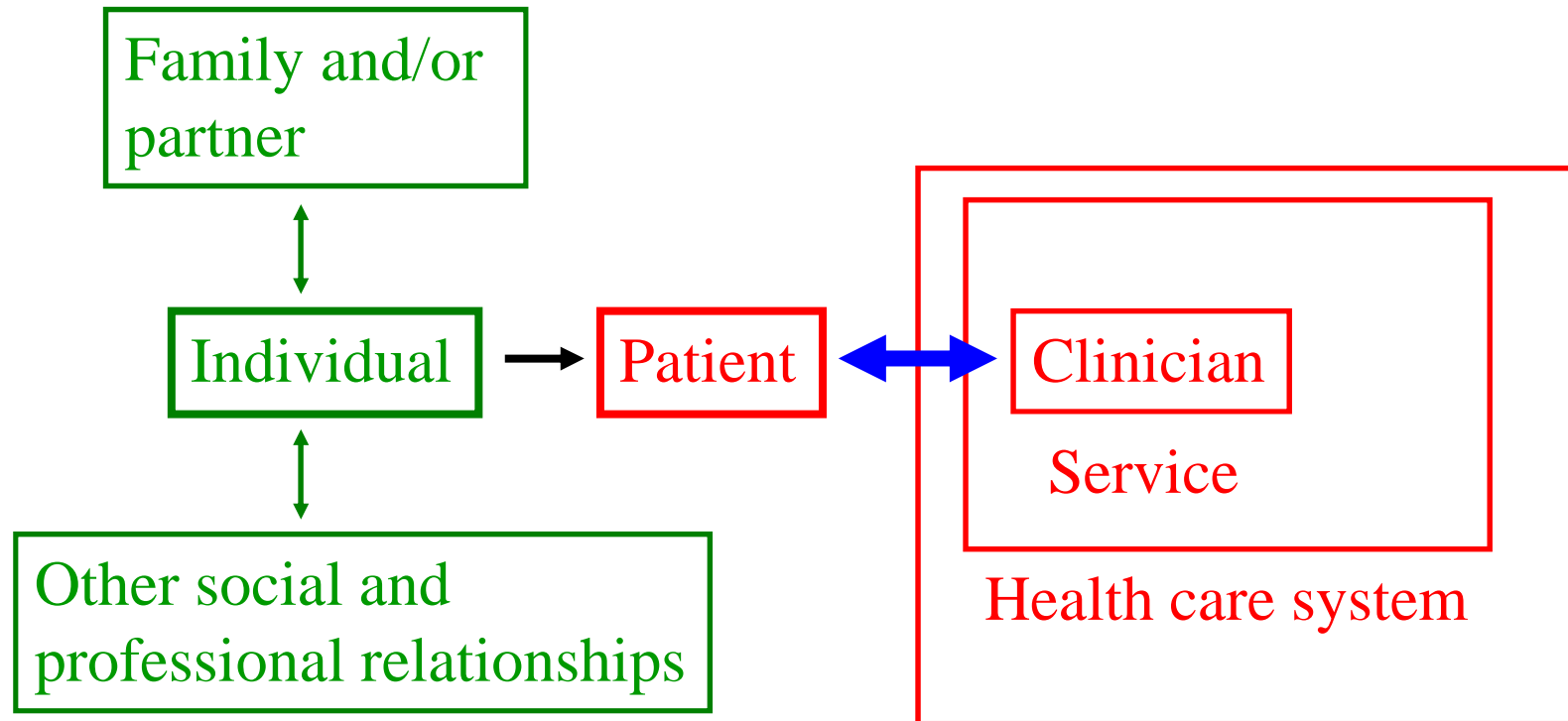# The therapeutic relationship and patient-reported outcomes in the treatment of patients with psychosis

Prof. Stefan Priebe

Queen Mary, University of London

Therapeutic relationship

Therapeutic relationship in psychiatry

- Defining element of health care
- In patient surveys consistently reported as the most important component of care
- In some quantitative studies predictor of adherence and outcomes
- Most important non-specific treatment factor

Poor relationship (I)

"I just felt I was fobbed off .....it was definitely a case with some psychiatrists of Them and Us. And you couldn't talk on the level at all, so in the end you didn't say very much ..... I used to think who does it benefit and thought not me."

"They are trying to take over your life, treating you like a kid."

Priebe et al., B J Psychiatr, 2005

Poor relationship (II)

"I felt they never listened to me and they were just making choices for me, and if they listened to me a bit more then I might have felt a bit more like I was. I just felt my life was out of control, and I didn't have a say in what I was doing."

"They didn't want to hear what you had to say…talking about something they want to talk about, which was very insulting."

