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## Feedback Informed Treatment in emergency psychiatry, a poor FIT?

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# *CHAPTER 1 INTRODUCTION*

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## 1.1 Personal note: why this study?

I have been working in a Crisis Intervention & Brief Treatment Team (Crisis Resolution Home Team) since 1985. At that time, there was a lot of experimentation in mental health looking at interventions for clients in crisis situations. The aim was to provide them with other and better prospects than the traditional medical-psychiatric model could offer. Rather than thinking about a crisis as an undesirable phenomenon that needed to be neutralised as quickly as possible – a process that was often limited to deciding whether a compulsory admission was needed – the field was looking at how the onset of the crisis could be understood in context and how the crisis could be used to introduce change.

The urge to understand the context of crises resulted in a new and inspiring approach based on the principle that relatives should be involved in treatment and that treatment plans should meet the needs, expectations and preferences of both clients and relatives. The frame of reference shifted from an individual to a systemic approach, the idea being that the therapist inevitably participates in the system he seeks to observe and therefore should make a careful appraisal of his own role in the process of change. This led to the development and description of treatment strategies (van Oenen et al., 2007) in the belief that successful treatment depends crucially on optimal collaboration with clients and relatives.

Furthermore, I came to realise that treatment delivered by bona fide therapists in no way ensures that clients feel helped or improved because many clients were referred to the Emergency Psychiatry department in the middle of their psychotherapy, arguing – fairly or unfairly – that their therapist was not providing them with adequate therapy.

In 2006, I got in touch with the psychologists Scott Miller and Barry Duncan. They had developed the Partners for Change Outcome Management System (PCOMS), a way of using client feedback to improve treatment results that was based on a radically different approach to psychotherapeutic research and practice. I felt inspired by their approach and their enthusiastic presentations and so I followed a course with them and was able to convince my management to use this method in the Emergency Psychiatry unit.

I was also inspired by Miller and Duncan's book, *The Heart and Soul of Change* (Duncan et al. 2010), in which they set out the theoretical basis for the need to connect to the 'theory of change' and the preferences of clients and their relatives. Their argument relies heavily on the extensive meta-analyses of researcher Bruce Wampold, who concludes in *The Great Psychotherapy Debate* (Wampold & Imel, 2015) that no psychotherapy model is more

effective than another (the ‘Dodo Bird Verdict’) and that ‘common factors’ predict outcomes of treatment better than the specific treatment method or the qualifications of the practitioner.

My own thinking about clinical practice concurred with these research findings and so I began to read further about the background and active ingredients of psychotherapy and to think in a more scientific way about treatment outcome. I consulted the Arkin research team and we decided that it would be useful and interesting to combine the implementation of the feedback method with a study of its efficacy. We were able to combine this with a study of another treatment approach I believed to be valuable: the involvement of relatives in psychiatric treatment in general and emergency treatment in particular.

This was the moment that I switched from being a ‘practitioner’ and ‘believer’ to a ‘researcher’. In other words, I was willing to put my convictions to the test of science. I also went on to think about models and theories that elaborate different aspects of the common factors: connecting with the client, the attitude and role of the therapist, and the involvement of relatives in treatment. I published a number of essays about these themes.

The interest in the effects of feedback in Emergency Psychiatry resulted in a randomised trial, which was followed by the associated papers discussing the impact of client feedback, and other papers looking at the effect of involving relatives.

This thesis includes both my essays and the research-based papers, with the essays coming before the research articles. However, this order does not reflect a hierarchy or chronology, since ideas emerged and developed during and in reaction to the research process. Clearly the layout of a book provides no opportunity to reflect this simultaneous interaction – one section has to follow the other – and so a necessarily arbitrary order had to be chosen.

