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Monitoring the Effects of Adult Psychotherapy in Routine Practice in Switzerland: A
Feasibility Trial

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Running Head: PSYCHOTHERAPY MONITORING IN ROUTINE PRACTICE

Monitoring the Effects of Adult Psychotherapy in

Routine Practice in Switzerland: A Feasibility Trial

Abstract

Several studies have been published on the effects of psychotherapy in routine practice. Complementing traditional views summarized as “dose-effect models”, Stiles et al. (2008) put forward data consistent with the responsive regulation model underlining the importance of the client’s active participant role in defining length of treatment. One may ask what level of change reached by a patient is considered to be the “good enough level” (GEL) and if it is related to the duration of psychotherapy. The main objective of the present feasibility trial is to monitor the patient’s session-by-session evolution using a self-report questionnaire in order to define the GEL, that is the number of sessions necessary for the patient to reach significant change. A total of $N = 13$ patients undergoing psychotherapy in routine practice participated in the study. They filled in the Outcome Questionnaire – 45.2 (OQ-45; Lambert et al., 2004), which assesses the symptom level, interpersonal relationships and social role after every psychotherapy session. The data was analysed using multi-level analyses (HLMs). High feasibility of fine-grained assessment of effects of psychotherapy in routine practice in Switzerland was shown; response rates being acceptable; however, detailed analysis of the GEL was not feasible within the short study time-frame. Finally, some reflections on the political context of monitoring in the specific case of routine psychiatric practice in Switzerland are discussed.

Key-Words: Clinical Governance; Outcome; Psychotherapy Monitoring; Routine Practice

MONITORING THE EFFECTS OF ADULT PSYCHOTHERAPY IN ROUTINE
PRACTICE IN SWITZERLAND: A FEASIBILITY TRIAL

In general, dose-effect models explain change across psychotherapy. These models are based on the pharmacological metaphor and imply that patients are passive receivers of psychotherapy, instead of active agents. Another way of interpreting dose-response relationships is the good-enough level (GEL) model. Indeed, it assumes different rates of change are to be seen with patients who come for different numbers of sessions (Barkham et al., 1996; Barkham et al., 2006; Stiles, Honos-Webb, & Surko, 1998; Stiles, Barkham, Connell, & Mellor-Clark, 2008). The GEL model puts forward the idea that patients will remain in therapy until they, in agreement with their therapist, determine that they have improved sufficiently, *i.e.* to the good-enough level. Therefore, treatment response is generally reflected in the dose of treatment which indicates the malleability of patients' symptoms; this contrasts with the dose-effect model which sees the patients' symptoms as the driving force of treatment response. Thus, the GEL model predicts that patients who receive low doses of treatment are those who change rapidly, whereas patients who receive high doses of treatment are those who change slowly. This process has been described as consistent with the *responsiveness* concept (Stiles et al., 1998). In the present context, Stiles et al. (2008) explain the GEL in case of negotiated terminations, as done so jointly by the therapist and the patient, as a responsive process on the part of the therapist toward the patient's demand. Stiles et al.'s (2008) study on $N = 9703$ psychotherapy patients in the UK showed that the GEL model is valid and demonstrated convincingly that the effect of psychotherapy in public mental health services is stable whatever its length (between 1 and 20 sessions). For this reason, it can be concluded that patients, together with their therapists, "know" how to assess quite finely the GEL for themselves (also see Barkham et al., 2006). Finally, in order to maximise the data related to clinical outcome in routine clinical practice, some researchers

have added alliance measures, such as the Agnew Alliance Measure (Miller et al., 2005; Whipple et al., 2003). However, whilst developing scientifically relevant models, none of these studies address the question of international generalizability to different political and economical contexts, outside the US or the UK. Such research may help to render explicit the context parameters, as well as their interaction with the quoted scientific models and ultimately, test their generalizability.

The overall objective of this project is to assess feasibility of progress tracking in adult psychotherapy in a routine practice context in one of Switzerland's states or cantons with regard to the afore-mentioned change models. To do so, two goals have been set in the present feasibility study: (1) To create a directory of psychotherapy, as defined under Art. 2 and 3 of the Swiss Ordinance on Health Care Coverage conducted in the three sectors or geographic regions (North, West, and Centre) of the state Department of psychiatry; (2) To track the evolution of the patients' problems, session-by-session, throughout the psychotherapy.