Priebe et al., B J Psychiatr, 2005

Positive relationship (I)

"*He seems more concerned about me..when I suggested that I wanted to stop my depot for a while, he actually let me and he did actually come across as if he was concerned about me hallucinating again. And he wasn't too pushy…He wanted me to be more involved in my own health, in looking after my own health rather than him.*"

Priebe et al., B J Psychiatr, 2005

Positive relationship (II)

"The team and I have been through a lot. They have seen me in a good position and the team have seen me in bad conditions, so they have an idea, a much better idea and understanding of my moods and how to react to things. So we have a good working relationship."

Priebe et al., B J Psychiatr, 2005

Theoretical models for understanding therapeutic relationships

- Role theory
- Psychoanalysis
- Social constructionism
- Systems theory
- Social psychology
- Cognitive behaviourism

McGuire et al., Soc Psychiatry Psychiatr Epidemiol, 2001

Therapeutic relationship and treatment outcomes in psychosis

- Significant prospective associations with outcomes:
  3 out of 6 for hospitalisations
  2 out of 6 for functioning
  3 out of 10 for symptoms

- Evidence consistent with the assumption of a small effect size, but not overwhelming

Priebe at al., Psychotherapy & Psychosomatics, 2011

STAR

- <u>S</u>cale <u>T</u>o <u>A</u>ssess Therapeutic <u>R</u>elationships (in Community Mental Health Care)
- A patient and a clinician version
- Each with 12 items
- Each assessing 3 distinct factors:
  a) positive collaboration (6 items)
  b) positive clinician input (3 items), and
  c) non-supportive clinician input/emotional difficulties (3 items)
- Good psychometric properties

McGuire-Snieckus et al., Psychol Med, 2007

K. Jaspers:

…the ultimate thing in the doctor-patient
relationship is *existential communication*,
which goes far beyond anything that can be
planned or methodically staged. The whole
treatment is … defined within a community
of two selves who live out the possibilities
of Existence itself, as reasonable beings.

Jaspers, General Psychopathology, 1913

All you need is love?

The Beatles, 1967

Love

- Universal and powerful construct - not evidence based!
- High appeal across cultures and over times
- Three factors:
  - Sexual desire
  - Romantic love
  - Long term attachment

Therapeutic relationship and communication

- Therapeutic relationship (like love): powerful and appealing concept, but: difficult to capture and influence

- Communication: assessable and measurable phenomenon, but: unclear significance

- Does good communication lead to good relationship or vice versa or both?

Relationship and interaction/communication

- Interaction/communication: Behavioural exchange between patient and clinician that is observable and may be described in objective terms

- Relationship: Psychological construct held by participating individuals on each other and their interaction

Priebe & McCabe, Acta Psichiatr Scand, 2006

Communication with psychotic patients (I)

- Disturbances of formal thoughts and content
- Other symptoms (e.g. distraction through voices)
- Deficits in social cognition
- Medication effects

Communication with psychotic patients (II)

- Unclear which communication problems are linked to poor social inclusion

- *'Praecox feeling'* (Rümke)

