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New education method or tool

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# Evaluation of a Psychotherapy Skills Training Program with Family Practice and Psychiatry Residents

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## Abstract

Many individuals with mental health issues first discuss them with their family physicians, who provide initial assessment and may also be the primary resource for treatment. Nevertheless, physicians-in-training may find it challenging to address these needs within the confines of a busy practice and without training specific to addressing psychological issues with patients. It is, therefore, vital that residency programs equip trainees to examine psychological aspects of current and future practice. At Memorial University, psychology faculty at the Student Wellness and Counselling Centre provide a weekly interpersonal process recall seminar (IPR) to first-year medical residents. This inter-professional training includes three components 1) peer consultation discussion, including difficult and/or interesting patients, 2) didactic psychotherapy component, on topics such as motivational interviewing, diversity and stages of change and, 3) video review of standardized and real patient encounters, during which residents are provided with detailed feedback on their interactions with patients. During IPR, participants develop knowledge, confidence and competence to work effectively with a variety of patients from a psychological perspective. The opportunity to develop inter-professional relationships is a noteworthy additional benefit. This paper will provide a description of the IPR training program and student feedback regarding the experience. Residents were asked to complete a 48-item questionnaire that assessed residents' attitudes to three distinct components of the 11-week course. The purpose of this research was to understand what aspects of the psychotherapy training were evaluated most highly by residents and why these specific aspects were valued.

**Keywords:** Medical education, interprofessional education, program evaluation

## Introduction

A 2003 review of mental health services in Canada, conducted by the Canadian Collaborative Mental Health Initiative, found that one in five Canadians reports having one or more mental health issues over the course of their lifetime. A wide range of issues were noted, including but not limited to, anxiety and depression, addictions and substance use and psychosis. It is important to note that many people who identified as having a mental health issue also reported that they did not get the assistance they needed (CCMHI, 2003). Family physicians are often the first point of contact for many people with mental health issues, frequently provide initial assessment and may be the primary resource for treatment (Saillant, Hudelson, Dominicé Dao & Junod Perron, 2016). Between 25-40% of patients in primary care settings suffer from mental health issues (Fluery, Farand, Aube & Imboua, 2007; Leigh & Streltzer, 2008). A 2007 Canadian mixed method study of the management of mental health problems by general practitioners (GP's) in Alberta, found that approximately 25% of patient visits are for mental health issues (Fluery et al, 2007). The rates were higher again in a 2009 Quebec study that found 35% of adults who visited their family physician were diagnosed with a mental health issue. Anxiety disorders were diagnosed most frequently (61%), followed by mood disorders (44%), substance use disorder (9%) and adjustment disorders (7%) (Slomp, Bland, Patterson & Whittaker, 2009). More recently, a 2011 Canadian Community Health Survey reported that 40% of Canadians indicated that they had mental health issues for which they sought health services (Canadian Mental Health Survey, 2011).

Despite the fact that Family Physicians provide a significant proportion of the service for patients with mental health issues (Fluery et al, 2007), many physicians-in-training find it challenging to assess and treat mental health needs within the confines of a busy practice and without specific training aimed at addressing psychological issues with patients (Fluery et al, 2007; Saillant et al, 2016; Zantinge, Verhaak, de Bakker, van der Meer & Bensing, 2006). In addition, the literature has indicated that patients with mental health issues require more physician time, especially if consultation with another professional is required (Zantinge, M., 2005; Zantinge, et al., 2006). Challenging this perspective however, Dutch researchers Zantinge and colleagues found that despite the perceived heavy demands that patients with mental health issues place on their health care provider, "GP's who pay particular attention to their patients' mental health problems, do not have a higher objective or subjective workload than GP's with less attention to mental health problems" (Zantinge et al., 2006).

Given that family physicians are often the initial and essential contact point for patients with mental health issues, it is vital that residency programs equip trainees to effectively engage with this population. Adequate preparation includes providing residents with the necessary tools to accurately identify, assess and treat a myriad of difficulties including, but not limited to, anxiety (5-10%) and depression (4%), which are the most common mental health problems (Van Rijswijk, van Hout, van de Lisdonk, Zitman, & van Weel, 2009). In Van Rijswijk and colleagues' qualitative Dutch study (2009), it was found that despite the fact that GP's saw recognizing, diagnosing and managing depression and anxiety as essential tasks, the GP's experienced several obstacles to caring for these patients. The study found that many patients were perceived as reluctant to accept the given diagnosis and subsequent treatment with pharmacotherapy and GP's felt they had little time for patient education and counselling. GP's also reported they lacked guidance in regard to assessing the patient's burden and had minimal collaboration with specialist mental health services, which was viewed as problematic. Lack of collaborative care was also espoused by a Canadian study within the province of Ontario, which found that 60% of participants who identified as having a mental health issue, reported receiving treatment exclusively from their GP, without involvement from other mental health professionals (Parikh, Lin & Lesage, 1997). In addition, GP's have reported that they were not able to provide patients with all relevant treatment options, as some patients were resistant to referral to a specialized mental health professional due to social, emotional and financial barriers (Van Rijswijk et al., 2009).

