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Interpersonal skills training for the emergency department – exploring a mentalizing approach

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Abstract

Patients with significant relational difficulties may present to the Emergency Department (ED) in crisis. If negative attitudes and responses arise from ED staff, this adversely impacts patients' outcomes. There is currently no established approach to training ED staff in interpersonal skills. Mentalizing Skills (MZ Skills) is a short training course in interpersonal skills that has shown promise within mental health settings, but has not yet been explored in the ED. We therefore conducted an evaluation of MZ Skills within an ED to explore if this approach may be useful and

acceptable. Outcomes were assessed using established self-report outcome scales. A hundred and seven (107) clinicians were trained in MZ Skills. From pre- to post- training, staff knowledge about mentalizing theory and practice improved (n=97; effect size 1.07); attitudes improved to a smaller degree. We suggest, pending further evaluation, that MZ skills could offer an acceptable approach for training ED staff in interpersonal dynamics.

Introduction

Emergency Departments (EDs) are often overcrowded, noisy, and have a high percentage of unwell patients. Patients who have significant relational and emotional difficulties may present to the ED in crisis, which can raise interactional challenges for clinicians. For example, when a patient presents with an overdose but refuses care, this may be stressful and emotionally demanding for treating clinicians. In high-emotion situations, it is harder for clinicians to remain reflective and even-handed. If negative attitudes arise from ED staff, this adversely impacts patients' outcomes and experience.[1]

Various approaches for teaching interpersonal skills have been explored in EDs, including using Cognitive-Behavioural Therapy principles.[2] However, there is no established approach to training ED staff in interpersonal skills.

Mentalization-Based Treatment (MBT) is an established therapy for people with significant relational difficulties.[3] MBT focusses on promoting the capacity in both clinician and patient to mentalize (reflect on mental states) during emotional crises. Whilst the full 18-month MBT programme requires specialist psychological practitioners, there is growing interest in training non-psychology staff in core skills from MBT for use in clinical interactions. Mentalizing Skills (MZ Skills) is a short training course that has shown promise within mental health settings in terms of improving clinicians' knowledge about mentalizing theory and practice.[4–6] For example, Welstead *et al.* found MZ Skills to be effective in improving mental health clinicians' mentalizing knowledge and attitudes towards people with relational difficulties.[7] A separate study, again from a psychiatric setting, found significant improvements in clinicians' mentalizing capacity following a MZ Skills

course, as measured by objective semi-structured interviews; these improvements were maintained at 6-months follow up with ongoing supervision for staff.[8]

Whilst MZ Skills training holds promise within mental health settings, no studies have yet explored delivering MZ Skills training within the ED setting. We therefore conducted a single-centre, pilot evaluation of MZ Skills for ED clinicians to explore if this approach may be useful and acceptable. The specific aims of this evaluation were: i) to examine the effect of MZ Skills on staff knowledge about mentalizing theory and practice, and staff attitudes towards patients with significant relational difficulties; ii) to explore if teaching MZ Skills in the ED is acceptable to staff.

Materials and Methods

We delivered a 1-day MZ Skills course for clinicians working in an Emergency Department. We carried out a before-and-after evaluation using self-report outcome measures relating to staff knowledge about mentalizing, and staff attitudes in relation to people with significant relational difficulties. To explore the acceptability of the training, we obtained feedback immediately post-course.

Ethics approval

The study was registered with the Emergency MedicinE Research Group Edinburgh (EMERGE) which provided project oversight. Ethical approval was not required as this was an educational evaluation of staff training and did not involve patients directly nor patient data.

Participants

All staff working in the ED of Edinburgh Royal Infirmary were offered a 1-day course in MZ Skills. Staff were eligible to be included in the evaluation if they attended the course. Participants gave written consent to taking part in the evaluation process and to the dissemination of findings through publication.

Characteristics of participants

The age range of participants was 19-61 years. The largest professional group was nursing (37% of the sample), followed by medical (31%; see Table 1).

Intervention

The intervention was a 1-day training session in Mentalizing Skills (MZ Skills). The materials were drawn from a MZ Skills package developed by MBT Scotland in collaboration with the Anna Freud Centre.[9] The training was delivered by JP (Consultant Medical Psychotherapist) and CM (Consultant Clinical Psychologist), who were both Anna Freud Centre-certified MBT facilitators, and KM (Art Psychotherapist) who was an MBT facilitator-in-training.

The training used a mixture of didactic teaching, role plays and video clips. The course content included: i) an attachment framework to understand interpersonal difficulties; ii) using role-play to practice providing support and empathy during tricky interactions; iii) training in specific mentalizing skills – including empathic validation and 'stop and stand' – to facilitate both clinician and patient to reflect during stressful interactions.