## 1.2 Feedback principles

Principal research showed, in a range of meta-analyses, that all bona fide psychotherapy treatments are, in broad terms, equally effective (Wampold et al., 1997; Cuijpers et al., 2008; Imel et al., 2008; Miller et al., 2008). This finding, in combination with economic considerations, has led to a search for methods that improve treatment outcomes in ways other than those resulting from traditional treatment-model-oriented research. This search resulted in the emergence of a new paradigm for evaluating psychotherapy that was introduced by Howard et al. (1996): patient-focused research. The central focus of this type of research is on monitoring, modelling and predicting individual treatment progress and providing feedback about this information to therapists (and patients) during the course of

treatment (Lueger et al., 2001; Lambert, 2007). In this ‘feedback-informed treatment’ (Miller et al., 2011), therapists are supposed to identify patients at risk of treatment failure at an early stage and to make changes to their approach when necessary (Howard et al., 1993; Brown et al., 1999; Lambert et al., 2001; Lambert, 2007; Whipple et al., 2003; Duncan et al., 2010; Miller et al., 2013).

Several feedback systems have been developed that provide therapists, patients or both with information about patient progress on a session-to-session basis (Lambert, 2007; Knaup et al., 2009; Carlier et al., 2010; Miller et al., 2013). The assumption in this feedback-informed treatment is that clients feel more engaged in the therapy and that therapists are better able to adapt their therapeutic approach when feedback information suggests that treatment is unsuccessful (Lambert, 2007; Duncan et al., 2010; Hannan et al., 2005). In a meta-analysis incorporating nine studies of feedback, Lambert & Shimokawa (2011) found effect sizes varying from .23 to .33. These are effects in the range of other determinants of outcome such as the use of antidepressants (ES .31, Turner et al., 2008) and psychotherapy (ES .39, Driessen et al., 2015) for depression. Lambert & Shimokawa (2011) concluded that the number of psychotherapy patients who deteriorate in routine care (5-10% in adult psychotherapy, 14-24% in child psychotherapy) could be reduced by half if their feedback method was used. However, a recent meta-analysis from the Cochrane Library (Kendrick et al., 2016) on the routine use of patient-reported outcome measures (for improving the treatment of common mental health disorders) found only very small differences between feedback and no-feedback groups in terms of outcome. The authors concluded that no firm conclusions can be drawn because the evidence was of low quality and that more trials are therefore needed, preferably using short measures like the Outcome Rating Scale and measuring a range of relevant symptom outcomes, as well as the possibly harmful effects of monitoring.

Since the alliance has been shown to be one of the strongest predictors of treatment success that research has been able to document (Hardy et al., 2007; Falkenstrom et al., 2014), this became a focus of feedback as well. Patient ratings of the therapeutic relationship between sessions 3 and 5 were shown to provide reasonable predictions of treatment outcome (Horvath et al., 1991) and a low score for the quality of the alliance emerged as a predictor for the premature termination of treatment (Safran et al., 2011; Sharf & Primavera, 2010). Furthermore, acknowledging and repairing ruptures in the alliance is strongly linked to positive treatment outcomes (Safran et al., 2011; Mc Laughlin et al., 2014). The use of patient feedback may be very helpful in this process since therapists and clients tend to rate the

quality of the alliance differently (Shick Tryon et al., 2007) and – probably for the same reason – therapists often find it difficult to identify ruptures (Hannan et al., 2005; Hatfield et al., 2010). This supports the idea that monitoring the alliance on a session-by-session basis is important to allow therapist and client to identify and repair ruptures in the alliance (Duncan et al., 2003; Miller, 2004).

The inclusion of feedback may prove particularly valuable in a psychiatric population since non-attendance levels in psychiatry are substantial, especially in the group with severe distress (Duncan et al., 2010; Mitchell et al., 2007). Duncan et al. (2010) stated that patients who have lost their sense of mastery and their faith in therapy can be expected to feel more empowered when their views and preferences are explicitly taken into account in a feedback process.

Monitoring the alliance may be especially valuable in emergency psychiatric settings since treatment is needed immediately and a relationship of trust with the patient needs to be established in a very short time (van Oenen et al., 2007).