This last point highlights the importance of physicians', and medical residents', ability to develop an awareness of the psychological processes that occur in their relationships with patients. Stewart and colleagues (2013) highlight the

importance of the physician-patient relationship by comparing the relationship to a river, which flows through each and every interaction. This flow between patient and physician is particularly important, as it is highly correlated not only with job satisfaction and physician burnout (Shanafelt, Sloan & Habberman, 2003; Spickard, Gabbe & Christensen, 2002) but also with patient health outcomes (Stewart, M.A., 1995). Stewart and colleagues suggest that strong relationships between patients and physicians are formed when clinicians are sensitive to power dynamics, provide continuity and constancy, engage in hopeful healing and focus on self-awareness. In recognition of the importance of the relationship between patient and physician, the IPR psychotherapy training program was developed to improve relationships between residents and their patients.

### **Development of The Psychotherapy Training Program at Memorial:**

The psychotherapy training seminar offered at Memorial known as Interpersonal Process Recall Seminar (IPR), was derived from the work of Norman Kagan and colleagues (Kagan, Schauble, Resnikoff, Danish & Krathwohl, 1969) Kagan developed a non-didactic supervisory approach for discovery learning that enables clinicians to gain an understanding of their own perceptions that may otherwise be outside of their awareness. IPR training endeavours to provide an opportunity for an in-depth examination of the covert thoughts and feelings of both clinician and client, practice expressing covert thoughts and feelings in the here and now without negative consequences, and cultivate clinical interview skills and, as a result, deepen the resident-physician/patient alliance (Kagan et al., 1969).

When engaged in an interview with a patient, physicians and trainees have several goals including gathering data regarding the patients' presenting concerns, formulating a treatment plan, and feeling competent, helpful and productive. The patients' goals may include feeling heard and understood, receiving clear communication about a treatment plan, developing coping strategies and expectations about symptom reduction and/or resolution.

Within the context of the resident/patient relationship, there are a variety of challenges that may interfere with establishing an effective therapeutic alliance. Subsequently, it may be difficult to achieve either the clinicians' or patients' goals. Over the past several years, while training family practice and psychiatry residents working with patients with mental health issues, three main challenges have been described by participants in the training program (Mullins-Richards et al., 2014). Firstly, patients often find it very difficult to discuss mental health concerns with their family doctor and are even more reluctant to disclose these issues to residents. This may be due to the nature of resident training as rotations are often short, denying the resident the time required to develop a strong therapeutic alliance, which is the foundation for the physician/patient relationship. Secondly, residents report they are often reluctant to delve into patients' psychological concerns due to the additional time it is anticipated this may take. Residents describe feeling overwhelmed by the number of patients they are expected to see in the clinic. Spending time on one patient's mental health issues can impact the number of patients the resident is able to see and ultimately make their day longer. Lastly, residents frequently report a perceived lack of adequate skills to counsel patients with mental health issues.

### **Program Description:**

At the study institution, clinical psychology faculty at the Student Wellness and Counselling Centre provide, with the assistance of psychology doctoral residents, the 11-week IPR seminar (2.5 hours/week) to family practice and psychiatry residents. The IPR seminar is inter-professional and designed to build residents' skills and confidence in working with patients with mental health issues and enhancing the physician/patient relationship.

The seminar is broken into three main components: 1) case consultation, including discussion of difficult and/or interesting cases from the previous week, 2) a didactic psychotherapy component on topics such as motivational interviewing and stages of change theory and, 3) video review of two interviews, one between the resident and a standardized patient and the second video of a real patient encounter, are reviewed in the seminar.

During this seminar, IPR participants develop knowledge, confidence and competence to work effectively with a variety of patients from a psychological perspective. In addition, the ability to develop inter-professional relationships is a noteworthy benefit as participants include both family practice and psychiatry residents, in addition to psychology doctoral residents and psychology faculty. This paper will provide a detailed description of the training and resident feedback regarding the specific components of the 11-week course.

It is important to note that IPR is not evaluated by either the family practice or psychiatry programs. The seminar is graded by the psychology faculty, based on attendance and participation, and a pass/fail is given. The IPR seminar has been in existence for the past 30 years and, to our knowledge, all residents have successfully completed the seminar. During the first session, we emphasize that the seminar is an opportunity for residents to discuss difficult patient issues in a safe and confidential environment and we explicitly state that we do not share any information that is discussed with medical faculty. This confidentiality allows residents to discuss important professional experiences in a safe environment and to get feedback and support from their peers. In addition, psychology faculty are trained to provide a non-judgmental atmosphere, which enables participants to disclose complex, sometimes difficult responses to their patients.

The seminar begins with a 45-minute inter-disciplinary peer consultation that provides an opportunity for both peer support and supervision while residents discuss issues pertaining to interesting or challenging patients they may have seen during the previous week. This part of the seminar gives residents time to connect with peers and share clinical experiences in a confidential, non-judgmental environment. Discussion frequently includes topics such as, 1) Interpersonal difficulties with patients including strong emotional reactions to patients that may be both positive and negative, 2) Experience experimenting with various psychotherapy techniques that were introduced during the previous week, (e.g. discussing what it was like to use a scaling question with a patient). There is an opportunity to explore what went well and to discuss what may have prevented the resident from having a successful intervention with the patient. Feedback and suggestions are made by both peers and faculty, 3) A variety of ethical issues pertaining to patient care are discussed e.g. (What is the best course of action when staff/faculty recommend a treatment that the resident believes is not in the patient's best interest?), 4) Issues pertaining to the residency program e.g. (difficulty with call schedules, learning/practicing in a medical culture that espouses "self-care" but does not provide adequate opportunities for its practice, inter-personal conflict with staff/faculty, general issues related to stress, fatigue, burnout and competency concerns).