For further details about the structure and content of the Mentalizing Skills training course, the reader is directed to Polnay *et al.*[4] and Welstead *et al.*[7]

Outcomes

Knowledge and Application of MBT Questionnaire-2

The main outcome measure was the *Knowledge and Application of MBT Questionnaire-2* (KAMQ-2). This 17-item self-report instrument uses a 5-point Likert scale (from 'strongly disagree' to 'strongly agree') to probe clinicians' knowledge about mentalizing skills theory and practice. Items relate to: skills and techniques used by a practitioner engaged in mentalizing; beliefs and attitudes relevant for the use of mentalizing skills (e.g. 'I believe treating people using psychological techniques is a poor use of resource' – scoring reversed for this item); and specific knowledge about mentalizing skills. A sample of 217 clinicians found good internal consistency ($\alpha = .85$, 95%

confidence interval [CI] = 0.80-0.89) and test-retest reliability (ICC = 0.84, 95% CI = 0.73-0.91).[10]

Attitudes to Personality Disorder Questionnaire

The secondary measure was the Attitudes to Personality Disorder Questionnaire (APDQ) which assesses clinicians' attitudes towards people with marked relational difficulties. This self-report 37-item questionnaire uses a 6-point Likert Scale, with a higher score indicating a more positive response. The APDQ has been found to have good internal consistency (α = .94) and test-retest reliability (r=0.71).[11]

Anonymised KAMQ-2 and APDQ measures were given to participants immediately pre- and post-course.

Training acceptability

This was evaluated through an anonymised feedback questionnaire given to participants immediately post-course.

Using Likert Scales, six items focussed on acceptability of the course content (e.g., 'The approach would be appropriate for a variety of staff') and a further six items asked for participants' perceptions about the acceptability of the teaching process (see supplementary data for feedback questionnaire).

Analysis of data

All questionnaires were collated and data entered into Excel by BG and DH from the EMERGE team (Emergency MedicinE Research Group Edinburgh), who also carried out the statistical analysis.

Mean within-person change in questionnaire scores from pre to post course was calculated for both the KAMQ-2 and the APDQ, using R version 3.5.1. For missing items at baseline, these were assumed to be missing at random, so mean values were inserted. For missing items post course, an

intention-to-treat approach was used and baseline scores were carried forwards. Cohen's d guidelines were used to interpret the meaning of effect sizes, where 0.2 represents a small effect, 0.5 moderate, and 0.8 large.[12]

Results from the feedback questionnaire were presented descriptively.

Results

The staffing establishment of the ED was approximately 220 clinicians.

Twelve (12) MBT-S Training courses, with a median 18 participants each (range 2–30), were delivered. Across all courses, a total of 107 participants attended the training and so were eligible for the evaluation.

Ten (10) participants did not complete the pre-course questionnaires, giving a final sample of 97 participants for the KAMQ-2 and APDQ evaluation. Across all baseline questionnaires, 79 individual items (1.37% of the total baseline data) were left blank and imputed mean values were inserted. Across all completed post-course questionnaires, 57 individual items (0.99% of the total end-of-programme data) were left blank, and baseline scores were carried forward.

Ninety-two (92) participants completed the post-course feedback questionnaire exploring training acceptability.

Outcomes

Knowledge and Application of MBT Questionnaire 2

The mean KAMQ-2 score at baseline was 62.4 (s.d. = 6.5). There was a mean within-person increase of 8.2 (95% CI 6.3 –10.0) from baseline to end-of-course. The effect size was 1.07, considered a large effect. Figure 1 depicts the results visually.

Attitudes to Personality Disorder Questionnaire

The mean APDQ score at baseline was 136.8 points (s.d. = 19.7). There was a mean within-person increase from baseline to end-of-course of 6.1 points (95% CI 0.2 – 11.6). The effect size was 0.31, considered a small effect.

Training acceptability

The feedback was overall positive (see table 2). 91% of respondents moderately or strongly agreed that the training approach 'would be appropriate for a variety of staff' and the same proportion would 'recommend it to others.' 95% of respondents felt the workshop helped them to develop work-related skills (either 'quite a lot' or 'a great deal') and 92% expected to make quite a lot, or a great deal, of use of the learning in their workplace.

Discussion

To our knowledge, this is the first evaluation of MZ Skills training in an ED department.

Staff knowledge about mentalizing theory and practice, as measured on a self-report outcome measure, improved significantly from pre- to post- training, with a large effect size. In addition, scores on a self-report attitudes measure also improved, with a small effect size. These outcomes appear similar to studies investigating MZ Skills for mental health staff,[5] including the differential effect on staff knowledge as compared to attitudes.[4,7] This is expectable, as attitudes are harder to change than knowledge.

