Brief psychological treatment in mental care

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Summary

In the late 1980's clinicians from Dutch Community Mental Health Centres (CMHC's)\(^{11}\) started, for a variety of reasons, to experiment with brief treatments (BT's) limited to five or six sessions. Although at that time there was already quite some literature about short-term treatment at an international level, it seemed that the BT-programmes developed in CMHC's were not a copy of a particular treatment approach already clearly described and investigated. However, at the end of the last century, the number of CMHC's that implemented a BT-programme increased, partially because patients as well as clinicians became more interested in BT's. This thesis describes the results of two studies that we executed to get a better picture of the place and role of BT within specialised mental health care, of the patients that are allocated to BT and of patient characteristics that are related to 'successful' BT outcome.

The first study was a nation wide telephone survey in which all 57 CMHC's participated. Using a semi-structured interview data was gathered regarding the extent, place and nature of BT for adult patients in these CMHC's.

Partially based on the results of the survey, we undertook a second study in which patients allocated to BT in six CMHC's were followed over a period of eight months. These patients completed questionnaires before the first BT-session and two, four and eight months after the start of their BT. The clinicians of these patients also completed questionnaires; one before the start of BT, one two months after the start and one when BT was ended (or eight months after the start of BT in case it was still not ended by then). In selecting the six CMHC's we preferred centres that allocated an as large and heterogeneous as possible group of patients to BT (i.e. centres that in our first study allocated about 30 to 35% of their new patients to BT). Additionally we aimed at a good geographical distribution over the Netherlands.

In the general introduction (chapter 1) we describe why the mental health field became interested in briefer psychological therapies. We also give information about the methods and materials for the study within the six centres as well as the study sample. Furthermore, chapter 1 comprises the main research questions of this thesis:

- What is the state of affairs with respect to brief treatment in the CMHC's in 1998?
- What patient characteristics make clinicians recommend brief treatment?
- For which patients, allocated to brief treatment, is this treatment approach 'successful'?
- What is the relation between working alliance (between the patient and clinician) and brief treatment outcome?
- Can the 'stages of change' concept be used to describe change within a group of patients allocated to brief treatment?

\(^{11}\) In 1982 57 Regional Institutes for Community Mental Health Care (RIAGGs) were established in the Netherlands to guarantee a diversified set of ambulatory services. In the second half of the nineties RIAGGs started mergers with other regional organisations like mental hospitals and sometimes also psychiatric departments of general hospitals and regional institutes of sheltered living. In this article we will refer to these former RIAGGs and the 'new' organisation in which they have been incorporated, as 'Community Mental Health Centres' (CMHC's).
Although there is no consensus in the literature on the precise upper limit of number of sessions in short-term treatments, the results of the nation wide survey (see chapter 2) showed that in practice treatment programmes extending beyond six sessions are seldom regarded as brief.

Consequently, a treatment programme was defined as ‘brief’ if the following criteria were met:
- A clinician providing treatment within such a programme must start the treatment with the intention to end it within six or fewer sessions
- The treatment programme itself must be clearly established within the CMHC and the clinicians providing it must constitute a separate team
- It should be neither a crisis intervention programme, nor some kind of group treatment programme

Over two thirds of the CMHC’s had established a BT-programme early 1998 and many of the remaining centres had clear plans on starting such a programme in the near future. Whilst there seems to be agreement on the number of sessions within a BT-programme, the picture is less clear regarding the time-spread of BT-sessions. Furthermore, almost all CMHC’s lacked a specific theory, working procedure or protocol that described their BT properly. This is partly due to the fact that nearly all CMHC’s gave their individual clinicians considerable freedom in what they did, a situation which resulted in a wide variety of practices. On the other hand, there are few brief six-sessions treatment protocols available and the specific trainings were often also without any clearly defined protocol. It seems BT-clinicians require a broad therapeutic and psycho-therapeutic background combined with several years of practical experience. This enables these clinicians to be quick, flexible, and creative in applying the right interventions, developing a clear treatment focus and maintaining this focus throughout BT.