Case consultation is followed by a 35-45-minute didactic component that is frequently lead by a psychology doctoral resident. This component covers an array of topics selected in consultation with the Faculty of Medicine including stages of change theory, motivational interviewing, solution-focused counselling, cognitive behavioural therapy, grief/bereavement, gender and sexuality, culture and diversity, transference/counter-transference and stress management and self-care. Instruction in each topic includes the use of video resources, clinical role-plays and online resources. Recently residents have requested that time is allotted to role-play new skills during the seminar, when applicable before they try it out in their respective clinics and the curriculum has been altered to accommodate their request.

The didactic component is followed by IPR video review and over the course of the 11 weeks, each resident presents two tapes: a standardized patient interaction (during weeks 1-4) and a real patient encounter (during weeks 5-11).

During the video review, residents are encouraged to reflect more deeply on the resident-patient interactions. The resident presenting their video and other group members are invited to pause the recording at any point to pose questions, reflect or provide feedback and suggestions. A variety of questions are asked during the video-review including, but not limited to, the following: 1) What do you think the patient might have been feeling or thinking?, 2) What would you have liked to say at that point?, 3) How do you think they might have reacted if you had?, 4) How did you want the patient to perceive you?, 5) How does the patient want to be perceived by you?, and 6) Does the patient remind you of anyone in your life?

## Method

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This study was conducted using a convenience sample of Family Practice and Psychiatry medical residents who were in the first year of their residency program. These residents, also known as Post-Grad Year Ones, participated in Interpersonal Process Recall (IPR) seminars. The study was reviewed by the Human Research Ethics Authority (HREA) and ethics approval was not required, as the study was for the purpose of program evaluation. Participants: All residents participating in the IPR seminar were eligible to participate and data collection occurred over one academic year (July 2015 – June 2016). A total of 31 first-year residents were recruited to participate in the study. Of the 31 residents, 27 were Family Medicine residents and 4 were Psychiatry residents. There were 9 male and 22 female residents. The age of the total sample ranged from 25 to 44 years of age. Procedure: The authors developed a questionnaire focused on residents' knowledge and confidence in relation to the particular skills learned in IPR aimed at enhancing the quality of care to patients with mental health issues. Four demographic items tracked resident speciality (family practice or psychiatry), years of practice experience, gender and age. The questionnaire consisted of 39 items rated on the following scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree or 6 = n/a. An additional item asked respondents to rank the three components of IPR, while two further open-ended questions asked participants: OEQ1. "What did you find most helpful about the IPR training?" and OEQ2. "What would you like to change about the IPR training?" Following completion of the 11 weeks of IPR, data collection took place at once, during the final session. Data Analysis: All quantitative data was analysed using SPSS Version 23.0. Descriptive statistics were used to discern residents' attitudes about the effectiveness of the skills learned as they pertained to clinical practice and whether residents were currently utilizing these skills. Additionally, the open-ended questions were analyzed to identify what residents perceived as most helpful within the IPR program and what they would like to see changed. The qualitative method of content analysis was utilized to analyze this information and excerpts referencing distinct ideas were coded. Codes were created on an ad hoc basis, rather than in advance, to reflect common themes and participant responses typically included multiple codes. Using Dedoose, a qualitative software program, a data set was created that comprised codes, associated text excerpts, and how frequently they were endorsed by residents. Codes similar in nature were grouped to create response categories. Of the 31 medical residents who completed the questionnaire, 29 responded to OEQ1 and 26 completed OEQ2.

## Results

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**Peer Consultation:** Residents were asked to rank which components of IPR (i.e. case consultation, the didactic component, and video review) they found most helpful (see Figure 1). Case consultation was ranked the highest of the three components with 64.5% of residents indicating it was the most helpful, 25.8% reporting it was second most helpful and 9.7% indicating it was third.

During the case consultation component, almost all residents (93.5%) reported that they found sharing their personal

practice experience with peers helpful or very helpful. Additionally, the majority of residents indicated that using IPR to devote time to personal growth was helpful (35.5%) or very helpful (51.6%). *Qualitative data provided in response to open-ended questions further supported this result. When asked what they found most helpful about IPR, the majority of participants responding (51.7%) cited group discussions facilitating "peer support", "sharing", and even "venting" as the most valuable aspects. Residents highlighted these consultations as allowing an opportunity to "talk through the residency experience" and "come up with strategies to deal with difficult patients." As one medical resident commented:*

*"Interacting with colleagues and learning from their clinical encounters; developing through others' styles" provided participants an opportunity to step outside the isolation of the residency experience.*

