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Review

Good communication in psychiatry – a conceptual review

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ABSTRACT

Background. – The communication between clinician and patient is the basis of psychiatric treatment. However, there has been little practical attention to training in it, and no specific theory of what constitutes good communication in psychiatry has been developed. This review aims to identify principles that guide good communication.

Methods. – A conceptual review of guiding principles for how clinicians should communicate with patients to achieve clinical objectives in psychiatry.

Results. – Five guiding principles for clinicians were identified: a focus on the patient's concerns; positive regard and personal respect; appropriate involvement of patients in decision making; genuineness with a personal touch; and the use of a psychological treatment model.

Conclusions. – The principles are mostly generic, but their implementation can be particularly challenging in psychiatry. They may guide further empirical research on effective communication in psychiatry and be utilised using different personal skills of clinicians.

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1. Introduction

The encounter between the patient and a clinician is at the centre of the delivery of care in psychiatry. The quality of their relationship has repeatedly been proposed as the most important factor for engaging patients in treatment and in facilitating positive outcomes [12,36,42,64]. However, the concept of the therapeutic relationship is complex. Like the powerful concept of love, it has a strong appeal that goes beyond cultural boundaries and remains relatively unchanged over time. Despite this, both are difficult to measure and even more difficult to influence. The most obvious way that clinicians form and develop a positive relationship with their patients is through appropriate communication. Communication – unlike the therapeutic relationship – is a behaviour, which can be observed and, at least in theory, objectively described and measured. Clinicians can be trained to improve their communicative behaviour [49,51,53], and communication can be assessed in empirical studies.

Experimental research studies have examined whether communication can be influenced directly by training and whether

specific forms of communication impact on outcomes. Over 30 years of research in general medicine has suggested that aspects of the communication between patient and clinician can have a positive impact on the patient's physical health [25,48,54], and also on their psychological health [10], treatment adherence, treatment satisfaction, and levels of litigation [19,20,31,57].

Thus, communication appears a useful concept to guide research, training and clinical practice. To do this, however, an understanding is required of what constitutes good communication in psychiatry. Several guides have been developed for how to communicate with patients in general medicine. Such guides, most notably the Calgary-Cambridge guide to the Medical Interview [50], have had a major impact on undergraduate teaching in medicine [62]. Such guides can be applied to psychiatry, but they do not fully cover the specific aspects and challenges of communicating with patients in psychiatry.

While communication is important in all medical specialties, it has a particularly central role in psychiatry. More than in other specialties, communication in psychiatry is the means to diagnose disorders and deliver therapeutic interventions. It can be particularly complicated as various mental disorders impact on the way patients communicate.

The context of psychiatric communication varies enormously, in contrast to conventional psychotherapeutic settings, which are generally standardised in venue, timeframe and purpose. Communication in psychiatry takes place in a range of settings, e.g.

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hospital wards, day hospitals, outpatient consultation rooms, and often in the patient's home or other places in the community. In addition, meetings can vary from a few minutes to several hours, and intervals between meetings can also range from just hours to many months. The aims of these communications can vary widely.

So, what is good communication in psychiatry? The term has two distinct meanings. One describes communication that it is in line with legal obligations, ethical, cultural and professional values. These general requirements are not necessarily linked to clinical effectiveness. For example, being polite to a patient may or may not be therapeutically beneficial in a given situation, but is a routine expectation in professional behaviour. Such general requirements are commonly captured in codes of good medical practice and professional conduct. They are fundamental to practice. Our review however focuses on principles that are relevant to clinical objectives and may directly or indirectly influence outcomes of treatment. These clinical objectives are that:

- the clinician obtains all necessary information;
- the patient also obtains and understands all information that is relevant to him or her;
- all necessary decisions have been made;
- a positive therapeutic relationship has been established and/or sustained;
- the patient has acquired the most helpful health attitudes;
- and positive therapeutic change and an improvement of distress/symptoms of the patient has been initiated or enhanced.

A precise understanding of how clinicians should communicate with patients to achieve these objectives should ideally be based on experimental research demonstrating the effects of different communication on relevant patient outcomes. Such empirical research however is still in its infancy. The aim of this study is to conceptually review the literature and identify principles that may guide good communication.

2. Methods

We conducted a conceptual review of communication in psychiatry and related empirical research. Conceptual reviews are not identical in their practice to standard systematic reviews familiar in medical journals. Lilford et al. [32] have made a number of recommendations on how to carry out conceptual reviews. These include: not attempting to review all literature, as in a Cochrane-style review, but searching widely using disparate databases and sources; building in safeguards to reduce potential biases, e.g. through using multidisciplinary teams; and allowing some overlap in the various stages of the review process, i.e. searching, analysis and writing up, so that the precise nature and scope of the review can be clarified. These recommendations have guided our approach to this review.