In terms of acceptability of MZ Skills training in an ED setting, approximately half of the 220 staff members in the ED undertook the 1-day MZ skills course. 12 courses had been delivered, which, in theory offered enough capacity to train the entire staffing establishment. The results from the post-course feedback questionnaire suggested that, for those that attended at least, the approach was felt to be appropriate and useful. On balance, we feel that an uptake of 50% for a 1-day training in a busy ED, coupled with the positive feedback, is encouraging as to the acceptability of the MZ approach within this setting.

Strengths and limitations

Strengths of the study include a good retention rate of participants, and the separation of data processing and analysis processes from those who delivered the training.

We identify several limitations. Firstly, we note the lack of a comparison arm in the study design, which means one cannot tease apart the influence of non-specific factors to the observed changes in the outcome measures. Secondly, it is relatively easy to achieve short-term improvements in knowledge through staff training, but without ongoing training or supervision, short-term benefits tend to recede.[13] The lack of follow-up means we cannot comment on whether the improvements in outcome measures persisted – indeed, we would expect that ongoing top-up training or supervision would be required to maintain and build on initial gains.

Thirdly, we acknowledge the limitations in relying on self-report outcome measures. This means it remains uncertain as to whether the improvements in measures of knowledge and attitudes translate to real-life practice or affect patient outcomes. One study from a mental health setting assessed staff outcomes more objectively by undertaking semi-structured interviews of staff and analysing the transcripts to give an rating of participants' capacity to mentalize about tricky clinical interactions.[8] This study – which included ongoing supervision after the initial training – found improvements in observed staff mentalizing which were maintained at 6-month period. It is plausible that similar changes might be possible, not only in mental health settings, but in the ED. This hypothesis requires testing.

Research and clinical practice context and wider implications

Clinicians working in ED settings often encounter simultaneous new patient encounters in a busy and chaotic environment. A literature review of clinician-patient interactions in ED found that, in the face of these pressures, clinicians tend to focus more on patients' physical discomfort and the biomedical tasks in hand, as opposed to more relational work.[14] However, these dimensions of care are not necessarily in opposition, as good relational communication is critical for effective investigation, treatment and ongoing management.[14] Moreover, the review emphasised the unique nature of the ED setting, in that one patient may interact with many members of the ED team during a short period of time.

In this light, a shared team approach to understanding interactions and psychological skills – such as MZ Skills – could offer coherence, both for intra-team communication and for patients' experiences of care. However, ED clinicians acknowledge a lack of a framework and language for relational work, as it does not form part of formal professional training.[15] Hence, there is a need for accessible training in this area.

The present evaluation suggests that MZ Skills could offer an acceptable approach for ED staff in terms of training in interpersonal dynamics; however, the methodology was limited by the absence of ongoing long-term supervision and follow-up. Our own experiences, echoed by the educational literature,[13] suggest that clinicians need time to develop and embed therapeutic skills such as mentalization, ranging from several months to over a year. Whilst it might be possible to rapidly facilitate spontaneous, everyday mentalizing through a one-off brief MZ Skills course, the process of developing and enhancing the capacity for mentalization during tricky clinical interactions – particularly in the stressful environment of the ED – is likely to demand consistent effort and time. Taking into account the identified limitations of the present paper, a future research study should include ongoing MZ supervision for staff, longer follow up, objective measures of staff interactions and assessment of patients' experiences.

Contributions: all authors critically revised the article, gave final approval for publication, and agreed to be accountable for all aspects of the work. Jon Patrick led the project, conceived and designed the study, and delivered the intervention; Bernadette Gallagher collated data, carried out the statistical analysis and interpretation of data, and wrote a report on the findings; Damien Hicks carried out the statistical analysis and interpretation of data; Kate Pestell contributed to the conception and design of the work and delivered the intervention; Claire MacLean contributed to the conception and design of the work and delivered the intervention; Emma-Beth Wilson contributed to the conception and design of the work; Edward James contributed to the conception and design of the work; Benjamin Clarke: contributed to the analysis and interpretation of data; Adam Polnay contributed to the analysis and interpretation of data, and wrote the first draft of the manuscript.

