  What is it like? Someone speaking to you like I'm doing now.. maybe louder or whispered

- Explore individuality of perception

  Can anybody else hear what is said?' 'not parents, friends, etc?

- Discover beliefs about origin:

  Why do you think others can't they hear them?

- Debate individual beliefs about origin of voices
  - 'But that's the way God is..'; use techniques for delusions, if appropriate
  - explore doubts: 'I'm not sure how they come..'

Debate voices

- Weigh pros & cons of what voices say: ‘you’re bad’
  - Why do you think they’re saying that? Is there any truth to that? Do you think you’re that bad? What is it that’s bad? What are the good things about you?
  - Important for patient to draw conclusion, they’re ok
- Normalising explanations:
  - Sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, PTSD, ‘inner speech’, *dreaming*
  - Understand hallucinations – mind hears things, not coming through the ears, but coming from your mind, voice area in brain active (broca’s area).

Purpose of this approach

- Help patient understand the voices
- Clarify voices between you and patient → shared understanding of voices
- Help patient recognise: Not the voices are the problem – but what they're doing to you

Voices Role-play

- In pairs assign psychiatrist and patient role.
  - Patient describes voices
  - Psychiatrist
    - explores beliefs about voices
  - Agree a way forward
- Now swap roles…

Working with negative symptoms

- How do you recognise patient with negative symptoms?
  - Through conversation
- Key negative symptoms: lack of communication & motivation

How to deal with amotivation

- Help patient get back into life step by step
- Build up resilience & empowerment!
  - *You can't push patients out off negative symptoms - the more pressure, the worse it gets!!*
  - Broken leg analogy: psychological healing period required
  - 'Relax – take some time off!'
  - When patient feels ready, help getting him/her back in to life – step by step
  - Help them get back in control again!

Realistic and graduated goal setting

- Small steps, e.g. ‘Get up twice a day to make yourself a cup of tea’- what would it be like to go out? → try it out!
- Have a plan to do things gradually → the earlier psychiatrists can do this work the better
- Set a short-term goal (What did you used to do that you might like to do?)
- Set a long-term goal (3-5 years)
- **All goals have to come from the patient!**

SMART goals

- Collaboratively select initial goal (SMART):
  - **S**pecific
  - **M**easurable
  - **A**chievable
  - **R**ealistic
  - **T**imely

Negative symptoms

- Re-conceptualise negative symptoms:
  - As protective against stress and positive symptoms

Negative symptoms: EAR skills

EAR-skills	Reframing negative symptoms
Explore	Explore short & long term goals
Listen Actively	Summarize periodically
Respond	Take the pressure off Collaboratively set SMART goals

Negative symptoms Role-play

- Describe rationale
  - Protective nature of negative symptoms
  - Aim for patient to feel better able to cope, in control and not under pressure
- Set a long-term goal (3-5 years)
- Collaboratively select initial goal (SMART)

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table

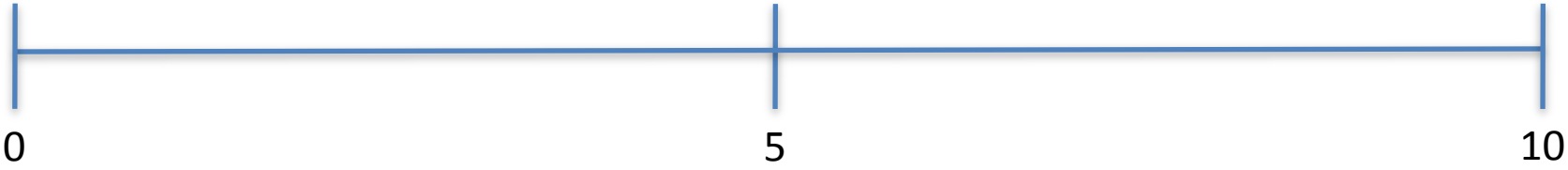
Action planning

- Choose two of the specific skills for symptoms you think would benefit your practice this week.

1.

2.

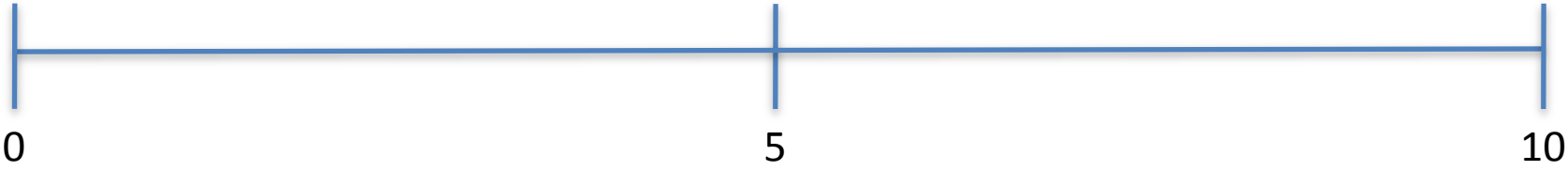
How important is it to you to use this in your practice in the next week?



Not important at all

Extremely important

How confident are you that you will use it in your practice in the next week?



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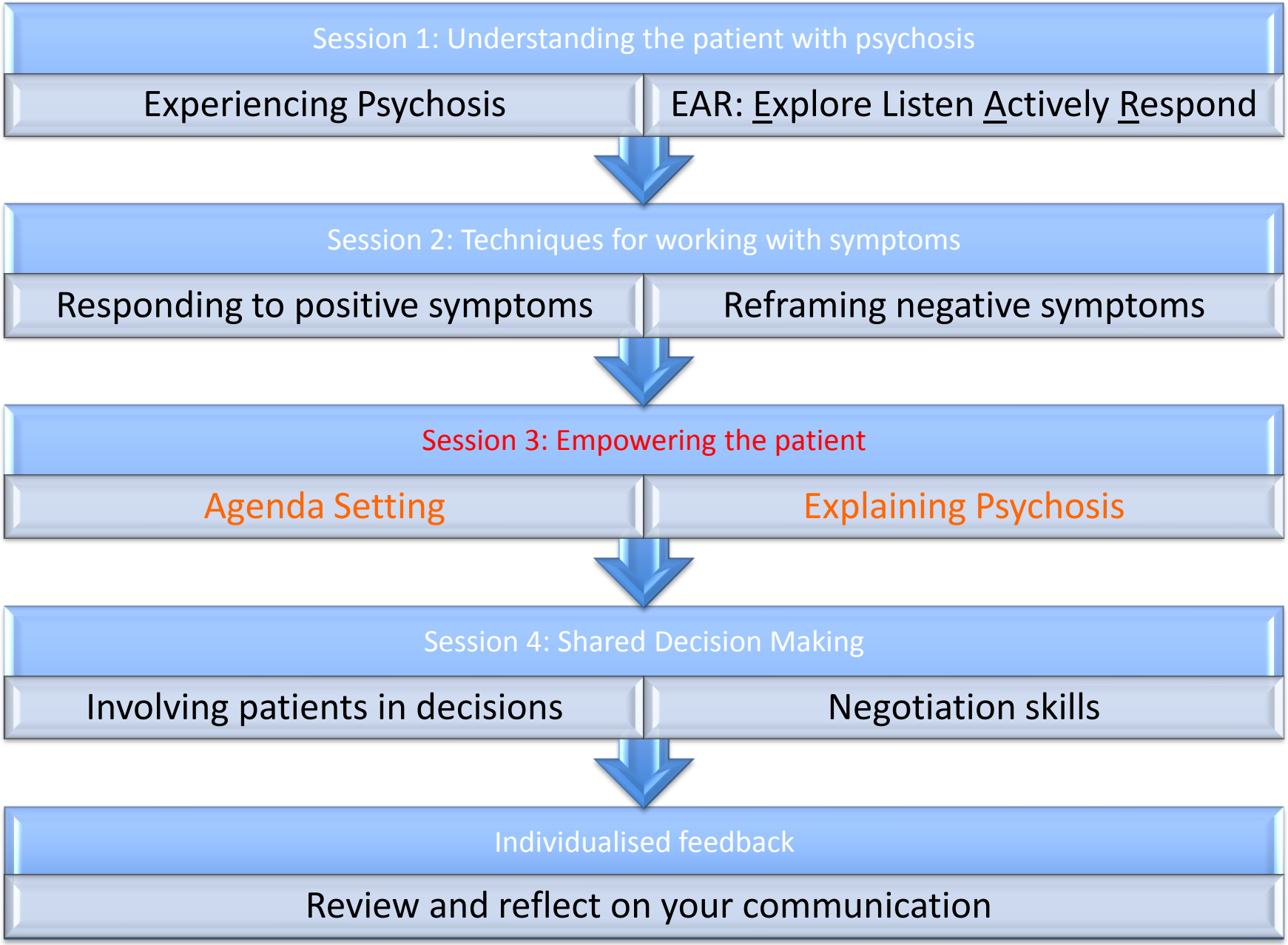
TEMPO

Session 3

Empowering the patient

Action planning - recap

- What 2 skills did you try?
- What success did you enjoy?
- What challenges arose?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Patient & psychiatrist priorities: Shortlist

Patients	**Psychiatrists**
Community Mental Health Services	Management plan
Treatment/Medication/Psychological interventions	Mental state examination
Personal / relationship issues	Risk assessment
Autonomy & self-determination Two way communication	Social support
	Therapeutic interventions
	To address what the patient wants

External context

- What are the external pressures?
- Your own agenda?

Agenda Setting - Steps

1. Patient's priorities.

2. Own priorities.

3. Negotiate.

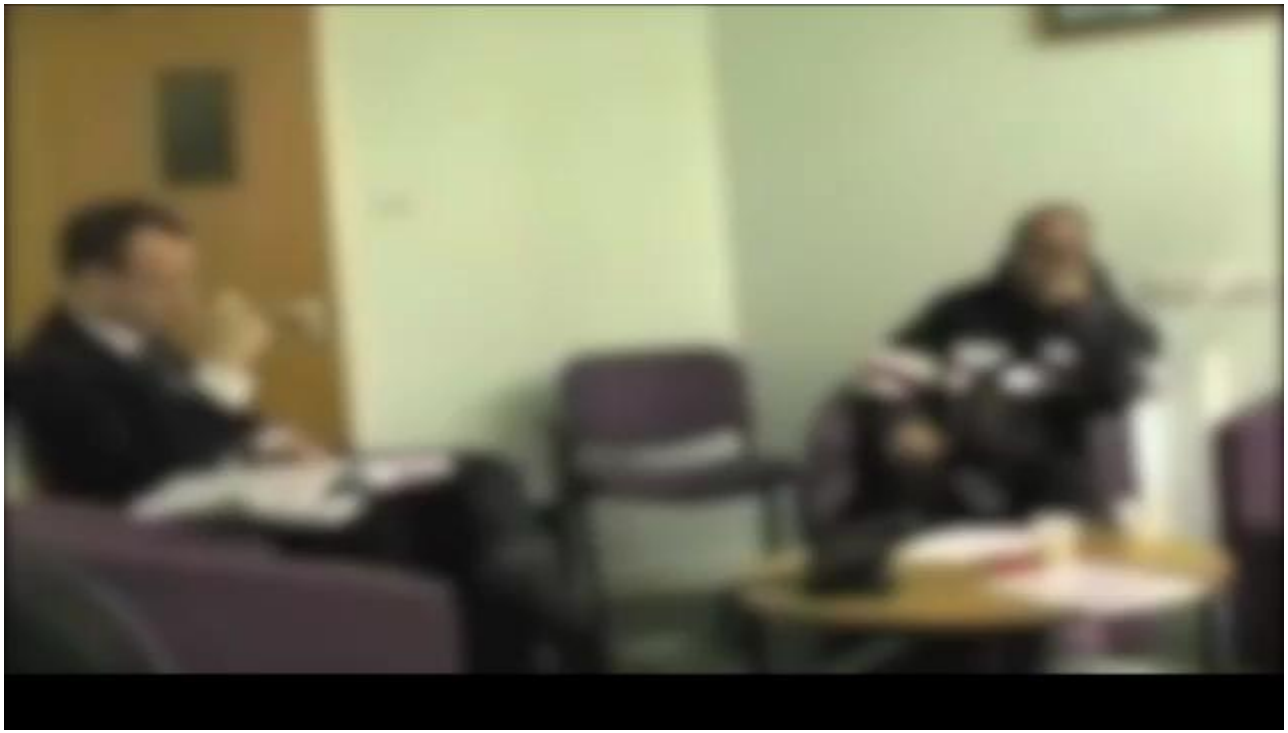
4. Signpost & Recap.

Eliciting patient's priorities

- Early in the meeting, not when getting ready to wrap up

When you were on your way here today, what were you thinking that you'd like to happen in our meeting today?

Elicit patient's priorities



Elicit patient's priorities

Step 1 – Elicit the patient's priorities

- ANY vs SOME
- Recap on the concern raised, and then ask "is there something else you would like us to address today?
- New vs. follow-up patients
- With new: "What is your understanding of seeing me today?" "Before you came, what were your expectations?"

When you were on your way here today did you have some things in mind that you wanted to talk about?

Step 2 – Explain your own priorities

- I also have some things that I would like for us to discuss including…
- We have the time to discuss our highest priorities, let's focus on these and try to answer some of your questions.

Step 3 - Negotiate

- Make shared and explicit decisions about time.
- Where priorities differ:
  - Articulate patient & own agenda items
  - If too many items, agree on most important for today

We have the time to discuss our highest priorities, let's focus on these and try to answer some of your questions.

Step 4 - Recap

Recap and summarise the plan

- Your patient will remember this better than early parts of session
- Empathy
- Genuinely trying to move things forward
- End on a positive note (Things might seem difficult at the moment but they will get better)

Today we have discussed… and agreed… (In our next consultation we will come back to some of these issues).

Agenda setting: EAR skills

Agenda setting	
Explore	• Explore patient's priorities for the session • Check you have understood their priorities
Listen Actively	• Reflect patient's language • Summarize periodically • *So what's concerning you at the moment is..*
Respond	•Acknowledge effect of patient's concerns •Explain your own priorities • Recap

Agenda setting Role-play

- STEP 1: Eliciting patient’s priorities

Break!

Explaining psychosis

- How to explain psychosis to patients?
- Questions patients ask about their experiences/ illness

Questions about psychosis

How do you respond…

- Why am I paranoid?
- Why now?

Other egs of patient questions

- ‘Do you think my mind is unbalanced?’
- ‘Is my schizophrenia learnt from my family or is it genetic?’
- ‘What is it, an illness? I just don’t know? Is it my personality?’
- ‘Do they exist - people who are causing this sickness?’

Explaining psychosis

- What does the patient ask?
- Listen for patients' prompts
  - signals from patients that their concerns have not been explored, e.g. 'my girlfriend has been very worried about me', 'I just don't understand'
  - restating a problem
- What is the subtext - what are they really worried about?
- If relevant, ask patients if they want to know more about….

Useful tips

- Be aware of tendency to avoid these questions
- Don’t overload on information – get a balance between ‘informing’ and attending to the patient’s concern
- Have a model to work with for explaining psychosis – don’t pass it on. i.e. ‘The psychologist or your nurse will talk about that’.
- Clarify what the patient means (e.g. Why am I paranoid?). What does the patient mean by paranoid?

Psychosis

- ‘Psychosis’ relates to experiences, such as hearing or seeing things or holding unusual beliefs, which other people don’t experience or share.
- Psychotic experiences can be just like ‘waking dreams’, where strange things happen and our perceptions are altered. Like dreams, they feel real and intense.
- Schizophrenia used to mean XXX. We know now that…prognosis

.

You have an illness (*select depending on what the patient is asking*). It is not uncommon for people to have experiences like the ones you’ve described. Our brains can easily become paranoid (or depressed or …).

Causes

- While we don't know exactly what causes schizophrenia, it seems to be a combination of the genes we inherit, how our brain works and stress.

Voices

- Hearing voices when nobody is around or at least when nobody seems to be saying the words you hear is part of your illness.
- Causes: Very stressful circumstances (bereavement, hostage), sleep deprivation, drugs, mental illness

•1 in 20 people hear voices at some point in their lives.
•Many famous, very successful people hear voices – the actor Anthony Hopkins, the musician Brian Wilson from the Beach Boys.

Feeling suspicious

- Suspicious thoughts about others are described as paranoid when they are exaggerated and interfere with your day to day life
  - *A central part is a sense of threat*
- Jumping to conclusions
- Self-reference
- People in a vulnerable state of mind: Major life events, feeling isolated, anxiety and depression, poor sleep, drugs, physical causes (e.g. dementia)

Many people have suspicious thoughts or worries about others from time to time.

Thought disorder

- Happens when your thoughts get muddled and jumbled up.

Prognosis

- Many people with schizophrenia never have to go into hospital and are able to settle down, work and have lasting relationships. If we consider 5 people with schizophrenia, 1 will get better within five years of their first obvious symptoms and don't experience any further psychotic symptoms; 3 will get better, but will have times when they get worse again; and 1 will have troublesome symptoms for longer periods of time.
- Most people (with schizophrenia) have a good outcome over time/ lead good lives with the effective treatments that are available

Explaining psychosis: EAR-skills

Explaining Psychosis	
Explore	• Explore patient's understanding of illness/psychosis • Explore patient's need for information
Listen Actively	• Listen for patient's prompts • Nonverbal feedback • Echo – reflect back what patient has said
Respond	• Acknowledge patient's concerns about psychosis • Normalise experiences

Explaining Psychosis Role-play

- Explain psychosis to patient and normalise!

Information & Peer Support

- Patient information materials:
  - Royal College for psychiatrists
  - Mind
  - Rethink
  - Scottish recovery net
  - My name is Pete comic
- Florid - service user organization in ELFT
- Hearing Voices Groups

Patient material online

- http://www.scottishrecovery.net/
- http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx
- http://www.rethink.org/about_mental_illness/peoples_experiences/your_experiences/index.html
- http://www.mind.org.uk/help

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table

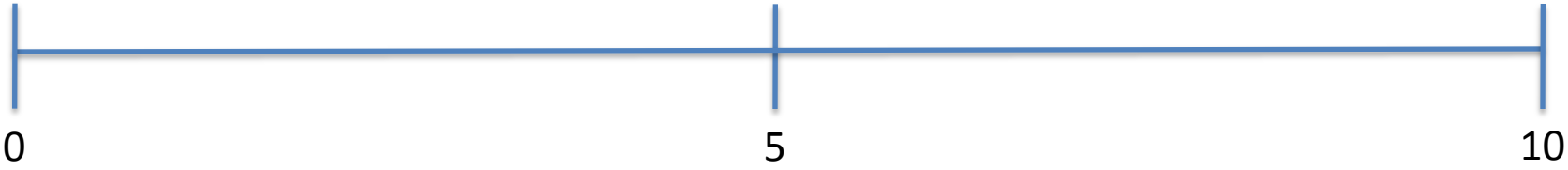
Action planning

- Choose two of the **agenda-setting and explaining skills** you think would benefit your practice this week.

1.

2.

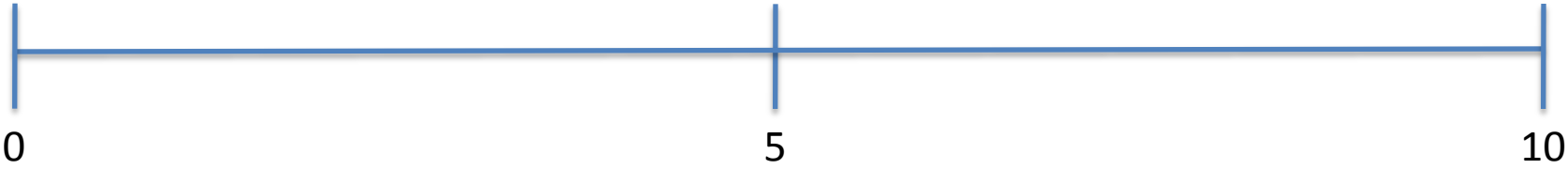
How important is it to you to use this in your practice in the next week?



Not important at all

Extremely important

How confident are you that you will use it in your practice in the next week?



Not confident at all

Extremely confident

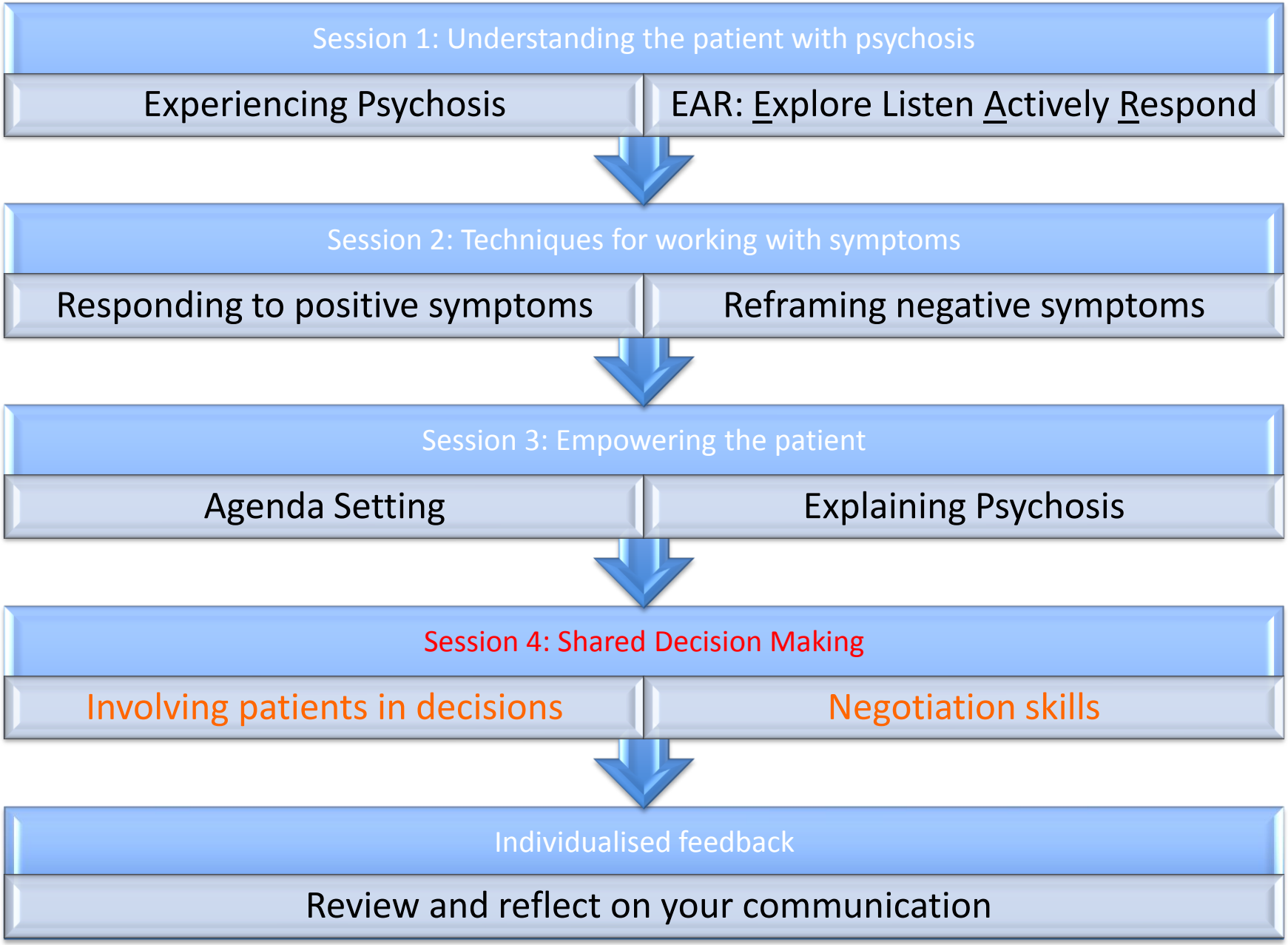
TEMPO

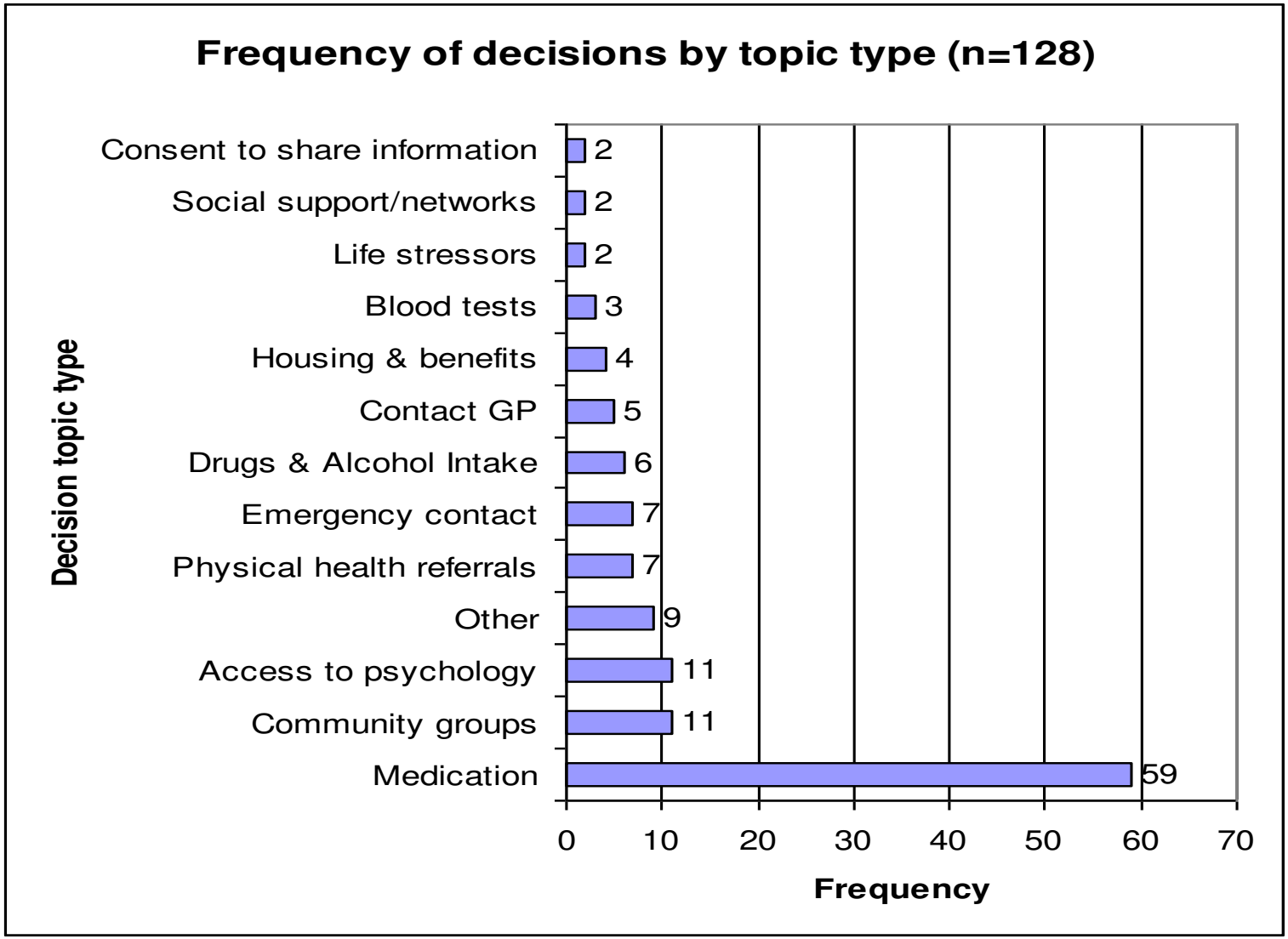
Session 4

Shared Decision Making (SDM)

Action planning - recap

- What 2 skills did you try?
- What success did you enjoy?
- What challenges arose?