- Non-verbal behaviour

- 'Flight' (avoidance of contact) at the beginning of interaction

- Association with symptom levels

Dimic et al., Psychopathology, 2010

Experiments with communication in groups

Movements of heads and bodies
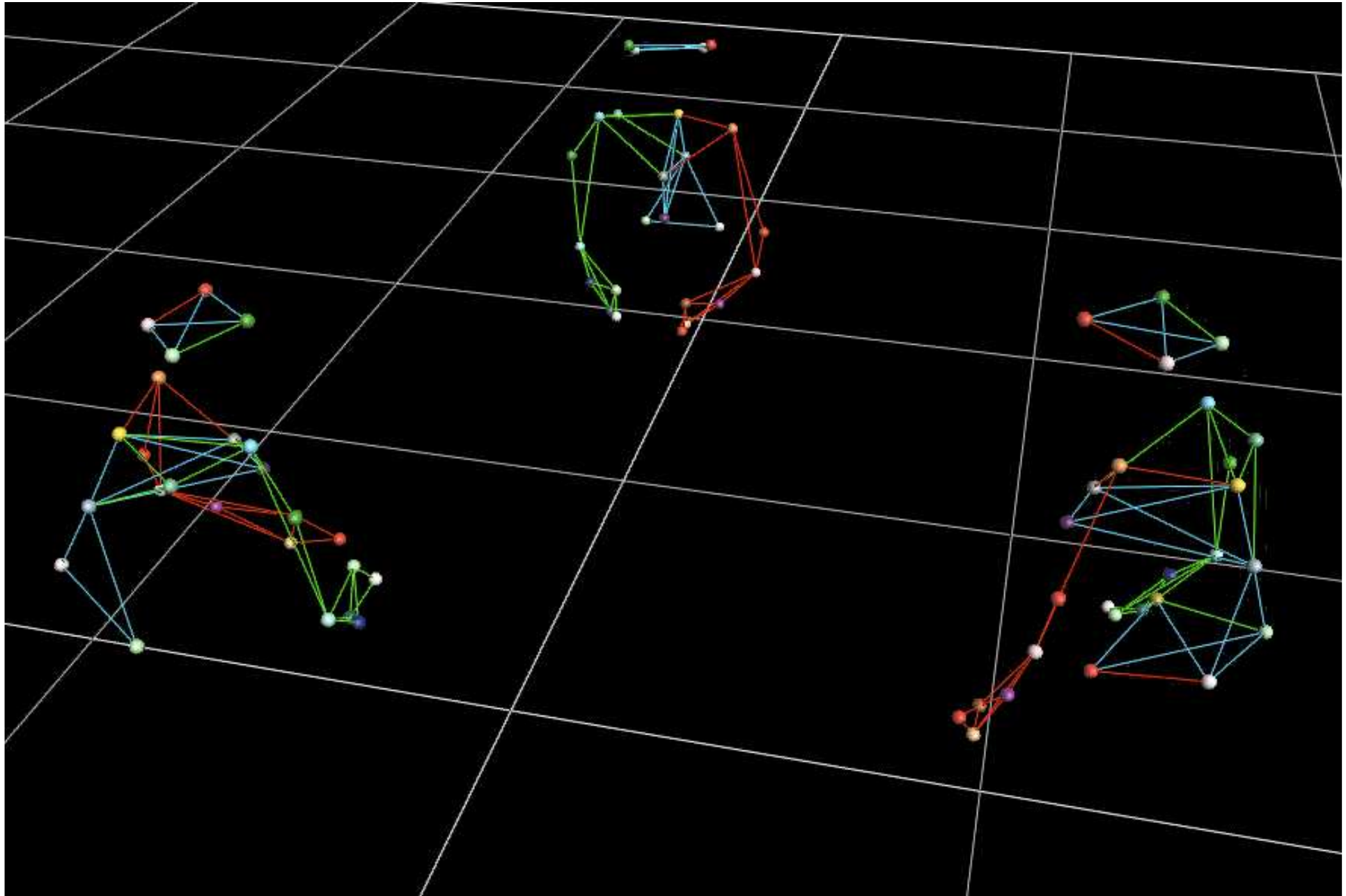
Experimental conditions

- Registration of movements and temporal co-ordination in three dimensions

- Groups of 3 with and without patient with schizophrenia

- Nobody was aware that there might be a patient

- Discussion of a moral dilemma

Lavalle et al., Scizophrenia Bulletin, 2012

Findings

- Co-ordination is reduced between patients and non-patients
- Associated with positive symptoms
- Non-patients show more movements in communication with patients
- Associated with negative symptoms

Lavalle et al., Schizophrenia Bulletin, 2012

Conclusion

- The presence of a patient with psychosis affects the behaviour of others
- The type and extent of influence is associated with specific symptoms

Lavalle et al., Schizophrenia Bulletin, 2012

Conversation analysis

- Analysis of what people do rather than what they say they do

- Videotaping and transcription of routine consultations

- Analysis of single elements of communication as well as patterns

McCabe et al., BMJ, 2002

DOCTOR:	Yes, of course, in 3 months time
PATIENT:	**Why don't people believe me doctor, when I say I'm God.** Why don't they believe me cos everyone knows I am, I think everyone knows. I mean its not nonsense its true.
DOCTOR:	**What should I say** now?
PATIENT:	I believe it anyway
DOCTOR:	Well, you are free to believe it anyway but people are free not to believe you.
PATIENT:	mm
DOCTOR:	You know what I mean. Alright this is your card.
PATIENT:	Yes
DOCTOR:	This is you [name], this is eh for reception.
PATIENT:	Next appointment, yes

Psychiatric consultation with patients with psychosis

- Psychiatrists explore psychotic experience only when checking medication effects
- Patients mention psychotic experience at pre-closing stages
- Psychiatrists respond with smiling and other avoiding behaviour
- Patients feel not understood

McCabe et al., BMJ, 2002

Why don't people believe me doctor, when I say I'm God?

McCabe & Priebe, Br J Psychiatr, 2008

Answers

- Why do you think they don't believe you?
- What exactly do you mean with God?
- Why do you think you are God?
- Do you feel misunderstood?
- Why should they believe since Jesus was not believed either?

Answers

- Because it is nonsense!
- Because most people have a different idea of what God may look like
- This is an important issue. Right now I am in a hurry; let's make sure that we take enough time for this at the beginning of the next consultation.