Relevant papers including reviews were identified in psychiatric journals and books. We also utilised the literature in general medicine and psychotherapy. As a starting point, we considered the literature known to the authors, hand searched six leading psychiatric journals for relevant papers published since 2000 and conducted an electronic search (Medline, Embase and PsychINFO) with the search terms “psychiatric” and “communication/interview”. This was later complemented through searches using more specific terms in line with emerging themes, including “consultation”, “decision making”, “patient centered” and “positive regard”. We did not restrict the review to one professional group of clinicians, although most of the literature – explicitly or implicitly – concerned psychiatrists.

The emerging principles, their specification and their description in the final summarising list were discussed and revised in the

research team in an iterative process. The team included two academic psychiatrists (S.P. and J.J.), two clinical psychiatrists (S.D. and C.W.), a specialist in medical education (A.C.) and a research psychologist (R.McC.). Two team members (S.P. and C.W.) had a psychotherapeutic qualification. The team combined clinical experiences in various clinical settings and different countries, expertise in undergraduate and postgraduate training, and a background of empirical research in therapeutic relationships and communication in psychiatry.

3. Results

The review identified five guiding principles for good communication. The degree to which these principles have been addressed and specified in the literature varies substantially. They appear to be conceptually distinct, although partly interconnected.

3.1. Focus on patient's concern

Communication should centre on the patient's concerns and be guided by the complaints and wishes of the patient. The interests of the provider organisation, the service and the individual clinician should all be secondary to the concerns and hopes that the patient brings into the communication.

A focus on the patient's concerns overlaps with established models of patient-centeredness, client-centeredness and person centeredness. Patient-centeredness is widely accepted as an important characteristic of positive communication throughout medicine including psychiatry [1,15,16,33,56,60]. “Patient-centeredness is becoming a widely used but poorly understood concept in medical practice. It may be most understood for what it is not – technology-centered, doctor-centered, hospital-centered, disease-centred [58]. Client-centeredness is a central, and defining, component of Rogerian client-centred therapy [46,48]. A person centred model has been suggested by Chadwick [7] as an overarching framework for therapy in psychiatry that places the person, including all the sources of distress and positive strengths, at the heart of the process [2].

These concepts of patient, client or person centeredness are much wider, and arguably less precise, than the more specific principle of having a focus on the patient's concerns throughout the communication. McCabe et al. [35] demonstrated one way in which psychiatrists' consultations with patients with psychotic disorders can fail to have such a focus. In their study, patients' concerns relating to the content of their psychotic experiences remained largely unaddressed in the meeting with their psychiatrist. That led to patients regularly re-raising these concerns in the pre-closing stages of the consultation, but clinicians still avoided discussing them.

A trial of computer mediated structuring of patient-clinician communication to focus on patients' satisfaction with life domains and treatment aspects and on their wishes for different treatment input suggested a positive effect on patients' quality of life at one year [43]. Similarly, a two-way communication checklist intended to ensure that patients' concerns were addressed in the meeting with their psychiatrists improved patients' satisfaction with the consultation [61].

3.2. Positive regard and personal respect

The patient should be accepted and valued as a person, and his/her views are to be taken seriously and regarded as important. Whatever potential differences in opinion and attitudes between patient and clinician exist, the patient should always feel respected on a personal level and not devalued or rejected. This is most often termed positive regard (sometimes “unconditional positive

regard”) but early studies and theoretical writings preferred the phrase non-possessive warmth [11]. It overlaps with the concepts of warmth, respect, acceptance, openness, support, and empathy, and with “therapist affirmation” [40]. It has been suggested that positive regard goes beyond the emotional response to a specific person, being part of a value system respecting and valuing human beings regardless of their behavior [13].

While respecting the patient is a general requirement throughout medicine, its function in psychiatry is particularly important to achieve the clinical objectives of the communication: it can be central to reducing feelings of worthlessness and improving self-esteem, and give patients freedom to explore feelings, thoughts and perceptions without the fear of negative judgments [13].

This principle has played a major role in client-centered therapy. Rogers [47] suggested that therapists’ positive regard (non possessive warmth) along with genuineness (see principle 4) and empathy were the necessary and sufficient conditions for therapeutic change. Subsequently, a substantial body of research has investigated the association between the therapist’s positive regard for the patient and therapeutic outcome. Unfortunately, the use of multiple and overlapping terms (e.g., affirmation, acceptance, warmth, support) have led to conceptual and measurement difficulties [11]. Studies often had small sample sizes and lacked standardized measures and operational definitions of the concepts with inconsistent findings [11].