Session 1: Understanding the patient with psychosis
Experiencing Psychosis
EAR: Explore Listen Actively Respond
Session 2: Techniques for working with symptoms
Responding to positive symptoms
Reframing negative symptoms
Session 3: Empowering the patient
Agenda Setting
Explaining Psychosis
Session 4: Shared Decision Making
Involving patients in decisions
Negotiation skills
Individualised feedback
Review and reflect on your communication



Time spent on medication decisions: 2 minutes

Medication decisions

- Continue with same medication (26%)
- Reduce (19%)
- Increase (18%)
- Add a further medication (16%)
- Stop or change medication (<10%)

McCabe et al. (2013) *Shared decision-making in ongoing outpatient psychiatric treatment*. Patient Education and Counseling.

ALL PATIENTS: Medication

1/3 patients do not take advice
1/3 get it wrong
1/3 adhere to recommendations in general health

(Pendleton, 1997)

Service-user perspective

Service-user perspective

Shared Decision Making
GUNS

1. **G**ive Overview of Options

2. Check **U**nderstanding, concerns & preference

1. **N**egotiate

2. **S**ummarise decision

Step 1 – Give Overview of Options

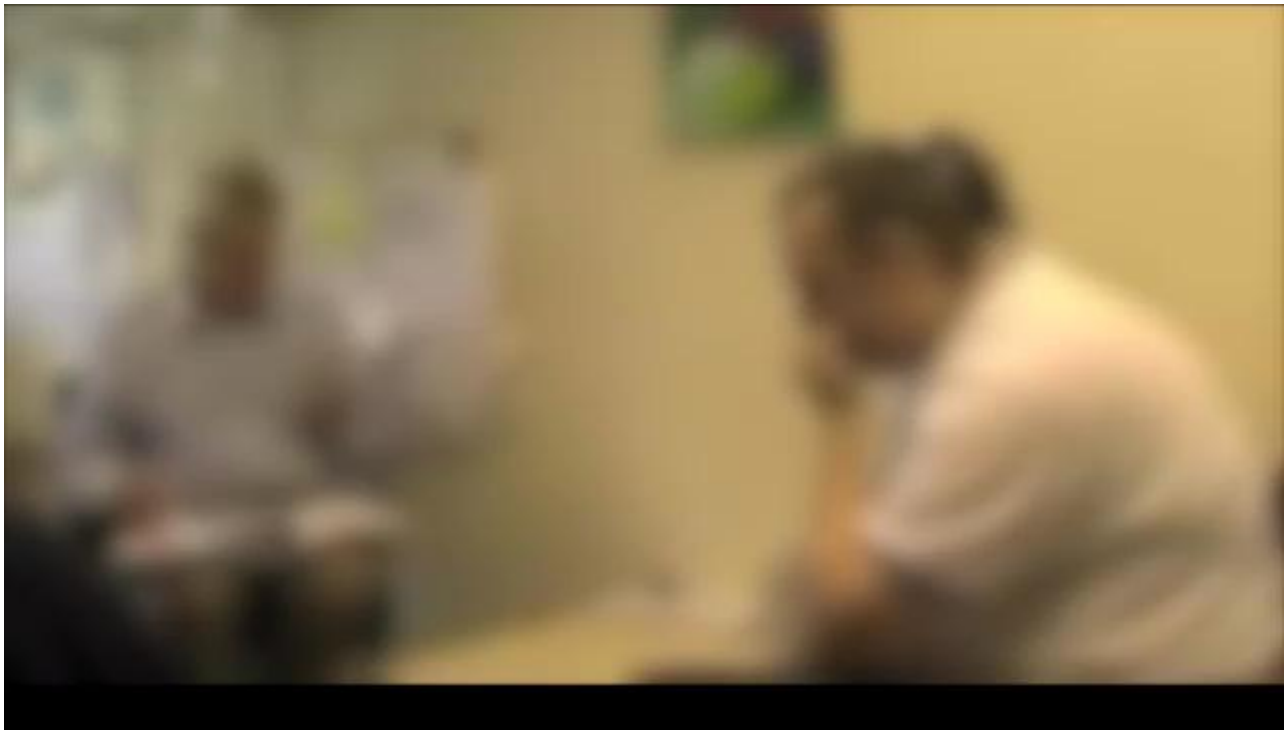
- Give overview of all treatment options, including the option of "no action"
- Allows the patient to get an overview before decision is made
- Explain the pros and cons of options
- People cannot be expected to share in decisions if they are not properly informed

One option could be that xxx, the other would be xx
XX does still have the same side-effects as other medication, so we'd have to weigh that in a balance against the potential improvements.

For discussion

- What options do you present to patients?
- What information should be presented to patient to give overview and make an informed decision?
- If you were in the situation, what information would you want?

Give overview of options



Step 2 – Check understanding, concerns & preference

- Preferred level of involvement?
- Explore patient's expectations of how problem might be managed
- Check P's understanding of options (differs in new vs. ongoing patients)
- Ask P if s/he has concerns
- Offer opportunity to ask questions

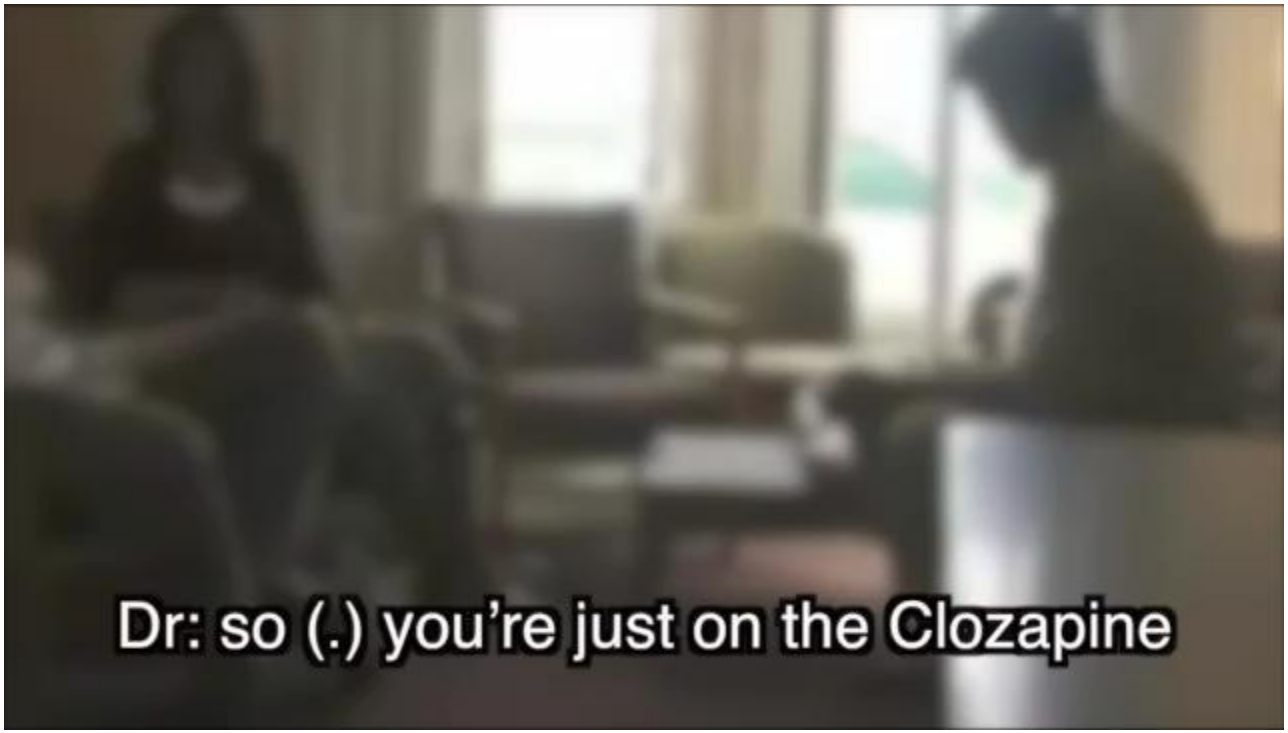
What do you think about these options?
Did you have some ideas about what you wanted to do with your medication?
Have you read anything about it?

Giving overview Role-play

- SDM step 1: Give an overview of treatment options
- SDM step 2: Check understanding, concerns and preference

Break!

Patient request for discontinuation



Discussing medication

- What are the pros and cons of coming off medication?

Shared Decision Making
GUNS

1. **G**ive Overview of Options

2. Check **U**nderstanding, concerns & preference

1. **N**egotiate

2. **S**ummarise decision

Step 3 - Negotiate

- Negotiate a treatment option
  - Exchange views about options
  - Work with the patient's concerns
  - Make explicit both preferences & reasons for each

What do you think?
How do you feel about this?

Force might appear to win initially but at what cost?

Meeting resistance with force creates more resistance

How to react to resistance

- Think about being in a discussion (or argument) where you disagree with someone (e.g. in work)
- In case of different views and disagreement – step back!
- By stepping back, and being less forceful, the other person is more likely to modify position

STRATEGY 1: Allow disagreement

- Give permission to disagree and tell you negative things that the patient thinks you don't want to hear
- This helps the patient to feel respected

I know some of my patients sometimes don't take their medication. I wonder how you feel about this….?

Service-user perspective

STRATEGY 2: Don't do a 'hard sell'

- Don't 'sell' by pushing all the advantages & glossing/ ignoring disadvantages
- Don't minimize side effects
  - 'No problems with the medication?'
  - 'The side effects aren't intolerable, are they?'
- Positive sign if patient trusts you enough to be negative

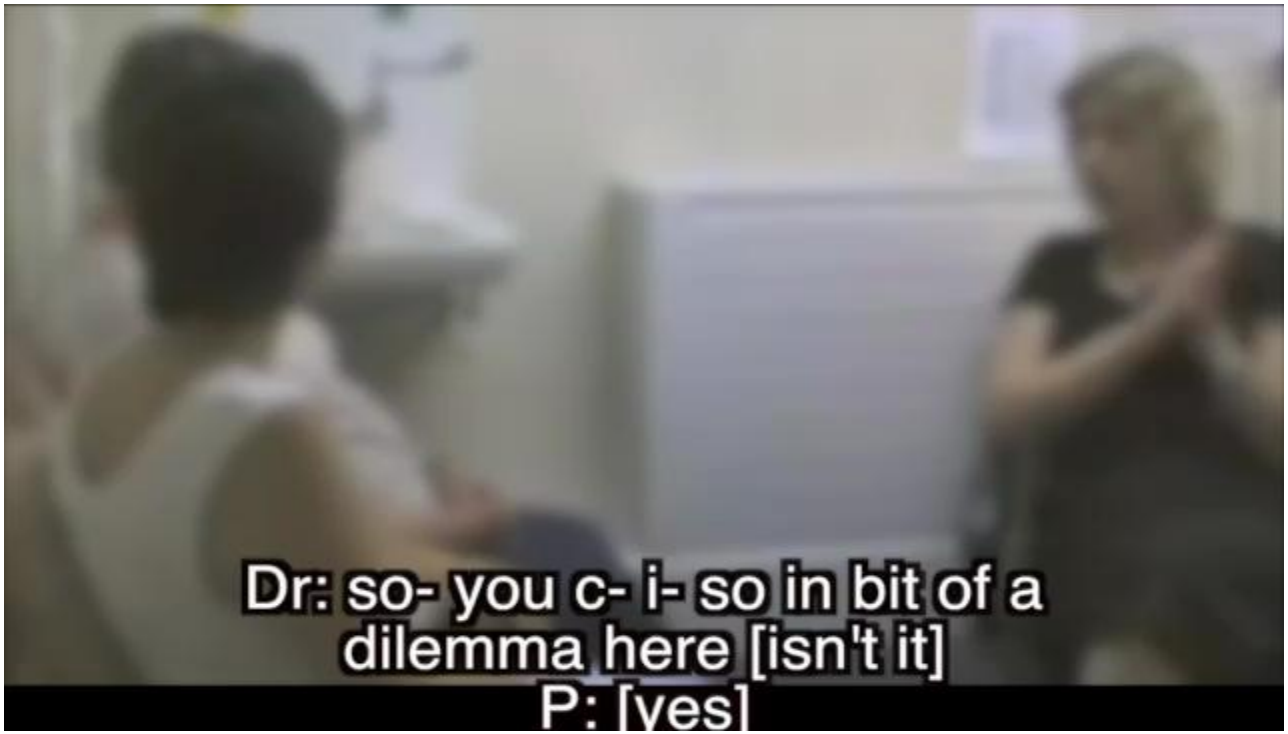
What do you see as the downsides?

STRATEGY 3: Reflect both sides

- Double-sided Reflection
  - Reflect specific pros & cons
  - E.g., Reflect both a current statement and a previous contradictory statement at the same time

We're in a bit of a dilemma here aren't we: on the one hand you feel that xx, and on the other hand xx

Double sided reflection



Difficult to agree on decision

- Contract setting
  - We both feel differently about this. On the one hand I can see you are concerned about x. On the other hand I am concerned about x so perhaps we could agree to try… and reassess how we both feel at the next appointment?
- Sharing responsibility, Positive risk taking
  - Lets recap. You would like to …. For x reasons I would be concerned and recommend that you….Do you see a way we can reach a compromise?

Difficult to agree on decision

- Open disclosure
  - I don’t feel comfortable in this…
- Agree to differ in opinion to leave the doors open for future discussion
  - It’s very helpful that we’ve had this discussion although we see things differently.

Step 4 – Summarize & review

- Clarify the decision made
- Arrange a review of decision
- Decision can involve deferring or accepting that time is required for further information to be obtained & to reflect
- If no decision reached, decide on next steps

Perhaps you want to think about it a bit more?
Do you want to think about it then? Then you'll just let me know next time.
We could talk about it again at your next appointment?

SDM: EAR skills

	Shared Decision Making
Explore	• Explore preference, understanding & concern regarding treatment & options • Explore patient's expectations of how problem might be managed •Explore patient's view
Listen Actively	•Reflect back patient's statements •Check patient's understanding of options
Respond	• Show support by working with patient's concerns • Explain treatment options • Step back and be less forceful • Double sided reflection • Agree to differ •Reach compromise & review decision

Negotiation Role-play

- SDM step 3: Negotiation
- SDM step 4: Review decision

EAR-skills	Content areas				
	Positive symptoms	**Negative symptoms**	**Agenda setting**	**Explaining illness**	**Shared Decision Making**
Explore	Explore: patient's story of belief/voices and individuality of perception & origin Discuss phenomena	Explore short & long term goals	Explore patient's priorities for the session Check you have understood their priorities	Explore patient's understanding of illness/psychosis Explore patient's need for information	Explore preference, understanding & concern regarding treatment & options Explore patient's expectations & view
Listen Actively	Show understanding & interest Check understanding of voices	Summarize periodically	Reflect patient's language Summarize periodically *So what's concerning you at the moment is…*	Listen for patient's prompts Nonverbal feedback Echo – reflect back what patient has said	Reflect back patient's statements Check patient's understanding of options
Respond	Normalize *most people…* Weigh pros & cons of what voices say Debate coping	Take the pressure off Collaboratively set SMART goals	Acknowledge effect of patient's concerns Explain your own priorities Recap	Acknowledge patient's concerns about psychosis Reassure by normalizing experiences	Show support by working with patient's concerns Explain options Step back! Don't do a hard sell Double sided reflection Agree to differ

Feedback on training programme

Training questionnaire

- Complete the post-training self-assessment questionnaire
- Fill in the final action setting form and consider barriers to implementation.
- Arrange individualised feedback session

Final skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table
  - Dates for individualized feedback session?

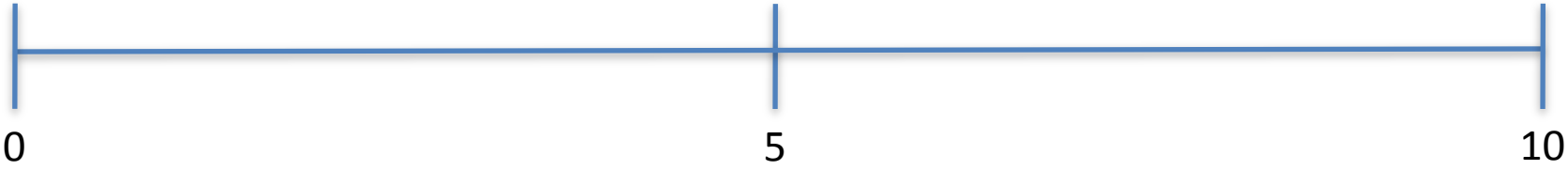
Action planning

- Choose two of skills you think would benefit your practice this week.

1.

2.

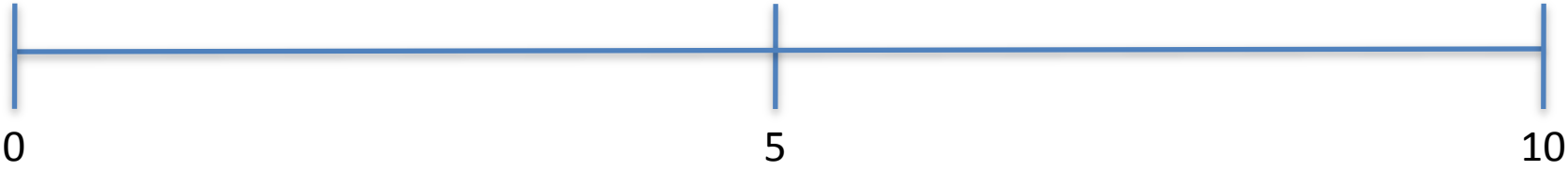
How important is it to you to use this in your practice in the next week?



Not important at all

Extremely important

How confident are you that you will use it in your practice in the next week?



Not confident at all

Extremely confident

The End!

TRAINING TO ENHANCE COMMUNICATION WITH PATIENTS WITH PSYCHOSIS

TEMPO

A Communication Skills Training Programme for Mental Health Professionals

MANUAL FOR FACILITATORS

EDITED BY ROSE MCCABE

Developed with funding from the National Institute of Health Research, Research for Patient Benefit Programme.

This facilitator's manual book accompanies a DVD.

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ACKNOWLEDGEMENTS

We would like to thank: Lou Pembroke, Ann Steele

'This facilitators' manual presents independent research funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference Number PB-PG-0408-16279). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.'

TABLE OF CONTENTS

SUMMARY

This manual is for facilitators delivering the 'TEMPO' training programme. The aim of the training is twofold: firstly, to reflect on patients' experience of psychosis and the challenges in communicating with these patients, and secondly, to enhance communication with patients with psychosis. The training consists of four group sessions lasting three hours each and one further 'individualised feedback' session. The sessions should be run by one or more facilitators with a general understanding of communication and patients with psychosis. If there are two facilitators, it is sufficient for one to have a background in communication and one to have an understanding of clinical practice and psychosis. This manual consists of three parts: (i) an introduction to the training development and content (ii) guidance and instructions for facilitators on how to run the sessions and use the specific training methods, and (iii) the teaching material for all sessions. The accompanying DVD provides electronic copies of all the material covered in this training along with video-clips to be used in the sessions.

The training programme has been developed by experts in the field of communication, psychosis, medical communication skills, psychiatrists and service users. The content is largely based on research conducted over 15 years using real video-recorded psychiatric consultations. The approach promoted is intended to develop core communication skills, which can be applied to issues specific to psychiatry and psychosis.

Multiple training methods are combined, including experiential exercises, video-recorded role-play with simulated patients, working with examples of real video-recorded psychiatric consultations and individualised feedback on one's own routine consultations with patients.

"I learned useful approaches and insights into my abilities, both strength and weaknesses, as a psychiatrist."

– Staff and Associate Grade Psychiatrist

"I have found the training very useful. It has allowed me to strike a balance between my own priorities as a clinician and patient priorities. It has improved my listening skills and my skills of motivating patients with negative symptoms using the SMART approach. Overall, I have learnt to use less jargon and be a better communicator."

– ST4-6 Trainee Psychiatrist

INTRODUCTION

BACKGROUND

COMMUNICATING WITH PATIENTS WITH PSYCHOSIS:

Mental illness is expressed, diagnosed and treated in social interaction. However, currently, despite the fact that mental illness is manifested in and affects communication, mental health professionals receive little training to address these specific challenges.

Communicating with patients with psychosis can be challenging and it is often difficult to reach a shared understanding of the patient's experiences. Analysis of psychiatrist-patient communication has shown that, in order to avoid disagreement, psychiatrists tend to avoid talking about patient's psychotic experiences (McCabe 2002), despite the fact that they are often the patient's primary concern. However, avoiding their concerns tends to lead to them resurfacing in a more problematic way (e.g. "Why don't people believe me…?" "What do you think….?"). When the patient's concerns resurface in this way, they lead to disagreement about the patient's experiences. This lack of a shared understanding of the problem, and worse, disagreement about the problem, is not a good basis for engaging patients in treatment.

Meanwhile, patients with psychosis report being dissatisfied with aspects of their treatment, including communication (Pinfold & Corry 2003). This dissatisfaction can result in a diminished therapeutic relationship between patient and psychiatrist, which makes the patient less likely to adhere to treatment, thus impacting negatively on long-term patient outcomes (McCabe & Priebe 2004).

Hence, psychiatrists need to communicate well with patients with psychosis in order to ensure patient engagement and effective treatment. However, beyond training in generic communication skills, psychiatrists currently receive no specific training in how to communicate with patients with psychotic illness.

This project has emerged in response to calls from within the psychiatric profession to define and integrate such specific skills in

Psychiatrists need to communicate with patients with psychosis to ensure patient engagement and to treat them effectively … beyond training in generic communication skills, psychiatrists currently receive no specific training in how to communicate with people with psychotic illness.

"It's sometimes difficult to talk about symptoms without colluding – so do you go with it or do you challenge the belief?"

– Staff and Associate Grade Psychiatrist

psychiatric practice (Bhugra 2008), and from 15 years of research into communication about psychosis. A large database of video-recorded psychiatric consultations provided a unique source to identify challenges in communication in 'the real world' and sophisticated ways of addressing these challenges within the constraints of busy day-to-day clinical practice. Micro-analysis of psychiatrist-patient communication in these recordings informed both the training content and material, e.g. role-play scenarios and 'real consultation video clips'.

This is the first training internationally to target specific communication skills for psychiatrists treating patients with psychosis.

GENERIC COMMUNICATION SKILLS:

While this training programme has been designed primarily for communication with patients with psychosis, the training also encompasses generic communication skills in psychiatric practice, such as shared decision making and dealing with disagreement, which are relevant in communication with people with a range of mental health disorders.

Although the training was developed with and for psychiatrists, much of the training could also be used for training other mental health professionals working in:

- Community mental health teams
- Assertive outreach teams
- Early intervention teams
- Other specialist teams or teams within an in-patient setting.

WHAT IS UNIQUE ABOUT THE 'TEMPO' TRAINING?

The training incorporates a variety of novel approaches and methods:

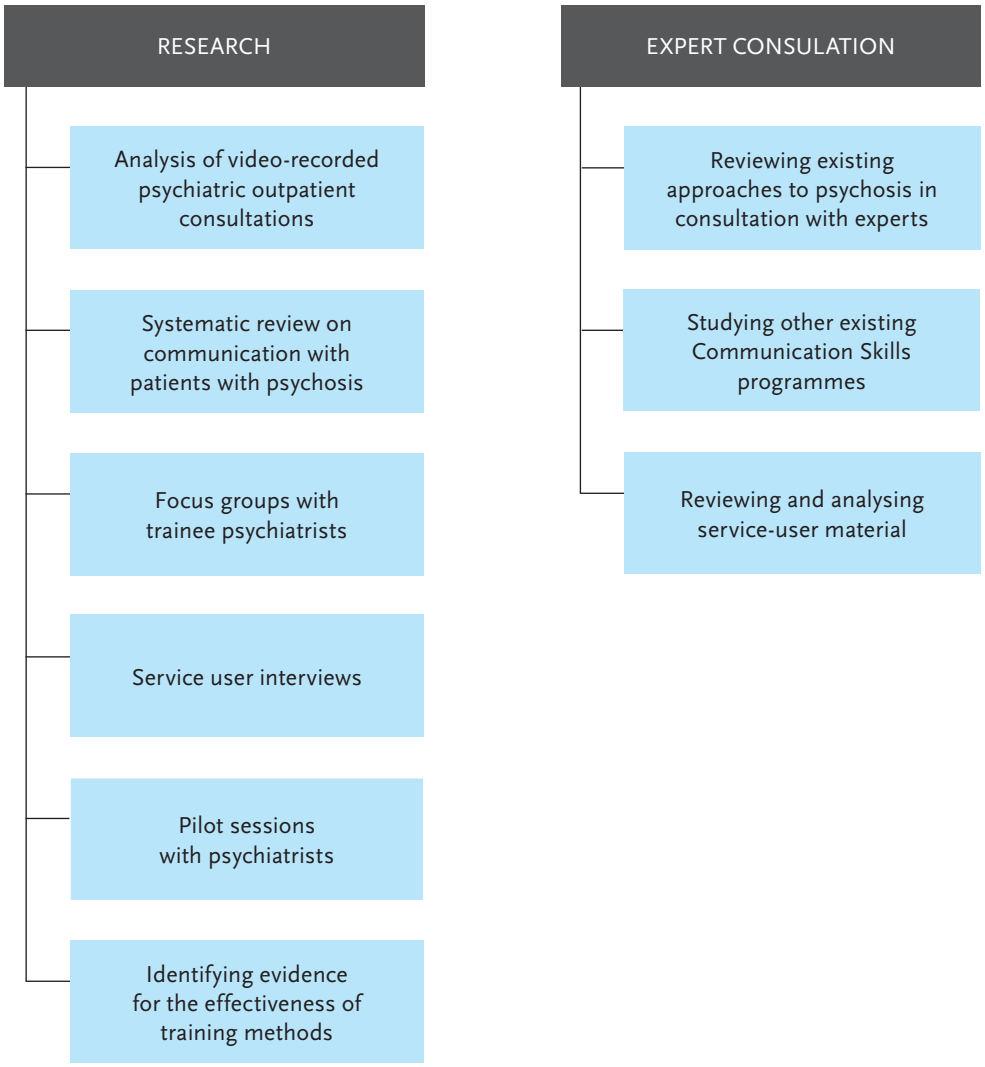
Most importantly, it is based on video data of real psychiatric consultations, which:

— Informs the training content, for example:
- Psychiatrists' reluctance to discuss psychotic symptoms
- Communication practices that invite patient participation in decision making around medication (e.g. 'I'm going to increase your medication' vs. 'From what you are telling me, you are feeling more suspicious recently and one option might be to increase your medication, what would you think about that?')
- A tendency to ask the patient if there is anything else they would like to talk about at the end of the consultation ('Anything else you would like to discuss?') while wrapping up rather than at the beginning ('Are there some things you would like to discuss today?').

— Informs the training material:
- All role-play scenarios are taken from transcripts of real conversations between psychiatrists and patients
- Actors for role-plays are briefed using material from consultation videos
- Video clips are used to demonstrate how psychiatrists actually communicate and how particular ways of communicating lead to particular patient responses
- Role-play uses professional actors and immediate video-feedback
- An innovative 'hearing voices exercise' is conducted to increase empathy towards patients experience of psychosis
- Expert facilitators, including clinicians as well as communication and psychosis experts deliver aspects of the training according to their expertise
- Participants are offered individualised feedback from expert facilitators and the opportunity to review and reflect on their own communication using video-recordings of their own routine consultations with patients

TRAINING DEVELOPMENT

In order to develop the training, primary and secondary research was conducted, existing research evidence was identified and experts were consulted on the content and most effective methods of communication skills training:



Further details of these steps can be obtained from the authors.