Patient clarifying understanding

Dr: yeah it doesn't happen in real life does it?

Pat: **What do you mean by real life?**

Dr: you can't- there are no messages coming
from the television to people are there?

Communication & adherence

	OR	p	95% CI
Doctor led clarification	1.52	0.312	0.67 to 3.43
Patient led clarification	**5.81**	**0.021**	**1.31 to 25.82**
Patient explanation	1.61	0.237	0.73 to 3.56
Doctor explanation	0.94	0.893	0.41 to 2.18
Length consultation	0.99	0.821	0.89 to 1.09
Symptoms	1.00	0.791	0.98 to 1.03

Good communication in psychiatry

- No specific theory of good communication in health care or psychiatry
- Differences from general medicine
- Differences from psychotherapy
- Appropriate communication varies in different situations and settings

Communication in psychiatry
- five principles

1) Focus on patient's concerns
2) Positive regard
3) Appropriate decision making practices
4) Genuineness with a personal touch
5) Application of a psychological model

Priebe et al., European Psychiatry, 2011

Potential interventions

- Allocating patients to clinicians in line with anticipated relationship
- Changing of clinician
- Training clinicians
- Interventions directly influencing the communication

Challenge for psychiatry

- Emphasise communication to
  a) improve adherence and outcomes
  b) strengthen professional status/qualification
  c) underline the fascination of psychiatry
- Better and individualised training
- Develop specific models for communication with psychotic patients
- More rigorous experimental research

Patient Reported Outcomes (PROs)

- Outcomes
- Reported by patients
- Reflecting their experiences and views
- Increasingly popular since 1970s
- Various drivers
- Many concepts
- Numerous measures (PROMs)

Concepts of PROs (I)

- Treatment satisfaction
- Quality of life
- Social functioning
- Therapeutic relationship
- Needs
- Sense of coherence
- Autonomy

Concepts of PROs (II)

- Empowerment
- Recovery
- Hope
- Well-being
- …………
- Concepts commonly based on intuitive appeal, but not on consensus or precise definition

Measures

- Huge and growing list
- Usually based on good intentions
- Little attention to psychometric properties (variance, reliability, validity)
- Many scales share similar problems

Problems (I)

- Little correlation with observer rated measures
- Questionable overall validity (but: predictive validity)

Characterizing Quality of Life
Among Patients With Chronic Mental Illness:
A Critical Examination of the Self-Report Methodology

Mark Atkinson, Ph.D., Sharon Zibin, M.Sc., and Henry Chuang, M.D.

Amidst the pressures to implement outcome studies, researchers and clinicians who work in the mental health field are advised to proceed critically. Each of the preceding issues raises concern about the meaning of results from self-report measurement with chronically mentally ill populations. Self-report measures are likely to contain biases due to cognition, periodic affective swings, and recent life events that may better reflect psychopathology and symptoms than actual life conditions or functions. Moreover, the refinement of instruments and methods that are sensitive to changes over the course of the illness will require greater attention as to how and when outcome measurements are made.

Problems (II)

- Ceiling effect and better distinction at the positive end
- High overlap of scores (> 50%) suggesting a general appraisal tendency
- The tendency is found cross-sectionally and longitudinally
- The tendency is associated with mood (r>0.60)
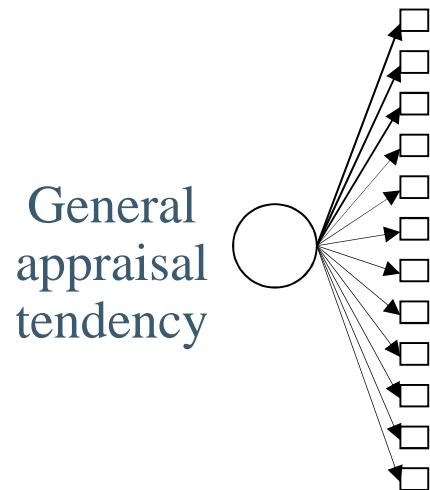- It can be measured by a small number of items

Are important patient-rated outcomes in community mental health care explained by only one factor?