The opposite of respecting the patient may be criticism and rejection. Both aspects are central to the concept of expressed emotion. The concept was originally developed to capture features of the family atmosphere associated with relapses in psychotic patients. Subsequently it has been applied to assess how clinicians feel and behave towards a patient. High expressed emotion in a clinician has been found to be associated with negative outcomes of care in schizophrenia [55].

Some established scales for the measurement of the quality of therapeutic relationships in psychiatry have items for assessing the principle from both aspects, respect and criticism [36]. However, the psychometrics of a specifically developed scale to assess therapeutic relationships in community mental health care (STAR) [38] suggest that the subscale for negative clinician input in the communication (e.g. criticism) is distinct from the subscale capturing positive clinician input (e.g. respect). The relative independence of these two subscales may indicate that respect and criticism are not two sides of the same coin. Poor communication in this respect can go beyond the mere absence of positive regard.

3.3. *Appropriate involvement of patients in decision making*

There is a wide and increasing consensus that for reaching appropriate decisions that meet patients’ and doctors’ concerns and that patients are likely to adhere to, patients should be fully involved in decision making. Shared decision-making has become a popular concept in medicine [9,17,30] and psychiatry [21]. A study on depressed patients in primary care found that shared decision making was associated with higher patient satisfaction [59]. In psychiatry, a programme promoting shared decision making in the treatment of patients with schizophrenia was associated with a trend towards more positive compliance and lower rehospitalisation rates, although the results were not conclusive [20].

However, shared decision making may not be uniformly the best option for all patients and in all situations. Charles et al. [8] suggested that patients typically express high preferences for information about their illness and its treatment options [4,58] but not necessarily to take the lead in treatment decision [52]. The level to which patients would like to be involved varies. This partly reflects preferences for different models of therapeutic relation-

ships. In a paternalistic model it is considered the role of the clinician to take decisions. In a partnership model clinician and patient negotiate and agree on their decisions. In a consumer model, the patient takes the lead and makes a choice between different options presented to him or her. Generally, a partnership model is preferred by most patients and associated with more favourable outcomes. This however is not always the case and varies depending on characteristics of the patient, the clinician and the context [37]. Preferences are likely to be different in an emergency situation to a routine outpatient appointment discussing a long-term problem. Research in psychiatric samples finds a high level of trust in doctors expecting them to lead on taking treatment decisions [27].

3.4. *Genuineness and personal touch*

Clinicians should also be genuine, warm and open, and communicate with patients as real human beings. This was already emphasised by Jaspers almost 100 years ago [24]. On the first page of his seminal work on general psychopathology he stated that “psychiatrists function primarily as living, comprehending and acting persons”. Genuineness and personal warmth have since been suggested as helpful factors in medical communication, most notably in client-centred psychotherapy [26]. Being genuine and “real” cannot be achieved by applying technical communication skills alone. Freeth [13] criticises an over-emphasis of the “skills” involved in doctor–patient relationship in psychiatry, i.e. “on what and how to do in the relationship rather than how to be in the relationship”.

In a psychoanalytical therapy review, Knight [26] emphasizes reciprocity, mutuality, authenticity, realness, openness, transparency and egalitarianism [14]. Mitchell [39] suggested that while patients previously expected a detached, rational observer hiding behind a couch they now expect a more receptive, facilitating human connection in therapy.

In psychiatry, a “personal touch” appears to be valued by patients and make them feel they have a trustworthy human relationship with their clinician. Castonguay et al. [6] showed that warmth and flexibility of clinicians were associated with a better alliance in psychiatry. Similarly, a qualitative study with severe mental illness patients in the United Kingdom [28] found that patients particularly valued when clinicians disclosed personal information. This “personal touch” made them trust the clinician more.

The role of self-disclosure has been controversial [22]. In psychoanalysis patients were more likely than not to find disclosures to be helpful and non-disclosure as unhelpful [23]. Physicians’ self-disclosure has been found to be significantly associated with higher patient satisfaction ratings for surgical visits, although not for primary care visits. Beach et al. [3] suggested distinguishing between several types of disclosure including:

- reassurance disclosures indicating that the doctor had the same experience as the patient (“I’ve used quite a bit of that medicine myself”);
- rapport-building disclosures with either humorous anecdotes or statements of empathy (“I know I’d be nervous, too”);
- casual disclosures with little obvious connection to the patient’s condition (“I wish I could sleep sitting up”);
- intimate disclosures referring to private revelations (“I also struggled to cope with the death of my father”);
- and extended narratives.