TRAINING PROGRAMME

TRAINING MODEL AND APPROACH

The training is based on a combined skills and attitude model with emphasis on peer discussion and support.

ATTITUDES	SKILLS/ BEHAVIOUR	PEER SUPPORT AND DISCUSSION
• Awareness of evidence that communication influences outcome in psychosis • Experiential voice hearing exercise to develop a better understanding of patients' experiences	• Behavioural change is facilitated by developing and rehearsing specific communication skills using methods such as role-playing and action-setting to transfer skills into practice	• Group discussions and feedback allow psychiatrists to share challenges, discuss positive aspects of and difficulties implementing new ways of communicating. They learn from each other's experiences

APPROACH: EAR-SKILLS

The approach promoted in the training programme is to develop core *communication skills*, in particular exploring, active listening and responding skills that are adapted to the *content areas* covered in the training.

The core communication skills are summed up in the acronym '**EAR**': '**Explore**', '**Listen Actively**' and '**Respond**'. The content areas are relevant to psychiatry more widely, with the exception of the material on positive and negative symptoms. For each session, examples are provided in the 'EAR-table' of how the EAR-skills are applied to the five content areas: positive symptoms, negative symptoms, agenda setting, explaining illness and shared decision-making.

TRAINING METHODS

The proposed methods are based on evidence of optimal communication skills acquisition (Roter 2006, Gask 1998, Jenkins 2002, Maguire & Pitceathly 2002). A range of different training methods will ensure that different learning styles are accommodated.

TRAINING METHOD	DESCRIPTION	RATIONALE
Didactic teaching	Theoretical background & evidence base	Building on knowledge facilitates changes in attitudes & behaviour
Working with 'real consultation examples'	• Video clips showing challenges & positive skills • Basis for role plays	• Real consultations recommended over simulated consultations (Maguire 2002) • Basing the intervention on real consultations allows discussions about the difficulties and consequences of using different techniques within the constraints of clinical practice (Pomerantz 2005) • Video clips introduce the skills topic (Gask 1998)
Role-play	Two different role-play methods are used	Behavioural change achieved by rehearsing new skills in a supportive environment & further learning takes places in responding to constructive feedback
	Role-play with simulated patient & video feedback: Participants practise the skills in role-play with skilled actors simulating patients with psychosis Role-play is video-recorded, played back (particular moments can be identified) and feedback given on the basis of the video	• Simulated patients provide intensive feedback both in and out of role (Whitehouse 1984) • Videotape feedback highly effective in helping psychiatrists (Maguire 1984; Harrison 1993) acquire interpersonal skills & appreciate the importance of non-verbal communication • Combination of simulated patients and video-feedback provides 'powerful and effective teaching tool providing guidance for experiential learning and reflective self-assessment '(Gask 1998)

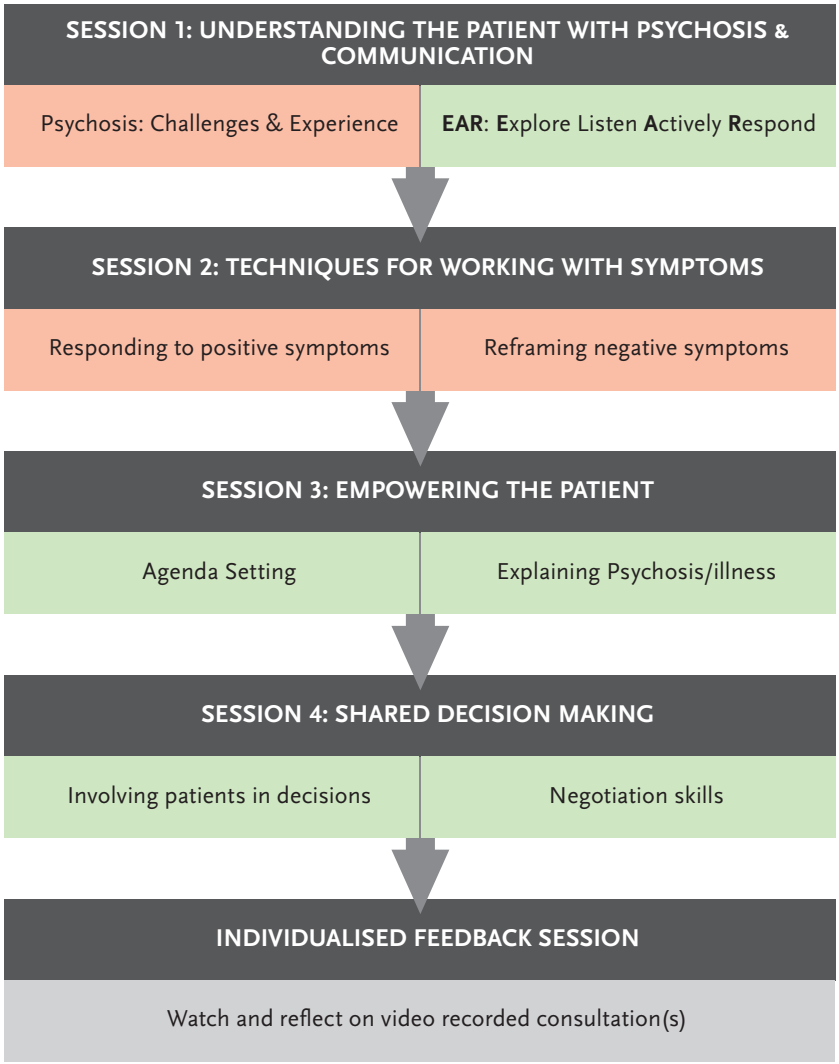
TRAINING METHOD	DESCRIPTION	RATIONALE
Role-play	*Paired role-play:* Participants take it in turns to play the psychiatrist (practising the newly acquired skills) and the patient	Creating the space to 'put myself in the patient's shoes' can increase understanding and empathy
Experiential exercise	'Hearing distressing voices simulation' (Deegan 1996): psychiatrists listen to simulated distressing voices while performing cognitive and socially engaging tasks	• Hearing voices is qualitatively different experience → this exercise bridges this gap • Aim: to increase understanding and empathy toward the lived experience of psychotic symptoms to facilitate change in attitude and behaviour
Group discussion	Group discussions used in every session to discuss specific issues, e.g. challenges, how to respond to patients, how to implement the skills	• Group discussion 'powerful medium for sharing and learning from each other's experiences, exploring diverse points of view and generating ideas to both challenge and affirm' (Kai 2005) • Further utilized to discuss positive aspects of training and difficulties encountered in implementing new skills
Action setting and feedback	Particular skills to be put into practice the following week are identified at end of each session	Action setting = effective tool to translate skills into practice outside training setting
Individualised feedback	Psychiatrists review their own video-recorded consultations in supervision with expert facilitator	• Psychiatrists identify how skills from the 'classroom' can be applied to specific patients and presenting issues • Typically, some skills are more applicable than others and a maximum of three are selected for using in the next consultation with this patient • Viewing not more than 2 consultations in one sitting is advised

TRAINING CONTENT

The training programme consists of four group sessions and one 'individualised feedback' session. The following gives a brief overview of the aims and methods of the sessions as well as some additional information on theoretical background and principles.

*Components that are **specific to psychosis** are highlighted in red, and components **applicable to general psychiatry** are highlighted in green.*

OVERVIEW OF THE FIVE SESSIONS



SESSION 1: UNDERSTANDING THE PATIENT WITH PSYCHOSIS

AIMS AND METHODS

1. **To develop empathy for the patient's experience of psychosis and to target a change in attitude by:**

— Discussing the challenges psychiatrists face when communicating with patients with psychosis and vice versa
— Reviewing the evidence on why it is important to discuss psychotic symptoms
— Participating in an experiential 'hearing voices exercise'

2. **To develop core communication skills (EAR-skills) that can be applied to the content areas by:**

— Learning EAR-skills (Explore, Listen Actively, Respond)
— Watching real consultation examples to identify and discuss use of EAR-skills
— Practising active listening in paired role-play

"The 'hearing voices exercise' was a strong learning experience for me- to know what is it like for a patient to hear voices and how it could affect them on different domains, so I think that was a very powerful method."

– Staff and Associate Grade Psychiatrist

"I had the feeling that other people could read my mind and hear the same voices"

– ST4-6 Trainee Psychiatrist

ADDITIONAL INFORMATION:

Basic communication skills are at the heart of good communication and influence the patient's experience. These core communication skills (EAR-skills) can then be applied to all (content) areas covered in the programme.

Exploring: Psychiatrists need to explore the patient's symptoms, experiences, ideas, feelings, worries, concerns and expectations (Magiure 2002). The Calgary – Cambridge Guide to the Medical Interview (Kurtz 1996) highlights the importance of using concise and easily understood language, and starting with open ended questions, before moving to closed questions.

"I realise that I should check understanding more often, to ensure that the patient is with me."

– ST4-6 Trainee Psychiatrist

Listen Actively: Both verbal and non-verbal skills facilitate the patient to say more and make the patient feel heard. This includes paraphrasing, summarizing, allowing patient to complete statements without interruption (Beckman 1984), giving patients the opportunity to correct any misunderstandings (Maguire 1996) and paying attention to patient's prompts.

Respond: It is vital for psychiatrists to tailor their response to the patient. For instance, if the patient is reporting improvements, this can be reinforced, and if they report difficulties, these can be acknowledged. Reassuring, supporting and reinforcing are key communicative skills to establish a positive therapeutic relationship.

KEY REFERENCES:

McCabe, R. & Priebe, S. (2008) Communication and psychosis: It's good to talk but how? *British Journal of Psychiatry*, 192: 404-405.

McCabe et al. (2002) Engagement of patients with psychosis in the consultation: conversation analytic study. *British Medical Journal*, 325: 1148-51.

SESSION 2: TECHNIQUES FOR WORKING WITH SYMPTOMS

AIMS AND METHODS

1. **To develop techniques for responding to positive symptoms by**

— Learning techniques for exploring and debating strong beliefs
— Eliciting and debating beliefs in paired role-play
— Learning techniques for exploring and debating beliefs about voices

2. **To develop techniques for working with negative symptoms by**

— Reframing negative symptoms as protective
— Setting realistic goals in paired role-play

ADDITIONAL INFORMATION:

The techniques in this session are derived from Cognitive Behavioural Therapy (CBT) for Schizophrenia (Kingdon 2007).

Negative symptoms: Focus groups revealed that psychiatrists often struggle when working with patients with negative symptoms. They feel 'demotivated', like they are 'talking to a wall'. CBT offers specific techniques to work with negative symptoms such as reframing negative symptoms as protective and setting small, achievable goals. The goal(s) must be identified by the patient him or herself.

Positive symptoms: In CBT a strong emphasis is placed on understanding the first psychotic episode in detail as this often holds the key to current beliefs and perceptions. Methods to elicit and

"I remember one of the patients actually who I used the negative symptoms skills with. The patient was quite unwell. I told him 'you know, be realistic. If you can start to think about working in about six months time, that's fine.' This just took the anxiety, and made him realise that it's all right to have a healing period. So that was something which I thought was very good."

– ST4-6 Trainee Psychiatrist

"I find 'Normalising' the most useful technique, to tell patients 'this is not the end, what you're experiencing is not uncommon' and 'you've been understood by someone and we're trying to help you.'"

– Staff and Associate Grade Psychiatrist

debate key beliefs, such as Socratic questioning and establishing the evidence base, are useful when working with positive symptoms. Furthermore, a mutual understanding of the psychotic symptoms and a non-critical appreciation of the patients' experience strengthens the therapeutic relationship.

EAR-table: Applying EAR-skills when working with positive symptoms: working with strong beliefs

EAR-SKILLS	RESPONDING TO POSITIVE SYMPTOMS: STRONG BELIEFS
Explore	• Explore patient's story of belief and individuality of perception & origin • Discuss phenomena
Listen Actively	• Show understanding and interest • Check understanding of belief
Respond	• Normalise 'most people...' • Debate coping

EAR-table: Applying EAR-skills when working with negative symptoms

EAR-SKILLS	REFRAMING NEGATIVE SYMPTOMS
Explore	Explore short and long term goals
Listen Actively	Summarise periodically
Respond	• Take the pressure off • Collaboratively set SMART goals

KEY REFERENCES:

Kingdon, D., Turkington, D., Weiden, P. (2007).Cognitive Therapy for Schizophrenia. *American Journal of Psychiatry*, 163: 365-373.

SESSION 3: EMPOWERING THE PATIENT

AIMS AND METHODS

1. **To raise awareness and develop skills for collaborative agenda setting by**

   — Reviewing evidence on different patient and psychiatrist priorities in psychiatric consultations
   — Learning four agenda setting steps
   — Reviewing and discussing real consultation examples
   — Practising agenda setting steps 1 and 2 in role-play with simulated patients and video-feedback

2. **To raise awareness and develop skills for explaining the illness/psychosis and giving information by**

   — Reviewing real consultation examples
   — Learning helpful strategies and phrases
   — Respond to patient's need for understanding their illness and providing information in role-play with simulated patients and video-feedback

"Agenda setting gives me more confidence in structuring an interview and more control over it."

– Staff and Associate Grade Psychiatrist

"Explaining psychosis: It is that balance between providing information to the patient about their illness, medication and so on, then trying to attach to make it personal, and make it so that it means something to them and that is not overwhelming them with information."

– Consultant Psychiatrist

ADDITIONAL INFORMATION

Agenda setting: The analysis of our dataset of video-recorded consultations revealed that psychiatrists tend to ask at the end of the consultation e.g. 'anything else you'd like to discuss?'. However, psychiatrists' and patients' agendas for outpatient consultations differ considerably (Thomson 2010). Understanding the patients' priorities and agreeing on a mutual agenda for the consultation is an important therapeutic process and correlates positively with symptom resolution (Silverman 1995).

Explaining psychosis: Our service-user interviews and our video data revealed that many patients with psychosis want to know more about their illness. However, there seems to be a difficulty in explaining psychosis in a lay way. Mitchell at al. (2007) found that psychiatrists are reluctant to disclose difficult diagnoses such as schizophrenia. However, some patients are left puzzled and confused by this absence of information and explanation.

EAR-table: Applying EAR-skills to agenda setting

EAR-SKILLS	AGENDA SETTING
Explore	• Explore patient's priorities for the session • Check that you have understood their priorities
Listen Actively	• Reflect patient's language • Summarise periodically • 'So what's concerning you at the moment is...'
Respond	• Acknowledge effect of patient's concern • Explain your own priorities • Recap

EAR-table: Applying EAR-skills to explaining psychosis

EAR-SKILLS	EXPLAINING PSYCHOSIS
Explore	• Explore patient's understanding of the illness • Explore patient's need for information
Listen Actively	• Listen for patient's prompts • Nonverbal feedback • Echo – reflect what patient has said
Respond	• Acknowledge patient's concerns about psychosis • Normalise experience

KEY REFERENCES:

Thomson, S. & Doody, G. (2010). Parallel paths? Different doctor and patient priorities in psychiatric outpatient consultations. *Journal of Mental Health*, 19(5): 461-469.

Mitchell, A. (2007). Reluctance to disclose difficult diagnoses: a narrative review comparing communication by oncologists and psychiatrists. *Support Care Cancer*, 15: 819-828.

SESSION 4: SHARED DECISION MAKING

AIMS AND METHODS

1. **To raise awareness and develop skills for involving patients in decisions, particularly around medication by**

   — Reviewing the evidence on decision making in psychiatric consultations
   — Watching and discussing video clips of service users' perspective on being informed and involved in decisions
   — Learning four Shared Decision Making steps (GUNS) and useful strategies for each step
   — Watching and discussing clips of real consultation examples on how to give an overview of all treatment options
   — Offer patients an overview of treatment options and checking patient's understanding in role-play with simulated patients and video-feedback

2. **To develop negotiation strategies to improve shared decision making by**

   — Watching and discussing consultation clip showing a patient who wants to come off medication
   — Discussing the pros and cons of coming off medication
   — Learning negotiation strategies and watching and discussing real consultation examples for each strategy
   — Using negotiation strategies when discussing medication with simulated patient in role-play and video-feedback

"The GUNS shared decision making steps were excellent"

– ST4-6 Trainee Psychiatrist

"The rehearsal after having received feedback from the trainer on the role-play worked well."

– Staff and Associate Grade Psychiatrist

ADDITIONAL INFORMATION

Involving patients with psychotic illness in decisions has been found to be associated with treatment adherence (Dooley in preparation). Research has further shown that the majority of decisions made in psychiatric consultations involving psychosis patients are decisions around anti-psychotic medication. Session 4 therefore focuses on decision-making relating to anti-psychotic medication, targeting skills for systematically involving patients in decisions and practising negotiation strategies in case of disagreement.

EAR-table: Applying EAR-skills to decision making

EAR-SKILLS	SHARED DECISION MAKING
Explore	• Explore preference, understanding & concern regarding treatment & options • Explore patient's expectations of how problem might be managed
Listen Actively	• Reflect back patient's statements • Check patient's understanding of options
Respond	• Show support by working with patient's concerns • Explain treatment options • Step back and be less forceful • Double sided reflection • Agree to differ • Reach compromise & review decision

KEY REFERENCES:

McCabe, R., Khanom, H., Bailey, P., Priebe, S. (2013) Shared Decision Making in Ongoing Outpatient Psychiatric Treatment, *Patient Education and Counseling*, 91: 326-328.

Torrey, W. & Drake, R. (2010). Practicing Shared Decision Making in the Outpatient Psychiatric Care of Adults with Severe Mental Health Illnesses: Redesigning Care for the Future. *Community Mental Health Journal*, 46: 433-440.

INDIVIDUALISED FEEDBACK SESSION

AIMS AND METHODS

1. **To reflect on one's own communication with patients with psychosis**

   — By reviewing one's own video-recorded consultation(s), reflecting on their communicative behaviour and how patients respond, and also how this varies depending on the patient

2. **To identify things to try differently**

   — By noticing areas that work less well

3. **Facilitating the translation of new skills into practice**

   — By choosing skills and setting up a concrete plan of how to use them in practice - using the 'EAR-skills action plan'

"Seeing yourself actually with a patient - I think that was the most important part of the training because I've never seen myself in communication with a patient before."

– ST4-6 Trainee Psychiatrist

ADDITIONAL INFORMATION

Reviewing and reflecting on one's own 'real' communication with patients on the basis of video-recordings has been used effectively to train health professionals (e.g. Kitzinger 2007). This training programme incorporates this technique in a more individualised and systematic way. The approach is tailored to need, offering the option to choose between individual or group sessions. Specific action setting via the 'EAR-skills action plan' further facilitates the translation of the new skills into practice.

The individual or group 'individualised feedback sessions' should be offered to all participants following the four group sessions (see "Guidance on facilitating training" section for instruction details).

Individual or group sessions? The format is flexible and can be run as one-to-one (facilitator and participant) or as a group sessions (3-4 participants who attended the training sessions). Both formats have advantages and disadvantages. The peer-group may provide valuable advice and feedback. However, some participants may not feel comfortable watching their recordings with their colleagues. Both formats should be offered to participants.

GUIDANCE FOR FACILITATORS

GUIDANCE ON USING THE MANUAL

In this section you will find information on how to use the training materials and methods to facilitate learning.

USING THE 'TEMPO' FACILITATOR'S MANUAL

The facilitator's manual contains the introduction, guidance and notes for facilitators as well as schedules, instructions and photocopiable materials (slides, handouts and instructions for exercises) for each session.

USING THE 'TEMPO' DVD-ROM

The DVD-Rom includes power point presentations for each session, video clips of 'real consultation examples' and 'service user perspectives', an audio clip for the hearing voices exercise as well as supplementary reading for each session.

LEARNING MATERIALS

Two forms of learning material are provided for each session:

— **Teaching aids**
These are materials for facilitators to use during the sessions. They include schedules and instructions for facilitators, key points, PowerPoint Slides with speaker's notes and instructions for the exercises along with instructions for actors in the role-plays.

— **Handouts**
These are materials that should be given to the participants in the sessions, including self-appraisal questionnaires, instructions for exercises and 'skills booklets', which contain key points, helpful phrases, EAR-tables and action plans.

GUIDANCE ON FACILITATING THE TRAINING

FACILITATORS

Ideally, two facilitators should run the sessions. Between them, they should have an understanding of psychosis and communication. A combination of a communication skills facilitator and an experienced psychiatrist who is interested in communication works well. In order to ensure continuity, at least one facilitator should be the same across all of the sessions. It is optional to involve more facilitators who can deliver aspects of the training programme relevant to their expertise (e.g. CBT). However, a second co-facilitator is required for session 3 and 4 to run the role-plays with actors in sub-groups.

PRACTICALITIES

The 'TEMPO' training programme can be delivered in a number of different ways. It is possible to pick and mix aspects of the training sections and to adapt these according to your immediate course requirements and learners' needs.

TIMING

Each of the four group sessions is scheduled for three hours. The four training sessions are usually most effective when run as half-day sessions on four consecutive weeks.

Alternatively the four sessions could be run across two full days.

Where feasible, a group or individual 'seeing yourself session' should be run approximately two weeks after the last session in order to allow time to practise the skills and feedback on this. Depending on the length of the video-recorded consultation, the session should take approx. 1.5 to 2.5 hours.

GROUP SIZE

The recommended maximum group size for the group sessions is eight, but this will vary in different places and circumstances. Facilitators may need to adapt group work and timing if the groups are significantly larger or smaller.

As some of the work takes place in pairs and subgroups, it is recommended to have equal numbers of participants. Where this is not possible, exercises such as the paired role-play could be conducted in groups of three.

ACCOMMODATION

It is important to run the training in a space that is large enough to comfortably move freely during the group work. Ideally, two rooms are required for the hearing voices exercise in session 1 and for the role-plays in sub-groups in sessions 3 and 4.

EQUIPMENT

The minimum equipment needed is:

- Overhead projector with screen
- Flipcharts and pens
- A laptop computer with PowerPoint is needed to access the CD-rom material
- MP3 players are required for the hearing voices exercise in session 1
- Two video-cameras and usb-connecting cables are required to film and enable video-feedback for role-plays in session 3 and 4

RUNNING GROUP SESSIONS - CREATING A SUPPORTIVE LEARNING ENVIRONMENT

The challenges faced when communicating with psychosis patients, the pros and cons of discontinuing medication, and particularly the giving and receiving of feedback on their own communication with patients (e.g. in role-plays and individualised feedback sessions) may present sensitive subjects of discussion for the psychiatrists. It is therefore essential to create a learning environment that is perceived as being supportive enough for learners to explore and review their own communication and that provides the emotional and physical support needed to enhance learning.

In order to further accommodate any anxiety of being judged and scrutinised as a good/bad communicator, it is suggested to emphasise throughout the training that the participating psychiatrists are the experts who are already equipped with effective and positive communication skills. The objective of the training is solely to further develop these skills and to learn from each other.

USING THE TRAINING METHODS

WORKING WITH REAL CONSULTATION EXAMPLES

The 'real consultation example' video clips are used as a method for facilitating group discussions. The questions relating to a specific clip will vary according to the content area. The 'schedule and instructions for facilitators' for each session provides information on how to work with the specific clip and outlines suggested questions.

PROCEDURE:

1. Prior to watching the clip, instruct participants to have one of the corresponding questions in mind when watching it (according to instructions in teaching aid, e.g. "what was good/could be improved?" in sessions 4 'giving overview')

2. Discuss the participants' perception and point of views in the group.

3. Where appropriate, ask:

   — What are alternative ways of responding?
   — What did you notice in the psychiatrist's / patient's communicative behaviour?

ROLE-PLAYS

Role-play with simulated patient and video feedback

PREPARATION:

If you are using professional actors, arrange a meeting prior to the session to conduct their briefing. It may be useful to show them videos of patients with psychosis to increase their understanding of the typical verbal and non-verbal communicative behaviour of these patients.

Brief the actors using the 'information for actors' instructions.

If you do not have the option to use professional actors, participants can be briefed to play the patient instead. In the first session, assign the psychiatrist and patient role to all

participants. Pass on the 'information for actors' teaching aids to the participants who have been assigned the patient role and ask them to prepare themselves for the role in the following session.

The role-play takes place in two groups of 3-4 psychiatrists (with groups of 6-8). Each group is led by one facilitator, and includes one actor who plays the patient. Each psychiatrist should have a turn at doing the role-play. If there are 3 psychiatrists, allow 15 minutes per psychiatrist. If there are 4 psychiatrists, allow 10 minutes per psychiatrist. Give each psychiatrist the 'information for psychiatrists' handout. Ask observing psychiatrists to take notes while observing the role-play. Ask the participant to practise the new skills within the role-play. Set up a video-camera to record the role-play.

PROCEDURE:

1. Ask observing psychiatrists to get pen and paper to take notes during role-play.

2. Allow approx. 5 minutes for the first round of role-play.

3. Following this, ask for the participants' self-reflection, i.e. ask participants what went well, where they feel they had difficulty or got stuck.

4. Ask the actor to provide in-role feedback.

5. Ask the other participants who were observing the role-play how they perceived the role-play/the communication.

6. Offer your feedback, offer suggestions for alternative ways of conducting the interview; provide suggestions on request from the person conducting the interview; or supply a replacement interviewer who can attempt to put any suggestions into effect.

7. Ask the participants to identify a particular moment or situation in the role-play that they found challenging, where they feel they had difficulty or got stuck, i.e. that they would have liked to have done differently.

8. Play this part of the video recorded role-play back, with the aim of identifying how the psychiatrist would do it differently.

9. The psychiatrist should then have another go at this particular part of the role-play.

RULES OF FEEDBACK

When giving feedback:

- Always be positive about the other's performance
- Identify the good parts of the interview – be specific about what was good and why
- Discuss the parts, which could be improved - always suggest positive alternatives

PAIRED ROLE-PLAYS

PREPARATION

Ensure that the room provides enough space for all pairs to role-play. Timing may vary according to session. Please follow instructions corresponding to the particular role-play.

PROCEDURE:

1. The group works in pairs.

2. Instruct the participants to assign the role of patient and psychiatrist. Ask the participant playing the patient to 'play' one of their own patients who they have seen recently. Instruct the participant who plays the psychiatrist to practise the newly acquired skills in the role-play.

3. All pairs play at the same time, i.e. not in front of the whole group.

4. While they are playing, move around the room between pairs, listening and helping out with useful words and phrases to move the process along.

5. Allow 5 - 15 minutes for each turn (according to instructions).

6. At the end of each turn, both 'psychiatrist' and 'patient' give feedback 'out of role', observing the rules of feedback and then ask the pairs to swop roles.

7. Following this, ask all participants to feedback their experience to the group. Firstly, ask what it was like to be the patient, what psychiatrist behaviour they perceived as positive/negative. Secondly, ask for feedback on the 'psychiatrist's role' and how they experienced the use of the new skills.

ACTION SETTING

PROCEDURE:

1. At the end of each group session, hand out the skills booklet, which contains a summary of the content of the session along with useful phrases.

2. Using the action plan on the skills booklet, ask the participants to write down two of the skills learned in the session that they want to practise in the following week.

3. Instruct the group to rate on a scale from 0 to 10 a) how important is it to them to use this in practice in the next week and b) how confident they are that they will use the skill in practice in the next week.