### **1.3 Conceptual considerations: medical model and contextual model**

Feedback informed treatment is rooted in ‘patient-focused research’ (Castonguay et al., 2013). Instead of studying particular treatments for particular diagnoses, as in clinical trials, patient-focused research focuses more on the improvement in real time of the actual treatment as implemented and the development of tools in order to achieve this goal (Lutz, 2002). This patient-focused research is part of a form of practice-oriented research called ‘practice-based evidence’ that aims to reprivilege the role of the practitioner as a central focus and participant in research activities. In this approach, every therapist is responsible for achieving commendable outcomes, regardless of the treatment he selects. Practice-based evidence claims to offer an alternative to ‘evidence-based practice’ on a practical level. On a conceptual level, the fundamental principles of practice-based evidence are described by Wampold in the ‘contextual model’ (Wampold, 2001).

Wampold and Imel (2015) argue that evidence-based practice and its roots in the medical model are inappropriate for field of psychotherapy and that research in recent decades supports the view that the medical model has little to offer for the development of the field since all comparisons show that no treatment method is superior to another (‘the Dodo Bird verdict’). The alternative, the contextual model, starts from the idea that specific methods and

techniques have no relation to the outcome of therapy, and that the effect of therapy is attributable to common factors that are characteristically present in all effective therapies. Common factors are defined and categorised in different ways by different authors. Tracey et al. (2003) identified fourteen common factor categories that can be used to code clients' perceptions of helpful therapist actions (such as the intervention or the way of being) in short-term psychotherapy. They found three clusters: Bond (which includes Insight and Relationship), Information, and Structure of therapy. Owen et al. (2010) identified three somewhat different client clusters based on patient perceptions of helpful therapist actions: Insight (44%), Relationship (30%), and Information (26%).

In the contextual model, the common factors are defined in a broad sense, and they concentrate on three elements: 1) a genuine, good alliance 2) creating expectations and 3) carrying out treatment actions. Furthermore, in the therapy process, the effect results from social processes and so it has to be evaluated in the social context, with the alliance as the crucial factor. This is an elaboration of the model of Frank & Frank (1991), who argue that therapy is a healing art involving a common faith (or rationale or 'myth') and a ritual as healing factors.

Although feedback has its roots in the contextual model, it is still unclear how feedback can boost 'the healing ritual'. If we look at the three key elements in the contextual model (the working alliance, creating expectations and carrying out meaningful actions), it is not unreasonable to argue that feedback affects all three elements. Firstly, the introduction of the method explicitly creates the expectation that 'the scores of the ORS (Outcome Rating Scale) will rise'. Secondly, therapists engage in various actions in response to feedback (Castonguay et al., 2013). Thirdly, there is a focus on collaboration and the alliance, particularly in the Partners for Change Outcome Management System, which includes a separate scale for evaluating the alliance.

### *Research as a common factor?*

Effective implementation of outcome monitoring is not easy (De Jong, 2016) and research in a naturalistic setting in general is difficult because it interferes at many levels in daily practice. However, it is also inspiring because it makes therapists look more closely at their own 'natural' assumptions, the implicit arrangements and rules in the treatment team and the logistics in their organisation. It introduces new elements as well: enthusiasm for a new experiment, different forms of cooperation, renewed peer review and supervision, empowerment of the therapists and appreciation of each other's work.

In this sense, the implementation of a research project can be seen as a healing ritual for the practitioners. New cooperation is initiated, an expectation is created, change and specific actions are taken. In this way, therapists' faith in their own strength is boosted. It does not seem far-fetched to assume that this will also improve the ability of therapists to create positive expectations in the patients and therefore to improve treatment results. This implies that the implementation of research could be seen as mediating factor for better outcomes in the treatment process. This sheds a somewhat different light on the well-known phenomenon that treatment outcomes in controlled research settings (*efficacy*) are often better than in the naturalistic environment (*effectiveness*): seen in this way, scientific research can be seen as one of the common factors in psychotherapy.