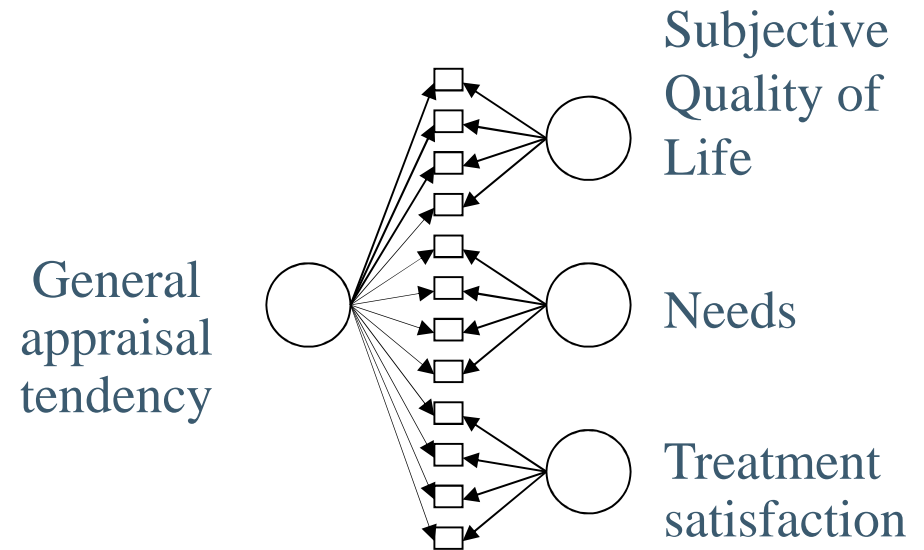**L. Hansson[1], T. Björkman[1], S. Priebe[2]**

As long as such new scales do not exist, one may argue that it is unnecessary and possibly even unethical to administer a battery of scales to patients, when the main variance of all of them can be assessed by no more than seven single items. The current instruments were all derived from theoretical considerations and have some face value. Yet, the findings of this study underline that the conceptual and methodological approach to assess patient-rated outcomes in mental health care may have to be re-considered and further developed. The increasing importance that is given to patient-rated outcomes should be matched by systematic conceptual work and systematic research to develop the best assessment instruments.

Measurement models

Unidimensional model

General appraisal tendency

Bifactor model

General appraisal tendency

Subjective Quality of Life

Needs

Treatment satisfaction

Measuring patients' views: a bifactor model of distinct patient-reported outcomes in psychosis

U. Reininghaus[1]*, R. McCabe[1], T. Burns[2], T. Croudace[3] and S. Priebe[1]

[1] *Queen Mary University of London, Unit for Social and Community Psychiatry, Barts and the London School of Medicine, London, UK*
[2] *University Department of Psychiatry, Warneford Hospital, Oxford, UK*
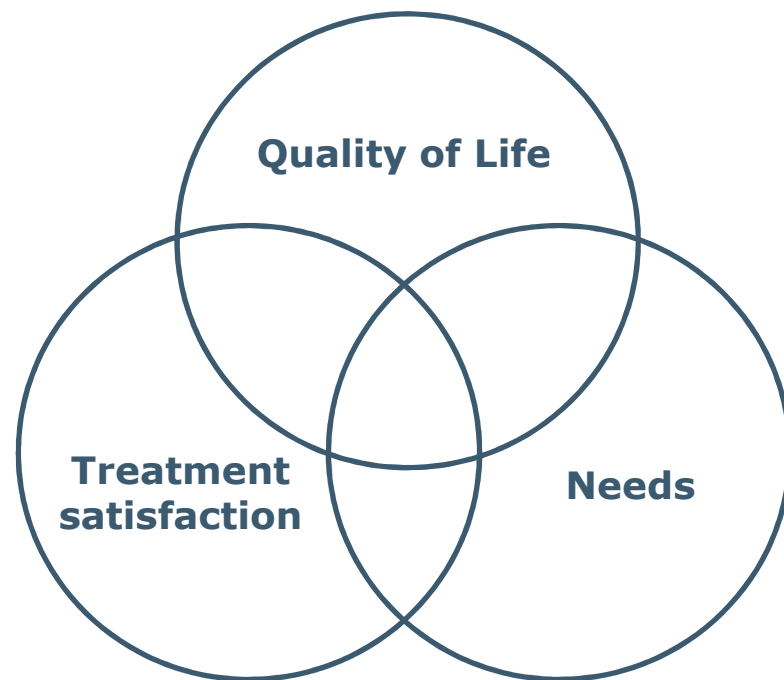[3] *Department of Psychiatry, University of Cambridge, UK*

Table 2. *Model fit statistics for unidimensional, multidimensional and bifactor models in the UK700 and DIALOG samples*

	Model 1	Model 2	Model 3	Model 4	Model 5
UK700 sample					
χ^2	1979.71	1346.38	984.96	929.81	500.90
CFI	0.60	0.74	0.83	0.84	0.94
TLI	0.68	0.80	0.87	0.87	0.96
RMSEA	0.10	0.08	0.06	0.06	0.04
DIALOG sample					
χ^2	1278.82	530.29	643.34	644.13	304.50
CFI	0.65	0.89	0.86	0.78	0.93
TLI	0.74	0.82	0.90	0.82	0.94
RMSEA	0.11	0.06	0.07	0.09	0.05