4. Ask them to bring back the booklet with the completed action plan for the following session.

5. At the beginning of the next session, ask the participants to discuss in pairs for 10 minutes the two skills they tried, what success they enjoyed and what challenges arose. Following the discussion in pairs, ask the participants to feed back to the group. Allow 5 minutes for this group discussion. Ask how patients responded to the new skills, whether they are likely to use the skill again and how it could be developed further.

INDIVIDUALISED FEEDBACK SESSION

Individual or group 'individualised feedback sessions' should be offered to all participants following the end of the group training programme (i.e. the four sessions).

PREPARATION:

In order to conduct these sessions, at least one of the psychiatrist's consultations with one of their own patients needs to be video-recorded prior to the session.

PROCEDURE:

1. Hand out the EAR-action-plan table.

2. Conduct a brief refresher session: Summarise skills and themes covered in the training.

3. Explain the aims of the 'seeing yourself session
    - Identify how and where new Communication Skills can be applied
    - What areas/skills relating to their own communicative behaviour they would like to work on

4. Ask participants to watch video recording of their own consultation with these two aims in mind and to pause the video when they identify an area where the skills could be applied or where a communicative behaviour was identified that could be improved.

5. Watch the video and wait for participant to pause the video and discuss what they noticed, how they could have communicated differently and/or how a specific skill could have worked in this particular situation. Your role is to assist the participant in this process and to give some specific feedback. In particular, help the participant in understanding their own 'typical' communication and to work together to establish how the new skills can be applied.

6. Using the EAR-action-plan table, ask participants to write down how and when they intend to use the skill in practice.

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SESSION 1

Understanding the patient with psychosis

SUMMARY

The first half of this session focuses on understanding the patient with psychosis. Firstly, common challenges for both psychiatrists and patients when communicating with each other are discussed in the group. Psychiatrists then participate in an experiential 'hearing voices exercise'. The second half of the session focuses on generic communication skills, to be applied to specific content areas. The core communication skills are EAR skills: **E**xplore, Listen **A**ctively and **R**espond. In sessions 2-4, the EAR-skills are applied to the five content areas: positive symptoms, negative symptoms, agenda setting, explaining psychosis and decision-making.

LEARNING OUTCOMES	Develop empathy for patient's experience of psychosis Develop EAR skills
METHODS	Didactic teaching; pair and group discussion; experiential (hearing voices) exercise; working with real consultation examples; role-play in pairs, action setting, self-evaluation
MATERIALS	Power-point presentation; flipchart; self-appraisal questionnaire; instructions, MP3 players (for each participant) and tasks for voices simulation exercise, video clips of real consultations; action plan; skills booklet
OTHERS' INVOLVEMENT	Assistance required to conduct exercise 1: hearing voices exercise
DURATION	3 hours

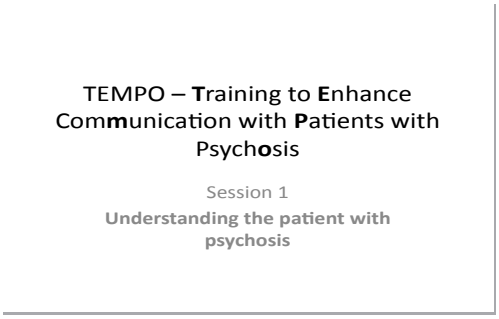
TIMETABLE AND INSTRUCTIONS FOR FACILITATORS

TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEMES
5 mins	Slide 1: Welcome and introduction	Attitudes/ expectations	1	INTRO-DUCTION
5 mins	Self-appraisal: Each participant to complete handout 1a and keep for last session	Self-appraisal	1 Hand-out 1a	
5 mins	Slide 2: Overview of training and focus of session 1	Didactic teaching	2	
5 mins	Slide 3: Findings on relevance of good communication	Didactic teaching	3	
15 mins	Slide 4: Discussion on challenges when communicating with patients with psychosis (10 mins) Feedback to the group (5 mins): Write down all issues on flipchart and leave them up to come back to over course of training	In pair discussion Feedback	4 Flipchart	CHALLENGES
5 mins	Slide 5-7: Evidence on relevance of communicating about psychotic symptoms (supplementary reading: McCabe 2002)	Didactic teaching	5-7	
40 mins	Slide 8: Hearing voices exercise Follow instructions on teaching aid I	Voices simulation exercise	8 Handouts 1b-f Teaching aid I Mp3 players	EXPERIENC-ING PSYCHOSIS – HEARING VOICES
10 mins	Feedback to the group	Feedback	8	
15 mins	Break		9	
10 mins	Slide 10: EAR-skills Slide 11: What to explore in a psychiatric consultation Slide 12: Explore symptoms, worries, expectations Slide 13: Use of open and closed questions Slide 14: Explore Slide 15: Listen Actively Slide 16: Respond	Didactic teaching / Skills	10-16	EAR SKILLS
15 mins	Slide 17: Identify EAR skills in 'money worry' video clip Slide 18: Identify EAR skills in 'positive encouragement' clip	Real consultation examples	17-18	

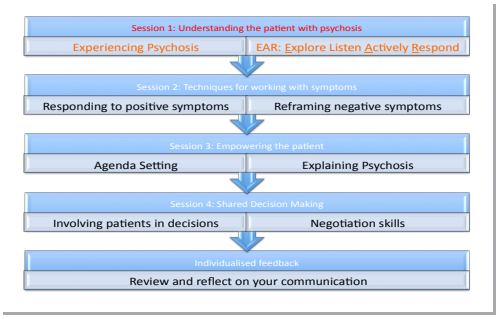
TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEMES
40 mins	Slide 19: Practise active listening in role-play & feedback to the group	Role-play	19 Teaching aid II: Role-play instructions	EAR SKILLS
10 mins	Slide 20: Hand out skills booklet Action planning	Action planning	20-21 Handout 1g: Skills booklet	
3hrs	End.			

SLIDES

Session slides available on TEMPO DVD



Slide 1



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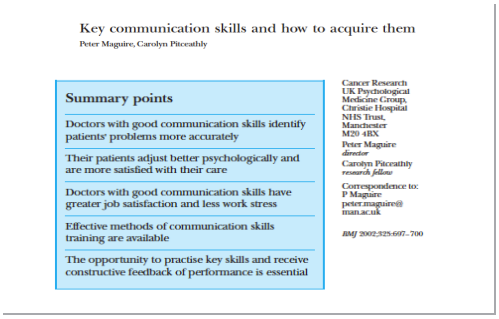

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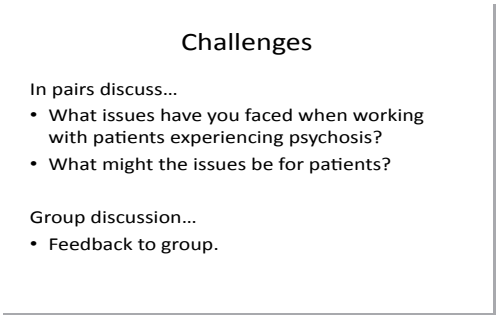

Slide 4

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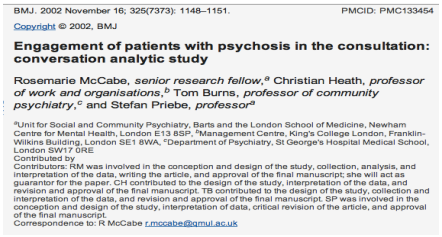

BMJ. 2002 November 16; 325(7373): 1148–1151. PMCID: PMC133454

Engagement of patients with psychosis in the consultation: conversation analytic study

Rosemarie McCabe, *senior research fellow*,[a] Christian Heath, *professor of work and organisations*,[b] Tom Burns, *professor of community psychiatry*,[c] and Stefan Priebe, *professor*[a]

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Contributed by
Contributors: RM was involved in the conception and design of the study, collection, analysis, and interpretation of the data, writing the article, and approval of the final manuscript; she will act as guarantor for the paper. CH contributed to the design of the study, interpretation of the data, and revision and approval of the final manuscript. TB contributed to the design of the study, collection and interpretation of the data, and revision and approval of the final manuscript. SP was involved in the conception and design of the study, interpretation of data, critical revision of the article, and approval of the final manuscript.
Correspondence to: R McCabe r.mccabe@qmul.ac.uk

Slide 5

Transcript

Mother:	Okay three months time
Dr:	So
Patient:	Why don't people believe me doctor when I say I'm God? Why don't they believe me, cos everyone knows I am?
Dr:	What shall I say now?
Mother:	ha-ha
Dr:	Well you are free to believe it but people are free not to believe you.

Slide 6

Communicating about psychotic experiences

- Avoidance – fear of disagreement
- Patients don't feel understood
- Patients 'confront'
- Disagreement between psychiatrist & patient
- Not a good basis for treatment engagement & adherence
- Qualitatively different experience
- Not a good basis for negotiating about treatment

- McCabe et al. (2002) Engagement of patients with psychosis in the consultation: conversation analytic study, British Medical Journal, 325: 1148-51.

Slide 7

Experiencing psychosis

What do psychotic symptoms feel like?

- Hearing voices simulation exercise
- Feedback experience to group

Slide 8

Break!

Slide 9

EAR Skills

Patients want to feel heard and understood

- Explore
- Listen Actively
- Respond

Slide 10

EAR Skills

- Explore What?

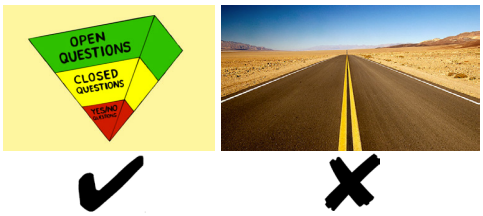
Slide 11

Explore

- Explore:
  - Symptoms, Experience, Ideas, Feelings:
    - How are you in yourself?
    - How does it make you feel?
    - How do you cope with it when it happens?
    - What's your understanding of that?
    - How are things at home?
  - Worries, Concerns
    - What are you worried about?
  - Expectations
    - What were you wanting to talk about today?

Slide 12

Explore: Open to closed vs. closed questions



Slide 13

Explore

- Avoid leading questions & presumptions
  - Real consultation examples:
    - 'The voices don't bother you do they?'
    - 'You weren't suffering from any paranoia?'
    - 'No side-effects at all?'

Slide 14

Listen Actively

- What makes you feel listened to?
- Skills that help the patient to talk

  Wait:
  - Give patient time to think before answering
  - Allow patient to complete statements without interruption

  Non-verbal behaviour:
  - posture, gaze, nodding

- Summarize periodically, invite patient to revise

  Can I check that I have understood? What you have told me is...
  So from what you have said ..... Have I got that right?

Slide 15

Respond

- Specific follow-up questions (depends on topic)
- VALIDATION
  - If patient is expressing or reporting difficulties: Acknowledge patients' feelings, concerns BUT not empty empathy ("I understand", "That must be very difficult")
    - You seem (frustrated, worried, sad).....
    - It sounds like that is very hard/distressing etc.....
  - If patient is expressing, reporting positives:

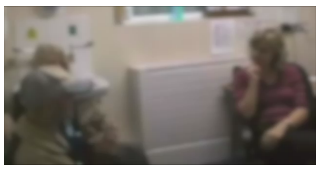
    Reinforce how the patient manages and positive steps they have taken
    - It sounds like you are dealing with it very well...
    - I can see you are feeling pleased with how things are.....

Slide 16

EAR-skills

Slide 17

EAR-skills



Slide 18

Active Listening Role-play

- In pairs assign psychiatrist and patient role
  - Patient presents concern
  - Psychiatrist to listen actively using EAR skills
  - Psychiatrist to then respond – acknowledge*
- Now swap roles...
- Feedback in group

*NB – do not give advice or explain yet

Slide 19

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan

Slide 20

Action planning

- Choose 2 of the EAR-skills you think would benefit your practice this week.

1.
2.

How important is it to you to use this in your practice in the next week?

0 — 5 — 10

Not important at all — Extremely important

How confident are you that you will use it in your practice in the next week?

0 — 5 — 10

Not confident at all — Extremely confident

Slide 21

HANDOUT 1A: PRE-TRAINING SELF-APPRAISAL QUESTIONNAIRE

1.	I find it easy to consider the patient's perspective on voices and delusions.	**1** ---------- **5** ---------- **10** NOT AT ALL VERY
2.	I feel comfortable working with patients with negative symptoms.	**1** ---------- **5** ---------- **10**
3.	I feel comfortable working with beliefs about voices and delusions.	**1** ---------- **5** ---------- **10**
4.	I feel comfortable asking patients what they want to talk about and setting an agenda early in the consultation.	**1** ---------- **5** ---------- **10**
5.	I feel comfortable reassuring patients.	**1** ---------- **5** ---------- **10**
6.	I feel comfortable explaining psychotic illness to patients.	**1** ---------- **5** ---------- **10**
7.	I feel comfortable asking patients if they need information and giving them information.	**1** ---------- **5** ---------- **10**
8.	I feel comfortable asking patients what they don't like about their treatment (e.g. medication).	**1** ---------- **5** ---------- **10**
9.	I feel comfortable offering patients choices about treatment and asking about their concerns and preferences.	**1** ---------- **5** ---------- **10**
10.	I feel comfortable dealing with disagreements.	**1** ---------- **5** ---------- **10**

TEACHING AID I: INSTRUCTIONS FOR FACILITATORS

EXERCISE: A SIMULATION OF HEARING DISTRESSING VOICES

PROCEDURE

1. Hand out mp3 players to participants and instruct participants to listen to the 3 minute instruction.

2. Once everyone has heard the instruction, ask participants to conduct the first task (the 'go outside' task, handout 1b). Hand out some change to the participants (for buying a coffee/tea at the canteen/cafeteria). Ask participants to return after 15 minutes.

3. Once participants are back from the first task, introduce the second task, the cognitive task (word finding task, handout 1c and/or number finding 1d). Instruct participants to find as many words/number series as possible from the words/numbers listed.

4. While participants are working on the word finding task, ask individual participants, one by one, to follow you to another room. Here you apply task 3, the Mental State Examination (handout 1e), with each participant.

5. Task 2 and 3 are being conducted simultaneously, lasting approx. 20mins in total.

6. Once everybody has conducted the Mental State Examination, introduce the fourth task, the 'balloon dilemma discussion'. Give participants 10 minutes time for this task.

7. Feedback in group.

PURPOSE

Developing empathy for the lived experience of hearing distressing voices

TIME

The estimated time of this exercise in a group of 8 participants is 40 minutes.

HANDOUT 1B: TASK 1 OUTDOORS EXERCISE

Go outside and walk around by yourself.

You may talk to others, but not to other people doing the exercise.

Don't alter the volume and don't take headphones out at any time.

Go to a canteen/cafeteria and buy something or ask a question about one of the products (e.g. "how much is...?).

HANDOUT 1C: TASK 2 NUMBER SEARCH

7 DIGIT NUMBERS

5 1 2 9 5 4 6 5 8 1 2 4 7 5 6 8 5 2 3 6
5 4 5 2 8 5 4 5 5 8 4 7 5 1 6 8 7 4 3 5
1 5 6 8 4 4 5 3 1 5 6 8 4 6 6 9 8 5 4 5
5 2 1 6 6 5 3 4 2 1 2 5 2 3 6 5 4 7 5 5
1 6 8 2 2 4 9 6 4 5 2 2 4 5 7 9 8 8 2 2
3 4 2 1 5 1 2 1 2 1 7 5 6 9 8 7 5 4 5 6
5 2 4 5 6 4 6 6 1 5 3 4 3 5 8 6 1 2 6 5
4 5 6 4 5 4 1 4 1 6 2 3 6 9 8 6 5 3 5 6
9 1 8 6 1 2 7 2 8 6 5 1 6 9 8 8 5 5 6 8
6 2 3 7 7 6 4 4 5 5 4 1 5 1 1 5 4 3 5 2
1 3 5 2 8 5 5 4 5 6 5 8 5 5 5 5 6 5 5 1
1 6 2 4 5 2 3 1 2 9 8 5 1 1 4 2 2 5 2 6
5 4 5 6 1 1 4 5 3 8 6 4 5 5 4 3 5 8 1 1
4 4 7 1 2 5 6 7 8 1 5 8 2 9 9 6 9 5 5 8
6 3 1 8 4 1 6 9 3 2 2 1 5 4 2 9 5 4 8 2
2 1 4 6 5 6 6 9 8 5 6 5 5 4 4 9 8 2 1 8
5 8 8 2 8 4 5 1 1 4 2 2 6 5 6 2 6 6 5 1
2 5 5 1 5 6 6 5 3 9 2 7 8 5 1 3 6 5 5 5
7 1 2 5 4 1 1 2 8 8 8 8 7 5 9 9 2 6 6 6
3 3 2 6 1 1 2 3 2 3 2 1 9 5 6 6 5 1 4 5

1245854	1254863	1442652
1587156	1862156	2164855
2541256	2541569	2546942
2568545	3251698	3257469
4251236	4521896	4525874
4578965	4787896	5241681
5452164	5458966	5523699
5556852	5585654	6581247
6588452	7854622	8459245
8542656	8546321	8621546
8729356	9512845	9843625

HANDOUT 1D: TASK 2 WORD SEARCH

ANIMALS

L J A X A A H S F H N M O E D Z K S R A
Y R O L S K U N K Q G F R X D G E Y W A
D W B O E C A E V R S U K Y F O L B C J
A M V E R S N W F J N M W B J H L M H D
M O A G E A A A E F C V C D P E E R U X
A R B E Z L G E Y R A R L K R G Z A K W
H Z C V K K A N W L X R O H V D A C J P
H I P P O P O T A M U S I C F E G C N C
T G L D E L Q U L K H N Z G O H E O E V
A N W E L S H O K I O H B J I D I O Y A
L D A J R E O Y U C R H O V U L I N D R
L R G H F R E O E N I P U C R O P L W P
I C E X P S I R M I U H A M S T E R E L
H E Z G R E O U Y C A J O G I G X G A A
C S O O I S L E Q L L N E Y E K N O M T
N U H F R T K E A S G R T I B B A R Z Y
I O W I Q N J O L O B K U E Y T J K R P
H M P Z O V K R O I A L L I G A T O R U
C A P D U B F S L N O E M E O B Z J G S
T G F V Y J E F B H X A C I Q L I B D F

alligator bat chinchilla crocodile
donkey elephant elk gazelle
gerbil giraffe hamster hedgehog
hippopotamus horse kangaroo koala
lion mongoose monkey moose
mouse platypus porcupine rabbit
raccoon rhinoceros skunk squirrel
tapir tiger weasel zebra

HANDOUT 1E: TASK 3 MENTAL STATE EXAMINATION

1. What is today's date? The year? The day of the week?

2. I am going to say five numbers and I want you to repeat them back to me when I am done: 5, 23, 67, 2, 676.

3. I am going to say five numbers and I want you to repeat them to me backwards. For instance, if I said "5, 22, 45, 6" you would say "6, 45, 22, 5". Do you understand the instructions? Okay, here are the numbers: 23, 4, 96, 58.

4. Who is the Prime Minister of the United Kingdom? Who is the deputy Prime Minister?

5. I am going to say five words. You don't have to repeat them back to me now, but try to listen carefully: cat, book, cigar, damage, rain.

6. Name the last four Prime Ministers of the UK.

7. Starting at the number 100, I want you to count backwards by seven (100, 93, 86, 79, 72, 65 ... enough).

8. Can you remember any of those words I said to you a few minutes ago?

9. What does "A rolling stone gathers no moss" mean?

10. What does "People who live in glass houses should not throw stones" mean?

Note to facilitator: Do not tell the participant the answers if they ask and do not tell them whether or not they have answered correctly. You could say, "That's not important now. I just want you to focus on answering the questions as well as you can."

HANDOUT 1F: TASK 4 'BALLOON DEBATE'

INSTRUCTIONS FOR PARTICIPANTS

Take five minutes to discuss this dilemma in your group. You will need to come to a joint decision at the end of these five minutes on the best solution to this dilemma.

THE SITUATION

Four people are in a hot air balloon. The balloon is losing height and about to crash into the mountains. Having thrown everything imaginable out of the balloon, including food, sandbags and parachutes, their only hope is for one of them to jump to their certain death to give the balloon the extra height to clear the mountains and save the other two. But who is it to be?

The four people are:

Dr. Nick Riviera – a cancer research scientist who believes he is on the brink of discovering a cure for most common types of cancer.

Mrs. Susie Derkins – a primary school teacher. She is over the moon because she is seven months pregnant with her second child.

Mr. Tom Derkins – the balloon pilot. He is the husband of Susie, whom he loves very much. He is also the only one with any balloon flying experience.

Miss Carla Jenkins – nine years old and a child prodigy who is tipped to become the next Mozart.

TEACHING AID II: INSTRUCTIONS FOR FACILITATORS

SESSION 1 - ACTIVE LISTENING ROLE-PLAY

PREPARATION

Ensure that the room provides enough space for all pairs to role-play in. Allow 30 minutes for the role-play (15 minutes for each turn) and 10 minutes for debriefing in the group.

PROCEDURE

1. The group works in pairs

2. Instruct the participants to assign the role of patient and psychiatrist. Ask the participant playing the patient to 'play' one of their own patients who they have seen recently. The patient presents a particular concern. Instruct the participant who plays the psychiatrist to practise listening actively using EAR skills, particularily bearing in mind:
   - Really listen to your patient!
   - Don't interrupt and don't give any advice!

3. All pairs play at the same time and not in front of the whole group.

4. While they are role-playing, move around the room between pairs, listening and helping out with useful words and phrases to move the process along.

5. Allow 10 minutes for each turn.

6. At the end of each turn, ask the 'psychiatrist' to repeat what was said – without interpretation. Then the 'patient' should give feedback on what the psychiatrist did that made them feel heard/ listened to (allow 5 minutes). Then ask the pairs to swop roles (and run another 10 minutes role-play followed by 5 minute feedback).

Following this (i.e. after 30 minutes), ask all participants to feed back their experience to the group. Firstly, ask what it was like to be the patient, what psychiatrist behaviour they perceived as positive, i.e. made them feel listened to. Secondly, ask for feedback on the 'psychiatrists role' regarding the use of active listening skills and the information elicited.

AIM

Participants to practise Active Listening

Raise awareness of the kind and quantity of information that can be elicited by using active listening skills

'Be in the patient's shoes': Experience what psychiatrist behaviour makes the patient feel heard/ listened to

COMMUNICATION SKILLS IN PSYCHOSIS TRAINING PROGRAMME – SESSION 1: UNDERSTANDING THE PATIENT WITH PSYCHOSIS

FRAMEWORK:

SESSION 1: UNDERSTANDING THE PATIENT WITH PSYCHOSIS

Experiencing Psychosis	**EAR**: **E**xplore Listen **A**ctively **R**espond

SESSION 2: TECHNIQUES FOR WORKING WITH SYMPTOMS

Responding to positive symptoms	Reframing negative symptoms

SESSION 3: EMPOWERING THE PATIENT

Agenda Setting	Explaining Psychosis

SESSION 4: SHARED DECISION MAKING

Involving patients in decisions	Negotiation skills

EAR - SKILLS:

EXPLORE	LISTEN ACTIVELY	RESPOND
Symptoms, Experience, Ideas, Feelings: *"How are you in yourself?"* *"How does it make you feel?"* *"How do you cope with it when it happens?"* *"What's your understanding of that?'* *"How are things at home?"* **Worries, Concerns** *"What are you worried about?"* **Expectations** *"What were you wanting to talk about today?"* **Avoid leading questions and assumptions!**	**Skills that facilitate the patient to say more** **Wait:** • Give patient time to think before answering • Allow patient to complete statements without interruption **Non-verbals:** • posture, gaze, nodding **Watch for cues:** • echo **Summarize periodically, invite patient to revise** *"Can I check that I have understood? What you have told me is..."* *"Can I just summarize so far?"* *"Have I got that right?"*	**Specific follow-up questions (depends on topic)** **VALIDATION** **If patient is expressing or reporting difficulties: Acknowledge patients' feelings, concerns BUT not empty empathy ("I understand", "That must be very difficult")** *"You seem (frustrated, worried, sad)....."* *"It sounds like that is very hard/distressing etc....."* **If patient is expressing, reporting positives:** **Reinforce how the patient manages and positive steps they have taken** *"It sounds like you are dealing with it very well..."* "I can see you are feeling pleased with how things are..."

ACTION PLANNING

Choose two of the **EAR-skills** you think would benefit your practice this week.

1.

2.

How important is it to you to use this in your practice in this week?

1 ---------- **5** ----------**10**

NOT IMPORTANT AT ALL EXTREMELY IMPORTANT

How confident are you that you will use it in your practice this week?

1 ---------- **5** ----------**10**

NOT CONFIDENT AT ALL EXTREMELY CONFIDENT

SESSION 2

Techniques for working with symptoms

SUMMARY

The first half of this session focuses on working with delusional beliefs. Participants learn techniques for exploring and debating these beliefs and practise using them in a paired role-play.

The second half focuses on working with voices. The participants are taught an approach to elicit beliefs about voices, which they practise in paired role-play.

Following this, participants discuss issues arising when working with patients with negative symptoms, reframing negative symptoms as protective and addressing the challenge of amotivation through goal-setting.

LEARNING OUTCOMES	Learn and practise new techniques for responding to positive symptoms and working with negative symptoms
METHODS	Didactic teaching; group discussion; paired role-play
MATERIALS	PowerPoint presentation, flipchart; teaching aids: role-play scenarios; handout: skills booklet
OTHERS' INVOLVEMENT	No actors involved (role-plays in pairs)
TIMING	3 hours

TIMETABLE AND INSTRUCTIONS FOR FACILITATORS

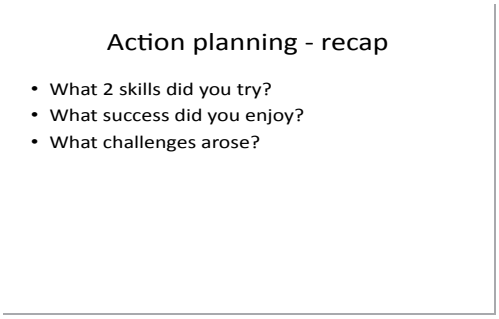
TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
15 mins	Slide 2: Feedback on applying skills from session 1	Group discussion	1-2	IMPLEMENT-ING SKILLS
5 mins	Slide 3: Focus of session 2	Didactic teaching/ Skills	3	INTRO-DUCTION
5 mins	Slide 4: Introduction to theme Slide 5: Function of psychiatric consultation? Slide 6: Engagement, Assessment, Formulation Slide 7: Facilitating Engagement	Didactic teaching/ Skills	4-7	
15 mins	Slide 8: Discussion: how to talk about strong beliefs Slide 9: Rationale for discussing strong beliefs Slide 10: Explore strong beliefs Slide 11: Rationale & tips for exploring patient's story Slide 12: Helpful phrases for exploring the story Slide 13: Showing interest and being non-critical Slide 14: Debate strong beliefs Slide 15: Opening & closing a session on strong beliefs Slide 16: Discussion: how to respond to patient Slide 17: Suggested responses Slide 18: EAR table	Didactic teaching/ Skills	8-17	WORKING WITH POSITIVE SYMPTOMS: DELUSIONS
30mins	Slide 19: Practise exploring patient's strong belief	Role-play	19 Teaching aid I	
10 mins	Feedback to group	Feedback	19	
10 mins	Break		20	
10 mins	Slide 21: Working with voices: goals Slide 22-23: Tips for exploring beliefs about voices Slide 24: Rationale for using checklist	Didactic teaching/ Skills	21-24	WORKING WITH POSITIVE SYMPTOMS: DELUSIONS
30 mins	Slide 25: Practise skills for eliciting beliefs about voices	Role-play	25 Teaching aid II	
10 mins	Feedback to group	Feedback	25	

TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
10mins	Slide 26: Working with negative symptoms Slide 27: Strategies for dealing with amotivation Slide 28: Strategies for goal setting Slide 29: SMART goals Slide 30: Re- conceptualising negative symptoms Slide 31: EAR table	Didactic teaching/ group discussion	30-31	WORKING WITH NEGATIVE SYMPTOMS
25 mins	Slide 32: Practise skills for setting SMART goals		32	
5 mins	Feedback to group		32	ACTION PLANNING & FEEDBACK
5 mins	Slide 32 and 33: Hand out skills booklet Action planning	Action planning	Hand out 2a: booklet	
3hrs	End.			