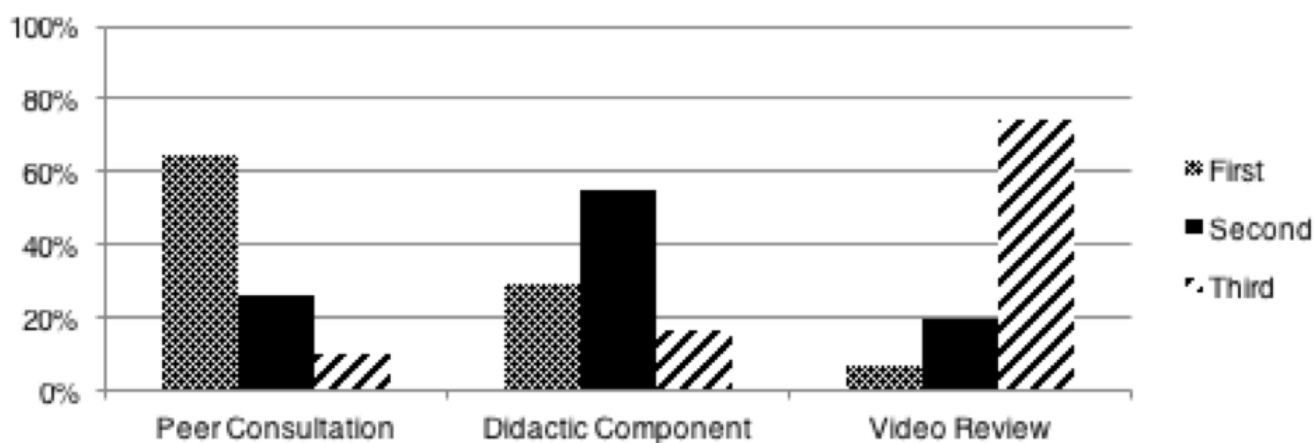
*Additionally, a third of participants (34.5%) underscored the benefit of working through difficult patient encounters through case consultation, frequently citing the "strategies" that resulted. An example is one resident's comment that most appreciated was the "chance to have moderated discussion and review complicated and complex [patient] interactions that we had."*

*"Having time to discuss challenges with my peers and work through them in a supportive environment with helpful input from IPR."*

*The "supportive" and "non-judgmental environment" of IPR was identified as facilitating the group discussion, peer support, and case consultation components of this section of the program and may speak to the value of a psychologically-informed inter-professional setting. Some 13.8% of respondents specifically noted the impact of this environment.*

*While the supportive element of peer consultation was widely endorsed across the sample, when asked what they would like to change about IPR a small number of respondents (n=2) suggested more structure for this portion of the program, maintaining focus on problem-solving and noting that "venting" can sometimes result in a negative focus. These comments highlight the importance of balancing support and guidance as well as facilitating a constructive tone. No further recommended changes were related to this section of the IPR program.*

**Figure 1.** Residents Ranking of Which Component was Most Helpful.



**Didactic Component:** The didactic component of IPR (i.e. the weekly seminars) was ranked as the second most helpful section; specifically, 54.8% ranked it as second most helpful, while 29.5% of residents ranked it as most helpful and 16.1% of residents ranked it as third most helpful. *Comments from residents (26.9%) in response to open-ended questions indicated that an applied and practice-oriented focus was viewed as critical and recommended the addition of even more role plays, as well as activities beyond role plays, to facilitate the translation of learned skills to practice.*

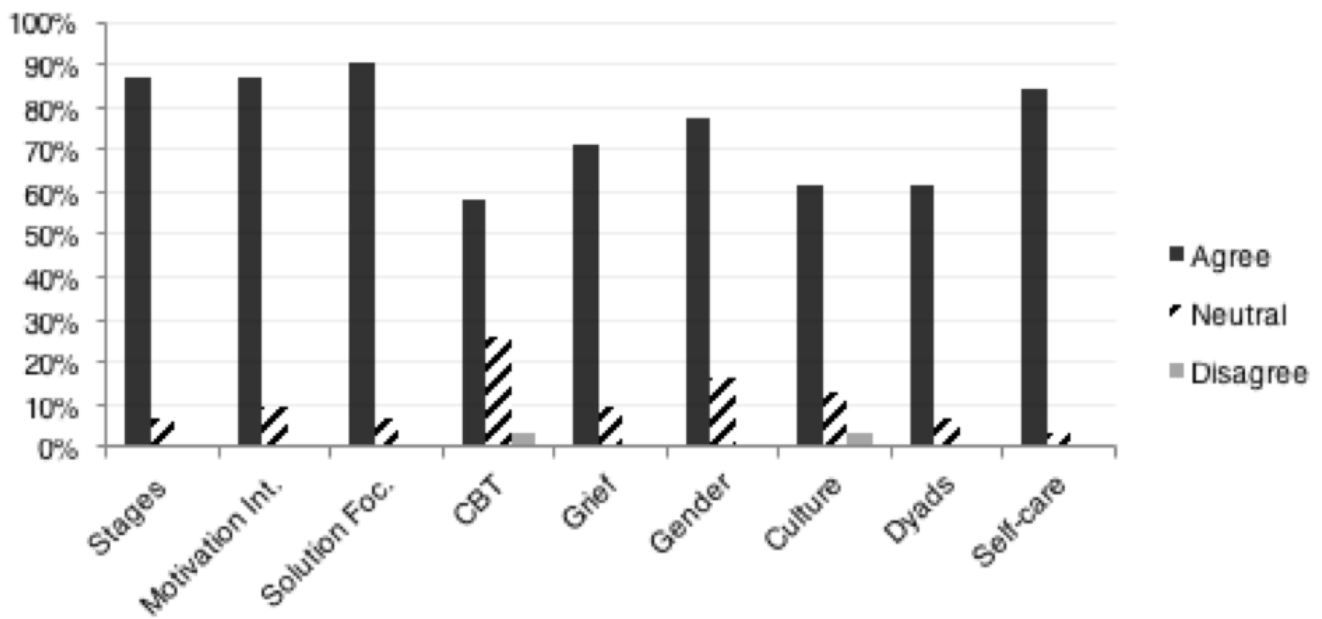
Residents were asked about the skills they learned during the didactic component of IPR (see Figure 2). For the ease of result presentation, the strongly agree and agree categories were collapsed into one "agree" category. The majority of participants agreed (87.1%) that the training they received helped them learn effective ways of identifying the stages of change and of using motivational interviewing with patients. Furthermore, almost all residents (90.3%) indicated that the training helped them learn how to use solution-focused interviewing skills. Interestingly, results indicated that fewer residents (58.1%) believed that they learned effective ways of using CBT with their patients.