METHOD

Procedure

Based on the internal billing statements, a research assistant contacted the psychotherapists having started a new psychotherapy (for the entire 9-month pilot phase (september 2010 – may 2011): $N = 300$ patients; for the procedure flowchart, see Figure 1). Once the therapists had confirmed they had started a new psychotherapy, the research assistant then personally saw every therapist who, in turn, presented and explained the project to their patients. The latter then accepted or refused to participate. If they accepted, they filled in the OQ-45 independently of the therapist. The questionnaire was put in a sealed envelope and sent back. The study received clearance by the Ethic Board.

Instruments

The *Outcome Questionnaire-45.2* (OQ-45; Lambert, Morton, Hatfield, Harmon, Hamilton et al., 2004) is a 45-item self-report questionnaire designed specifically to assess patients' progress during the course of therapy. The OQ-45 has three subscales: symptom distress, interpersonal relations, and social role functioning. The French version of this questionnaire was carried out by Emond, Savard, Lalande, Boisvert, Boutin et al. (2004) and showed satisfactory results. In this present study, the patients were asked to answer the OQ-45 after every therapy session. Cronbach alpha for the total score was .90 for the present sample.

Participants

As can be seen in Figure 1, a total of $N = 300$ cases of psychotherapy were announced and a total of $N = 96$ therapists, treating a total of $N = 199$ patients, were contacted. A total of $N = 101$ patients were not suited for the project, in particular as regards the non-suitability of the questionnaire for children and adolescents. Out of the 199 patients, $N = 26$ were contacted by their therapists to participate in the study. This means that $N = 173$ patients were lost at this stage of the procedure. As shown in Figure 1, most of them ($n = 80$) were revealed to be false positives or therapist oversights or non-response ($n = 46$), despite a procedure of reminding the therapists. Additionally, some ($n = 21$) concerned a terminated or suspended therapy, some others ($n = 21$) were pending at the end of the feasibility trial, along with some others ($n = 5$). Finally, some patients refused to participate ($n = 11$) and for two recent inclusions, no data was available, yet; therefore, the data analysed concerned a total of $N = 13$ patients treated by $N = 11$ psychotherapists.

Patients

A total of 13 French-speaking outpatients were included in the present pilot study. 69% (9) were women. The mean age in the sample was 35.4 years ($SD = 12.6$, ages ranging from 20 to 60). Table 1 sums up the DSM-IV-TR (APA, 2000) diagnoses presented by the patients; these were noted from the patients' medical file; the patients presented on average

1.27 diagnoses ($SD = .62$) on axis I and .27 ($SD = .45$) on axis II. All patients gave written informed consent.

Therapists

In total, $N = 11$ psychotherapists were involved, of which 5 psychiatrists and 6 psychologists of different allegiances (psychodynamic, CBT, and systemic) and from diverse outpatient services (e.g., community psychiatry, general psychiatry, liaison psychiatry, old age psychiatry). Their level of expertise varied from 3 to 30 years of experience. The therapies monitored took place once weekly, except for one therapy which took place twice weekly for which one questionnaire per week was filled out.

Data analysis

Two types of data were collected from (1) the OQ-45 and (2) routine information which included the diagnostic, the GAF, the number of sessions monitored, and socio-demographic data (Table 1). Hierarchical Linear Model (HLM; Bryk & Raudenbush, 1987) and the HLM-6 programme was used. The dependent variables were the OQ-45 subscales, on level 1: the psychotherapy session (Level 1: $\gamma_{ij} = \beta_{0j} * (\text{session}) + \beta_{1j} + \varepsilon$), on level 2: the individual patient ($\beta_{0j} = \gamma_{00} + \mu_{0j}$; $\beta_{1j} = \gamma_{10} + \gamma_{11} * (\text{patient}) + \mu_{1j}$). The use of HLMs permits to look at intra- as well as inter-individual change, as well as to track symptom change over time. Even if the number of data points may not be sufficient to justify the use of HLMs; nevertheless, we opted for this data analytic strategies, as it is ultimately the aim to apply HLMs to a larger data set. Thus, the study clearly have an exploratory character and the results should be interpreted with caution.

RESULTS

Estimated return rate, by counting the number of weeks for each psychotherapy (minus the regular absences related to vacation), was 90% for the $n = 13$ cases which was judged excellent. The therapists' spontaneous reactions to the pilot study were collected and varied greatly in their degree of approval of the project. Some therapists displayed enthusiasm for the project, some had very specific criticism to address to the project. Among the critical comments, several therapists noted the length of the questionnaire (*i.e.*, 45 items being too long), as well as the rhythm of monitoring (*i.e.*, assessment after each session was judged too time-consuming for the patients).

