Feedback Informed Treatment in emergency psychiatry, a poor FIT?

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SUMMARY

The aim of this thesis is to look at whether using feedback results in better treatment for clients with psychiatric and/or severe psychosocial problems when they are referred in a crisis situation. The type of feedback studied here is 'immediate client feedback', in which clients score symptoms, well-being and their perception of the alliance using a formal measuring instrument. The scores collected in this way are identified and discussed by the therapist and client at each session. The effect of this feedback was studied in a randomised controlled trial comparing the results for two groups of clients: a group of clients whose treatment included additional feedback and a group of clients with no additional feedback.
At a broader level, the aims of the thesis are to provide a picture of the background to the use of feedback, to provide inspiration and suggestions for clinicians about using feedback and, more in general, to optimise the match between treatment on the one hand and the client and the client context on the other.
To provide clinicians with inspiration, the thesis includes three essays that sketch out a number of discussions relating to practice, further considerations and models that can help clinicians to guide the process of attunement to the client and relatives.
The essays are followed by three research papers that describe how the use of client feedback was studied in an emergency service and present the results of the study. In addition, a fourth research paper describes a study of another component of the process of attunement to the client context, namely the involvement of relatives in treatment. This was an observational patient control study looking at whether a link could be found between the involvement of relatives and the outcome of the treatment for the client.
The findings of the research covered by this thesis are then discussed in general terms, a number of methodological considerations are reviewed, the implications of the findings for practice are discussed and, finally, recommendations are made for further research.

Introduction

The introduction describes how the use of feedback is based on a theoretical model referred to as the *contextual model*. The core idea behind that model is that it is not specific models that account for the effect of psychotherapy but general therapeutic factors that are common to all forms of therapy. These are 1) an authentic, sound alliance 2) the creation of

expectations and 3) carrying out treatment actions. It is also assumed that therapeutic effects are the result of social processes and that the results therefore have to be evaluated in the social context as well, with the alliance being seen as the crucial factor. From this perspective, psychotherapy is primarily a 'healing ritual' in which the specific content is not important (within ethical boundaries) as long as the therapist is able to put the substance of the approach across in a convincing way. In addition, in this view, the match between the therapist and the patient – and therefore the personal characteristics of both – determine to a major extent the effectiveness of the approach.

The principles underlying the contextual model contradict, in a number of respects, the principles underlying the model which dominates psychotherapeutic research: the medical model. In particular, the assumptions of the medical model that the type of therapy and specific therapeutic elements in of the therapy determine effectiveness, and that the personal characteristics of the participants in the therapeutic process are of secondary importance, are at odds with the principles underlying the contextual model.

The introduction then goes on to describe a number of dilemmas in the relationship between science and practice, describing a spectrum with, at one end, the 'intuitive therapist' who derives his inspiration mainly from striking cases and ideas that he can use in his own practice and, at the other end, the 'scientist' who primarily wants to identify replicable models that are based on statistics and that can be used in multiple settings. It is argued that the 'scientist-practitioner' can, in this conflict, be a bridge-builder who draws on and produces both inspiring essays and scientific studies.

Turning to the second focus of this thesis, the involvement of relatives in treatment, it is noted that many guidelines advise involving relatives in treatment but that this happens only little in practice.

Finally, the author argues that engaging in a research project can be seen as a healing ritual for the therapists that strengthens their belief in their own abilities.

Chapter 2: *A triple-role model for the psychiatrist: a scientific, contextual and personal approach in psychiatry*

This essay aims to encourage therapists to think about the different roles they adopt and the importance of switching between these roles in order to achieve the best possible match with the client and his preferences. A triple-role model is proposed in which each role is linked to a conceptual framework, a conversation form, a specific discourse, and an appropriate form of feedback.

It advocates a different interpretation of the role of the psychiatrist and argues that the traditional psychiatric 'therapeutic discourse' does not provide adequate opportunities to express the added value of different roles and conceptual frameworks.

