Despite the high prevalence of psychiatric and behavioral problems in primary care, many physicians receive little training in psychiatry. A model curriculum has been developed for the Federated Council for Internal Medicine Task Force on the Internal Medicine Residency Curriculum. A detailed description of the curriculum was outlined by Steven A. Cole and colleagues (General Hospital Psychiatry 17, 13-18, 1995). The curriculum roughly is divided into knowledge and skills objectives. The knowledge objectives involve diagnosing and treating mental disorders as well as familiarity with application of the biopsychosocial model. The skills objectives involve clinical interviewing and basic psychotherapeutic interventions (e.g. emotional support, basic behavioral interventions). Three recent publications significantly contribute to the literature for teaching clinical interviewing skills, a major part of the psychiatric skills objectives.

Smith and colleagues published a randomized and controlled study of a one-month intensive training for residents in interviewing. Annals of Internal Medicine, 128:118-126 (1998). By using a randomized, controlled approach the specific effects of the training were distinguished from the general effects of the residency training. Trained residents improved in their knowledge, self-confidence, and skills in interviewing patients. This study provides us with one of the most thoroughly data-based interviewing models and gives educational program directors a valuable model.

Langewitz and colleagues proposed a behaviorally oriented program for improving specific interviewing skills. Psychosomatic Medicine 60:268-276 (1998). The authors argue the large amount of time required in providing labor-intensive models such Smith and colleagues as a major obstacle to teaching programs. They tested a behaviorally oriented program that required a modest 22.5 extra hours. Specific communication behaviors that needed to be improved were identified in each resident following a videotaped interview. Behavioral goals for these communication skills were then developed and monitored by the trainee and supervisor over the subsequent six months. At the end of six months, both the control group and the intervention group showed improvement in communication skills. However, the intervention group showed statistically significant improvement in the targeted communication skills. This study is relevant because it demonstrates that positive behaviors within patient-physician communication can be effectively taught in a behavioral model. The major limitation is the assumption that the targeted communication behaviors are correlated with better patient care.
Smith and Langewitz’s articles provide two different models for interviewing training, but they did not demonstrate a significant clinical outcome. Giron and colleagues demonstrated a significant correlation between clinical interviewing skills and the identification of emotional disorders in the primary care setting. *American Journal of Psychiatry, 155:4, 530-535(1998).* They chose 10 practicing physicians and videotaped their interactions with patients. After each patient interaction, the study physician rated the degree of the patient’s mental disorder on a 6-point scale ranging from “no mental illness” (score 0) to “severe mental illness” (score 5). Then a psychiatrist using a structured format interviewed the patient to determine if an emotional disorder was present. Psychodiagnostic ability was rated based on the degree of correlation between the study physician’s and the psychiatrist’s rating scales. The videotapes of the physicians’ interviews were analyzed for communication skills utilized and psychodiagnostic ability. A total of 233 patients and their interviews were assessed.

Physicians with “good” psychodiagnostic ability detected 93.3% of patients with psychiatric illness, whereas those with “medium” psychodiagnostic ability or “poor” psychodiagnostic ability identified 33.3% and 10% of the psychiatric cases respectively. Also physicians with “good” psychodiagnostic ability as compared with physicians with “poor” psychodiagnostic ability had significantly more eye contact, had a more open posture, used less leading questions, more questions with psychological content and were more likely to provide the patient verbal and nonverbal facilitations.

Two caveats: the authors acknowledge bias in their choice of physicians, who were “selected with the aim of obtaining maximum variation in the physician’s ability to identify emotional distress.” This selection bias introduces the possibility that unmeasured or unrecognized behaviors may be accounting for the “good” psychodiagnostic ability, and the sample is not generalizable. Also “psychodiagnostic ability” was a sensitive measure for mental disorders and not a specific one. Nevertheless, this small study nicely monitored and measured clinical interviewing skills, and when good communication skills were applied the physician made the correct diagnosis of mental illness. This suggests that one of the first steps in improving mental health care in the primary care setting is improving the clinical interviewing skills of the primary care physician.