In terms of working with different client presentations, *the didactic area receiving the highest level of endorsement by residents was stress management and self-care, with the vast majority of the sample (83.9%) agreeing that they learned effective skills during IPR.* Some 77.4% of residents agreed that they learned effective skills to work with issues related to gender and sexuality while 71% of residents indicated that they learned effective skills to work with patients experiencing grief or bereavement. *The majority of residents (61.3%) agreed they learned effective skills to work with issues related to culture and diversity as well.* Finally, residents also received a seminar focusing on working with dyads and it was determined that 61.3% believed they learned effective skills for working with dyads.

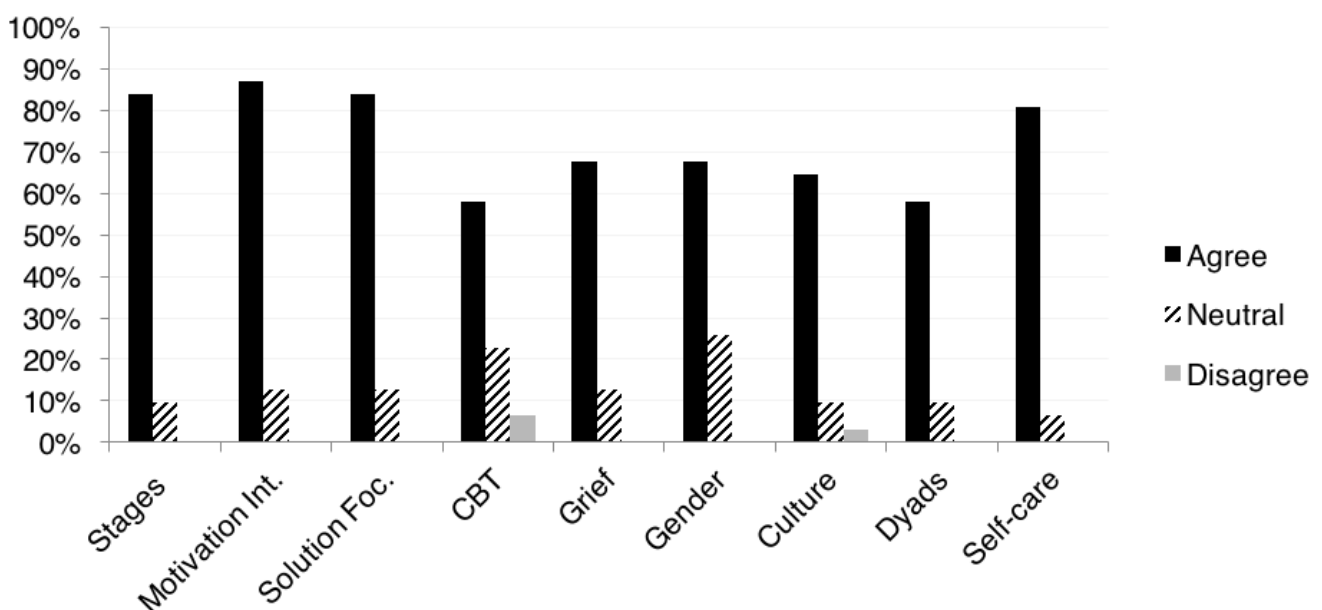
It is notable that a similar pattern of results was found when residents were asked about their confidence using the skills they learned during the didactic component of IPR with their patients (See Figure 3).

*Didactic skills featured prominently in participants' responses to what was most helpful about IPR as well. Over half of these residents (52.7%) identified skills learned, generally or specifically, and resources provided as valued, with one participant reporting that the "psychologically-minded skills" learned in IPR "are not taught anywhere else in the program." Another resident stated, "I was very sceptical initially...but as it went on the practical skills were much more prominent and I found it useful."*

## **Figure 2.** Residents' Beliefs About Whether They Learned Effective Skills



**Figure 3.** Residents ‘Confidence Using Skills Learned



**Video Review:** The video review component of IPR was most often ranked the least helpful component; specifically, 74.2% of residents ranked it as third, while 6.5% ranked it as most helpful and 19.4% ranked it as second most helpful.