Chapter 3: *'Your wish is my concern': the importance of role selection and surprise in the attunement process*

This essay provides ideas and suggestions for therapists relating to the use of different roles in the search for attunement to the client at the outset of the treatment.
In order to give an affirmative answer to the client's crucial question 'Can this person help me?', the therapist must establish both a professional and a personal connection with the client during the very first treatment contact. The triple-role model can serve as a guide in this respect. In addition to demonstrating professional and personal role fulfilment, the therapist will also have to instil confidence that he can both provide a safe setting and help to bring about the desired change. The therapist can draw on the tension between validation and challenge to create surprises which introduce hope of change. Finally, because adjustment is a unique personal process, the therapist will have to ask constantly for feedback from clients and relatives to check whether an adequate connection is being established.

Chapter 4: *It is my friend who shows me my shortcomings: client feedback as a guide for treatment*

This essay describes the background to feedback and aims to encourage therapists to use feedback. It notes that the alliance is by far the most important of the known therapeutic factors in psychotherapy and that the therapy model used plays a much smaller role. However, researchers and therapists are still investing large amounts of energy in developing new 'evidence-based' models. This is not improving the effectiveness (in other words, the outcomes) of psychotherapy and so a paradigm shift is needed: the alliance and the outcomes should be centre-stage rather than the model.
The personal responsibility of the therapist for the results of his treatments is also emphasised and a description is given of the principles of patient-oriented research, feedback in general and more specifically the Partners for Change Outcome Management System (PCOMS). This systematic and formalised feedback system obtains feedback from the clients about the quality of the alliance as they perceive it and the effects of the therapy at each session. The premise is that the treatment approach will be adjusted in good time in consultation with the

client and so the results of the treatment will be improved and drop-out will be reduced. In addition, using this method results in interesting therapeutic possibilities.

Chapter 5: *The study design: the 'randomised controlled trial'*

This article contains a description of the design of the study of the effectiveness of immediate patient feedback in emergency therapy delivered by the Arkin Crisis Intervention and Brief Therapy Team, which provides crisis intervention and short-term treatment for clients referred to the team during a crisis.
The thinking behind the study design and the benefits and advantages of the design are described, in addition to the underlying principles of the PCOMS, which was the feedback instrument used.
PCOMS rates satisfaction with the alliance and the outcomes of therapy using simple scales: the 'Outcome Rating Scale' and the 'Session Rating Scale'. The Outcome Rating Scale, in Dutch the 'Hoe gaat het met u?' form, scores client assessments of various areas of their functioning and it is completed at the start of the session. It consists of one A4 form with four lines (*visual analogue scales*), each of which relate to one aspect of client well-being: 'individual', 'relational', 'social' and 'general'. The client places a cross on each line to describe his functioning in the previous period. The Session Rating Scale, in Dutch the 'Hoe vond u de bijeenkomst?' form, measures various aspects of the alliance and it is completed at the end of the session. It looks at four aspects of the treatment session: the relationship, the goals, the approach and the session as a whole.

Chapter 6: *The effect of feedback on the treatment results*

This article describes the results of the comparative study of the groups of clients who were treated with and without feedback. Contrary to what the authors had expected, the results in the group with immediate feedback were not found to improve in this emergency psychiatric setting. Indeed, after six weeks, the group receiving feedback actually performed worse. In other words, the *treatment as usual* group did better than the feedback group.
This result contradicts a number of previous studies looking at the effects of the feedback tool used here, the PCOMS, in other treatment settings, where outcomes were found to improve considerably when this feedback instrument was used. As far as we know, this is the first study to find that immediate feedback in psychiatry is not successful and can even be counter-productive.

An explanation could be that patients did not benefit from feedback because they were in crisis and so they were unable to reflect adequately about the therapeutic process and, in addition, were repeatedly confronted by their poor functioning and therefore became demoralised.
If this is true, immediate feedback should not be used with patients in crisis situations. Another possible implication is that the effect of direct feedback is linked to the treatment setting and the level of patient functioning and it would therefore be better not to use feedback either in some other patient groups.