No clear answer emerged from our survey on the question which patients are eligible for BT, partly because patient allocation to BT was dependent on all kinds of internal and external CMHC factors. It was apparent, however, that when a CMHC offered BT, at least 10% of CMHC-patients were allocated to this programme. Depending on the organisational embedding of a BT-programme and the nature of the treatment goals, this percentage could rise to anywhere between 25 and 35%.

To assess which patients are actually allocated to BT and to compare them with patients that are allocated to an unlimited or long-term treatment programme, all patients from two CMHC’s (in which an average of 26% of the total patient-population is allocated to BT) completed some questionnaires before starting their treatment (see chapter 3).

After univariate analyses it appeared that the group of patients allocated to BT (n=71) differed ($P \leq 0.05$) from the group of patients not allocated to BT (n=145) on the following variables: patients are more likely to be allocated to BT when they are older than 50 years, have only primary education or less, have less avoidant copingstrategies, more self-esteem, an increasing desire to ventilate their feelings in treatment, and are more satisfied with the emotional support they receive, their social network and leisure time. There were also some U-shaped relations; low as well as high scores involving daily hassles make allocation to BT less likely compared to moderate scores. The same holds for ‘desire to confess’ as an intervention (i.e. want to talk about
their feelings of guilt), while the opposite is true for number of social activities. Some specific target complaints (anxiety, burn-out problems and problems in social contact in general) make allocation to BT less likely.

After stepwise logistic regression the final model contains (next to gender and age which we fixed in de model as potential confounders) the following variables: education, kind of most distressing complaint, daily hassles, emotional support, self-esteem, and support (i.e. the request for more support increases the chance of allocation to BT) and confession as intervention requests. When clinicians allocate patients to BT they pay attention to patients strengths, specific aspects of their lives in which they function well and on patients request for specific types of intervention. This shows that recommending BT only on the basis of kind and severity of the target problem resembles not what clinicians do in practice.

Chapter 4 assesses for which patients, allocated to BT, this kind of treatment is 'successful'. For 47% of the 176 patients who participated in this study was BT considered 'successful' according to our criteria (i.e. BT ended within six sessions with a positive treatment-result as rated by the patient).

First we assessed which patient-variables rated by the patients themselves were related to a 'successful' BT ($P \leq 0.05$). Univariate analyses showed that the following variables were related to BT 'success': the probability that BT is 'successful' is higher for those patients that are younger (<30 years of age), are more satisfied with the emotional support they get, have a more active coping style when encountering problems, are feeling more in control over their own life-chances (mastery), want less structure (i.e. needed the clinician less to take over responsibility) and less insight (search the subconscious and the past to understand why one gets in to trouble) as a treatment intervention. After stepwise logistic regression the final model comprised (next to gender and age which we fixed in de model as potential confounders) the variables 'active coping style' style and 'request for structure'.

We then assessed which patient-variables rated by the clinician were related to a 'successful' BT ($P \leq 0.05$). Univariate analyses showed that the following variables were related to BT 'success': the probability that BT is 'successful' is higher for those patients that are younger (<30 years of age), are functioning better (have a higher Global Assessment of Functioning -GAF- score), and have three or fewer different complaints. All these variables stayed, after stepwise logistic regression, in the final model.

It was possible to improve the final model based on clinician ratings with the variables from the final model based on patient ratings. When clinicians hesitate to allocate a particular patient to BT and they really wish to end BT within six sessions, it seems not wise to allocate patients who have more than three different target complaints, who have a relatively low GAF-score, who are overwhelmed by feelings and are less able to keep control over themselves (more helplessness), and have difficulty to be active when encountering problems.
In chapter 5 we assessed whether BT ‘success’ was also related to the working alliance between the patient and the clinician. Two months after the start of BT patients completed the Working Alliance Inventory. This questionnaire contains the following three scales: goal agreement, task agreement, and bond between the patient and clinician. It was found that more agreement on tasks or goals between the patient and clinician (according to the patient) made a ‘successful’ BT approach more likely. The amount of bonding between patient and clinician (as rated by the patient), however, was not related to BT ‘success’ in our sample. When all three scales were entered in a stepwise regression procedure with backward elimination only the scale agreement on tasks remained in the prediction-model. This variable could significantly improve the two multiple logistic regression models with baseline patient variables mentioned above. It seems recommendable to draw the clinicians attention to the fact that agreement on tasks (and goals) is very important in BT and that when they pay more attention to this fact they probably can help more patients ‘successfully’ within BT.