Factors influencing subjective quality of life in patients with schizophrenia and other mental disorders: A pooled analysis

Stefan Priebe [a,*], Ulrich Reininghaus [a], Rosemarie McCabe [a], Tom Burns [b], Mona Eklund [c],
Lars Hansson [c], Ulrich Junghan [d], Thomas Kallert [e], Chijs van Nieuwenhuizen [f],
Mirella Ruggeri [g], Mike Slade [h], Duolao Wang [i]

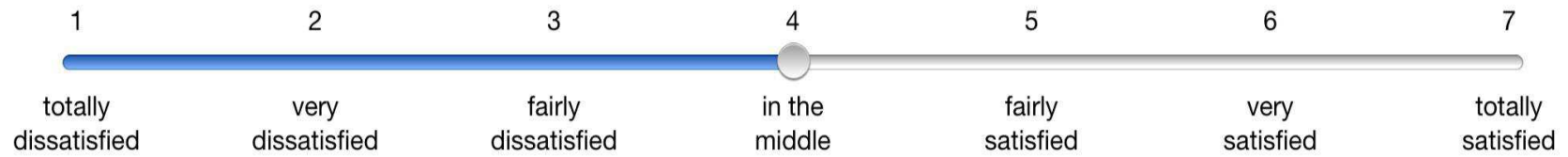| Influential factor	Fixed part		
	Standardized beta	Unstandardized beta (95% CI)	P
Age	.067	.006 (.003 to .009)	<.001
Married/partnership vs. other	.07	.07 (−.02 to .15)	.129
Unemployed vs. other	−.18	−.18 (−.26 to −.10)	<.001
ICD-10 clinical diagnosis			
Mood disorders vs. schizophrenia	−.49	−.47 (−.58 to −.37)	<.001
Neurotic disorders vs. schizophrenia	−.43	−.42 (−.54 to −.30)	<.001
BPRS-18 total score	−.250	−.024 (−.027 to −.020)	<.001
Depression/anxiety subscale	−.35	−.08 (−.09 to −.07)	<.001
Anergia subscale	−.06	−.02 (−.03 to −.01)	.003
Thought disorder subscale	−.10	−.03 (−.04 to −.02)	<.001
Activation subscale	−.05	−.02 (−.04 to −.01)	.007
Hostility subscale	−.19	−.07 (−.09 to −.06)	<.001

PROs - conclusions

- Various problems – methodologically sound procedure required
- Satisfaction based concepts best studied
- Not several concepts at the same time
- Brief, simple and transparent scales with sufficient psychometric properties
- Assessed in a clinically meaningful procedure

DIALOG

- Clinicians ask patients for their satisfaction with 8 life domains and 3 treatment domains and wishes for additional help
- Computer mediated procedure

How satisfied are you with your mental health?

1	2	3	4	5	6	7
totally dissatisfied	very dissatisfied	fairly dissatisfied	in the middle	fairly satisfied	very satisfied	totally satisfied