Although video review was identified by the majority of residents as the least helpful component in comparison to the other components, results suggest that it was still perceived as helpful. Specifically, 77.4% of residents reported that video review enhanced their understanding of physician-patient dynamics; 74.2% reported that it enhanced their



understanding of their reactions to various types of patients and presenting concerns; and 83.8% indicated that video review enhanced their awareness of ways to improve physician-patient interactions. *Notably, however, recommendations regarding video review featured prominently in residents' responses to an open-ended question on what they would like to change about IPR, with 39.8% suggesting video review be removed, reduced, or changed. Suggestions for changes included offering a greater variety of SP cases, a preference for "real patient" interview videos, and assigning video review slots to participants in advance.*

Interprofessional Training: Results indicated that the majority of residents either agreed (48.4%) or strongly agreed (45.2%) that IPR has enhanced their understanding of how psychology and psychiatry can work together to support patients. Similarly, the majority of residents either agreed (51.6%) or strongly agreed (41.9%) that IPR has given them opportunities to learn how to communicate effectively with other professionals (e.g. psychologists, psychiatrists, family physicians) about patients and patient care. One respondent specifically recommended including other disciplines in IPR when asked about suggestions for change, while another *articulated this advantage in the following comment:*

*"Being able to discuss total person care beyond medication and disease process is very valuable."*

## Conclusion

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The results of the IPR survey suggest that residents value all three components of the 11-week psychotherapy training program, however, 93% of residents found discussion regarding interesting and difficult patients to be most useful. There may be several reasons as to why this component of IPR was ranked most highly. This particular section of IPR provides an opportunity for residents to openly discuss and reflect upon their mistakes, regrets, and areas for growth, within the context of the resident/patient interaction. This opportunity is unique within the "hidden culture" of medicine. As Haidet and Stein (2006) note in their study on the role of the student-teacher relationship in the formation of physicians and the hidden curriculum process, there is rarely an opportunity within the culture of medicine to say "I don't know the answer", as there is always a "demand for right answers."

The psychology faculty who teach IPR explicitly state that we expect residents to sometimes struggle within the context of the resident-patient relationship and that we do not expect them to have the "right answers." We encourage residents to welcome uncertainty and request that they be curious about the process occurring between them and their patients. Giving residents permission to not have all the answers may play a central role in why the interesting and difficult patients component was ranked most highly.

It is also feasible that encouraging the residents' to be open about their perceived difficult encounters, and mistakes with patients generates a feeling of connection with their peers. This sense of joining is particularly important given Mavor and colleagues 2004 finding, that medical trainees' experience of feeling connected to their peers facilitated resilience.

The vast majority of residents (87%) said that protected time devoted to personal growth/reflection was a helpful aspect of IPR. We speculate that the interactive nature of the case consultation component and the opportunity to reflect may be of particular importance, as reflective skills are noted by Epstein (2008) as being a core aspect in developing professional competency.

In addition, the location of the IPR seminar is physically removed from the medical school, creating a natural boundary between the institutional culture of medicine and the Student Wellness and Counselling Centre. It is of

note that the least resource-intensive component of IPR, requiring the smallest financial investment, is perceived as most valuable. This highlights a valued and accessible resource that could easily be adopted by resident training programs.

The didactic section of IPR was identified as the second most helpful component of the 11-week course, with the majority of residents reporting that all topics were useful. However, within topics, more residents identified stages of change, motivational interviewing, solution focused, gender and self-care as somewhat more helpful than CBT, grief, culture and dyads.

It is of note that the stages of change, motivational interviewing and solution focused therapy topics included two sessions, which allowed residents to receive more knowledge and technical skill about each topic. This more in-depth exposure to each topic may explain why residents reported these seminars to be most helpful. Additionally, both the gender and self-care topics were identified as areas in which residents felt they lacked specific training within the context of the medical school curriculum. This may in part explain why they ranked these topics to be particularly important.

Although cognitive behaviour therapy (CBT) is cited in the literature as an area in which residents need more education and skills (Kearley & Croft, 2010), resident participants found it to be the least helpful of the didactic sessions, despite its concrete structure and focus on physician-friendly tools tailored to resident feedback. This prompts the question as to whether physicians may believe that CBT falls outside of their scope of practice or role, as historically physicians view CBT as the purview of psychology, therefore (Kearley & Croft, 2010).

Although only one session was devoted to the self-care seminar, it ranked very highly with 83.9% of residents indicating that they learned skills to effectively manage stress and engage in self-care. Residents appear to value an opportunity to openly acknowledge the contrast between what is taught and what is practiced with regard to routine self-care among physicians. Self-care within the context of resident education is of particular importance as Mavor and colleagues found that medical students who are solely focused on medical education and do not engage in other activities are more stressed and at risk of burnout. In addition, Epstein and colleagues (1998) have found that when physicians take time for self-care, including investing in professional and relationships, they build a foundation for resiliency.