### 1.4 Involving relatives

Research shows that couple- and family-based clinical interventions address a wide range of clinical problems, like psychosis, bipolar disorders, substance abuse and behaviour problems, with strong evidence of effectiveness (Sexton et al., 2013). Collaboration with patients' relatives results in fewer inpatient admissions, shorter inpatient stays and better quality of life reports by patients (Eassom et al., 2014). Furthermore, it is widely accepted that relatives should be involved in the treatment of patients and that they are entitled to receive information and support, as noted in a Dutch guideline setting out an approach for working with relatives, the *Modelregeling Naastbetrokkenenbeleid* (GGZ Nederland, 2004).

However, family involvement may not always improve results (Miklowitz, 2004) and involving relatives in an effective way takes time: Cuijpers (1999) found that interventions of less than ten sessions have no effect on the family burden, and Pitschel-Walz et al. (2001) found that family psycho-educational interventions are most effective when they last at least three months. Finally, data are lacking about relatives' emotional involvement as a predictor of which clients respond best to family-based interventions (Fredman et al., 2015). Notwithstanding these difficulties, international guidelines have been outlining in detail the importance of early family involvement for over fifteen years (APA, 2000; guideline of Dutch Psychiatric Association, 2012). However, despite the vast evidence base in favour of family interventions, family involvement is often not a feature of routine mental health care (Eassom et al., 2014; Maybery et al., 2014; Kim and Salyers, 2008). Burbach and Stanbridge (2006) reported that the number of contacts with family members of psychotic patients increased after staff members were trained in systemic therapy, but studies looking specifically at



CRHT teams (Murphy et al., 2012; Wheeler et al., 2015) have not provided specific information about the effect of involving relatives.

There has been only one study (Cramer et al., 2009) reporting specifically on this issue in an inpatient emergency setting. These authors found no improvement in outcome after implementing a systemic treatment model. To our knowledge, there have been no studies of the effect of collaboration with relatives on the symptoms and well-being of patients in Crisis Resolution and Home Treatment teams.

## **1.5 The relationship between science and practice**

Science and practice in mental health care have a long and complicated combined history. The term ‘scientist-practitioner’ was launched as early as the 1940s (Frank, 1984) with the aim of encouraging therapists to integrate scientific findings in their practice and, at the same time, to establish directions for scientific research based on their clinical experience. Seen from this perspective, there is a spectrum of combinations of science and practice with, at one end of the spectrum, the ‘intuitive practitioner’ primarily focusing on practice and, at the other, the ‘clinical scientist’ focusing primarily on science (Hutschemakers, 2014).

**Intuitive practitioner (trusting completely in his own experience)**

**Reflective practitioner (making implicit knowledge explicit)**

**Scientist-practitioner (combining perspectives)**

**Evidence-based practitioner (applying protocols)**

**Clinical scientist (trusting completely in science)**

The motivations and perspectives of the two extreme positions in this spectrum, the clinical scientist and the intuitive practitioner, differ greatly. One might say that the scientist strives to make the personal universal and that the practitioner strives to make the universal personal. The intuitive practitioner is motivated by the question: what inspires me? The clinical scientist thinks: what works best and how does it work? Both adopt specific discourses: the intuitive practitioner prefers an inspiring story without complicated figures that he can apply in his own work immediately. The clinical scientist prefers a meta-analysis that is written as factually as possible so as to be able to evaluate the applicability of the findings in different settings. The preferred form for the practitioner is therefore the essay with case studies, and the preferred style for the scientist is the study report with tables (van Oppen, 2015).

Both will be reluctant to accept the style and language of the other: scientists will disregard ‘believers’ stories’ and practitioners will have an aversion to pages full of incomprehensible numbers.

Scientists prefer, as it were, a small cup of the most concentrated espresso, whereas practitioners want an extra-large frothy latte with a flavour (vanilla / almond?) of their own preference, and both are horrified by the taste of the other. And at the same time, a practitioner will prefer more of these coffee metaphors to visualise the discourse and a scientist will wish to eliminate them since they provide no factual extra information.