In terms of the quantitative results, the mean GAF score of the patients at intake was of 67.3 (SD = 8.5), which indicates, on average, mild symptoms. Table 1 shows that the patients mean score on the OQ-45 was 64 (SD = 20.8; ranging from 35 to 94) which is over the cut-off score for clinical populations (63). 6 patients scored above the cut-off score on their first questionnaire. On their last session monitored, the patients scored on average 50.1 (SD = 20.8). It should be noted that although only two patients have finished their treatment, only three patients scored above the cut-off score at the last session monitored. This shows a general tendency towards a diminution in score between the first and last session monitored. HLMs were used on the 94 sessions monitored (Coefficient: 57.66; SE:5.61; T -ratio: 10.28; df: 12, $p = .00$) in order to model the process towards recovery. This provides information that the overall outcome, as well as at the symptom, interpersonal and social role levels, have improved significantly over the course of treatment.

DISCUSSION

The findings of the present feasibility trial suggest that progress tracking in routine practice in an public adult psychiatric department is feasible, under certain conditions. Moreover, even with a small routine practice sample, some hypotheses of change have

tentatively been corroborated, such as clinical change over time, as measured session by session. However, most of the treatments being long-term (*i.e.*, session number greater than 20) and still ongoing at the end of the study period, it was not possible within the short time-frame of this study to draw any conclusions related to the GEL-model which requires terminated psychotherapies.

This pilot study, along with the examination of the project feasibility, brought to light several limitations that we wish to address. First, as we were dependent on the billing statements to contact therapists, there were a number of false positives (e.g., the treatment administered was not psychotherapy or, on the other hand, it was but had already begun months previously) and an unknown number of false negatives (*i.e.*, new psychotherapies that were missed). A way to avoid this problem would be to have a person of reference in every unit that would contact the tracking center immediately a new psychotherapy has started. Second, the comments psychotherapists most often made were about the length of the questionnaire and the high rate of monitoring which may have to be adapted in the future, by using short versions of the questionnaires (for an example, see Miller et al., 2005).

Despite the good feasibility documented, the low number of psychotherapies included is striking and in particular the high number of therapists not responding to the research assistant's repetitive reminders to participate. We may hypothesize that the notion of clinical governance, even if well-intentioned, provokes some unspecific, albeit negative, reactions on part of the therapists. Clinicians are described to have polarized feelings about outcome measurement (Trauer, 2010). Some accept it very well, whereas others present high levels of resistance which may be linked to the impression of losing control, a fear of intrusion of administration in the therapeutic relationship or of disqualification of the quality of their work (Callaly, Hyland, Coombs, & Trauer, 2005; Johnston & Gowers, 2005; Oldham & Sederer, 2002; Unsworth, Cowie, & Green, in press). Alternately, the project might have benefitted

from additional research questions related to the progression of the therapeutic alliance and a feed-back procedure (directly to the therapists) related to these variables, as they evolve over time (e.g., Miller et al., 2005; Whipple et al., 2003).

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Table 1.

Sample description (N = 13)

Variables	First session monitored	Last session monitored
Female	9 (69 %)	
Mean age (SD)	35.4 (12.6)	
Total number of sessions monitored	94	
Mean number of sessions monitored (SD)	7.8 (5.3)	
Axis I diagnosis (<i>n</i> = 9) ^a		
<i>Substance dependence</i>	2	
<i>Depressive episode / recurrent depressive disorder</i>	3	
<i>Adjustment disorder</i>	3	
<i>Post-traumatic stress disorder</i>	1	
<i>Sexual relationship disorder</i>	1	
Axis II diagnosis (<i>n</i> = 3) ^a		
<i>Borderline personality disorder</i>	2	
<i>Mixed and other personality disorders</i>	1	
Global Assessment of Functioning ^b	67.3 (8.5)	

Outcome Questionnaire ^c	64.00 (20.80)	50.10 (20.80)
<i>Symptom Distress</i>	39.00 (13.90)	32.08 (14.67)
<i>Interpersonal Relations</i>	14.31 (5.26)	11.92 (5.20)
<i>Social Role</i>	10.69 (4.00)	9.46 (4.42)

Note. ^aMultiple diagnoses possible; ^bScore ranges from 1-100; Mean (SD); ^cTotal Score ranges from 71-124; Mean (SD).