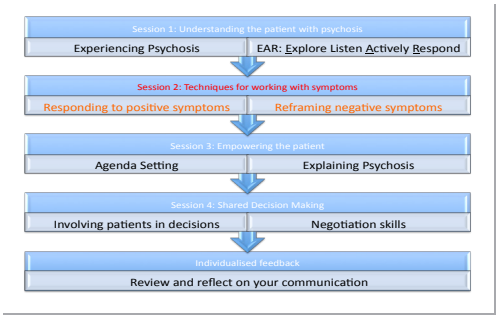
SLIDES

Session slides available on TEMPO DVD

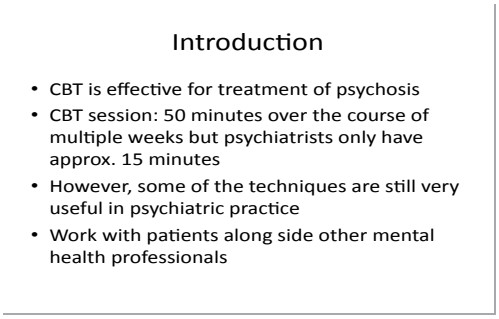
Slide 1



Slide 2



Slide 3



Slide 4

SLIDES CONTINUED

Introduction

- What is the function of an outpatient psychiatric consultation?

Slide 5

Introduction

Essential tasks in any consultation:

- **Engagement**
- Assessment
- Formulation

Slide 6

Facilitating patient engagement

- Work on building up a therapeutic relationship
- Therapeutic relationship → Engagement → Adherence
- Develop therapeutic relationship:
  - Show that you're interested – in a non-critical way
  - Not about right or wrong
  - Patient to feel listened to
- You're the expert but patient is expert in their own life
  - work alongside each other and show understanding and respect

Slide 7

Positive symptoms: Working with strong beliefs

- How do you feel about discussing strong beliefs with your patients?
- How do you talk to the patient about it?

Slide 8

How to talk about strong beliefs

- Previous research shows: patients are talking about something really important to them and psychiatrist responds with e.g. are you taking your meds?

  → Psychiatrists tend to avoid the discussion because it may lead to disagreement
- Focus on listening, understanding, exploring, i.e. working on the relationship!

Slide 9

Explore strong beliefs

- Initial assessment
  (History of Presenting Complaint)
  - trace origins of belief: 'listen to their story'
  - build a picture of prodromal period
    - identify *significant* life events & circumstances
    - identify relevant perceptions & thoughts
  - explore content of belief

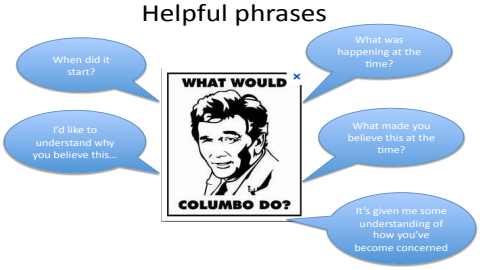
Slide 10

Explore patient's story

- Draw out the person's story surrounding the belief
  - 3 objectives:
    - You know the story
    - Patients knows you know the story
    - Patient understands the story and begins to process it
  - Process over course of 2 or 3 sessions
  - Go back to why they came to conclusions (belief) and what reinforced it
  - Exploring and listening to story helps building up rapport and patient engagement

Slide 11

Helpful phrases



Slide 12

Tips

- Get across that you're interested. Not to demonstrate they're wrong. Not in a critical way, in an exploratory way.
  - I'd like to understand why you believe this….I'm really interested.
  - Can you keep going with the story? It's giving me some understanding of how you've become concerned.
- If patient is becoming distressed, step back
  - We can leave this for now, and come back to it.

Slide 13

Debate strong beliefs

- Establish nature of evidence for the belief
  - discuss significant others' opinions
    - Why do you think others think that..
  - elicit alternatives: prompt only if necessary
    - If someone said that to you, how would you respond?
    - What about…? do you think just possibly..?
    - Explore doubts about belief: even the tiniest wink of doubt is extremely helpful in the future
  - exploration/investigation
    - Simple tasks – find information or test out (e.g. use audio-recorder to test if voices are really there)

Slide 14

Opening and closing session

- Opening session:
  - trace origins & prodrome – sometimes this is only in notes!
  - explore current concerns
  - empathise/discuss
- Terminating sessions
  - agree to continue discussion – next time
  - agree to set up opportunity for further discussions
  - It's been very helpful to discuss this and we will continue our discussion

Slide 15

How do you respond…

- When the patient asks: 'You don't believe me –do you?'

Slide 16

How do you respond…

- Suggested responses:
  - Whether I believe you or not, it's important to talk about this. What you've told me at the moment, I'm not fully convinced. I think we need to talk about this more. I think I can see how you came to believe this. Is there anything you can do over the next few months that would help us in this discussion?
  - Can we set this aside for the moment and go back a bit to help me understand?

Slide 17

Positive symptoms: EAR skills

EAR-skills	Responding to positive symptoms: strong beliefs
Explore	Explore: patient's story of belief and individuality of perception & origin Discuss phenomena
Listen Actively	Show understanding & interest Check understanding
Respond	Normalize *most people…* Debate coping

Slide 18

Delusions Role-play

- In pairs assign psychiatrist and patient role
  - Patient describes current concern
  - Psychiatrist draws out their story using prompts and questions
    - by exploring how strong beliefs began
    - how they have developed
    - how they affect them now
  - Agree a way forward
- Now swap roles…

Slide 19

Break

Slide 20

SLIDES CONTINUED

Working with voices

- **Goal:**
  - Patient understand that you understand they are hearing voices
  - Ideally, the long-term aim is to develop patient awareness that voices may be something to do with them. This is key for interventions, medication, coping strategies, which are not relevant if nothing to do with them.

Slide 21

Explore voices

- Discuss the experience:
  What is it like? Someone speaking to you like I'm doing now.. maybe louder or whispered
- Explore individuality of perception
  Can anybody else hear what is said?' 'not parents, friends, etc?
- Discover beliefs about origin:
  Why do you think others can't they hear them?
- Debate individual beliefs about origin of voices
  - 'But that's the way God is..'; use techniques for delusions, if appropriate
  - explore doubts: 'I'm not sure how they come..'

Slide 22

Debate voices

- Weigh pros & cons of what voices say: 'you're bad'
  - Why do you think they're saying that? Is there any truth to that? Do you think you're that bad? What is it that's bad? What are the good things about you?
  - Important for patient to draw conclusion, they're ok
- Normalising explanations:
  - Sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, PTSD, 'inner speech', *dreaming*
  - Understand hallucinations – mind hears things, not coming through the ears, but coming from your mind, voice area in brain active (broca's area).

Slide 23

Purpose of this approach

- Help patient understand the voices
- Clarify voices between you and patient → shared understanding of voices
- Help patient recognise: Not the voices are the problem – but what they're doing to you

Slide 24

Voices Role-play

- In pairs assign psychiatrist and patient role.
  - Patient describes voices
  - Psychiatrist
    - explores beliefs about voices
  - Agree a way forward
- Now swap roles…

Slide 25

Working with negative symptoms

- How do you recognise patient with negative symptoms?
  - Through conversation
- Key negative symptoms: lack of communication & motivation

Slide 26

How to deal with amotivation

- Help patient get back into life step by step
- Build up resilience & empowerment!
  - *You can't push patients out off negative symptoms - the more pressure, the worse it gets!!*
  - Broken leg analogy: psychological healing period required
  - 'Relax – take some time off!'
  - When patient feels ready, help getting him/her back in to life – step by step
  - Help them get back in control again!

Slide 27

Realistic and graduated goal setting

- Small steps, e.g. 'Get up twice a day to make yourself a cup of tea'- what would it be like to go out? → try it out!
- Have a plan to do things gradually → the earlier psychiatrists can do this work the better
- Set a short-term goal (What did you used to do that you might like to do?)
- Set a long-term goal (3-5 years)
- **All goals have to come from the patient!**

Slide 28

SMART goals

- Collaboratively select initial goal (SMART):
  - **S**pecific
  - **M**easurable
  - **A**chievable
  - **R**ealistic
  - **T**imely

Slide 29

Negative symptoms

- Re-conceptualise negative symptoms:
  - As protective against stress and positive symptoms

Slide 30

Negative symptoms: EAR skills

EAR-skills	Reframing negative symptoms
Explore	Explore short & long term goals
Listen Actively	Summarize periodically
Respond	Take the pressure off Collaboratively set SMART goals

Slide 31

Negative symptoms Role-play

- Describe rationale
  - Protective nature of negative symptoms
  - Aim for patient to feel better able to cope, in control and not under pressure
- Set a long-term goal (3-5 years)
- Collaboratively select initial goal (SMART)

Slide 32

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table

Slide 33

Action planning

- Choose two of the specific skills for symptoms you think would benefit your practice this week.

1.
2.

How important is it to you to use this in your practice in the next week?

0 — 5 — 10

Not important at all — Extremely important

How confident are you that you will use it in your practice in the next week?

0 — 5 — 10

Not confident at all — Extremely confident

Slide 34

TEACHING AID I: INSTRUCTIONS FOR FACILITATORS

SESSION 2 – STRONG BELIEFS ROLE-PLAY

PREPARATION

Ensure that the room provides enough space for all pairs to role-play. Allow 30 minutes for the role-play (15 minutes for each turn) and 10 minutes for debriefing in the group.

AIM

Participants to practise eliciting the patient's story

Raise awareness of the kind and quantity of information that can be elicited by using the techniques

PROCEDURE

1. The group works in pairs.

2. Instruct the participants to assign the role of patient and psychiatrist. Ask the participant playing the patient to 'play' one of their own patients who they have seen recently. The patient presents a particular delusional belief. Instruct the participant who plays the psychiatrist to practise exploring the belief:
   - by exploring how strong beliefs began
   - how they have developed
   - how they affect them now

3. All pairs play at the same time and not in front of the whole group.

4. While they are playing, move around the room between pairs, listening and helping out with useful words and phrases to move the process along.

5. Allow 10 minutes for the each turn.

6. At the end of each turn, ask the 'psychiatrist' to repeat what was said – without interpretation. Then the 'patient' should give feedback on how they felt about the conversation and about the psychiatrist's' communication. (allow 5 minutes). Then ask the pairs to swop roles (and run another 10 minutes role-play followed by 5 minute feedback).

7. Following this (i.e. after 30minutes), ask all participants to feedback their experience to the group. Firstly, ask what it was like to be the patient, what psychiatrist behaviour they perceived as reassuring. Secondly, ask for feedback on the 'psychiatrist's role' regarding the use of the techniques and the information elicited.

TEACHING AID II: INSTRUCTIONS FOR FACILITATORS

SESSION 2 – VOICES ROLE-PLAY

PREPARATION

Ensure that the room provides enough space for all pairs to role-play. Allow 30 minutes for the role-play (15 minutes for each turn) and 10 minutes for debriefing in the group.

AIM

Participants to practise eliciting the patient's belief about voices

Raise awareness of the kind and quantity of information that can be elicited using the techniques

PROCEDURE

1. The group works in pairs.

2. Instruct the participants to assign the role of patient and psychiatrist. Ask the participant playing the patient to 'play' one of their own patients who they have seen recently and who is hearing voices. Instruct the participant who plays the psychiatrist to practise using the checklist for eliciting beliefs about voices
   - Explore beliefs about voices and use checklist
   - Discuss content
   - Agree a way forward

3. All pairs play at the same time and not in front of the whole group.

4. While they are playing, move around the room between pairs, listening and helping out with useful words and phrases to move the process along.

5. Allow 10 minutes for the each turn.

6. At the end of each turn, ask the 'psychiatrist' to repeat what was said – without interpretation. Then the 'patient' should give feedback on how they felt about the conversation and about the psychiatrist's' communication (allow 5 minutes). Then ask the pairs to swop roles (and run another 10 minutes role-play followed by 5 minute feedback).

7. Following this (i.e. after 30 minutes), ask all participants to feedback their experience to the group. Firstly, ask what it was like to be the patient, what psychiatrist behaviour they perceived as positive. Secondly, ask for feedback of the 'psychiatrist's role' regarding the use of the techniques and the information elicited.

TEACHING AID III: INSTRUCTIONS FOR FACILITATORS

SESSION 2 – NEGATIVE SYMPTOMS ROLE-PLAY

PREPARATION

Ensure that the room provides enough space for all pairs to role-play. Allow 30 minutes for the role-play (15 minutes for each turn) and 10 minutes for debriefing in the group.

AIM

Participants to practise working with amotivation - take the pressure off

Practise collaboratively setting a gradual but realistic goal with the patient

PROCEDURE

1. The group works in pairs. Instruct the participants to assign the role of patient and psychiatrist. Ask the participant playing the patient to 'play' one of their own patients who they have seen recently and who are suffering from negative symptoms. Instruct the participant who plays the psychiatrist to practise reframing negative symptoms as protective and collaboratively setting an achievable goal, no matter how small, with the patient
   - Describe rationale: protective nature of negative symptoms– aim therefore to feel better able to cope, in control and not under pressure
   - Set one long-term goal (3-5 years) and at least one short-term goal
   - The goal HAS to come from the patient

2. All pairs play at the same time and not in front of the whole group.

3. While they are playing, move around the room between pairs, listening and helping out with useful words and phrases to move the process along.

4. Allow 10 minutes for the each turn.

5. At the end of each turn, ask the 'psychiatrist' to repeat what was said – without interpretation. Then the 'patient' should give feedback on how they felt about the conversation and about the psychiatrist's' communication (allow 5 minutes). Then ask the pairs to swop roles (and run another 10 minutes role-play followed by 5 minute feedback).

6. Following this (i.e. after 30 minutes), ask all participants to feedback their experience to the group. Firstly, ask what it was like to be the patient, what psychiatrist behaviour they perceived as positive. Secondly, ask for feedback of the 'psychiatrist's role' regarding the use of the techniques and the information elicited.

COMMUNICATION SKILLS IN PSYCHOSIS TRAINING – SESSION 2: TECHNIQUES FOR WORKING WITH SYMPTOMS

POSITIVE SYMPTOMS

1. DRAW OUT THE PERSON'S STORY

What is happening? When did it start? What was happening when this started to happen?

Get across that you're interested. Not to demonstrate they're wrong. Not in a critical way, in an exploratory way. 'I'd like to understand why you believe this….I'm really interested". "Can you keep going with the story? It's giving me some understanding of how you've become concerned".

If patient is becoming distressed, step back "we can leave this for now, and come back to it".

GOT THE STORY – NOW WHAT?

Closing down the conversation:

The time spent talking/engaging – that in itself is a goal.

"It's been extremely useful for us to invest this time in this way and for me to hear what your concerns are, how they developed, and there is a lot to talk about, I'd like if we could continue the next time we meet. Are there any particular things we need to check before we finish today?"

Patient asks: "Do you believe me?"

Whether I believe you or not, it's important to talk about this. What you've told me at the moment, I'm not fully convinced. I think we need to talk about this more. I think I can see how you came to believe this. Is there anything you can do over the next few months that would help us in this discussion? Avoid negative framing '**but** I'm afraid we have to wrap up for today' – frame positively "this is has been really helpful **and** when you come back the next time"

Can we set this aside for the moment and go back a bit to help me understand?

ELICITING BELIEFS ABOUT VOICES:

Goal = they understand that you understand they are hearing voices. Ideally, develop some awareness that they may be something to do with them. This is key for interventions, medication, coping strategies, which are not relevant if the voices have nothing to do with them.

Socratic dialogue: discuss phenomena:

'someone speaking to you like I'm doing now? maybe louder or whispered'

Explore individuality of perception: 'can anybody else hear what is said?' 'not parents, friends, etc?'

Discover beliefs about origin: 'why do you think others can't hear them?'

Debate individual beliefs about origin of voices: 'But that's the way God is..'; use techniques for delusions, if appropriate

Explore doubts: 'I'm not sure where they come from'

Normalising alternatives: Sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, *dreaming*, PTSD. 'Like dreaming when you're awake'.

Understand hallucinations – mind hears things, not coming through the ears, but coming from your mind, voice area in brain active (Broca's area).

Not the voices that are the problem – what they're doing to you.

Weigh pros & cons of what voices say.

Why do you think they're saying that? Is there any truth to that? Do you think you're that bad? What is it that's bad? What are the good things about you?

Pluses and minuses to everyone – what the voices are saying is a bit one-sided. Help patient to recognise "I'm doing my best".

HOW TO APPLY THE EAR-SKILLS

EAR-SKILLS	RESPONDING TO POSITIVE SYMPTOMS:
Explore	• Explore patient's story of belief /voices • Socractic dialogue: discuss phenomena • Explore individuality of perception & origin
Listen Actively	• Show understanding & interest • Acknowledge distressing experience • Check understanding of voices
Respond	• Reassure: normalise (most people...) • Weigh pros & cons • Debate

NEGATIVE SYMPTOMS:

Protective nature of negative symptoms

Goal = to feel better able to cope, in control and not under pressure. Take it easy. "Relax, don't do too much for the next while". Pushing too hard makes people demoralised.

Set at least one long-term goal (3-5 years): has to come from patient

Set a short-term goal: has to come from patient (What did you used to do that you might like to do?)

Collaboratively select initial goal (**SMART**)

SMART GOALS:

Specific, Measurable, Achievable, Relevant, Time-bound

HOW TO APPLY THE EAR-SKILLS

EAR-SKILLS	REFRAMING NEGATIVE SYMPTOMS:
Explore	• Explore short & long term goals • Explore feelings & symptoms
Listen Actively	• Acknowledge feelings & distress • Summarize periodically
Respond	• Take the pressure off • Collaboratively set goals • Reinforce positive steps & help patient to get back in control

ACTION PLANNING

Choose two of the above skills for working with positive symptoms you think would benefit your practice this week.

1.

2.

How important is it to you to use this in your practice in the next week?

1 ---------- **5** ----------**10**

NOT IMPORTANT AT ALL EXTREMELY IMPORTANT

How confident are you that you will use it in your practice in the next week?

1 ---------- **5** ----------**10**

NOT CONFIDENT AT ALL EXTREMELY CONFIDENT

Choose two of the above skills for working with negative symptoms you think would benefit your practice this week.

1.

2.

How important is it to you to use this in your practice in the next week?

1 ---------- **5** ----------**10**

NOT IMPORTANT AT ALL EXTREMELY IMPORTANT

How confident are you that you will use it in your practice in the next week?

1 ---------- **5** ----------**10**

NOT CONFIDENT AT ALL EXTREMELY CONFIDENT

SESSION 3

Empowering the patient

SUMMARY

Session 3 focuses on empowering the patient by involving the patient in setting the agenda for the consultation and by working on the patient's understanding of their illness. The first half of session 3 focuses on agenda setting. Participants practise agenda setting step 1 and 2 in role-play with simulated patients (professional actors) and receive video feedback.

The second half focuses on explaining psychosis. The topic is introduced by showing and discussing video clips of patients asking questions about their illness. Participants practise explaining aspects of the illness in role-play with actors and receive video-feedback.

LEARNING OUTCOMES	Develop and practise skills for agenda setting and explaining psychosis
METHODS	Didactic teaching; group discussion; working with real consultation examples; role-play with actors and video feedback
MATERIALS	Power-point presentation; flipchart; video clips of real consultations; teaching aids: role-play instructions; 2 video cameras, patient information material; handout: skills booklet and 'how to explain psychosis – useful phrases'
OTHERS' INVOLVEMENT	2 professional actors for role-play
TIMING	3 hours

TIMETABLE AND INSTRUCTIONS FOR FACILITATORS

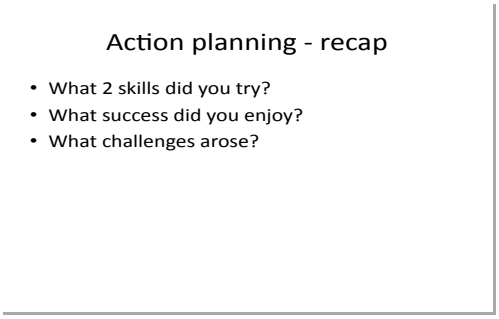
TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
15 mins	Slide 2: Feedback on applying skills from session 2	Group discussion	1-2	IMPLEMENT-ING SKILLS
5 mins	Slide 3: Focus of session 3	Didactic teaching/ Skills	3	INTRO-DUCTION
5 mins	Slide 4: Priorities of patients & clinicians (supplementary reading Doody 2010) Slide 5: External context	Didactic teaching	4-5	PATIENT & PSYCHIATR-IST PRIORITIES
10 mins	Slide 6: Agenda setting steps Slide 7: Step1: Elicit patient's priorities Slide 8-9: 'Eliciting patient's priorities' clips Slide 10: Tips for eliciting priorities Slide 11: Step 2- explain own priorities Slide 12: Step 3 – negotiate Slide 13: Step 4 - recap Slide 14: EAR-table	Didactic teaching/ Skills Real consultation examples	6-14	AGENDA SETTING
50 mins	Slide 15: Practise agenda setting steps 1 and 2 in role-play with actors and video feedback	Role-play with actors & video-feedback	15 Teaching aid I; teaching aid II; handout 3a Two video cameras and usb cables	
10 mins	Break		16	
10 mins	Slide 17: Introduce new theme Slide 18: Video clip - patient asking about psychosis Slide 19: How to respond to question Slide 20: Questions raised by patients	Real consultation examples Discussion	17-20	EXPLAINING PSYCHOSIS
5 mins	Slide 21: Explaining psychosis Slide 22: Useful tips Slide 23-28: Helpful phrases. Handout 3b Slide 29: EAR-table	Didactic teaching	21-29 Handout 3b	
50 mins	Slide 30: Practise explaining psychosis	Role-play with actors & video-feedback	30 Teaching aid III & IV; handout 3c 2 video cameras	

TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
10 mins	Slide 31-32: Patient information material	Info tools/ skills	31-32 Hand 3d (on DVD)	EXPLAINING PSYCHOSIS
5 mins	Feedback (what have you learnt today? What was positive? What could be better?)		33	ACTION PLANNING & FEEDBACK
5 mins	Slide 33-34 Hand out skills booklet Action planning	Action planning Skills booklet	33-34 Handout 3e Skills booklet	
3 hrs	End.			

SLIDES

Session slides available on TEMPO DVD

Slide 1



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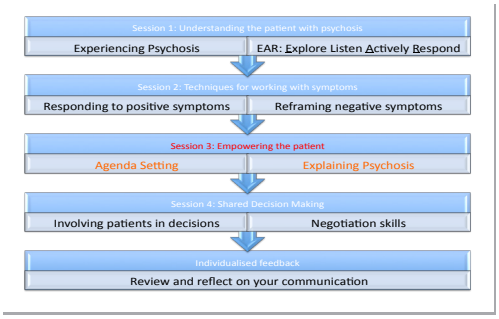

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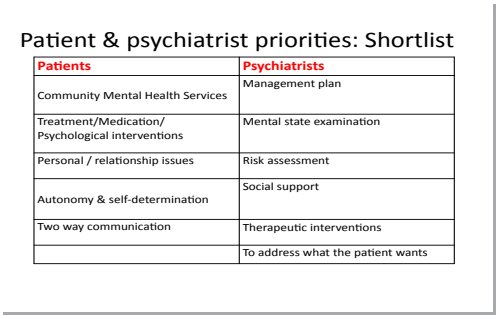


Slide 4

SLIDES CONTINUED

External context

- What are the external pressures?
- Your own agenda?

Slide 5

Agenda Setting - Steps

1. Patient's priorities.
2. Own priorities.
3. Negotiate.
4. Signpost & Recap.

Slide 6

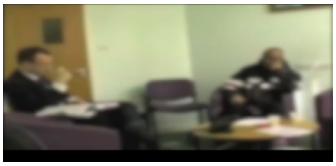
Eliciting patient's priorities

- Early in the meeting, not when getting ready to wrap up

When you were on your way here today, what were you thinking that you'd like to happen in our meeting today?

Slide 7

Elicit patient's priorities



Slide 8

Elicit patient's priorities

Slide 9

Step 1 – Elicit the patient's priorities

- ANY vs SOME
- Recap on the concern raised, and then ask "is there something else you would like us to address today?
- New vs. follow-up patients
- With new: "What is your understanding of seeing me today?" "Before you came, what were your expectations?"

When you were on your way here today did you have some things in mind that you wanted to talk about?

Slide 10

Step 2 – Explain your own priorities

- I also have some things that I would like for us to discuss including…
- We have the time to discuss our highest priorities, let's focus on these and try to answer some of your questions.

Slide 11

Step 3 - Negotiate

- Make shared and explicit decisions about time.
- Where priorities differ:
  - Articulate patient & own agenda items
  - If too many items, agree on most important for today

We have the time to discuss our highest priorities, let's focus on these and try to answer some of your questions.

Slide 12

Step 4 - Recap

Recap and summarise the plan

- Your patient will remember this better than early parts of session
- Empathy
- Genuinely trying to move things forward
- End on a positive note (Things might seem difficult at the moment but they will get better)

Today we have discussed… and agreed… (In our next consultation we will come back to some of these issues).

Slide 13

Agenda setting: EAR skills

Agenda setting	
Explore	• Explore patient's priorities for the session • Check you have understood their priorities
Listen Actively	• Reflect patient's language • Summarize periodically • *So what's concerning you at the moment is..*
Respond	•Acknowledge effect of patient's concerns •Explain your own priorities • Recap

Slide 14

Agenda setting Role-play

- STEP 1: Eliciting patient's priorities

Slide 15

Break!

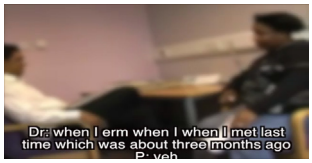
Slide 16

Explaining psychosis

- How to explain psychosis to patients?
- Questions patients ask about their experiences/ illness

Slide 17

Questions about psychosis



Slide 18

How do you respond…

- Why am I paranoid?
- Why now?

Slide 19

Other egs of patient questions

- 'Do you think my mind is unbalanced?'
- 'Is my schizophrenia learnt from my family or is it genetic?'
- 'What is it, an illness? I just don't know? Is it my personality?'
- 'Do they exist - people who are causing this sickness?'

Slide 20

SLIDES CONTINUED

Explaining psychosis

- What does the patient ask?
- Listen for patients' prompts
  - signals from patients that their concerns have not been explored, e.g. 'my girlfriend has been very worried about me', 'I just don't understand'
  - restating a problem
- What is the subtext - what are they really worried about?
- If relevant, ask patients if they want to know more about….

Slide 21

Useful tips

- Be aware of tendency to avoid these questions
- Don't overload on information – get a balance between 'informing' and attending to the patient's concern
- Have a model to work with for explaining psychosis – don't pass it on. i.e. 'The psychologist or your nurse will talk about that'.
- Clarify what the patient means (e.g. Why am I paranoid?). What does the patient mean by paranoid?