Because the group of patients allocated to BT is often heterogeneous with regard to target problems and treatment goals and because the primary aim of BT is not always a reduction of symptoms, it is difficult to find a good measure for treatment effect. In our survey many clinicians mentioned that the most important goal within BT is: offering patients, stuck in their process of change, the right tools to continue this process on their own. From a ‘stages of change’ perspective this could be described as ‘helping the patient to make a specific stages of change transition’. In chapter 6 it was assessed whether it was possible to make ‘stages of change’ profiles (SOC-profiles), on the basis of scores on the questionnaire ‘University of Rhode Island Change Assessment’, and whether such SOC-profiles change over a period of eight months.

At three assessment moments (respectively before the start of BT and at four and eight months after the start) we were able to allocate an average of 92% of 129 patients to one of six SOC-profiles. On baseline most patients were allocated to the profiles ‘Contemplators, taking some action’ and ‘Action stagers, still contemplating’ (respectively 63 and 26%). It seems possible to assess change in SOC-profile and to predict change with baseline variables like satisfaction with emotional support and feelings of control over ones life-chances (mastery). Nevertheless, evaluation of treatment on the basis of SOC-profile changes is not without problems. The relations we found between (changes regarding) different outcome measures and patients who were assessed at the same SOC-profile versus patients who made a SOC-transition were not easy to interpret. Future research must give more insight in what is actually measured when patients have the same or different SOC-profiles over time and how this relates to other outcome measures.

In chapter 7, the general discussion, the results of both studies are described and discussed. Because in practice one does not use a clearly described BT-protocol and clinicians are free to use a variety of interventions, BT provided within CMHC’s can not be characterised as a particular therapeutic method, but more as a treatment given by clinicians who share the same ‘basic BT-attitude’. BT-clinicians believe that many patients are able to work out most of their problems by themselves, but are demoralised at the time they ask for help within the CMHC. The goal of BT is hardly ever ‘total cure’, but to overcome demoralisation and providing the patients with the tools needed to continue the process of change on their own. Much used interventions
are: placing thoughts and feelings in a new perspective, reminding patients of their (neglected) strengths and competences, stimulating a solution-focused and active working attitude, and gently making patients more responsible for working on their problems. The 'basic BT-attitude' and the interventions mentioned are not restricted to a particular therapeutic approach. Some BT-clinicians work quite mono-methodical (e.g. directive, behavioural) others more eclectic.

The existing literature about the relation between patient-variables and short-term treatment outcome very seldom assesses brief six-session treatment with a heterogeneous group of patients. Some variables that we found to be related to BT-'success' in our study correspond with variables mentioned in the literature about short-term treatments in general. However, the variables we found pertain to situations in which a clinician has to allocate a patient to BT done by a clinician with the intention to end it within six sessions or fewer. In our study we also found a new variable, 'request for structure', as a predictor for BT-'success', which needs more research. Interestingly, for older patients the probability regarding a 'successful' BT was lower than for younger patients, although older patients were more likely to be allocated to BT. With regard to education a trend was found that when the level of education decreased the probability of a 'successful' BT decreased, although patients with 'only' primary education or less were more likely to be allocated to BT. Future research is necessary to give more insight in why these relation are found.

The naturalistic study design that we used has advantages and disadvantages. Our study design made it possible to assess what actually happens in BT and the results can be generalised to the clinical practice setting in the specialised mental health care. However our study design also poses some methodological problems. These are addressed in each chapter and are summarised in chapter 7.

This final chapter ends with suggestions for future research. We recommend, for example, to use in future research other outcome measures for treatment result as well as another limit with regard to the number of sessions. The limitation of six sessions is perhaps too restrictive. Research should also focus on the effect of specific interventions within BT (in relation to other treatment possibilities or no treatment at all) for specific patient-populations. The question is however, to what extent BT should be protocollised and where it should be situated in the centre. Regardless of all this, and apart from the fact that a group of patients wants to be helped in only a few sessions and clinicians seem to be satisfied with working in a BT-programme, there is a group of patients that benefit from BT. This group can probably increase when the effect of BT is seen within a 'stepped care approach'.