Though both ends of the spectrum may represent a somewhat caricatural position, the gap between science and practice is still wide. Here, it is the scientist-practitioner who bridges the gap most adequately. And although one might argue that the evidenced-based practitioner could also fulfil this role, since evidence-based practice in principle integrates both individual clinical expertise and the best available external evidence (Sackett et al., 1996), the way positions are sketched in the spectrum would seem to be an adequate representation of the gradual shift of focus from the science-oriented academic view to the narrative-oriented non-academic view. To bridge the gap, the ideal go-between (the scientist-practitioner) understands both the academic language of the clinical scientist and the intuitive language of the practitioner, and translates the one into the other. He reflects on practice in essays, adopting the stance of a ‘reflective practitioner’, while at the same time publishing research articles adopting the stance of an ‘evidence-based scientist’.

The scientist-practitioner should therefore be familiar with both the style and language of the essay and of the academic research article. This implies that he will use both the language of the narrative and the language of scientific research to encourage both scientists and practitioners to develop new insights. Accordingly, he should write both essays and research articles in order to fulfil his task as a go-between as well as possible.

In essays, the aim is to make some implicit frameworks explicit for the reflective practitioner and to provide tools for reflection in daily practice; in research articles, the aim is to assess the efficacy of specific interventions and to put forward new hypotheses for assessment and appraisal in academic studies.

This thesis draws on the ‘discourses’ and expressive styles of both the practitioner and scientist.

Switching between the practitioner and scientist places a lot of demands on the average clinician, whose own convictions have to be stated as open hypotheses, and whose own questions need to make way for general questions, while axioms of day-to-day work

have to be reworked critically to produce formal descriptions. And the individual motivation ('this method appeals to me, I work here, so I use this method') has to be combined with a general scientific question ('What makes this method appropriate, what makes this method relevant for my area of work and how do I implement this method optimally?').

Personal motives must also be conveyed to the institution, to managers who must give consent, to colleagues who have to implement the method systematically and to a research team that has to collect the data properly. The implementation of the method must be designed to make it possible to appraise the effects of the method. In this study, this meant that therapists were required to operate in both conditions (see section on design). Fortunately, this approach was a good match for the most feasible logistics in the setting of emergency psychiatry.

Hutschemakers (2014) writes that the scientist-practitioner has to be a doubter by nature, in the sense that this doubt does not reflect a lack of self-confidence, but a methodical doubt. He states: 'The added value of the scientist-practitioner comes from his sense of professional and scientific limitations' (p.39).

The discussion section analyses the paradoxical quest of the scientist-practitioner combining self-confidence and doubt.

## **1.6 Study setting**

The study setting was a Crisis Intervention & Brief Therapy team (CIBT team/Acuut Behandelteam) in Amsterdam where patients with severe psychiatric and psychosocial problems are treated on an outpatient basis for a maximum of six months. Patients are referred by GPs, mental-health workers and the police. An indication for treatment by the CIBT team is based upon the need for immediate help felt by the patient or referring professional. 'Crisis' is defined as: the patient needs help within 24 hours due to a risk of suicide, serious behavioural problems, problems with the law and safety concerns, a sudden loss of social support and/or need for involuntary admission.

The CIBT team works from a trans-diagnostic perspective, which means that the assessment is not based solely on the diagnostic category but on the overall presentation of symptoms, and the needs and capacity of the patient and relatives. The need for acute help or treatment is integrated with a diagnostic screening and interventions are initiated immediately if necessary. The group of participating therapists consists of a highly experienced permanent staff of six psychiatrists, ten social psychiatric nurses, two psychologists and a family and marital therapist. In addition, the team includes a group of – on average – eight experienced

and intensively supervised residents in psychiatry who each work at the CIBT team for a period of six months.