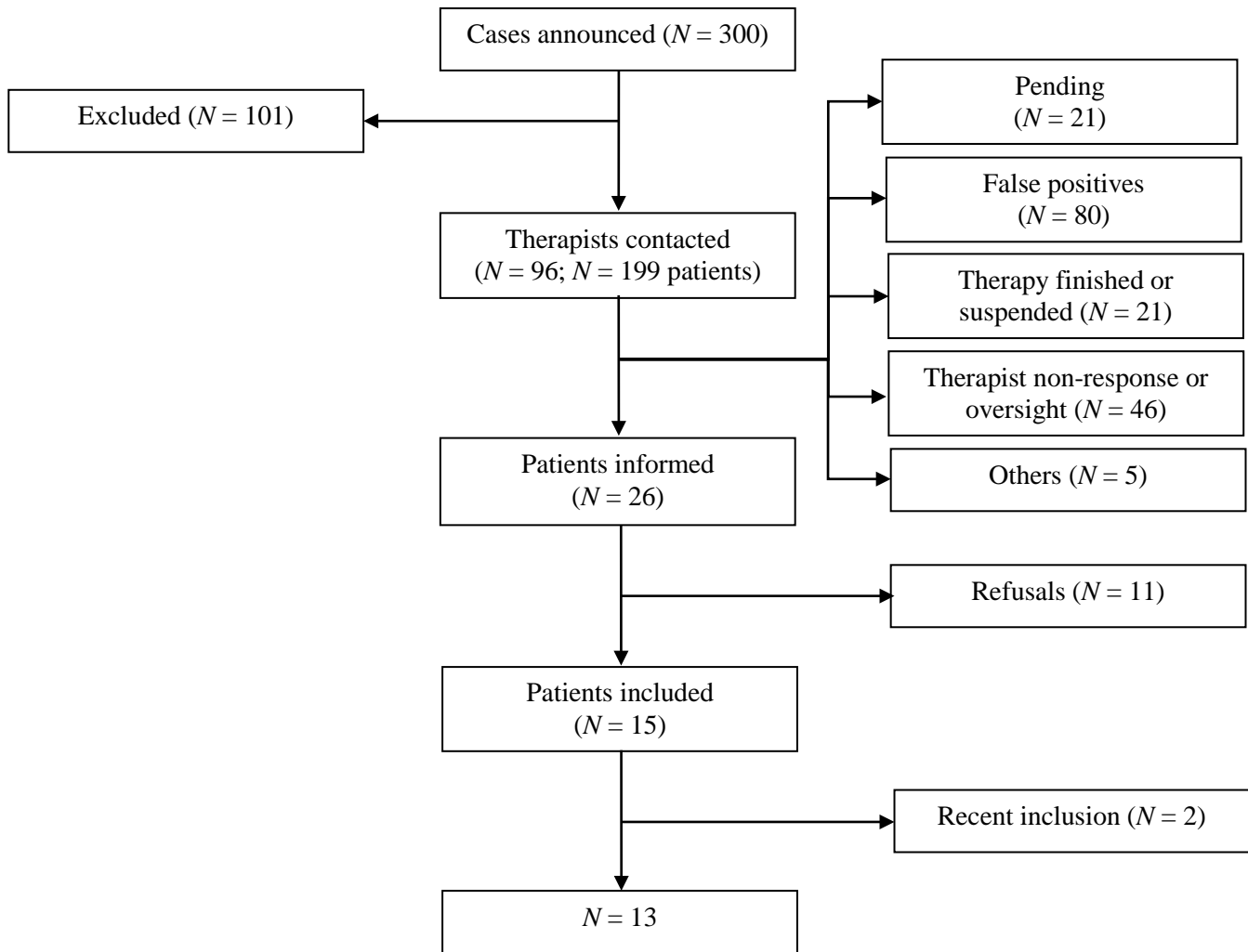


Figure 1.

Note. Cases announced: patients said to have started psychotherapy via billing statement; *Excluded:* patients not suited for the project (e.g., children and adolescents); *Pending:* awaiting therapist response; *False positives:* treatments administered that aren't psychotherapy, psychotherapies having started for over 3 months, or psychotherapists not found; *Therapy finished or suspended:* therapies that had already finished before the therapist was contacted or that were suspended in agreement with the patient; *Therapist non-response or oversight:* therapists that did not answer when contacted or who forgot to propose participation to the patient; *Others:* 2 wards and 3 subjects with poor compliance.

FIGURE CAPTIONS

Figure 1: Procedure Flowchart