Future research should indicate whether the level of functioning and the patient's ability to reflect (or rather the lack of that ability) undermine the effect of feedback. Because the negative effect of feedback would not have emerged if this study had not used a separate measuring instrument alongside the feedback instrument, studies of this kind should include independent outcome measures to prevent bias as a result of socially desirable scoring in the feedback process.

Chapter 7*: Effect of feedback on the alliance*

This study describes the effect of feedback on the alliance, in the same study population as in the previous chapter, as part of the same study. Feedback about the alliance was obtained by scoring and discussing the Session Rating Scale*,* which is included in the PCOMS. Clients and therapists scored the perceived quality of the alliance every six weeks using a separate questionnaire (the HAQ-II). Once again, contrary to the expectations of the researchers, feedback was not found to have a positive effect. Feedback did not affect either the quality of the alliance or the difference between how clients and therapists rated the alliance. Since this study was, as far as is known, the first to look at the link between immediate feedback about the alliance and the perceived quality of the relationship using a separate measuring instrument, so a comparison with the results of other studies is not possible.

The results may indicate that using the alliance-oriented Session Rating Scale has no added value in the feedback process. This could imply that the positive results of feedback found previously are primarily a result of feedback about outcome scores (from the Outcome Rating Scale) and not of feedback about the alliance. If this is true, formalised feedback about the alliance can be left out of the feedback system.

One possibility is that more specific training is required for therapists in order to benefit from feedback about the alliance. Training of this kind should not focus on the content

of the feedback, but on the attitude needed to receive feedback constructively. More research is needed to confirm this hypothesis.

In general, the scores found in this study with the Session Rating Scale support the idea that scores in European studies are lower on average than in studies in the USA. This suggests that the alliance scores must be interpreted in the cultural context and the context of the specific treatment and no fixed international thresholds for determining the adequacy of alliances should be set.

Chapter 8*: The involvement of relatives and its relation to treatment outcomes*

An observational patient-control study based on the data from the study described in the previous chapters was conducted to determine the extent to which the therapists in the Crisis Intervention and Brief Therapy team were successful in involving relatives and to see whether a link could be found between the involvement of relatives and treatment outcomes. Using a model for the systematic motivation of clients, it proved to be possible to involve the relatives of approximately two-thirds of the emergency psychiatric patients.

This can be considered a high rate given that the involvement of relatives in treatment is surprisingly infrequent and the fact that some patients hardly have any contacts with their families. However, it can also be thought of as a fairly low percentage given the strong commitment of the therapists in the Crisis Intervention and Brief Therapy team to involving relatives. This study also found that 'living alone' was a negative predictor of family involvement.

The results for the clients whose relatives were involved were compared with the results from the group whose relatives were not. In this open study, treatment outcomes – including patient satisfaction – were the same. This suggests that there is no reason to be reticent about involving relatives.

A randomised study would be needed to state with more certainty whether the involvement of relatives in a crisis situation has no added value for the client. However, a study of this kind will not be easy to implement.

This study did not look at the burden on relatives or levels of satisfaction among family members and so no conclusions can be drawn about the effect on them.

Chapter 9: *Discussion*

This chapter begins with a critical appraisal of the outcomes of this study. First of all, there is a discussion of the methodological considerations relating to the study design. It is

argued that the design of the study is appropriate for the underlying principles of the contextual model – the meta-theory upon which the use of feedback is largely based – in the sense that all therapists participate in both conditions and so the differences (in personal efficacy) between therapists do not affect the comparison of the groups. The drawback of this decision is that there can be 'interference' because therapists may apply elements of the feedback method without thinking in the other group or vice-versa. A strength of this study is that it was conducted in a naturalistic setting. However, this also generally involves a number of objections and restrictions: a pre-randomisation procedure was required, and the duration and number of sessions varied widely. There was also no check to determine the extent to which the feedback was used consistently.
A limitation of the study of the involvement of relatives is that the groups were formed on the basis of the willingness of client and relatives, leading to a selection that makes the interpretation of the results difficult.