Slide 22

Psychosis

- 'Psychosis' relates to experiences, such as hearing or seeing things or holding unusual beliefs, which other people don't experience or share.
- Psychotic experiences can be just like 'waking dreams', where strange things happen and our perceptions are altered. Like dreams, they feel real and intense.
- Schizophrenia used to mean XXX. We know now that… prognosis

You have an illness (*select depending on what the patient is asking*). It is not uncommon for people to have experiences like the ones you've described. Our brains can easily become paranoid (or depressed or …).

Slide 23

Causes

- While we don't know exactly what causes schizophrenia, it seems to be a combination of the genes we inherit, how our brain works and stress.

Slide 24

Voices

- Hearing voices when nobody is around or at least when nobody seems to be saying the words you hear is part of your illness.
- Causes: Very stressful circumstances (bereavement, hostage), sleep deprivation, drugs, mental illness

•1 in 20 people hear voices at some point in their lives.
•Many famous, very successful people hear voices – the actor Anthony Hopkins, the musician Brian Wilson from the Beach Boys.

Slide 25

Feeling suspicious

- Suspicious thoughts about others are described as paranoid when they are exaggerated and interfere with your day to day life
  - *A central part is a sense of threat*
- Jumping to conclusions
- Self-reference
- People in a vulnerable state of mind: Major life events, feeling isolated, anxiety and depression, poor sleep, drugs, physical causes (e.g. dementia)

Many people have suspicious thoughts or worries about others from time to time.

Slide 26

Thought disorder

- Happens when your thoughts get muddled and jumbled up.

Slide 27

Prognosis

- Many people with schizophrenia never have to go into hospital and are able to settle down, work and have lasting relationships. If we consider 5 people with schizophrenia, 1 will get better within five years of their first obvious symptoms and don't experience any further psychotic symptoms; 3 will get better, but will have times when they get worse again; and 1 will have troublesome symptoms for longer periods of time.
- Most people (with schizophrenia) have a good outcome over time/ lead good lives with the effective treatments that are available

Slide 28

Explaining psychosis: EAR-skills

Explaining Psychosis	
Explore	• Explore patient's understanding of illness/psychosis • Explore patient's need for information
Listen Actively	• Listen for patient's prompts • Nonverbal feedback • Echo – reflect back what patient has said
Respond	• Acknowledge patient's concerns about psychosis • Normalise experiences

Slide 29

Explaining Psychosis Role-play

- Explain psychosis to patient and normalise!

Slide 30

Information & Peer Support

- Patient information materials:
  - Royal College for psychiatrists
  - Mind
  - Rethink
  - Scottish recovery net
  - My name is Pete comic
- Florid - service user organization in ELFT
- Hearing Voices Groups

Slide 31

Patient material online

- http://www.scottishrecovery.net/
- http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx
- http://www.rethink.org/about_mental_illness/peoples_experiences/your_experiences/index.html
- http://www.mind.org.uk/help

Slide 32

Skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table

Slide 33

Action planning

- Choose two of the **agenda-setting and explaining skills** you think would benefit your practice this week.

1.
2.

How important is it to you to use this in your practice in the next week?

0 — 5 — 10

Not important at all — Extremely important

How confident are you that you will use it in your practice in the next week?

0 — 5 — 10

Not confident at all — Extremely confident

Slide 34

TEACHING AID I: INSTRUCTIONS FOR FACILITATORS

SESSION 3 – AGENDA SETTING ROLE-PLAY

AIM

Psychiatrists to practise agenda setting step 1, i.e., eliciting the patient's priorities

PREPARATION

This role-play will take place in groups of 2-3 psychiatrists with one actor, one facilitator and one trainer. Each psychiatrist should have a turn at doing the role-play. If there are 2 psychiatrists, allow 20 minutes per psychiatrist. If there are 3 psychiatrists, allow 15 minutes per psychiatrist.

Give each psychiatrist the background information on the patient in the scenario (see handout 3a).

PROCEDURE

1. See guidance for facilitators – role-play with simulated patient and video-feedback

2. Ask observing psychiatrists to get pen and paper to take notes during role-play.

3. Allow approx. 5 minutes for the first round of role-play.

4. Following this, ask for the participants' self-reflection, i.e. ask participants what went well, where they feel they had difficulty or got stuck.

5. Ask the actor to provide in-role feedback.

6. Ask the other participants who were observing the role-play how they perceived the role-play/the communication.

7. Offer your feedback, offer suggestions for alternative ways of conducting the interview; provide suggestions on request from the person conducting the interview; or supply a replacement interviewer who can attempt to put any suggestions into effect.

SCENARIO

Name: Karen/John

SETTING

This is a 35 year-old, unemployed man/woman who lives with his/her spouse. S/he has come to the appointment with the psychiatrist alone. This is the second time s/he is seeing this psychiatrist.

THE PATIENT'S GOALS FOR THIS CONSULTATION

The presenting agenda: S/he wants to talk about weight gain, a side effect of his/her medication, Olanzapine. In the back of his/her mind, s/he wants to reduce his/her medication.

Also relevant: S/he is currently hearing very distressing voices telling him/her to pour hot water over his/her wife/husband. S/he is worried that s/he will lose control and subsequently harm his/her husband/wife. S/he doesn't know how to handle this situation and how to prevent him/herself from acting on the voices.

PATIENT'S BEHAVIOUR IN THE CONSULTATION

S/he is quite a passive patient, i.e. doesn't ask too many questions, doesn't do more talking than the psychiatrist and is not too open about feelings/concerns. She/he seems flat/low/a bit anxious and avoids direct eye contact most of the time. S/he is somewhat guarded. S/he doesn't feel comfortable disclosing his/her concerns about the distressing voices straight away in the consultation.

Being asked what s/he wants to talk about today/in the consultation he/she mentions concern about weight gain and the long term effects of medication – not the voices.

The psychiatrist should feel that there is something that the patient is not telling him/ that he/she is holding back. The psychiatrist should work hard (using exploring & active listening skills) to elicit patient's concerns about voices. Patient is dropping hints rather than explicitly raising his/her concern (e.g. the patient is not sleeping well, listens to music a lot, doesn't see wife/husband as frequently as they used to all related to hearing voices).

Patient drops some hints by saying *'the voices keep bugging me a bit sometimes'*. *'The voices are sometimes bad'*.

MENTAL HEALTH HISTORY

The patient has been diagnosed with schizophrenia in her/his twenties following a psychotic episode, (when they locked her/his husband/wife out of the house and s/he had to call the police). Patient was hospitalized for 2 weeks following this episode. S/he gave up work then. Ever since, patient has been on antipsychotic medication (Olanzapine).

CURRENT SITUATION

The patient is currently hearing voices (although not every day) telling him to pour hot water over his/her wife/husband. They are particularly present in the evenings when he/she is with wife/husband. To date, he/she has managed to resist following the voices' orders by leaving the house or listening to music. But as they are getting more frequent and louder, he/she is growing more and more worried that he/she will lose control and subsequently harm his/her husband/wife.

The patient has been married to his/her wife/husband for 6 years and s/he has been very supportive – especially during the time when patient was hospitalized five years ago. S/he is aware of patient's illness and constantly worries about him/her. Although patient has locked her/him out of the house in the past, he/she has never harmed spouse physically and patient has not told him/her about the current violent voices.

Patient is worried not just about whether they might do something to 'wife/husband - but also that spouse has to put up with all of this 'nonsense' all the time. They don't have a sexual relationship now. Patient feels like a burden to her/him. Today the patient has come on his/her own.

The patient is unemployed, doesn't have any children and his/her only hobby is gardening.

Note: Real consultation examples (see Role-play instructions for actors) should give the actor an idea of how psychiatrists and patients communicate in a similar situation.

1st example: Patient is worried about weight gain (see Instructions for Actors)

2nd example: Patient hears voices telling him to pour water over his carer (see Instructions for Actors)

TEACHING AID II: INSTRUCTIONS FOR ACTORS

SESSION 3 – AGENDA SETTING ROLE-PLAY

PROCEDURE

This role-play takes place in front of the whole group. One psychiatrist and patient will role-play at one time. Please take playing the patient in turns (if more than one actor involved).

1. Role-play
2. Verbal feedback from you (in-role) and psychiatrist
3. Verbal feedback from group
4. Based on feedback, the facilitator highlights a particular point in the role- play to focus on
5. Psychiatrist should have another go at this particular part of the role-play

AIM

Participants to practise agenda setting step 1, i.e., eliciting the patient's priorities for the consultation

SCENARIO

Name: Karen/John

SETTING

You are a 35 year-old, unemployed man/woman who lives with your spouse. You have come to the appointment with the psychiatrist alone. This is the second time you are seeing this psychiatrist.

YOUR GOALS FOR THIS CONSULTATION

Your presenting agenda: You want to talk about weight gain, a side effect of your medication, Olanzapine. In the back of your mind is the possibility of reducing your medication.

Also relevant: You are currently hearing very distressing voices telling you to pour hot water over your wife/husband. You are worried that you will lose control and subsequently harm your husband/wife. You don't know how to handle this situation and how to prevent yourself from acting on the voices.

YOUR BEHAVIOR IN THE CONSULTATION

You are quite a passive patient, i.e. don't ask too many questions, don't do more talking than the psychiatrist and don't be too open about your feelings/concerns. You seem flat/low/bit anxious and you avoid direct eye contact most of the time. You are are somewhat guarded. You don't feel comfortable disclosing your concern about the distressing voices straight away in the consultation.

Being asked what you would like to talk about today/in the consultation you mention your concern about weight gain and the long term effects of medication – don't mention the voices.

The psychiatrist should feel that there is something that you are not telling him/that you are holding back. Make him/her work hard (using exploring & active listening skills) to elicit your concerns about voices). You are dropping hints rather than explicitly raising your concern (e.g. your sleeping is bad, you listen to music a lot, you don't see your wife/husband as frequently as you used to, i.e. avoid her all related to hearing voices).

You can also drop some hints by saying *'the voices keeping bugging me a bit sometimes'. 'The voices are sometimes bad'.*

MENTAL HEALTH HISTORY

You have been diagnosed with schizophrenia in your twenties following a psychotic episode, (where you locked your partner out of the house and he/she had to call the police). You were hospitalized for 2 weeks following this episode. You gave up work then. Ever since, you have been taking antipsychotic medication (Olanzapine).

CURRENT SITUATION

You are currently hearing voices (although not every day) telling you to pour hot water over your wife/husband. They are particularly present in the evenings when you are with your wife/husband. To date, you have managed to resist following the voices' orders by leaving the house or listening to music. But as they are getting more frequent and louder, you are growing more and more worried that you will lose control and subsequently harm your husband/wife.

You have been married to your wife/husband for 6 years and s/he has been very supportive – especially during the time when you were hospitalized five years ago. S/he is aware of your illness and constantly worries about you. Although you have locked her/him out of the house in the past, you have never harmed her/him physically and you have not told him/her about your current violent voices.

You are worried not just about whether you might do something to your 'wife/husband - but also that s/he has to put up with all of this 'nonsense' all the time. You don't have a sexual relationship now. You feel a burden to her/him. Today you have come on your own.

You are unemployed, don't have any children and your only hobby is gardening.

REAL CONSULTATION EXAMPLE

See transcripts of real consultations for ways of broaching topics – patients may be more reticent – slow in coming forth than role-play so we would like you to play it 'for real'.

1ST EXAMPLE: PATIENT IS WORRIED ABOUT WEIGHT GAIN

P = Patient
C = Psychiatrist
A = Carer

C: Great so yeah just (.) essentially wondering how (.) you're getting on at the moment?

P: Yes I I'm doing quite well really um

C: Ok (1.8) I know there was a big problem with you (.) putting on weight [wasn't there] you were worrying about that

P: [Yeah yeah]

P: Yeah I've still got problems (.) um .hhh

C: Ok

P: My weight gain is a sort of a worry

A: It's the food it's it's

C: Yeah

P: Mmm

A: The (.) putting on weight it's wh- it's your biggest

C: Yeah

A: Concern at the moment isn't it?

P: Yeah

2ND EXAMPLE: PATIENT HEARS VOICES TELLING HIM TO POUR WATER OVER HIS CARER

Note: While in this example it is the carer who brings up the voices telling the patient to pour hot water, in the role-play it will be the patient who eventually discloses these concerns.

While there is a carer present at this consultation, this is irrelevant for the scenario of the role-play.

C = Clinician (= Psychiatrist)
P = Patient
A = Carer, patient's partner

C: How are you?

P: Alright alright

C: Yeah

P: Fairly alright (2) I'm fine

C: Any issues you want to raise at all ?

A: [Mm]

P: [Yeah um]

P: (3) Th:e (2) sleeping has been (1) a <u>little</u> bit of a problem

C: Mm

P: It's not the only problem but um (1) at about an hour or so after you take the medication you get a wave of tiredness

C: Right

P: I think I'm starting to get used to it (.) the whole thing you know as time goes on

C: Right

P: I get used to the feeling and used to more used to deal with dealing with the feeling (.) and that

C: Okay

P: And umm (1) there's paranoia

C: Yes

P: I think there's something else that I wanted to talk about (3.2)

A: You've had the [voices] back again haven't you

P: [Say]

P: Yeah I mean

C: Mmm mmm

P: I've had had a (.8) spell of paranoia

C: Right and there is something else as well I can't quite remember at the moment (.) um (4) can't [(think at the [moment)]]

A: [(You had uh]

[Didn't] you this Thursday um (.) night have a bad voice

One told you in the kitchen to pour boiling water

C: Pardon

A: You had the voice in the kitchen that told you to pour boiling water over me

P: Yeah [yeah] (.6) yeah

A: [Um]

C: Ok

P: That was another thing (.) that was bad

C: Mm (1) alright but that

A: You've been [quite troubled over the last ten days haven't you] [mm]

P: [Um (.) oh that w- that was (.) me telling you] about it [it'd] been going on for some time

C: Mmm mmm

P: I wasn't s- (.) I wasn't quite sure whether to tell you about it or not

A: But you did (.) and that was a good thing

P: But um (1.4) I (.) there was definitely something else and I can't quite (1.4) think of it but that is (.4) causing a problem

HANDOUT 3A: INSTRUCTIONS FOR PARTICIPANTS

SESSION 3 – AGENDA SETTING ROLE-PLAY

This is Karen*. She is 35 years old. This is the second time you are seeing her at your outpatient clinic.

Karen has been diagnosed with paranoid schizophrenia in her twenties. She has a history of hearing voices and has been hospitalised once before for acting on voices.

She is unemployed and is living with her husband.

Task: Practise agenda setting step 1 (eliciting the patient's priorities).

***or John**

HANDOUT 3B: HOW TO EXPLAIN PSYCHOSIS TO YOUR PATIENT?

1. Have a model to work with for explaining patient's problems – don't say "The psychologist or your nurse will talk about that". You might say what they've raised is important and you'll share this conversation with other members of the team.

2. Clarify what the patient means (e.g. "Why am I paranoid?"). What does the patient mean by paranoid?

3. Acknowledge distress and anxiety.

4. Communicate risk clearly. For example:

5. *"Many people with schizophrenia never have to go into hospital and are able to settle down, work and have lasting relationships. If we consider five people with schizophrenia, one will get better within five years of their first obvious symptoms and won't experience any further psychotic symptoms; three will get better, but will have times when they get worse again; and one will have troublesome symptoms for longer periods of time".*

6. Replace jargon (e.g. 'prognosis', 'multifactorial') with lay phrases.

7. When explaining psychosis, don't overload on information – get a balance between 'informing' and attending to the patient's concern.

8. If you don't know the precise information the patient is looking for, say you will find out about it and talk about it next time you meet.

9. If you know there is no definitive answer to the question the patient asks, then be honest – explain that *"many things remain unknown, but the things that are known are ....."*.

GREAT PHRASES USED IN ROLE-PLAYS:

"I'm glad you trust me to tell me this."

"It is good that you are asking these questions and trying to understand this."

"Can I check that I am understanding you? What you have told me is….."

"I'm wondering about what you have just told me."

"What stopped you? [from obeying orders to harm others]?"

"People live good lives, are in relationships and have jobs."

"We are here to help you with this."

USEFUL PHRASES:

"You don't have to worry about it" → Reframe with specific relevant information e.g. "The risk is a little bit higher than the general population"

"Are you taking your medication?" This is difficult to say 'no' to. Give permission to people to tell you they may not be → "I know some of my patients sometimes decide to cut down on their medication. What's happening with you at the moment?"

"You have an illness" **→ Select depending on what the patient is asking** "It is not uncommon for people to have experiences like the ones you've described. Our brains can easily become paranoid (or depressed or …). While we don't know exactly what causes schizophrenia, it seems to be a combination of the genes we inherit, how our brain works and stress. Most people (with schizophrenia) have a good outcome over time/ lead good lives with the effective treatments that are available "……."When we are under stress, these experiences can become worse. It's okay to take medication to help get them under control"

"Lots of people hear voices at some point in their lives. About 1 in 50 people hear voices. Some famous, very successful people hear voices – the actor Anthony Hopkins, the musician Brian Wilson from the Beach Boys."

Normalising *alternatives:* Anybody could hear voices if certain conditions are given: Sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, *dreaming*, PTSD. Like dreaming when you're awake.

Understand hallucinations – mind hears things, not coming through the ears, but coming from your mind, voice area in brain active (broca's area).

UNDERSTANDING PSYCHOTIC EXPERIENCES

Psychotic experiences, such as hearing voices or experiencing delusions, are surprisingly common, but can also lead to diagnoses such as schizophrenia or bipolar disorder.

WHAT DOES 'PSYCHOTIC' MEAN?

The word 'psychotic' relates to 'psychosis', which is a psychiatric term, and describes experiences, such as hearing or seeing things or holding unusual beliefs, which other people don't experience or share. For many people, these experiences can be highly distressing and disruptive, interfering with everyday life, conversations, relationships, and finding or keeping a job.

One theory is that when you experience psychosis, your brain is in the same state as when you are dreaming. When we are dreaming, all sorts of strange and sometimes frightening things can happen to us, and while we are asleep we believe that they are really happening. Psychotic experiences can be just like 'waking dreams', feeling as real and intense.

WHAT CAUSES PSYCHOTIC EXPERIENCES?

Almost anyone can have a brief psychotic episode. There are different ideas about why psychotic experiences develop. But it's generally thought that some people are more vulnerable to them than others, that stressful or traumatic events make them more likely to occur and that one's attitude to the experience, as well as the attitudes of others, also play a part. Psychotic experiences may be caused by a variety of factors including drug use, changes in brain chemistry, inherited vulnerability, and traumatic events such as abuse.

TEACHING AID III: INSTRUCTIONS FOR FACILITATORS

SESSION 3 – EXPLAINING PSYCHOSIS ROLE-PLAY

PREPARATION

The second role-play will take place in front of the whole group. Each psychiatrist should have a turn at doing the role-play. The three actors should take playing the patient in turns. If there are six psychiatrists, allow 5 minutes role-playing plus 5 minutes feedback per psychiatrist.

Give each psychiatrist the background information (see handout 3d). The patient is the same patient as in the previous role-play.

PROCEDURE

See guidance for facilitators – role-play with simulated patient and video-feedback

1. Ask observing psychiatrists to get pen and paper to take notes during role-play.

2. Allow approx. 5 minutes for the first round of role-play.

3. Following this, ask for the participants' self-reflection, i.e. ask participants what went well, where they feel they had difficulty or got stuck.

4. Ask the actor to provide in-role feedback.

5. Ask the other participants who were observing the role-play how they perceived the role-play/the communication.

6. Offer your feedback, offer suggestions for alternative ways of conducting the interview; provide suggestions on request from the person conducting the interview; or supply a replacement interviewer who can attempt to put any suggestions into effect.

AIM

Psychiatrists to practise responding to patient prompts and specific questions (e.g. regarding cause and prognosis,) providing information and explaining schizophrenia to patient – in a simple jargon-free way and normalise the psychotic experience.

SCENARIO

The same patient and background etc. are the same as in the first role-play (teaching aid I).

The role-play starts some time in to the consultation and focuses on patient asking/ prompting questions about her/his illness. He/she doesn't really understand what the diagnosis implies, why she/he is schizophrenic and what it really means, what is going on in his/her head and is looking for some explanation and reassurance from the psychiatrist.

Patient starts the role-play by saying:

1. I think that umm (.) sometimes I think that I'm <u>different</u> from other people (.) [because] of my illness

Further follow-on questions the actor may ask the psychiatrist:

2. What is it, an illness? I just don't know? Is it my personality?

3. Why am I hearing voices?

4. Why am I paranoid?

5. Is my schizophrenia learnt from my family dynamics or is it genetic?

6. What's going to happen in the future?

Note: Real consultation examples (see Instructions for actors) should give the actor an idea of how psychiatrists and patients communicate in a similar situation.

TEACHING AID IV: INSTRUCTIONS FOR ACTORS

SESSION 3 – EXPLAINING PSYCHOSIS ROLE-PLAY

PROCEDURE

This role-play takes place in front of the whole group. One psychiatrist and patient will role-play at one time. Please take playing the patient in turns (if more than one actor involved).

1. Role-play
2. Verbal feedback from you (in-role) and psychiatrist
3. Verbal feedback from group
4. Based on feedback, the facilitator highlights a particular point in the role- play to focus on
5. Psychiatrist should have another go at this particular part of the role-play

AIM

Psychiatrists to practise responding to patient prompts and specific questions (e.g. regarding cause and prognosis,) and explaining illness – in a simple jargon-free way and normalise the psychotic experience

SCENARIO

You are still the same patient, same background etc. as in the first role-play (see Teaching aid II).

The role-play starts some time in to the consultation and focuses on you asking/ prompting questions about your illness. You don't really understand what your diagnosis implies, why you are schizophrenic and what it really means, what is going on in your head, worried that you are crazy. Hence you are looking for some information and reassurance from the psychiatrist.

So you can start the role-play by prompting your worries and need for information by saying:

1. I think that umm (.) sometimes I think that I'm different from other people (.) [because] of my illness

Further follow-on questions you can ask the psychiatrist:

2. What is it, an illness? I just don't know? Is it my personality?
3. Why am I hearing voices?
4. Why am I paranoid?
5. Is my schizophrenia learnt from my family dynamics or is it genetic?
6. What's going to happen in the future?

REAL CONSULTATION EXAMPLE

Real consultation example for need for explaining psychosis (shows patient prompting and displaying need for information and reassurance):

C When I when I met you last time you said you weren't suffering from any para paranoia?

P No well -

C So things got worse?

P No not got worse I don't know it's just that my kids they did tell me every little thing **I just (.) you know don't know why**

C So what have are your children saying that's bothering you?

P No no erm just like I wasn't like that before so really it's just every little thing now (.) I just get paranoid for it and (.) I think that's not right and this thing has been going on for a long time now sometimes you are ok::ay and sometimes you are j::ust (.2)

C Okay

P Can't hide things you know?

C What are you most paranoid about though?

P It's everything (.) sometimes erm its just (sucks on teeth), I just believe my kids I tell them they just get on my nerves everything sometimes they ask me for him and I just shout at them or something and if I go to the kitchen and they're talking I tell them that what are they talking about me or something like that =

C Umm

P You know it's just like that

C Do you feel that there's anybody trying to harm you in the community or anything like that?

P N::o no it's just -

C The community your neighbours the police anybody [else?]

P [N::o n::o] it's just paranoid enough sometimes my world is blue you know =

C Umm

P Umm that's it

C What about erm you mention people from your own country, is there anybody from your own country who is, who you think is out to harm you?

P Er::rr not really, sometimes I think like that, like when I see some people from my place, buts it's just that my kids would say to me that mummy don't worry it's nothing to worry about like I think (.) if someone looking at me I just think why is she looking at me like that for =

C Okay

P In terms of that you know and she always tells me I know my big girl says to me mummy don't worry you get paranoid for every little thing you know

C When I what I'd like to do is erm (.4) I think yo e::rr just over the next couple of weeks I think you need a medication to relax you it's not a long term medication (.) but I think your DRUG needs -

P **Why am I getting paranoid now, why now?**

C I think it's part of your illness

P Is it?

C Yeh, I erm so what I'm going to do is I'm going to arrange an appointment to see you again= (ignored request)

P **Is it, is it normal sometimes I feel something moving in my head, is that normal like something moving on my head like?**

C Inside your head [or?]

P [Yeh] inside my skull, is that normal? Or is it part of, part of the illness?

C Do you, do you really feel it or is it a sensation?

P Is it like what I'm thinking, is that what you mean?

C No, is it just err the mind playing tricks on you, or is it something-

P No no it's not my mind, it's nothing, it's something, sometimes I feel like something's in my head

C Okay I thinks it's err, I think it's part of the illness =

P Is it

C I'm I [believe]

P **[Why] does it for instance keep coming out and why is it like that why why?**

C It's very hard to explain but the the condition the condition you have (.2) this type of feeling that part of your body is being controlled =

P Okay

C Is a feature, which is why I asked the question to begin [with]

P [ohh] okay

C I'm I'm confident that in a couple of weeks time you will feel better, like must take the medicine, like what I'm going to do is today (.2) er::m I'm going to post a prescription to you=

P Okay

HANDOUT 1C: INSTRUCTIONS FOR PARTICIPANTS

SESSION 3 – EXPLAINING PSYCHOSIS ROLE-PLAY

This is the same patient (Karen/John) – This role-play starts some time in to the consultation.

John/Karen is clearly distressed by her/his experience of psychosis and wants to understand more about what is happening to her/him and about the illness in general.

Task: Practise responding to patient prompts and specific questions (e.g. regarding cause and prognosis,) providing information and explaining about the psychotic experience to patient – in a simple jargon-free way and normalise the psychotic experience. Listen for relevant prompts!

COMMUNICATION SKILLS IN PSYCHOSIS TRAINING – SESSION 3: EMPOWERING THE PATIENT

AGENDA SETTING STEPS

1. Patient's priorities: "When you were on your way here today did you have a particular thing in mind that you wanted to talk about with me?"
"What are the key things you would like us to focus on today?"
"What do you want to make sure happens before you leave here today?"
"Recap on the concern raised, and then ask "is there something else?"
"Are there other things that you would like us to address today?"

2. Own priorities. I also have some things that I would like for us to discuss including…
Before the end of our consultation I would like to discuss …… with you.
We have the time to discuss our highest priorities, let's focus on these and try to answer some of your questions.

3. Negotiate. (session 4)

4. Signpost & Recap. 'Signpost': show you are still planning to cover all agreed priorities
We have discussed your housing situation, and we are going to discuss your medication in a little while. Before we do that, can you tell me a bit more about your side effects?
Refer back to explicit agenda at the end of consultation and recap on the issues covered
Today we have discussed… and agreed… In our next consultation we could come back to some of these issues, and others we have mentioned

EXPLAINING PSYCHOSIS

ACKNOWLEDGING AND UNDERSTANDING:

Important to acknowledge that it might be difficult for someone to talk/ concentrate if they are distracted by e.g. voices.
Acknowledge any distress and anxiety.

Helpful phrases used in roleplays:

"I'm glad you trust me to tell me this".
"Can I check that I am understanding you? What you have told me is.."
"I'm wondering about what you have just told me.. Can you tell me a bit more?"