Do you need additional help?   Yes   No

Physical health

Job situation

Accommodation

Leisure activities

Partner / family

Friendships

Personal safety

Medication

Practical help

Meetings

	1	2	3	4	5	6	7
04/11/2011		10/12/2011		17/01/2012		15/02/2012	15/03/2012

Mental health ✓

Physical health

Job situation

Accommodation ✓

Leisure activities

Partner / family

Friendships

Personal safety

Medication

Practical help

Meetings

	1	2	3	4	5	6	7

04/11/2011 10/12/2011 17/01/2012 13/02/2012 15/03/2012

Mental health ✓

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Accommodation ✓
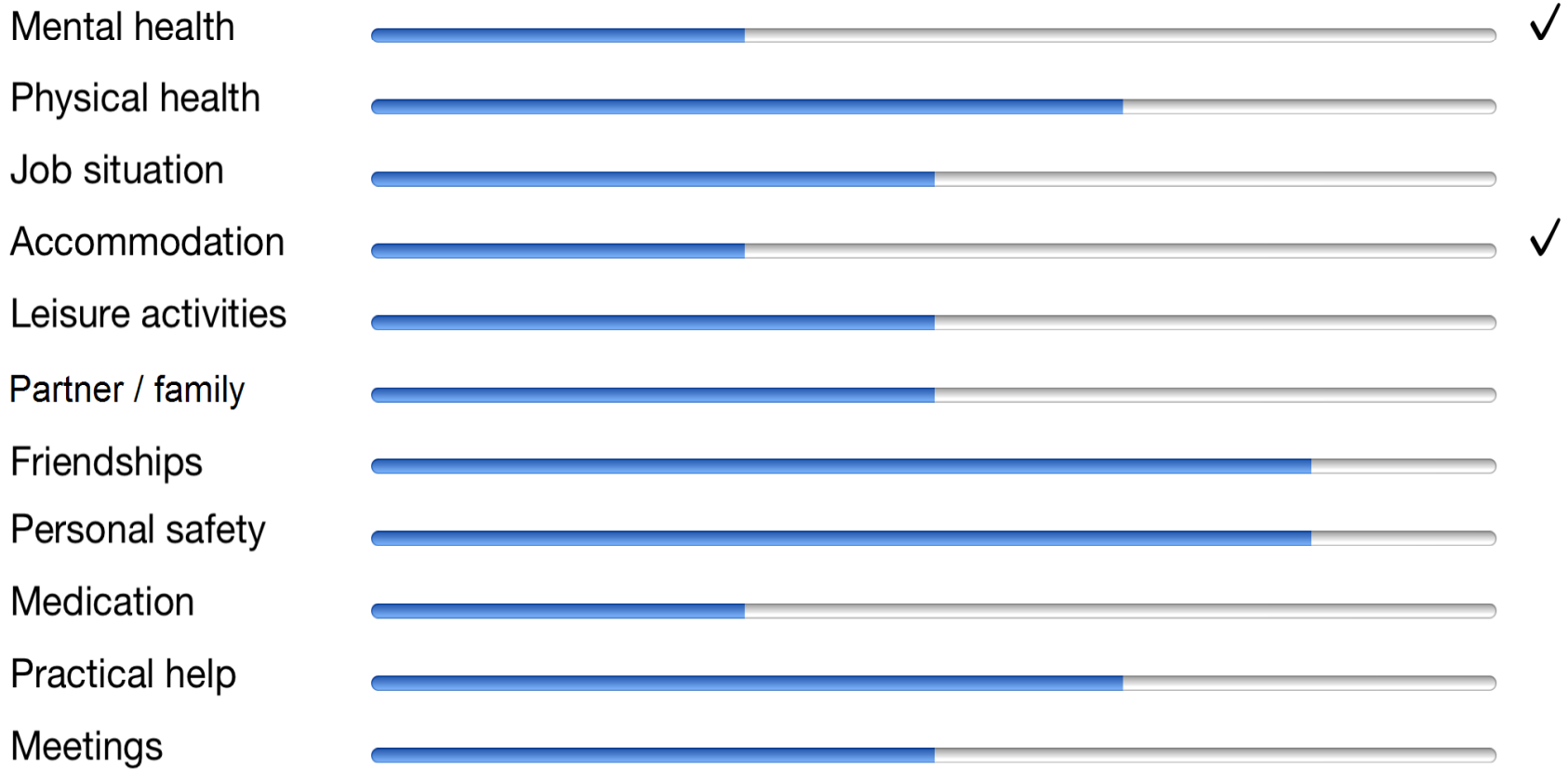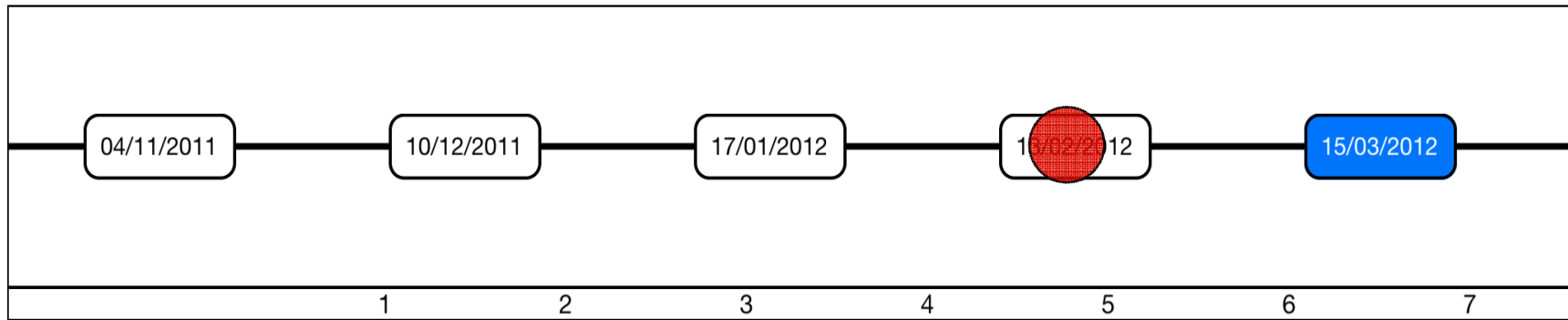
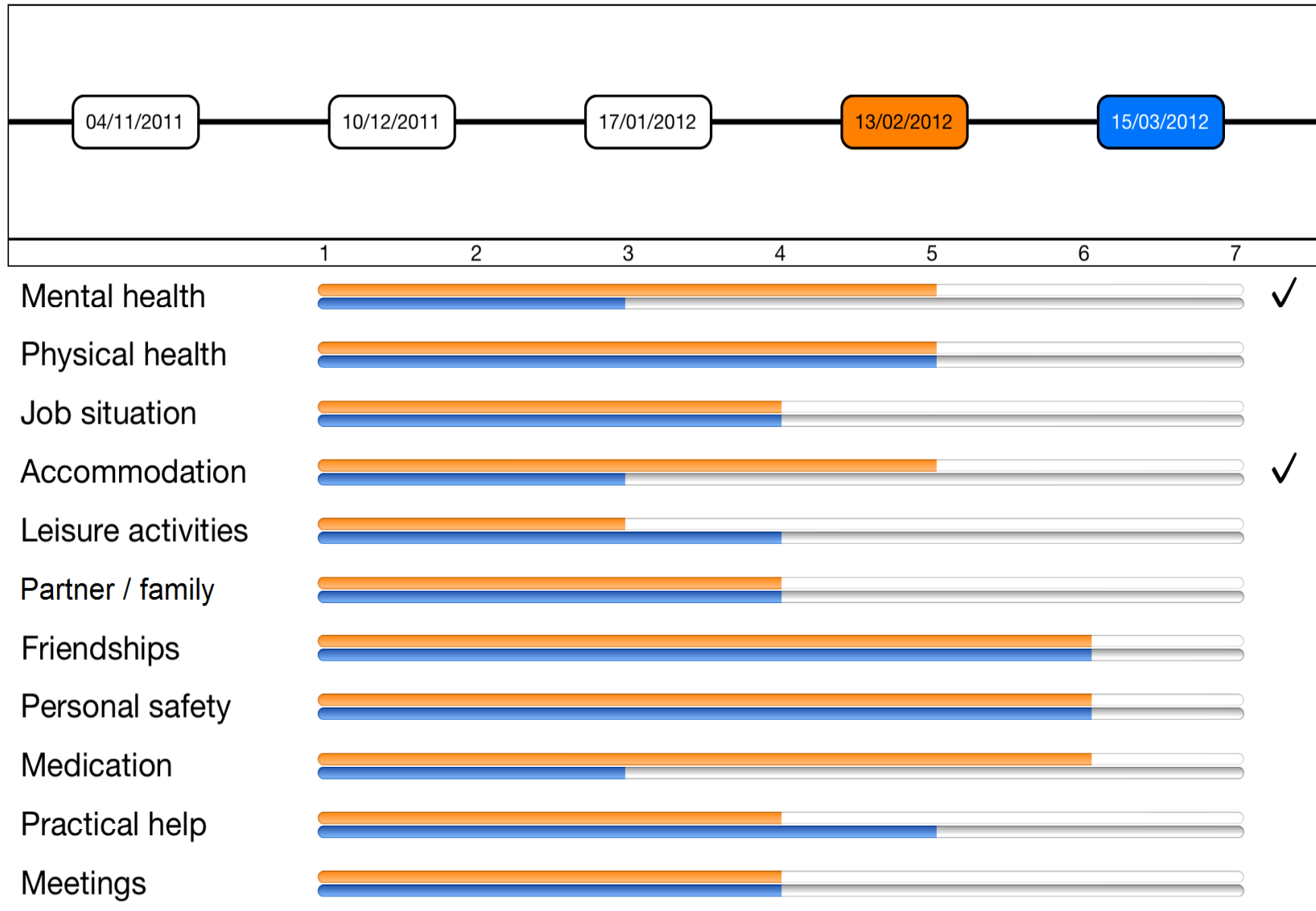Leisure activities

Partner / family

Friendships

Personal safety

Medication

Practical help

Meetings

DIALOG

- Randomised controlled trial in community mental health care in six countries
- DIALOG led to
  a) better quality of life
  b) higher treatment satisfaction
  c) fewer unmet needs for care
- Because communication is more comprehensive, patient-centered, forward looking?

Priebe et al., British Journal of Psychiatry, 2007

DIALOG

- Turns routine meeting into therapeutic intervention

- Used in research in general and forensic psychiatry in NL, UK and US

- Provides PRO data in a meaningful procedure

- Data have reasonable reliability and validity, and good sensitivity to change

Priebe et al., BMC Psychiatry, 2012

DIALOG+

- Four step model to respond to ratings
  1) understanding
  2) looking forward
  3) exploring options
  4) action plan
- A new trial in East London

Conclusions

- Therapeutic relationship and communication at the centre of psychiatric practice
- Little clarity and evidence about PROs
- PROs can be used to improve relationships
- Very exciting area of research!!