The fact that, in addition to the feedback instruments, several questionnaires were completed that measure (among other things) symptoms, well-being and the alliance is a strength of this study that sets it apart from many previous studies of feedback. The adverse effect after six weeks of using feedback would not have been found if separate measuring instruments (BSI and OQ45) had not been used since the scores on the Outcome Rating Scale did not identify this negative effect.

As for the clinical implications, it must be noted that the disease burden and the level of functioning of the clients in this study were so high that caution is advisable when making comparisons with other populations.

Secondly, this chapter makes recommendations for clinical practice.
Situational factors may mean that immediate feedback should not be used. This applies to acute crisis situations: immediate feedback is not advisable here. A similar consideration may apply to client factors: when the personality structure of clients leaves little leeway for reflection, feedback will also have little added value. Turning to therapist factors, the negative effect of feedback may be the result in part of the undermining of the therapist role, particularly in situations in which therapists who have adopted the expert role ask for feedback about the alliance. In this situation trust in the expert could be undermined because that same expert invites the questioning of his own approach. The nature and form of the feedback process should therefore perhaps be determined in part on the basis of the role

adopted by the therapist. In situations in which the therapist predominantly adopts the role of expert, it will probably be better not to ask for formal feedback about the alliance.

The client should therefore always be asked for feedback in a way that is appropriate for the therapist, the client and the context in accordance with the underlying principles of the contextual model. During this process, the possibility of the patient giving socially desirable scores should be kept in mind. For the time being, it is unclear whether formal scoring of the alliance results in better collaboration. It should also be kept in mind that feedback scores seem to be culturally sensitive and so scores must be interpreted in the light of the local context.

Finally, it is noted that there is a paradoxical situation in mental health care: research has shown that all treatment models are equally effective but that therapists still continue to embrace new models. This can be explained by the fact that all parties involved in mental health care are systematically committed to the search for new and improved models. This leads to the wasting of financial resources, the undermining of professional self-confidence among therapists and unrealistic patient expectations. The author argues that therapists should be aware of this paradoxical situation and that they should emphasise the limitations of our understanding of the therapeutic process. Because no treatment model is better than any other, therapists can feel free to choose the model that best suits them on condition that they check to see whether the model is also appropriate for the patient.
This means that, in the present state of affairs, the scientist-practitioner must accept that he is constantly looking for the optimal combination of – unreliable – intuition and –limited – knowledge. Ultimately, this requires *phronesis,* practical wisdom.

Thirdly, the chapter sets out recommendations for further research.
Research will be required to decide whether the capacity for reflection and the level of the disease burden (whether or not determined by the actual situation) affect the possibility of benefiting from feedback. Studies of this kind should include separate measuring instruments in addition to the feedback instruments in order to correct for socially desirable scores on the feedback instrument.

Furthermore, research will be needed to determine whether formal immediate feedback about the alliance results in better collaboration and/or better therapy outcomes. The design of future studies should include the influence of the therapist as a variable; differences between therapists can be eliminated as much as possible by allowing therapists to participate

in both conditions. However, care will then have to be taken to eliminate bias resulting from commitment to a particular model.
Research will also be needed to see whether the involvement of relatives in crisis situations results in better treatment outcomes and generates added value for the relatives.

Finally, a conclusion will need to be drawn about whether the medical model or the contextual model represents a better point of departure for the further development of the field of psychotherapy. If there are no breakthroughs in either area, it will be necessary to contemplate seeing psychotherapy more as an art than as a science, with scientific research primarily serving to set out the boundaries of the discipline and not to determine the specific treatment actions. The emphasis will then be more on qualitative than on quantitative research.