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Brief Reports

A Pilot Trial of Treatment Changes according to Schizophrenic Patients' Wishes

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Various studies have demonstrated that schizophrenic patients who assess their current treatment more negatively are more likely to terminate their treatment early, which appears a trivial finding. However, even if patients do not drop out and treatment continues to be administered properly, those with a more negative assessment benefit less from short-term as well as from long-term treatment.

In a study of long-term treatment in community care, patients with schizophrenia expressing doubts as to whether their current treatment was right for them had more and longer hospitalizations during the following 30 months than patients with a more positive assessment of treatment (Priebe and Bröker, 1999; Priebe and Gruyters, 1995). In studies of short-term treatment, patients who initially responded to neuroleptics with dysphoria and believed that the medication was not right for them within the first 2 days were shown to have a less favorable outcome after 4 weeks (Bartkó et al., 1987; Hogan et al., 1985; Van Putten and May, 1978; Van Putten et al., 1981, 1984). A similar predictive relationship was found in complex treatment settings. Schizophrenic patients with a more negative initial global assessment of in-patient treatment (Bröker et al., 1995) and of day hospital treatment (Priebe and Gruyters, 1994) showed less improvement in psychopathology until discharge.

The aforementioned studies examined the predictive power of patients' views of treatment under naturalistic conditions. They lead to the conclusion that patients with a more negative assessment of treatment have a poorer prognosis for treatment outcome. Yet, the question arises as to whether there may be specific interventions targeted at the negative views of treatment in order to improve both patients' view of treatment and clinical outcome.

The present pilot study is a randomized controlled trial in an acute day hospital. Schizophrenic patients with a more negative assessment of treatment 1 week after admission were allocated to two groups: those in one group were specifically asked for their treatment wishes, and treatment

was changed or modified according to the patients' wishes as far as possible; the other group received standard care with no additional intervention. We tested the hypothesis that the intervention would lead to a more positive assessment of treatment and to a more favorable change in psychopathology within the following 2 weeks.

Methods

The study was carried out in a day hospital in Berlin, Germany. The day hospital serves an inner-city district (Berlin-Charlottenburg) and is for acute treatment with an average length of stay of less than 2 months. It has a fixed program based on various group activities (*e.g.,* creative activities, work therapy, sport, cognitive and social skills training, music therapy, role play, and bibliotherapy). Patients are expected to attend the full program Mondays to Fridays from 8:30 a.m. to 5:00 p.m.

We investigated 24 consecutively admitted patients with a diagnosis of schizophrenia according to DSM-III-R (American Psychiatric Association, 1987) who expressed a comparatively negative global assessment of treatment on day 8 after admission. Patients rated their assessment on a 11-point rating scale ("Is the treatment you are currently receiving here right for you?"; extreme points: 0 = not right at all, 10 = completely right). A score of ≤ 7.0 was regarded as a more negative assessment. The same scale and cut-off point have been used and shown to have predictive validity in previous studies (Bröker et al., 1995; Priebe, 1987; Priebe and Bröker, 1999; Priebe and Gruyters, 1995). The treatment setting and the method for identifying patients with a more negative assessment were the same as in a previous naturalistic study (Priebe, 1992; Priebe and Gruyters, 1994).

Following a random table, patients were allocated to the experimental or to the control group. In the control group, there was no additional intervention beyond the routine program. The specific intervention in the experimental group was a single meeting of the patient, his or her clinical case manager, and the medical director of the day hospital. The meeting took place on day 8 after admission or as soon as possible thereafter. In the meeting, patients were asked what they would like changed in their treatment. If necessary, patients were asked to explain and detail their statements. The wishes were written down, and patients were told which of their wishes would be met within the following 2 weeks. The intention was to meet all patients' wishes as far as it would be viable and medically agreeable.

Patients rated their assessment of treatment on day 8 and on day 22 after admission. At the same point of time, they self-rated their general condition on a 100-mm-long visual analogue scale (VAS) according to Aitken (1969; 0 = my condition is generally good, 100 = my condition is generally bad). Psychopathology was observer rated on the Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962). Diagnoses were first made by the responsible consultant psychiatrist and then confirmed by an independent researcher who did all of the interviews and observer ratings, and who was otherwise not involved in treatment. Differences between day 8 and day 22 in patients' assessment of treatment, the self-rated general condition, and BPRS total score were the outcome criteria.