Conflict of interest: Jon Patrick has received payment from the University of the West of Scotland (UWS) and NHS Education for Scotland (NES) for teaching MZ Skills, and Kate Pestell has

received payment from MBT Scotland for delivering MZ Skills workshops. None of these organisations had any involvement in this article. Jon Patrick receives personal fees for delivering MZ Skills supervision. Kate Pestell, Claire MacLean, and Adam Polnay are Anna Freud Centre accredited MBT Practitioners. Kate Pestell is also an MBT Scotland accredited skills trainer. Jon Patrick is an Anna Freud Centre accredited MBT supervisor and is co-head of training for MBT-Scotland, a global partner of the Anna Freud Centre. The remaining authors declare no competing interests.

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Ethics approval: the study was registered with the Emergency MedicinE Research Group Edinburgh (EMERGE) which provided project oversight. Ethical approval was not required as this was an educational evaluation of staff training and did not involve patients directly nor patient data.

Informed consent: all clinicians participating in this study gave written consent to participating in this study

Patient consent for publication: not applicable as this was an educational evaluation of staff training and did not involve patients directly nor patient data.

Availability of data and material: The datasets used and/or analyzed during the current study are available upon reasonable request from the corresponding author.

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Table 1. Characteristics of participants included in the sample (n=97).

Age	Years post qualification	Gender (n, %)	Professional group (n, %)
19 - 61	0 - 39	Female (69, 71) Male (24, 25) Prefer not to answer (4, 4)	Emergency Department Nursing (36, 37) Medical (30, 31) Mental Health nursing (14, 14)

			Clinical support worker (6, 6) Occupational therapist (3) Radiographer (2) Other (3) Not stated (3)

Table 2. Results from the feedback questionnaire. n=92 participants. Numbers in cells indicate the number of participants endorsing each option, with percentages in brackets.

Statement	**Strongly disagree n(%)**	**Moderately disagree n(%)**	**Slightly disagree n(%)**	**Slightly agree n(%)**	**Moderately agree n(%)**	**Strongly agree n(%)**
Appropriate for a variety of staff	1 (1)	0 (0)	1 (1)	6 (7)	21 (23)	63 (68)
Training beneficial for staff	1 (1)	0 (0)	0 (0)	4 (4)	15 (16)	72 (78)
Training may disrupt/harm client	52 (57)	20 (22)	1 (1)	2 (2)	3 (3)	14 (15)
Staff may not accept training	31 (34)	29 (32)	5 (5)	10 (11)	6 (7)	11 (12)
Consistent with good practice	1 (1)	2 (2)	1 (1)	5 (5)	26 (28)	57 62)
Staff would recommend training	1 (1)	0 (0)	0 (0)	7 (8)	24 (26)	60 (65)

	Not at all	**A little**	**Quite a lot**	**A great deal**
Improved understanding	0 (0)	2 (2)	36 (39)	54 (59)
Developed work-related skills	0 (0)	5 (5)	43 (47)	44 (48)

Expected workplace application	0 (0)	7 (8)	36 (39)	49 (53)
Competency of trainers	0 (0)	0 (0)	6 (7)	86 (93)
Overall satisfaction	0 (0)	1 (1)	15 (16)	76 (83)
Covered intended topics	0 (0)	3 (3)	17 (18)	72 (78)

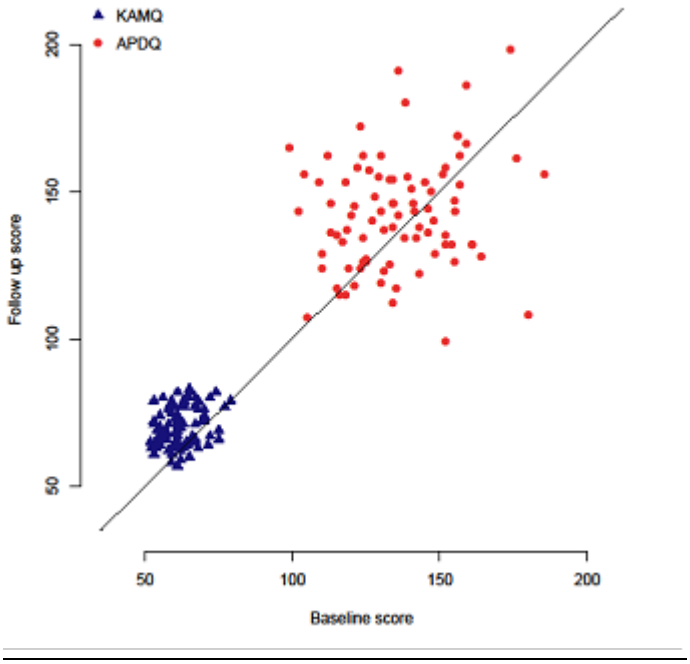

Figure 1. Jacobson plot of within-person change in KAMQ-2 and APDQ scores. Markings above the oblique line indicate an increase in scores from baseline to end of course.