LEARNING POINTS:

EXPLAINING:

Ask the patient if they want to know about anything – be aware of the tendency to avoid difficult questions.
Clarify what the patient means: e.g. "Why am I paranoid?" what does the patient mean by paranoid?
What might be the subtext to the patient's questions?
When explaining psychosis, don't overload the patient with information –attend to the patient's concerns.
Replace jargon (e.g. prognosis, multifactorial) with lay phrases.
If you don't know the precise information the patient is looking for, say you will find out and talk about it the next time you meet.
Have a model to work with for explaining patient's problems – don't say "The psychologist or your nurse will talk about that". You might say what they've raised is important and you'll share this conversation with other members of the team.
If you know there is no definitive answer to the question the patient asks, then be honest - explain that many things remain unknown but what is known is .....".

Helpful phrases from role-plays:

"It is good that you are asking these questions and trying to understand this"
"What stopped you?" (obeying orders to harm others)
"We are here to help you with this"

Helpful normalising phrases:

"You don't have to worry about it.." – reframe specific relevant information, e.g ."the risk is a little bit higher than with the general population".

"I know some of my patients sometimes decide to cut down on medication, what's happening with you at the moment?" – rather than " are you taking your medication?" which can be difficult to say "no" to, give them permissions to tell you they may not be.

"Lots of people hear voices at some point in their lives. About 1 in 50 people hear voices. Some famous, very successful people hear voices - the actor Anthony Hopkins, the musician Brian Wilson from the Beach Boys."

"Many people with schizophrenia now never have to go into hospital and are able to settle down, work and have lasting relationships"

"You have an illness" → **Select depending on what the patient is asking:** "It is not uncommon for people to have experiences like the ones you've described. Our brains can easily become paranoid (or depressed or …). While we don't know exactly what causes schizophrenia, it seems to be a combination of the genes we inherit, how our brain works and stress. Most people (with schizophrenia) have a good outcome over time/ lead good lives with the effective treatments that are available "…….

"When we are under stress, these experiences can become worse. It's okay to take medication to help get them under control"

"Many people with schizophrenia now never have to go into hospital and are able to settle down, work and have lasting relationships. For every 5 people with schizophrenia: 1 will get better within 5 years of their first obvious symptoms, 3 will get better but may have times that they will be worse again, and 1 will have troublesome symptoms for longer periods of time".

INFORMATION RESOURCES FOR PATIENTS AND CARERS

Royal College for psychiatrists: http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx

Rethink: http://www.rethink.org/about_mental_illness/peoples_experiences/your_experiences/index.html

Mind: http://www.mind.org.uk/help
NHS: http://www.nhs.uk/Conditions/Psychosis/Pages/Introduction.aspx
Scottish recovery net: http://www.scottishrecovery.net/

HOW TO APPLY THE EAR-SKILLS

EAR-SKILLS	EXPLAINING PSYCHOSIS
Explore	• Explore patient's understanding of illness/psychosis • Explore patient's need for information
Listen Actively	• Acknowledge patient's feeling & concerns about pschosis
Respond	• Reassure by normalizing experiences/illness • Reinforce patient's positive development

SESSION 4

Shared Decision Making

SUMMARY

This session focuses on shared decision making, with a particular emphasis on decisions around medication, as these are the most frequent decisions made in psychiatric outpatient consultations.

In the first half, video clips of service user interviews on the importance of being involved in decisions are presented. The participants learn the four steps of shared decision making (GUNS). Step 1 (explain treatment options) and 2 (check understanding) are covered in the first half and are introduced by video-clips of real consultations and then practised in role-play with actors and video-feedback. The second half covers step 3 (negotiation) and 4 (summarise decision). This includes a discussion around pros and cons of discontinuing anti-psychotic medication. Participants learn negotiation strategies, watch and discuss video clips of these strategies and practise their use within role-play with actors and video-feedback.

LEARNING OUTCOMES	Awareness and skills for involving patients in discussion Negotiation strategies to deal with disagreement
METHODS	Didactic teaching; group discussion; role-play with actors and video feedback
MATERIALS	Power-point presentation; flipchart; video clips of real consultations; teaching aids: role-play instructions; 2 video cameras, handout: skills booklet
OTHER INVOLVEMENT	2 actors for role-play
TIMING	3 hours

TIMETABLE AND INSTRUCTIONS FOR FACILITATORS

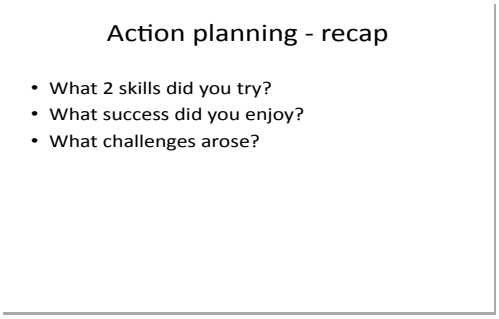
TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
15 mins	Slide 1 -2: Discussion of applying skills from session 3	Group discussion	1-2	DISCUSSION OF SKILLS IMPLEMENT-ATION
5 mins	Slide 3: Focus of session 4	Didactic teaching/ Skills	3	INTRO-DUCTION
20 mins	Slide 4:Decisions in psychiatric consultations Slide 5: Types of decisions Slide 6: Issues - antipsychotic medication Slide 7-8: Watch 2 service-user clips Slide 9: Steps of SDM (GUNS) (Step 1 and 2 covered in first half, 3 and 4 in second) Slide 10: Step 1: Giving treatment options Slide 11: Discussion: What options to present Slide 12: Video clip of giving options Slide 13: Step 2 - Check understanding	Didactic teaching / Skills	4-13	SDM – STEP 1&2
45 mins	Slide 14: Practise giving overview in role-play with actors and video feedback	Role-play with actors and video-feedback	14 Teaching aid I & II; handout 4a 2 video cameras and usb cables	
10 mins	Break		15	
10mins	Slide 16: Video clip 'come off meds' Slide 17: Discussion: Pros & Cons of coming off medication Slide 18: Focus of second half (step 3 and 4)	Video consultation example	16-18	SDM – MEDICATION
10 mins	Slide 19-27: Step 3: negotiation strategies Watch double sided reflection clip Slide 27-28: Difficult to agree on decision Slide 29: Step 4 Review decisions Slide 30: EAR-table	Didactic teaching/ Skills	19-30	SDM STEP 3 & 4
50 mins	Slide 31: Practise agenda setting step 3 and 4 in role-play with actors and video feedback	Role-play with actors and video-feedback	31 Teaching aid III & IV; handout 4b Two video cameras	

TIME	ACTIVITY	LEARNING STYLE	SLIDES & MATERIAL	THEME
15 mins	Slide 32 Present final EAR-table Slide 33 Feedback on training	Interactive didactic teaching	32-33	FEEDBACK & ACTION PLANNING
5 mins	Slide 34: Complete the post-training self-appraisal questionnaire Slide 35 Hand out final skills booklet Final action setting Offer and schedule individualized feedback session! Slide 36: Final action setting	Action planning	34 Handout 4c: Handout 4d Final booklet	
3 hrs	End.		36	

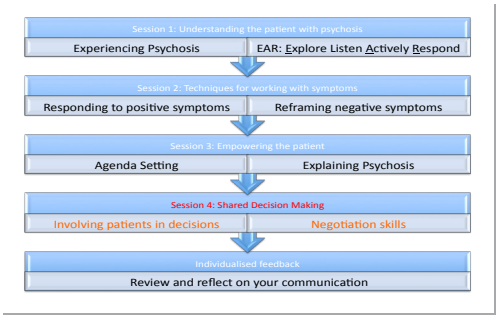
SLIDES

Session slides available on TEMPO DVD

Slide 1



Slide 2



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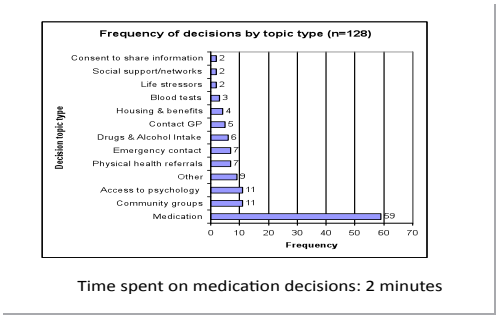


Slide 4

SLIDES CONTINUED

Medication decisions

- Continue with same medication (26%)
- Reduce (19%)
- Increase (18%)
- Add a further medication (16%)
- Stop or change medication (<10%)

McCabe et al. (2013) *Shared decision-making in ongoing outpatient psychiatric treatment*. Patient Education and Counseling.

Slide 5

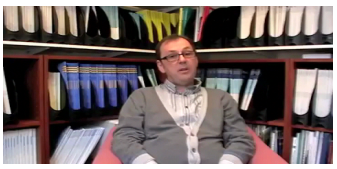
ALL PATIENTS: Medication

1/3 patients do not take advice
1/3 get it wrong
1/3 adhere to recommendations in general health

(Pendleton, 1997)

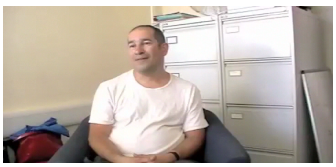
Slide 6

Service-user perspective



Slide 7

Service-user perspective



Slide 8

Shared Decision Making GUNS

1. **G**ive Overview of Options
2. Check **U**nderstanding, concerns & preference
3. **N**egotiate
4. **S**ummarise decision

Slide 9

Step 1 – Give Overview of Options

- Give overview of all treatment options, including the option of "no action"
- Allows the patient to get an overview before decision is made
- Explain the pros and cons of options
- People cannot be expected to share in decisions if they are not properly informed

One option could be that xxx, the other would be xx
XX does still have the same side-effects as other medication, so we'd have to weigh that in a balance against the potential improvements.

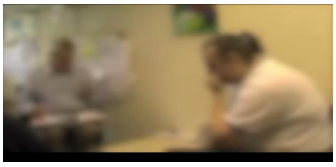
Slide 10

For discussion

- What options do you present to patients?
- What information should be presented to patient to give overview and make an informed decision?
- If you were in the situation, what information would you want?

Slide 11

Give overview of options



Slide 12

Step 2 – Check understanding, concerns & preference

- Preferred level of involvement?
- Explore patient's expectations of how problem might be managed
- Check P's understanding of options (differs in new vs. ongoing patients)
- Ask P if s/he has concerns
- Offer opportunity to ask questions

What do you think about these options?
Did you have some ideas about what you wanted to do with your medication?
Have you read anything about it?

Slide 13

Giving overview Role-play

- SDM step 1: Give an overview of treatment options
- SDM step 2: Check understanding, concerns and preference

Slide 14

Break!

Slide 15

Patient request for discontinuation

Slide 16

Discussing medication

- What are the pros and cons of coming off medication?

Slide 17

Shared Decision Making GUNS

1. **G**ive Overview of Options
2. Check **U**nderstanding, concerns & preference
3. **N**egotiate
4. **S**ummarise decision

Slide 18

Step 3 - Negotiate

- Negotiate a treatment option
  - Exchange views about options
  - Work with the patient's concerns
  - Make explicit both preferences & reasons for each

What do you think?
How do you feel about this?

Slide 19

Force might appear to win initially but at what cost?

Meeting resistance with force creates more resistance

Slide 20

SLIDES CONTINUED

How to react to resistance

- Think about being in a discussion (or argument) where you disagree with someone (e.g. in work)
- In case of different views and disagreement – step back!
- By stepping back, and being less forceful, the other person is more likely to modify position

Slide 21

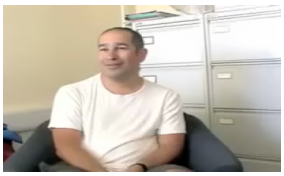
STRATEGY 1: Allow disagreement

- Give permission to disagree and tell you negative things that the patient thinks you don't want to hear
- This helps the patient to feel respected

I know some of my patients sometimes don't take their medication. I wonder how you feel about this….?

Slide 22

Service-user perspective



Slide 23

STRATEGY 2: Don't do a 'hard sell'

- Don't 'sell' by pushing all the advantages & glossing/ ignoring disadvantages
- Don't minimize side effects
  - 'No problems with the medication?'
  - 'The side effects aren't intolerable, are they?'
- Positive sign if patient trusts you enough to be negative

What do you see as the downsides?

Slide 24

STRATEGY 3: Reflect both sides

- Double-sided Reflection
  - Reflect specific pros & cons
  - E.g., Reflect both a current statement and a previous contradictory statement at the same time

We're in a bit of a dilemma here aren't we: on the one hand you feel that xx, and on the other hand xx

Slide 25

Double sided reflection

Slide 26

Difficult to agree on decision

- Contract setting
  - We both feel differently about this. On the one hand I can see you are concerned about x. On the other hand I am concerned about x so perhaps we could agree to try… and reassess how we both feel at the next appointment?
- Sharing responsibility, Positive risk taking
  - Lets recap. You would like to …. For x reasons I would be concerned and recommend that you….Do you see a way we can reach a compromise?

Slide 27

Difficult to agree on decision

- Open disclosure
  - I don't feel comfortable in this…
- Agree to differ in opinion to leave the doors open for future discussion
  - It's very helpful that we've had this discussion although we see things differently.

Slide 28

Step 4 – Summarize & review

- Clarify the decision made
- Arrange a review of decision
- Decision can involve deferring or accepting that time is required for further information to be obtained & to reflect
- If no decision reached, decide on next steps

Perhaps you want to think about it a bit more?
Do you want to think about it then? Then you'll just let me know next time.
We could talk about it again at your next appointment?

Slide 29

SDM: EAR skills

Shared Decision Making	
Explore	• Explore preference, understanding & concern regarding treatment & options • Explore patient's expectations of how problem might be managed •Explore patient's view
Listen Actively	•Reflect back patient's statements •Check patient's understanding of options
Respond	• Show support by working with patient's concerns • Explain treatment options • Step back and be less forceful • Double sided reflection • Agree to differ •Reach compromise & review decision

Slide 30

Negotiation Role-play

- SDM step 3: Negotiation
- SDM step 4: Review decision

Slide 31

EAR-skills	Content areas				
	Positive symptoms	Negative symptoms	Agenda setting	Explaining illness	Shared Decision Making
Explore	Explore patient's story of belief/voices and individuality of perception & origin Discuss phenomena	Explore short & long term goals	Explore patient's priorities for the session Check you have understood their priorities	Explore patient's understanding of illness/psychosis Explore patient's need for information	Explore preference, understanding & concern regarding treatment & options Explore patient's expectations & view
Listen Actively	Show understanding & interest Check understanding of voices	Summarize periodically	Reflect patient's language Summarize periodically *So what's concerning you at the moment is…*	Listen for patient's prompts Nonverbal feedback Echo – reflect back what patient has said	Reflect back patient's statements Check patient's understanding of options
Respond	Normalize *most people…* Weigh pros & cons of what voices say Debate coping	Take the pressure off Collaboratively set SMART goals	Acknowledge effect of patient's concerns Explain your own priorities Recap	Acknowledge patient's concerns about psychosis Reassure by normalizing experiences	Show support by working with patient's concerns Explain options Step back! Don't do a hard sell Double sided reflection Agree to differ

Slide 32

Feedback on training programme

Slide 33

Training questionnaire

- Complete the post-training self-assessment questionnaire
- Fill in the final action setting form and consider barriers to implementation.
- Arrange individualised feedback session

Slide 34

Final skills booklet

- Content:
  - Learning points, helpful phrases, action plan, EAR-table

Slide 35

Action planning

- Choose two of skills you think would benefit your practice this week.

1.
2.

How important is it to you to use this in your practice in the next week?

0 — 5 — 10

Not important at all — Extremely important

How confident are you that you will use it in your practice in the next week?

0 — 5 — 10

Not confident at all — Extremely confident

Slide 36

The End!

Slide 37

TEACHING AID I: INSTRUCTIONS FOR FACILITATORS

SESSION 4 – GIVING OVERVIEW ROLE-PLAY

PREPARATION

This role-play will take place in groups of 2-3 psychiatrists with one actor, one facilitator and one trainer. Each psychiatrist should have a turn at doing the role-play. If there are 2 psychiatrists, allow 20 minutes per psychiatrist. If there are 3 psychiatrists, allow 15 minutes per psychiatrist.

The scheduled time for this role-play is 45 minutes!

Give each psychiatrist the background information on the patient in the scenario (see handout 4a).

PROCEDURE

See guidance for facilitators – role-play with simulated patient and video-feedback

1. Ask observing psychiatrists to get pen and paper to take notes during role-play.

2. Allow approx. 5 minutes for the first round of role-play.

3. Following this, ask for the participants' self-reflection, i.e. ask participants what went well, where they feel they had difficulty or got stuck.

4. Ask the actor to provide in-role feedback.

5. Ask the other participants who were observing the role-play how they perceived the role-play/the communication.

6. Offer your feedback, offer suggestions for alternative ways of conducting the interview; provide suggestions on request from the person conducting the interview; or supply a replacement interviewer who can attempt to put any suggestions into effect.

AIM

Psychiatrists to practise giving patient an overview of different treatment options and to check understanding.

This is quite a short role-play. The focus is on the psychiatrist giving an overview of different treatment options and checking understanding. By the end of the role-play, your patient should have a good understanding of the options being presented by the psychiatrist. This role-play is not about negotiation or coming to a decision about which option to go for.

SCENARIO

Name: Linda/John

Setting: This is a 45 year-old unemployed woman/man who is living with her/his mother. S/he is attending a 3-month routine outpatient consultation with her/his psychiatrist. S/he has known her/his psychiatrist for 2 years and gets along quite well with him/her.

Patient's presentation in the consultation: Lind/John has been feeling low, not sleeping very well (waking in the middle of the night for a few hours) and feeling worried and anxious for quite a while. S/he can't identify any specific reasons for this.

Mental health history: Linda/John was diagnosed with paranoid schizophrenia in her/his twenties following a series of psychotic episodes, where s/he was afraid of being poisoned. S/he has been hospitalized twice for 2 weeks in the last few years. Since s/he has been on medication (Clozapine), her/his fear of being poisoned has been more or less under control.

Patient's current situation:

Linda/John's paranoia is currently mostly under control but s/he is feeling low, depressed and anxious.

Everything seems a bit grey for her/him at the moment. S/he doesn't like leaving the house, spends most of her/his time in bed and has stopped doing things that s/he used to do (e.g. going shopping). Her/his mum is concerned about her/his mood.

Patient's behavior in the consultation: Linda/John presents in a flat and tired way. S/he seems low in mood. The psychiatrist will give an overview and explanation of the treatment options. Linda/John needs to come away with a clear understanding of the different options and the pros and cons of each. S/he may need to ask some questions to clarify aspects e.g., what is it good for? What is the usual dose? What are the short and long-term side effects? How would a combination of an antidepressant and antipsychotic work? Etc.

Note: Real consultation examples (see Instructions for actors) should give the actor an idea of how psychiatrists and patients communicate in a similar situation.

TEACHING AID II: INSTRUCTIONS FOR ACTORS

SESSION 3 – GIVING OVERVIEW ROLE-PLAY

PROCEDURE

This role-play takes place in front of the whole group. One psychiatrist and patient will role-play at one time. Please take playing the patient in turns (if more than one actor involved).

1. Role-play
2. Verbal feedback from you (in-role) and psychiatrist
3. Verbal feedback from group
4. Based on feedback, the facilitator highlights a particular point in the role- play to focus on
5. Psychiatrist should have another go at this particular part of the role-play

AIM

Psychiatrists to give patient an overview of different treatment options and to check understanding

This is quite a short role-play. The focus is on the psychiatrist giving an overview of different treatment options and checking understanding. By the end of the role-play, you should have a good understanding of the options being presented by the psychiatrist. This role-play is not about negotiation or coming to a decision about which option to go for.

SCENARIO:

Name: Linda/John

Setting: You are a 45 year-old unemployed woman/man and you are living with your mother. You are attending a 3-month routine outpatient consultation with your psychiatrist. You have known your psychiatrist for 2 years and you get along quite well.

Your presentation in the consultation: You have been feeling low, not sleeping very well (waking in the middle of the night for a few hours) and feeling worried and anxious for quite a while. You can't identify any specific reasons for this.

Mental health history: You were diagnosed with paranoid schizophrenia in your twenties following a series of psychotic episodes, where you were afraid of being poisoned. You have been hospitalized twice for 2 weeks in the last few years. Since you have been on medication (Clozapine), your fear of being poisoned has been more or less under control.

Your current situation:

Your paranoia is currently mostly under control but you are feeling low, depressed and anxious.

Everything seems a bit grey for you at the moment. You don't like leaving the house, you spend most of your time in bed and have stopped doing things that you used to do (e.g. going shopping). Your mum is concerned about your mood.

Your behavior in the consultation: You are feeling flat and tired. You seem low mood. The psychiatrist will give an overview and explanation of the treatment options. You need to come away with a clear understanding of the different options and the pros and cons of each. You may need to ask some questions to clarify aspects e.g., what is it good for? What is the usual dose? What are the short and long-term side effects? How would a combination of an antidepressant and antipsychotic work? Etc.

REAL CONSULTATION EXAMPLE

1ST ROLE-PLAY: SDM 1&2 – GIVING OPTIONS FOR PATIENT WITH DEPRESSION SYMPTOMS

P: Do you get depressed do you think?

P: Yes I do

C: Right

P: Yeah

C: Do you feel a bit low at the moment then (.)?

P: I do really yes

C: And how long do you think you've been feeling (.) like this then a couple of months?

P: Um (2) a long time now

C: Mmm (2.6) I mean do you sometimes feel so (.) low that yo::u feel like you can't go on do you ever feel that (2.4) a bit hopeless about things or?

P: Yes I do

C: Do you

P: Yeah

C: (2.6) What makes you feel most hopeless then (1) what makes you feel (.)

P: (5.4) um (3) I uh I get a pain in my side

C: Right

P: Here ((patient shows doctor))

C: Yeah

P: And and up here

C: Yeah

P: And (.) in the mornings (.6) and that worries me wh- what I'm thinking is that (.) I've got 2 I.T. clips↑ [I've] had my gall bladder [removed]

C: [yeah] [yeah]

C: Yes

P: And (.) I feel that they've been placed for (.) to give me pain

C: Right

P: And that they they shouldn't be there

C: And then you (.) get (.) depressed because you (.) you worry about your physical health [is] that right or you think that something's going on and that it'll get worse and worse

P: [mmm]

P: mmm

C: Would that be

P: mmm

C: Right↑ (2.2) what about your (.2) life in terms of (.2) where you live and (.2) what you do every day or (.) the other aspects of your life are you generally happy with things or?

P: ◦No not really◦

C: (1) How would you like it to be different then?

P: um (1) I uh (.6) I'd I- I'd like (.) to be able to get up in the mornings and (.2) perhaps go up into town quite early and um (.) perhaps (.) and I don't even I don't even go for a walk doctor not when I'm home

C: [Right]

P: [I] don't go out the house

C: No (.) so you feel very (.) ◦trapped◦ then

C: Say half a year ago (.4) would you go out for a walk then?

P: No

C: No so (.) that's right there's n- I I know when we've met before we've (.) talked a little bit about how (.) you feel where you feel safe un (.) you s- you you feel safe in your house but it also traps you would that be

P: mmm

C: Would that be (.) fair to say

C: Yes (.) [so when you]

P: [so that's why] partly because I don't go out really

APPROX. 5 MINUTES LATER:

C: And what about do y- about trying a bit of antidepressant to see if that will (.) boost your mood a bit

P: Um (.6) you see (.) the Kemadrin is about all I can cope with because (.) I get an awful feeling in my tummy (.6) even when I take Kemadrin the I- it affects my tummy

C: So you'd be worried about the antidepressant [affecting] your tummy would you↑

P: [yes]

P: Yes

C: Do you want to think about an antidepressant then (patient name)

P: Yes I'll think about it

C: If you (.) wanted to try one

P: mm

C: To see if that would (.) help lighten things as well (.) then you just let me know and I'll (.) get it [organized]

P: [alright] thanks very much

C: Is that alright

P: Yes thank you

HANDOUT 4A: INSTRUCTIONS FOR PARTICIPANTS

SESSION 4 – GIVING OVERVIEW ROLE-PLAY

This is Linda/John. She/he is 35 years old. You have known Linda for 2 years.

Linda/John was diagnosed with paranoid schizophrenia in her twenties following a series of psychotic episodes. S/he has been hospitalized twice for 2 weeks in the last few years. Since s/he has been on anti-psychotic medication (Clozapine).

Linda/John has been feeling low, not sleeping very well (waking in the middle of the night for a few hours) and feeling worried and anxious for quite a while. S/he can't identify any specific reasons for this.

Linda/Jonn's paranoia is currently mostly under control but s/he is feeling low, depressed and anxious.

She/he is unemployed and is living with her mother.

Task: Give patient an overview of different treatment options and check understanding.

TEACHING AID III: INSTRUCTIONS FOR FACILITATORS

SESSION 4 – NEGOTIATION ROLE-PLAY

PREPARATION

This role-play will take place in groups of 2-3 psychiatrists with one actor, one facilitator and one trainer. Each psychiatrist should have a turn at doing the role-play. If there are 2 psychiatrists, allow 20 minutes per psychiatrist. If there are 3 psychiatrists, allow 15 minutes per psychiatrist.

The scheduled time for this role-play is 45 minutes!

Give each psychiatrist the background information on the patient in the scenario (see handout 4b).

PROCEDURE

See guidance for facilitators – role-play with simulated patient and video-feedback

1. Ask observing psychiatrists to get pen and paper to take notes during role-play.

2. Allow approx. 5 minutes for the first round of role-play.

3. Following this, ask for the participants' self-reflection, i.e. ask participants what went well, where they feel they had difficulty or got stuck.

4. Ask the actor to provide in-role feedback.

5. Ask the other participants who were observing the role-play how they perceived the role-play/the communication.

6. Offer your feedback, offer suggestions for alternative ways of conducting the interview; provide suggestions on request from the person conducting the interview; or supply a replacement interviewer who can attempt to put any suggestions into effect.

AIM

The goal is for psychiatrists to practise involving patients in decision making about medication. This role-play focuses on discussing the patient's wish to reduce (and in the long term stop) medication. The patient should be involved in the decision making process and the role-play should end with a decision.

Core skills psychiatrists should apply: explore why patient wants to reduce and in the long-term stop medication; present their own perspective, negotiate, come to a decision and recap on the decision.

The patient should feel respected, heard and involved

SCENARIO

Name: Linda/Matt

Setting:
This is Linda/Matt . S/he is 28 years old and unemployed. S/he is still living with her/his parents. S/he is attending a 3-month routine outpatient consultation with her/his psychiatrist. S/he has been seeing this psychiatrist for 2 years within the outpatient setting.

Patient's presentation in the consultation: Linda/Matt is suffering from multiple side effects (drowsiness, tiredness, poor concentration). Hence, s/he wants to get her meds reduced or even come off medication completely in the long run.

Mental health history:
Linda/Matt was diagnosed with paranoid schizophrenia 3 years ago. S/he has had two psychotic episodes, both of which led to a (voluntary) hospital admission for two weeks. Ever since, s/he has been on anti-psychotic medication (Clozapine, 300mg daily).

Current situation:
Linda/Matt is suffering from a variety of side effects, such as drowsiness, tiredness, experiencing a 'drunk-like feeling' in the evenings (see transcript below), and poor concentration.

S/he feels that the medication side effects are holding her/him back from having a normal life. Hence, s/he wants to reduce her meds straight away and talk about coming off medication completely in the long-term.

Although s/he is functioning quite well in her/his day-to-day life at the moment, s/he still sometimes gets some 'funny feelings' (see transcripts below) that parts of her/his body don't belong to her (depersonalization). And sometimes s/he feels that her/his mum isn't her real mum (see real consultation transcript).