Many residents discussed the barriers to engaging in self-care due to the mixed messages regarding work-life balance that are prevalent in medical education. It has been discussed within the context of the IPR seminars and is reported by Haidet and Stein (2006), that leaving the hospital to eat and/or sleep is frowned upon and may be perceived as weakness by some staff. In his 2004 study, Heyworth asserts that stress is the norm and is the expected state for a physician, although this runs counter to the broad evidence indicating the detrimental impact of stress on patient care. This highlights one considerable advantage of utilizing an inter-professional learning design as it provides residents with an opportunity to step outside of the culture of medicine and view their culture through an alternative lens.

While video review was deemed helpful by the majority of participants, it was viewed as least helpful relative to other sections of IPR, yet is the most resource-intensive component. Many residents stated that they were anxious showing video. The purpose of video review is to reflect on the resident/patient interaction, interviewing strengths, areas for growth and what residents may have done differently in retrospect. As discussed previously, this task may provoke anxiety due to the "hidden curriculum," which suggests that physicians are not allowed to make mistakes (Haidet & Stein, 2006). This process may be particularly difficult if the resident or group of residents have experienced intimidation, public shaming and/or humiliation within another learning context, which has been identified as a frequent occurrence within the institutional culture of medicine (Haidet & Stein, 2006). One of our

goals during the video review is to provide a positive, safe environment for learning, as negative emotions such as shame, anxiety and anger can affect a person's ability to process information and therefore their ability to learn (Goleman, D).

The inter-professional component of IPR was found to be very helpful by the majority of residents, with over 90% reporting that IPR provided opportunities to hone their ability to communicate with other health professionals. Effective communication between physicians and other medical professionals is of particular importance given benefits to patient care (Stewart, 1995; Zolnierok, & DiMatteo, 2009). It was our experience that most residents regularly spoke about personal events and expressed vulnerabilities throughout IPR. Inter-professional learning environments may facilitate residents' engagement in truthful interactions, as they may feel less vulnerable with faculty who are not medical experts. Parker Palmer, in *The Courage to Teach* (1998), stated that ideal educational experience occurs within a "community of truth," and challenges the traditional view of the teacher as expert and student as a blank slate. Instead, within the context of the "community of truth," both teacher and student are assumed to be "knowers." Central to this approach is the assumption that the learner has a wealth of experience and knowledge to bring to the learning environment, and through engaging in the learning process they generate new insights for both the teacher and themselves.

## **Strengths and Limitations**

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As with all studies, our results should be interpreted in light of the study limitations. The study was a program evaluation and therefore not empirical. The data was self-report and subjective and we did not use objective pre and post measures to determine differences over time.

Residents provided the feedback outside of a highly evaluative environment and each resident completed the survey in private after all final evaluations and paperwork were completed.

This evaluation provides a comprehensive look at each specific area of IPR and provides some suggestions for how training programs might address multiple needs at once including; ways of learning that will contribute to developing self-care, collegial support, an alternative to hidden curriculum – right answers are not required, physicians are not perceived as being all-knowing, and intimidation, shaming and humiliation are not used as learning strategies. The learner's voice is critical and all learning takes place in a reciprocal way between faculty and residents. Through reflection activities, an interpersonal context is created and there is the possibility of teacher and residents learning about each other in a curious way.

Medical residents' feedback on an 11-week psychotherapy training program suggests that psychotherapy training is highly valued. The case consultation component of the program was most highly valued, as this provided an opportunity for residents to speak openly with their peers, in a safe environment about sensitive issues such as mistakes, competency concerns, difficulty with patients and/or faculty. The cost- and resource-efficient nature of this valued component positions it as worthy of consideration for residency training programs interested in enhancing resident's skill in strengthening the physician-patient relationship, as well as building resident resiliency by teaching self-care practices.

## **Take Home Messages**

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## Notes On Contributors

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Beth Whelan is an Assistant Professor and Training Director at the Student Wellness and Counselling Centre (SWCC), Memorial University, in St. John's NL. Dr. Whelan is cross-appointed to the Faculty of Medicine, the Center for Collaborative Health & Professional Education, and Psychology Faculty. She is engaged in assessment & intervention, training, supervision, research and program development within the SWCC Psychology Doctoral Residency program. In addition, she provides teaching and supervision to Family practice and psychiatry residents as well as PsyD. Psychology students.

Lisa Moores is also an Assistant Professor at Memorial University's Student Wellness and Counselling Centre, where she leads the Healthy Campus strategy. Dr. Moores' interprofessional activities include teaching and supervising family practice, psychiatry, and psychology residents and providing interprofessional skills training to students of health professions. She is interested in positive psychology, cross-cultural transition, and qualitative design.

Heather Quinlan is a recent graduate from the Doctor of Psychology (PsyD) program at Memorial University, in St. John's NL. Currently, she is working as a psychologist in a residential facility for addictions treatment. Other interests include trauma, personality disorders, mindfulness and self-compassion.

Adam Reid is a program evaluator and research coordinator at the Centre for Collaborative Health Professional Education in St. John's NL. Adam holds a Masters of Applied Social Psychology, with ten years of research experience, including 4 years' experience evaluating interprofessional education and collaboration initiatives. Areas of interest include quasi-experimental design, experiential learning and post-secondary health/social care education.

## Acknowledgements

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## Bibliography/References

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Epstein, R. M. (2008). Reflection, perception and the acquisition of wisdom. *Medical Education*.