Such genuineness and personal disclosure can be difficult to accommodate with rules and codes of professionalism and notions of professional boundaries. Disclosing personal

information – possibly linked with emotions – to a patient may compromise notions of strict boundaries, risk aversion and self-control. There are specific difficulties in remaining frank and communicating true feelings when these feelings are negative towards the patient. Such disclosure might disrupt treatment, burden the patient and deflect the attention from the patient's concerns [44,45] and amount to criticism of the patient according to the concept of “expressed emotion”. The appropriateness of self-disclosure appears to depend on the context and the given therapeutic situation [13,18,45]. Despite these reservations, our review indicates that genuineness and a personal touch constitute an important guiding principle.

3.5. Using a psychological model

Although routine meetings in psychiatry are highly varied and differ from conventional psychological treatment sessions, clinicians can apply elements of psychological treatment models to induce therapeutic change. The number of psychotherapy orientations is enormous. A few models are generic enough to be applied across different settings in psychiatry, in very different therapeutic situations and in the treatment of different mental disorders. These include client-centred therapy, solution focused therapy, and possibly cognitive-behavioural and problem solving approaches. There is some limited literature on how to apply these and other methods of psychological treatments in the context of psychiatric settings (i.e. outside formal settings of psychological treatments). However, we found only very limited evidence from randomised controlled trials in psychiatric contexts.

Irrespective of the precise model of psychological treatment, being guided by a coherent model is likely to be beneficial. Therapeutic change has been suggested to be more likely to occur when a good relationship is combined with the competent and flexible application of a tried and empirically tested method [29,41]. Wampold [63] suggests that believing in the efficacy of a specific technique is more important for therapy effectiveness than the characteristics of the chosen model. Having and being guided by a psychological model appears preferable for a clinician in psychiatry to not having one.

4. Discussion

4.1. Main findings

This review identified five guiding principles of good communication in psychiatry. They are proposed to help achieve the clinical objectives of patient-clinician communication, although not all principles are equally relevant for all objectives. For example, a focus on the patient's concern may be particularly helpful for eliciting necessary information, genuineness for building up a positive therapeutic relationship, and having a psychological model for inducing therapeutic change. The five principles are conceptually distinct, although their use is likely to overlap in practice.

4.2. Strengths and limitations

The strengths of the review are that it considered literature from different areas including general medicine and psychotherapy, combined the disparate expertise of the authors and provided a list of guiding principles that appears sufficiently comprehensive to map all relevant major concepts against them.

The review has a number of shortcomings. It is a conceptual review and was not based on a systematic literature search, so may

have missed relevant literature. The review refers to psychiatric settings, the boundaries of which are not precisely defined. The principles are based on the judgement of the authors. Although they reflect extensive discussions within the research team, they inevitably have a degree of arbitrariness.

4.3. Principles and skills

The principles in themselves are not new and have been described in the literature before, although to our knowledge not in this comprehensive synopsis. Their descriptions repeatedly referred to the literature on client centred therapy. This probably reflects Roger's original aim, which was similar to that of our review. He intended to identify those principles of communication that are helpful and induce positive change in clients. Whilst he originally based his conclusions on experiences in psychotherapy, they were later applied to practically all types of communication within, and outside, health care. Our review addressed good communication specifically in psychiatry and was conducted half a century after Rogers' work, but the findings still overlap with the client centred approach.

We identified guiding principles rather than skills or personal characteristics of clinicians. Different individual skills and characteristics as well as different techniques may be used to implement the principles. Various important skills can be acquired and improved in training [34,49] In many countries, there are courses on communication skills, and doctors are encouraged to review their skills regularly as part of the continuing professional development [5] Some important communication skills (such as using humour or easing tension) are however very difficult to teach, and many key personal characteristics can hardly be changed. The principles provide a flexible framework to utilise different individual skills, resources and strengths of clinicians in the communication with their patients. Such principles can guide training and supervision enabling clinicians to develop and improve their personal strengths and communicate effectively.

5. Conclusions

The identified principles of good communication in psychiatry reflect the current literature and the conceptual interpretation of the authors. They should be revised and refined on the basis of new concepts and new evidence. They overlap with those of helpful communication across medicine and in other relationships between a client and a professional helper. Their implementation however can be particularly challenging in psychiatry, and can be complicated by the symptoms of the patient (e.g. a depressed patient who speaks very little) and the given therapeutic situation (e.g. involuntary treatment).

The identified principles may provide a preliminary framework for analysing and investigating communication in psychiatry, but do not constitute a coherent theoretical model of good communication. In this conceptual review, we neither started with an overarching theory nor developed one. However, the principles outlined could support further conceptual work towards such a theory of good communication in psychiatry. This is clearly of some potential value as it has been argued that health care in general and not just psychiatry lacks such a theory.

In the absence of a coherent theoretical model of good communication in psychiatry, the principles may be used to inform systematic empirical research and they might be considered in training and supervision. Such increased attention should encourage clinicians to improve what is, after all, at the heart of their trade: communicating with patients.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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