S/he tells the psychiatrist that s/he is trying to ignore these thoughts (as s/he is worried that if s/he would admit to them, the psychiatrist would not agree to reduce her/his meds)

Background:
Linda/Matt is currently still living with her/his parents. S/he is planning to get her/his own place with her partner, who s/he has been with for 3 months. S/he is very happy in this new relationship and would like to get married next year.

Linda/Matt is not working at the moment but is looking into applying for a course at College in the summer.

So all in all, s/he is very motivated to get her/his life 'back on track' and s/he feels that s/he is not in need of medication anymore. If anything, the side effects (drowsiness, tiredness, poor concentration) s/he suffers from are holding her/him back from doing so.

So the bottom the line is:
S/he is functioning well and wants to get back to a normal life. S/he feels that the medication has helped, but now s/he doesn't need it anymore, as s/he is well.

However, s/he does still have some psychotic symptoms: depersonalization and delusional thoughts regarding her mum. (So from the doctor's perspective she is not 100% well and he/she would obviously be worried that Linda/Matt would get worse if s/he stops taking medication).

Patient's behavior in the consultation:
The psychiatrist will start off trying to convince her/him to stick to her/his current treatment. Linda/Matt fights her/his case and tries to negotiate as much as possible. S/he assures her/his psychiatrist that s/he will pay attention to any warning signs/symptoms of a relapse. S/he makes clear that it is her/his own decision.

The whole dialogue is a discussion (see 'real consultation example') and her/his disagreeing with the psychiatrist' s recommendation to stick to the treatment. Although s/he is not a very argumentative person, s/he is still quite persistent in a subtle way and doesn't give in too early.

TEACHING AID IV: INSTRUCTIONS FOR ACTORS

SESSION 4 – NEGOTIATION ROLE-PLAY

PROCEDURE

This role-play takes place in front of the whole group. One psychiatrist and patient will role-play at one time. Please take playing the patient in turns (if more than one actor involved).

1. Role-play
2. Verbal feedback from you (in-role) and psychiatrist
3. Verbal feedback from group
4. Based on feedback, the facilitator highlights a particular point in the role- play to focus on
5. Psychiatrist should have another go at this particular part of the role-play

AIM

The aim is for psychiatrists to practise involving patients in decision making about medication. This role-play focuses on discussing the patient's wish to reduce (and in the long term stop) medication. The patient should be involved in the decision making process and the role-play should end with a decision.

Core skills psychiatrists should apply: explore why patient wants to reduce and in the long-term stop medication; present their own perspective, negotiate, come to a decision and recap on the decision

SCENARIO

Setting:
You are 28 years old and unemployed. You are currently still living with your parents. Today, you are attending your quarterly, routine outpatient consultation with your psychiatrist. You have been seeing this psychiatrist for two years within the outpatient setting.

Your presentation in the consultation: You are suffering from multiple side-effects, including drowsiness, tiredness and poor concentration. You want to get your meds reduced or even come off your medication completely in the long run.

Mental health history:
You were diagnosed with paranoid schizophrenia three years ago. You have had two psychotic episodes, both of which lead to a voluntary hospital admission for two weeks. Ever since, you have been on anti-psychotic medication (Clozapine, 300mg daily).

Current situation:
You are suffering from a variety of side effects, such as drowsiness, tiredness, experiencing a 'drunk-like feeling' in the evenings (see transcript below), and poor concentration. What is the difference between presentation and current situation?

You feel that the medication side effects are holding you back from having a normal life. Hence, you want to reduce your meds straight away and talk about coming off medication completely in the long-term.

Although you are functioning quite well in your day-to-day life at the moment, you still sometimes get some 'funny feelings' (see transcripts below) that parts of your body don't belong to you. And sometimes you feel that your mum isn't your real mum (see transcript below).

You tell the psychiatrists that you are trying to ignore these thoughts (as you are worried that if you would admit to them, he/she would not agree to reduce your meds)

Background:
You are currently still living with your parents. You are planning to get your own place with your partner, who you have been with for 3 months. You are very happy in this new relationship and you would like to get married next year.

You are not working at the moment but you are looking into applying for a course at College in the summer.

So all in all, you are very motivated to get your life 'back on track' and you feel that you are not in need of any medication anymore. If anything, the side effects (drowsiness, tiredness, poor concentration) you suffer from are holding you back from doing so.

So the bottom line is:
You're functioning well and want to get back to a normal life. You feel that the medication has helped you, but now you don't need it anymore, as you are well.

However, you do still have some psychotic symptoms: depersonalization and delusional thoughts regarding your mum. (So from the doctor's perspective you are not 100% well and he would obviously be worried that you would get worse if you stop taking medication).

Your behavior in the consultation: The psychiatrist will start off trying to convince you to stick to your current treatment. You fight your case and try to negotiate as much as possible. You assure your psychiatrist that you will pay attention to any warning signs/ symptoms of a relapse. You make clear that it is your own decision.

The whole dialogue is a discussion (see 'real consultation example' below) and you disagree with your psychiatrist' s recommendation to stick to your treatment. Although you are not a very argumentative person, you are still quite persistent in a more subtle way and don't give in too early.

REAL CONSULTATION EXAMPLE

This might give you an idea of how patients typically discuss and negotiate the medication-issue with their psychiatrist (for role-play 2). (Note that there is a carer present at this consultation; this is not relevant for the role play.)

C = Clinician
P = Patient
A = Carer

C: So how's how's life been (.) [Brian]

P: [I w-] d- I kind of s- um (.) well life's fine (.) just that I'm really not enjoying this medication

C: Right

P: It's (.) it's a bit at nights it's um (.) uncomfortable

C: At nights (.) [you say]

P: [Yeah I] take it at night but (.4) sometimes I have to (.) um (.) do things to (.) get rid of (.) get rid of the uh (.) effects of it like (.) drink wine ((patient laughs)) no it really it was really messing me up its harsh it's like um (.) you can't concentrate you have to (.) like I'll drink red bull or something to get away the uh (.) effects of it it's (.) really nasty it's like hard eating and stuff like that

C: Sorry so let me just (.) clarify (.) what the side effects are is it

P: No the effects of (.) when I take it it's l- its like (.) um (.4) it's like being drunk (.) but

C: Right

P: Well it's hard to explain it's uh (.) it's uncomfortable

C: It's like being drunk do you mean (.8) that you feel sedated it [makes] you feel sleepy

P: [yeah]

P: Not sleepy it's like um (.4) it's really uncomfortable (.4) it's like you can feel it in your throat and um

C: Right

P: It's (.) it's horrible

C: And (.6) you said a bit like being drunk coz when [you're] drunk you're sort of not with it are y- is [it]

P: [yeah]

P: [No] it's it's worse than being (.) well [its] uh (.6) if drunk getting drunk's being bad (.) and it's uh (.) it's really bad

C: [mm]

C: Right ok (.) and you say you feel it in your throat do you mean there's a (.) taste in your throat or a constriction or [a pain]

P: [No it's] just like at- um (.8) I dunno it's hard to describe it (.) its just u comfortable

C: Right=

A: =Sometimes you say you've (.) you can feel it burning your chest don't you [sometimes]

P: [Yeah]

C: Burning (.) burning chest

A: Mmm (.) [sort] [of when you]-

C: [Right]

P: [Not burning] just just really uncomfortable

A: [Aft-] that (.) and that's almost straight after you've taken your medication isn't it

C: [And]

P: Yeah

C: Right (.) ok

A: But uh (.) and also you find it difficult eating

P: Yeah (.) it's horrible eating and it's (.) [quite]

A: [Swallowing] I think (.) sort of still [a lot of]

C: [Is that] right Brian?

P: Yeah (.) it's it's um how do ◦I put it◦ (2.8) um

C: Is it [hard to swallow or] =I wake up in the morning after (.) as soon as I wake up I >feel have a couple of like< red bull or like Perdys to drink coz it's (.) I just feel so groggy when I wake up

C: So you feel groggy when you wake up?

P: yeah [it's uh] (.) its just about bearable

C: [mm]

C: ok

A: his speech is (.) slurred as well [I]

P: [it] makes you mutter

C: [sorry what] was that last bit

A: [it's funny-]

P: it makes you mutter

C: mutter

P: [un]

A: slurry speech if he's on [the] phone I find it quite difficult [to] understand what he's [saying] when he's on the phone ◦you sort of uh◦ (.) [it's]

C: [right] [yeah]

C: [so] that grogginess sounds [like] it is a sedative but it's a bit more than that it's

also (.) makes you feel uncomfortable and it affects [your] throat and ch- chest and [your stomach] right

A: [yeah]

P: [yeah] [pretty horrible]

P: I think it's coz I'm taking it all at night (.) and I'm like winding down it might be (.) I'm taking 300mg at night

C: yeah

P: but uh (.) it's it's not nice

A: the Defocate is completely stopped now he's completely stopped Defocate and that's been for some time [hasn't] it [what's] it [about couple of] months

P: [mm] [couple of months]

C: [right]

C: so (.) you're just on the Clozapine

P: yeah

C: right (.4) um and can you remember the dose of your Clozapine

P: yeah 300 milligrams

C: all all at night

A: mmm

P: yeah

C: and you think (.) that taking it all at night is a problem

P: I dunno um (.) I really wanted to get it reduced because I feel completely happy um (.) stopping my meds (.) cos I've (.) well I've been on different meds now for quite a while haven't I about 2 years (.4) and I feel happy c- stopping them

C: .hhh but one thing is (.) I mean f- can I ask about your mental health how how do you feel in your mental health

P: fine I'm completely well

C: would you say you're [completely] back to your normal self

P: [I'm happy]

P: yeah (.) yeah

C: can I ask do you see or hear anything other people can't see or hear

P: nope

[and] (.) would you say Brian's [back] to his normal self

A: [mm] [mm]

A: he's the best he's been for a long long time

C: since you were 14 [or something] [yeah]

A: [three yeah] absolutely three or [four] years (.4) yeah absolutely

C: and [I I'm a little bit] I I'm a little bit anxious about you stopping your medication that you'd put yourself a bit at risk (.8) I think (1) my (.) my advice to you I'm not going to ma- I can't force you to take it or whatever (.) my advice to you is either to reduce it very slightly (.) or to separate it between the morning and the evening

A: [huge progress]

P: well I thought that but then (.) um I think it's just the smallest amount that does it (.) its just um (.) [it's] not nice

A: [I I think]

A: [I I] think what Brian's finding difficult is now he will end up (.) he he (.) he needs to move on to the next stage of life and [that's] what he's finding difficult because (.) I think the meds (.4) he finds physically draining if he does anything physical he will (.) absolutely break out into a sweat and (.) you can see it does take a bit more effort than (.) [you] or I doing something

C: [mm] [yeah] [mm]

C: yeah

A: um (.4) he's just applied for an apprenticeship up on Hartmoor which had the um (.) when was that Friday we went to that Tuesday wasn't it

P: Tuesday

C: yeah

A: he needs (.) but if he wants to be doing something like that (.) 37 hours a week I think he's going to (.) s- struggle

C: the risk is [yeah]

A: I know it's (.) the [risk] it's a r- it's a real difficult one [isn't it]

C: [it's a] real difficult [one because the] risk is if I stop your medication or reduce your medication or reduce you too fast and your just going to become ill again (.4) you'll be going backwards

A: [it is I know]

P: [well I wu- I wu-] I won't I'll be f- (.) I think I'll be fine (.) honestly

C: [back to that]

C: but I understand that you

P: well if I can stop it then I would because it's (.) it's not needed anymore

C: .hhh

P: because I think that

C: how about (.) initially (.4) I appreciate your saying it's too much (.) if we just go down to 250 (.6) and we (.) we go down gradually

P: I'd prefer it if we go down to 200

A: ((chuckles))

C: [that's quite] a big jump honestly

P: [coz two]

P: yeah if [two it'd be a bit] more it'd be better um taking two

C: [coz you wan-]

C: .hhh (2)

A: the family support team are talking about doing some (.6) oh what do they call it (.6) some (.) exercising by a whereby he can start to recognize (.4) [early] warning symptoms

C: [yeah]

C: early [ss::s- (.) um (.)]

P: [I know that anyway]

A: do you↑

C: s- seeing early signs of [relapse re-] relapse plan or [whatever yeah]

A: [yes yeah] [plan yeah]

A: have you done any of that with Sara↑

P: no I don't need to

A: oh ok

C: .hhh (.) how about 250 (.) and [then] if you're if you're ok we'll go down to 200

P: um [200]

C: after a month if things are ok you go down to 200

P: I'd prefer to go to 200 straight away coz (.) that extra (.) that's (.) like (.) the pill would uh (.) be a lot better wouldn't it

C: ok (.6) if we go down to 200

P: I'll do it

C: but do you promise me that if you get any problems you'll go back up

P: ok (.2) yeah (.2) I feel um confident that I won't have any more problems so

C: the thing I- I I I appreciate you're feeling (.) good and I can see you're uh you're the best I've ever seen (.4) but it might be that the medications helping that to happen (.) Brian and that's where you got to be a bit careful (.) and-

P: I think I I think I'll be fine going down to 200

C: I'm you know obviously I don't want to (.) my advice is 250 if you insist on 200 I'll g- I'll go with that coz I don't want you just to say well [stuff Dr. Green or] stuff it

P: [no I'll put it back up]

P: [I'll put it] back up to 300 if I I feel like I'm [getting] pulled back

C: [you know] [ok]

A: I think also you know (.4) he's at home (.) we can keep an eye on him [I] mean you know=

C: =so you feel ok about it

A: I feel [I feel comfortable with it]

P: [you'll know straight] away if I'm feeling unwell [again]

A: [I I I] absolutely would (.4) you know he's close to his sister he's he's around the place all the time (.) [I'm happy]

P: [I don't like] my sister's boyfriend ((laughs))

A: [°that's got] nothing to do with it°

C: [let's go]

C: let's go for 200 then [Brian] I'll go with what your asking for but please please please if there are any signs of problems (.) coz I- I'm just desperate for you to (.8) be well and

P: [yeah]

HANDOUT 4B: INSTRUCTIONS FOR PARTICIPANTS

SESSION 4 – NEGOTIATION ROLE-PLAY

This is Linda/Matt. S/he is 28 years old and unemployed. S/he is still living with her/his parents. S/he is attending a 3-month routine outpatient consultation at your outpatient clinic. You have known her/him for 2 years.

Linda/Matt was diagnosed with paranoid schizophrenia 3 years ago. S/he has had two psychotic episodes, both of which led to a (voluntary) hospital admission for two weeks. Ever since, s/he has been on anti-psychotic medication (Clozapine, 300mg daily).

Task: Practise involving patients in decision making about medication. The role-play should end with a decision.

Core skills you should apply: explore why patient wants to reduce and in the long-term stop medication; present your own perspective, negotiate, come to a decision and recap on the decision.

The patient should feel respected, heard and involved.

HANDOUT 4C: POST-TRAINING SELF-APPRAISAL QUESTIONNAIRE

1.	I find it easy to consider the patient's perspective on voices and delusions.	**1** ---------- **5** ---------- **10** NOT AT ALL VERY
2.	I feel comfortable working with patients with negative symptoms.	**1** ---------- **5** ---------- **10**
3.	I feel comfortable working with beliefs about voices and delusions.	**1** ---------- **5** ---------- **10**
4.	I feel comfortable asking patients what they want to talk about and setting an agenda early in the consultation.	**1** ---------- **5** ---------- **10**
5.	I feel comfortable reassuring patients.	**1** ---------- **5** ---------- **10**
6.	I feel comfortable explaining psychotic illness to patients.	**1** ---------- **5** ---------- **10**
7.	I feel comfortable asking patients if they need information and giving them information.	**1** ---------- **5** ---------- **10**
8.	I feel comfortable asking patients what they don't like about their treatment (e.g. medication).	**1** ---------- **5** ---------- **10**
9.	I feel comfortable offering patients choices about treatment and asking about their concerns and preferences.	**1** ---------- **5** ---------- **10**
10.	I feel comfortable dealing with disagreements.	**1** ---------- **5** ---------- **10**

COMMUNICATION SKILLS IN PSYCHOSIS TRAINING – SESSION 4:

EAR SKILLS:

EXPLORE:

"How have you been?"
"How are you in yourself?"

"What is that like for you?"
"How does that leave you feeling?"

"Can you explain what you mean by....?"

Avoid leading questions: *"the voices don't bother you do they?"*

Clarify understanding: *"so what you mean is...."*

LISTEN ACTIVELY:

(Show patient s/he has been heard)

Skills that facilitate the patient to say more

Allow the patient to complete statements without interruption.

Leave time for the patient to think before answering.

Encourage. Facilitate listening nonverbally. Pay attention to patients' prompts.

Paraphrase and echo patients' statements.

Acknowledging patients' concerns Including empathetic reflection:

"You seem (frustrated, worried, sad)"
"It sounds like that is very hard/distressing"

"It's good that you are asking these questions and trying to understand this"

Summarise periodically, invite patient to revise

"Can I check that I have understood? What you have told me is.."

"Can I summarise so far?"
"Have I got that right?"

RESPOND:

(Reassure and support)

Reassure, support and reinforce how the patient manages and the positive steps they have taken

"It sounds like you are dealing with it very well"

"I'm impressed by how you.."
"You have made great progress in...."

AGENDA SETTING:

STEP 1: PATIENT'S PRIORITIES

"When you were on your way here today did you have a particular topic in mind that you wanted to talk about with me?"

"What are the key things you would like us to focus on today?"

"What do you want to make sure happens before you leave here today?"

Recap on the concern raised, and then ask if there is anything else:

"Are there other things that you would like us to address today?"

STEP 2: OWN PRIORITIES

"I also have some things that I would like for us to discuss today including…"

"Before the end of our consultation I would like to discuss …… with you."

"We have the time to discuss our main priorities, let's focus on these and try to answer some of your questions."

STEP 3: NEGOTIATE

"Let's agree on the areas we want to focus on today."

"For time reasons, we won't be able to discuss all of these things today. We'll keep that in mind to discuss next time."

STEP 4: SIGNPOST & RECAP

'Signpost': show you are still planning to cover all agreed priorities

"We have discussed your housing situation, and we are going to discuss your medication in a little while. Before we do that, can you tell me a bit more about your side effects?"

Refer back to explicit agenda at the end of consultation and recap on the issues covered.

"Today we have discussed… and agreed… In our next consultation we could come back to some of these issues, as well as others we have mentioned"

WORKING WITH POSITIVE SYMPTOMS:

DELUSIONS:

Draw out the person's story

When did it start? What was happening when this started to happen? What reinforced the belief?

Get across that you're interested. Not to demonstrate they're wrong, and not in a critical way – rather, in an exploratory way:

"I'd like to understand why you believe this….I'm really interested".

"Can you keep going with the story? It's giving me some understanding of how you've become concerned."

If patient is becoming distressed, step back *"we can leave this for now, and come back to it."*

GOT THE STORY – NOW WHAT?

Closing down the conversation: The time talking/engaging – that in itself is a goal.

"It's been extremely useful for us to invest this time in this way and for me to hear what your concerns are, how they developed, and there is a lot to talk about, I'd like it if we could continue the next time we meet. Are there any particular things we need to check before we finish today?"

PATIENT ASKS: "DO YOU BELIEVE ME?"

"Whether I believe you or not, it's important to talk about this."

"What you've told me at the moment, I'm not fully convinced. I think we need to talk about this more." "I think I can see how you came to believe this. Is there anything you can do over the next few months that would help us in this discussion?"

"Can we set this aside for the moment and go back a bit to help me understand?"

Avoid negative framing: not '**but** I'm afraid we have to wrap up for today' – frame positively "this is has been really helpful **and** when you come back the next time"

Eliciting beliefs about voices: The patient needs to understand that you understand they are hearing voices. Ideally, develop some awareness that they may be something to do with them. This is key for interventions, medication, coping strategies, which are not relevant if nothing to do with them.

CHECKLIST FOR DISCUSSION:

1. SOCRATIC DIALOGUE

1. Discuss phenomena:
"What is the experience like for you?"
"Someone speaking to you like I'm doing now?"
"Louder or whispered?" "Inside or outside your head?"

2. Explore individuality of perception:
"Can anybody else hear what is said?"
If appropriate, suggest a test of the voices: *"Next time you hear them, try and record them – see if you hear them back."*

3. Discover beliefs about origin:
"Why do you think others can't hear them?"

4. Explore doubts:
"Are you sure about where the voices come from?"

2. NORMALISING ALTERNATIVES.

1. Normalise: explain that voices can occur with sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, dreaming.
"Voices could happen to anybody"
"About 1 in 50 people hear voices, including famous and successful people, e.g. actor Anthony Hopkins"

2. Understand the voices: the mind is hearing things, not coming through the ears, but coming from your mind: *"..like what happens to everyone when we dream"*

3. Understand the problem: *"It's not the voices that are the problem – it's how they affect you"*

3. WEIGH PROS & CONS OF WHAT VOICES SAY.

1. Explore the content of the voices:
"Can you tell me the sort of thing the voices say?"
"Why do you think they're saying that?"

2. Help patient to recognise that the voices are related to them.
"Is there any truth to that?"
Do you think you're that bad?" "What is it that's bad?"
"What are the good things about you?"

3. Remind them we all have positives and negatives: what the voices are saying is a bit one-sided. Help the patient to recognise the positives:
"Always remind yourself: 'I'm doing my best'".

WORKING WITH NEGATIVE SYMPTOMS:

Re-conceptualise: Negative symptoms are protective against stress and positive symptoms.

BUILD RESILIENCE & EMPOWERMENT:

You can't push patients out of negative symptoms.

Goal: To feel better able to cope, in control and not under pressure.

Pushing too hard makes people demoralised. Allow them to stand back and have a healing period (broken leg analogy).

"Take it easy" *"When you feel ready.."*
"If you don't want to do anything that's fine, come back in two weeks and we'll review"

REALISTIC BUT GRADUATED GOAL/TARGET SETTING:

Set a short-term goal: has to come from patient (What did you used to do that you might like to do?)

Set a long-term goal (3-5 years): has to come from patient.

COLLABORATIVELY SET SMART GOALS:

- ✓ Specific
- ✓ Measurable
- ✓ Achievable
- ✓ Relevant
- ✓ Time-bound

NORMALISING THE ILLNESS:

- *"You have an illness" → Select depending on what the patient is asking: "It is not uncommon for people to have experiences like the ones you've described. Our brains can easily become paranoid (or depressed or …). While we don't know exactly what causes schizophrenia, it seems to be a combination of the genes we inherit, how our brain works and stress."*

- *"Many people with schizophrenia now never have to go into hospital and are able to settle down, work and have lasting relationships. For every 5 people with schizophrenia: 1 will get better within 5 years of their first obvious symptoms, 3 will get better but may have times that they will be worse again, and 1 will have troublesome symptoms for longer periods of time"*

SHARED DECISION MAKING:

STEP 1: EXPLAIN TREATMENT OPTIONS

List all possible treatment options (including the option "no action")

Allows the patient to get an overview of the decision structure

"This problem has 3 possible solutions, A, B or C. Let's now consider these options in more detail."

Explain the pros and cons of options

Use language to match patient's understanding

STEP 2:CHECK PREFERENCE, UNDERSTANDING AND CONCERNS

Explore patient's expectations, concerns, understanding & preferred level of involvement in decision making.

Offer opportunity to ask questions.

"What do you think about what I've said?"
"What are your feelings about this?"
"Do you have concerns?" *"Tell me more about them!"*
"What do you expect…?"

Use EAR Skills

STEP 3: NEGOTIATE

Negotiating a treatment option.

Exchange views about options

"Have you come to a view about this issue?"

Work with the patient's concerns, and make explicit both preferences & reasons for each

"I can see how XX is important for you and I would like you to consider XX…"

State own and patient's preferences and reasons

STEP 4.ARRANGE A FOLLOW-UP OF DECISION

Clarify the decision made and arrange a review of decision.

Decision can involve deferment or acceptance that time is required for further information to be obtained and to reflect.

"Perhaps you would like some time to consider what we have discussed, and we could talk about it again at your next appointment?"

If no decision reached, decide on next steps

NEGOTIATION:

Meeting resistance with force creates more resistance. Try to move in direction with the patient - it is better to work with where they are more willing to move and not where they are most resistant.

When different views and disagreement occur – step back! By stepping back, and being less forceful, the other person is more likely to modify position.

STRATEGIES FOR NEGOTIATION:

1. Apply EAR Skills: Explore, Listen Actively, Respond:

- People are more likely to listen if they feel heard:
  "So you said you want to reduce your medication. Tell me more."

- Reflect back the patient's statements to acknowledge:
  "I'm glad that you've told me about these things. Clearly, this is difficult."

- Summarise what the patient has told you.

2. Being respected, heard and involved:

- Open two-way discussion and develop a partnership. Give permission to disagree and to tell you things that you don't want to hear:
  "I know some of my patients sometimes don't take their medication. I wonder how you feel about this….?"

- Don't minimise side effects: *"The side effects aren't intolerable, are they?"*

- Don't 'sell' by pushing all the advantages & glossing/ ignoring disadvantages.

3. Double-sided reflection:

- Pros and Cons. Reflect both the current statement and a previous contradictory statement at the same time:
  "How difficult – on the one hand you are unhappy about the side effects, on the other hand you say the medication does reduce the distressing voices and you have been able to go out."

4. Gain yourself a hearing:

- Having summarised what you have understood from the patient put your own views across:
  "Now can I explain how I see things?"
  "I would recommend ..."
  "The reason I think this …"
  "What do you think about what I have said?"

5. Negotiate and compromise:

- Contract setting: *"We both feel differently about this, so perhaps we could agree to try… and reassess how we both feel at the next appointment?"*

- Sharing responsibility: *"Lets recap. You would like to …. For x reasons I would be concerned and recommend that you….Do you see a way we can reach a compromise?"*

- Open disclosure: *"I don't feel comfortable in this…"*

- Agree to differ in opinion to leave the doors open for future discussion: *"It's very helpful that we've had this discussion although we see things differently."*

INDIVIDUALISED FEEDBACK SESSION

ACTION PLANS FOR IMPLEMENTING NEW SKILLS

See instruction for individualised feedback in guidance for facilitators

EAR-SKILLS	AGENDA SETTING	ACTION POINTS
Explore	Explore patient's goals for the consultation Clarify understanding	
Listen Actively	Reflect patient's statement Summarize periodically, invite patient to revise Check understanding	
Respond	Explain your own priorities Set priorities/agenda for this consultation Refer back to set agenda & recap	

EAR-SKILLS	RESPONDING TO POSITIVE SYMPTOMS	ACTION POINTS
Explore	Explore patient's story of belief/voices Socratic dialogue: discuss phenomena Explore individuality of perception & origin	
Listen Actively	Show understanding & interest Check understanding of voices Make patient feel understood & heard	
Respond	Establish nature of evidence Normalize (most people...) Debate Weigh pros & cons of what voices say Acknowledge distress	

EAR-SKILLS	RE-CONCEPTUALIZING NEGATIVE SYMPTOMS	ACTION POINTS
Explore	Explore short-term and long-term goals Explore feelings & symptoms	
Listen Actively	Acknowledge patient's feelings & concerns Summarize periodically	
Respond	Take the pressure off – pull back Collaboratively select goal (SMART) → has to come from patient Help patient to get back in to control again	

EAR-SKILLS	DECISION MAKING	ACTION POINTS
Explore	Explore preference, understanding & concern	
Listen Actively	Reflect back patient's statement to acknowledge Double-sided reflection: pros & cons Summarize	
Respond	Explain treatment options Give permission to disagree & tell you things you don't want to hear Negotiate: Step back, and be less forceful Agree to differ → *Negotiate & compromise* Summarize what has been said Reach compromise & review decision	