<https://doi.org/10.1111/j.1365-2923.2008.03181.x>

Epstein, R. M. (1999). Mindful practice. *Jama*, 282 (9), 833-839.

<https://doi.org/10.1001/jama.282.9.833>

Fleury, M. J., Farand, L., Aubé, D., & Imboua, A. (2012). Management of mental health problems by general practitioners in Quebec. *Canadian Family Physician*, 58(12), 732-738.

Fleury, M. J., Imboua, A., Aubé, D., Farand, L., & Lambert, Y. (2007). General practitioners' management of mental disorders: A rewarding practice with considerable obstacles. *BMC Family Practice*, 13(1), 2-12.

Goleman, D. (2006). *Emotional intelligence*. Bantam.

Haidet, P., & Stein, H. F. (2006). The role of the Student-Teacher relationship in the formation of physicians. *Journal of General Internal Medicine*, 21(S1), S16-S20.

<https://doi.org/10.1111/j.1525-1497.2006.00304.x>

Heyworth, J. (2004) Stress: A badge of honour in the emergency department? *Emergency Medicine*, 16 (1), 5-6.

<https://doi.org/10.1111/j.1742-6723.2004.00545.x>

Kagan, N., Schauble, P., Resnikoff, A., Danish, S. J., & Krathwohl, D. R. (1969). Interpersonal process recall. *The Journal of nervous and mental disease*, 148(4), 365-374.

<https://doi.org/10.1097/00005053-196904000-00004>

Kearley, K., & Croft, A. (2010). Cognitive-behavioural skills training for medical students: development and evaluation. *The Psychiatrist*, 34(6), 251-256.

<https://doi.org/10.1192/pb.bp.108.023994>

Mavor, K. I., McNeill, K. G., Anderson, K., Kerr, A., O'Reilly, E., & Platow, M. J. (2014). Beyond prevalence to process: the role of self and identity in medical student well-being. *Medical education*, 48(4), 351-360.

<https://doi.org/10.1111/medu.12375>

Mullins-Richards, P., Tarrant, G., Godwin, M., Cornish, P., Hurley, G., Bethune, C., Ohle, L. & Mitchell, K. (2014) *Medical Education Scholarship Forum Proceedings*.

Palmer, P. (1998). *The courage to teach*.

Parikh, S. V., Lin, E., & Lesage, A. D. (1997). Mental health treatment in Ontario: selected Comparisons between the primary care and speciality sectors. *The Canadian Journal of Psychiatry*, 42(9), 929- 934.

<https://doi.org/10.1177/070674379704200903>

Saillant, S., Hudelson, P., Dominicé Dao, M., & Junod Perron, N. (2016). The primary care physician/psychiatrist joint consultation: A paradigm shift in caring for patients with mental health problems? *Patient Education and Counselling*, 99(2), 279–283.

<https://doi.org/10.1016/j.pec.2015.08.028>

Shanafelt, T. D., Sloan, J. A., & Habermann, T. M. (2003). The well-being of physicians. *The American Journal of Medicine*, 114(6), 513–519.

[https://doi.org/10.1016/S0002-9343\(03\)00117-7](https://doi.org/10.1016/S0002-9343(03)00117-7)

Slomp, M., Bland, R., Patterson, S., & Whittaker, L. (2009). Three-year physician treated prevalence rate of mental disorders in Alberta. *The Canadian Journal of Psychiatry*, 54(3), 199-203.

<https://doi.org/10.1177/070674370905400308>

Spickard Jr, A., Gabbe, S. G., & Christensen, J. F. (2002). Mid-career burnout in generalist and specialist physicians. *JAMA*, 288(12), 1447-1450.

<https://doi.org/10.1001/jama.288.12.1447>

Starkes, J. M., Poulin, C. C., & Kisely, S. R. (2005). Unmet need for the treatment of depression in Atlantic Canada. *The Canadian Journal of Psychiatry*, 50(10), 580-590.

<https://doi.org/10.1177/070674370505001003>

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian Medical Association Journal*, 152(9), 1423-1433.

Van Rijswijk, E., van Hout, H., van de Lisdonk, E., Zitman, F., & van Weel, C. (2009). Barriers in recognising, diagnosing and managing depressive and anxiety disorders as experienced by Family Physicians; a focus group study. *BMC Family Practice*, 10(1) 52-59.

<https://doi.org/10.1186/1471-2296-10-52>

Zantinge, E. M. (2005). The workload of GPs: patients with psychological and somatic problems compared. *Family Practice*, 22(3), 293-297.

<https://doi.org/10.1093/fampra/cmh732>

Zantinge, E. M., Verhaak, P. F., de Bakker, D. H., van der Meer, K., & Bensing, J. M. (2006). Does the attention General Practitioners pay to their patients' mental health problems add to their workload? A cross-sectional national survey. *BMC Family Practice*, 7(1), 1-8.

<https://doi.org/10.1186/1471-2296-7-71>

Zolnierek, K. B. H., & DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: a meta-analysis. *Medical Care*, 47(8), 826-834.

<https://doi.org/10.1097/MLR.0b013e31819a5acc>

## Appendices

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## Declarations

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*The author has declared that there are no conflicts of interest.*

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