## **1.7 Aims, research questions and hypotheses in this study**

### **General aims**

In the light of these background considerations, the following general aims can be formulated and elaborated in research questions accompanied by a hypothesis that is linked to each question.

#### **Aim 1: Feedback and outcome**

To investigate the effect of applying feedback about treatment outcomes in a population of patients in emergency psychiatry.

Q.1 Does applying immediate feedback at each treatment session in a psychiatric setting involving intensive outpatient care following a crisis evaluation result in better outcomes, higher client satisfaction and more efficient treatment (shorter treatment duration) compared with the no-feedback condition?

#### **Aim 2: Feedback and alliance**

To investigate the effect of applying feedback about the quality of the alliance in a population of patients in emergency psychiatry.

Q.2: Does applying immediate feedback at each treatment session result in improvements to the alliance; and is there a link between any improvement in the alliance and improvements in treatment outcome?

#### **Aim 3: Involvement of relatives and outcome**

Q.3: In a naturalistic emergency psychiatry setting in a population of patients with different diagnoses, to what extent do the therapists of the CIBT team manage to involve relatives in treatment and does the involvement of relatives affect treatment outcome?

### **Hypotheses**

The four hypotheses link up with the four research questions. The number of each hypothesis corresponds to the number of the associated research question. The hypotheses are based on findings in previous research.

H 1. Applying feedback at each treatment session in a psychiatric population with severe distress results in better outcomes (fewer symptoms, enhanced well-being) and higher satisfaction than in the no-feedback condition (Chapter 6).

H 2. Applying session-by-session feedback about the working alliance, goals and cooperation will improve the quality of the alliance over the course of treatment in an acute psychiatric setting. In addition, there will be greater congruence between client and therapist scoring of the alliance (Chapter 7).

H 3. In a naturalistic emergency psychiatry setting in a population of patients with different diagnoses, the therapists of the CIBT team, when encouraging clients to involve relatives, will manage to involve relatives in treatment in almost all cases (Chapter 8).

H 4. Outcomes of treatments in which relatives are involved will be better than the outcomes of treatments in which no relatives are involved (Chapter 8).

## **1.8 Content of the thesis**

Chapters 2, 3 and 4 are essays that formulate ideas about clinically relevant aspects of applying feedback, connecting to clients and cooperating on goals and targets. The essays are primarily intended to encourage therapists to reflect on their role and attitude, and offer them a framework and a language to discuss their intentions and actions in a systematic way.

### Chapter 2

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

The aim of this essay is to encourage therapists to reflect on the different roles they fulfil.

### Chapter 3

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

This essay provides ideas and tips about how therapists can use different roles to build alliances with clients.

#### Chapter 4

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

The aim of this essay is to encourage therapists to use feedback.

#### Chapter 5

*Study design; efficacy of immediate patient feedback in emergency psychiatry: a randomised controlled trial in a crisis intervention and brief therapy team.*

This article contains a description of the study design of the randomised clinical trial.

#### Chapter 6

*Feedback informed treatment in emergency psychiatry: a randomised controlled trial.*

In this study the effect of applying feedback about the outcome of treatment is investigated in a psychiatric setting involving intensive outpatient care following a crisis evaluation.

#### Chapter 7

*Immediate feedback does not affect the alliance in short-term psychiatric treatment: a randomised controlled trial.*

The aim of this study is to investigate whether applying feedback affects the quality of the alliance as scored by both clients and therapists. There is also an analysis of the congruence between client and therapist scoring of the alliance.

#### Chapter 8

*Involving relatives in emergency psychiatry: an observational patient-control study in a Crisis Resolution and Home Treatment Team*

This study consists of an observational patient-control study investigating to what extent the therapists of the CRHT team managed to involve relatives in treatment and whether the involvement of relatives affected treatment outcome.

#### Chapter 9

*General discussion*

The final chapter provides a critical review of the main findings.

Furthermore, a meta-reflection is presented about the paradoxical position of the scientist-practitioner as it emerges from the outcomes of research.

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