Because of the small sample size, nonparametric *U*-tests for pair differences were conducted. Tests were one-tailed according to the hypothesis that the intervention group would show more favorable changes than the control group. Because of the nature of the study, *i.e.,* a pilot trial, results significant at $p < .10$ were regarded as consistent with the hypothesis.

Patients gave informed consent to participate in the study, and the trial was approved of by the ethics committee of the Medical Faculty of the Freie Universität Berlin.

Results

Sample Characteristics. The mean age of the 24 patients (14 women, 10 men) was 38.4 years (SD = 8.8). The duration of illness varied between 8 months and 25 years (mean = 8.8 years). The number of previous periods of full hospitalization ranged from 0 to 10 (mean = 4.0), and partial hospitalization, from 0 to 7 (mean = 1.0).

Patients' Wishes. In the meeting with the case manager and the medical director of the day hospital, three patients stated that they did not have any specific wishes for a change in their current treatment for the time being, although they did not believe that the treatment was entirely right for them. One patient expressed one wish for change, six patients expressed two wishes, and two patients three wishes. Five patients wanted to be allocated to different group activities, which were provided in the day hospital program (*e.g.,* music therapy instead of sport at the same time). Four patients wished to have one more regular talk with their case manager every week. Two patients each wanted a dose reduction of their medication, and to have one afternoon off or a longer break within the program, respectively. One patient each wanted an additional drug for sleeping, a different neuroleptic drug, literature on neuroleptic drugs, a massage once a week, and additional cognitive skills training twice a week beyond the training routinely provided in the day hospital.

Some wishes were modified by the patients during the meeting. All wishes expressed by the end of the meeting were met within the following 2 weeks, although there was some reluctance in the therapeutic team to change their program because of patients' wishes. Figures 1, 2, and 3 show changes in patients' assessment of treatment, self-rated general condition, and BPRS total score in the experimental and in the control group within the trial period.

Outcome. Three patients in each group dropped out of treatment between day 8 and day 22 so that the outcome of the intervention was assessed only in 9 patients from each group. The 6 drop-outs did not differ significantly from the remaining 18 patients ($\chi 2$ tests and Wilcoxon tests) in any of the variables assessed.

In the 2 weeks after the intervention, assessment of treatment improved in the experimental group whereas it deteriorated in the control group. The same result was obtained in the case of one's self-rated general condition. BPRS total score improved in both groups, with the degree of improvement being slightly greater in the intervention group. Differences of changes in assessment of treatment ($u = 18.5$, $z = -1.456$, $p = .072$) and in the self-rated general condition (u

= 12.0, z = -1.617, p = .053) were statistically significant on the hypothesized level of $p < .10$. Differences in BPRS change failed to reach this level of statistical significance.

Discussion

Patients who have severe doubts as to whether their treatment is right for them are a minority in most services; numerous studies have shown that the majority of patients express a high level of global satisfaction with treatment in any setting (Corrigan, 1990; Kalman, 1983; Lebow, 1982). Every service for the acute treatment of schizophrenia, however, is likely to have some patients who believe that the treatment provided is not right for them and who usually have a relatively poor prognosis. The aim of this study was to investigate the viability and effectiveness of a relatively simple intervention in those patients. A drop-out rate of 25% within a 2-week trial appears high but was probably to be expected in such a sample of patients who are known to have an increased drop-out rate.

Given the small size and heterogeneity of the remaining sample, the results must be interpreted with caution. Yet, the findings suggest that a specific intervention is viable and may lead to a more positive assessment of treatment and a favorable change in the self-rated condition. Changes in observer rated psychopathology were not affected in any statistically significant way. One might assume that self-rated outcome criteria are easier to improve by such interventions than objective criteria, particularly because patients' assessment of treatment-the primary target of the intervention- and self-rated symptoms overlap substantially (Priebe et al., 1998).

The wishes expressed by the patients were surprisingly modest. For instance, no patient insisted on termination of drug treatment or a change of case manager. Most patients wanted relatively small changes in a program, which they voluntarily attended, although they doubted its appropriateness for them. It is difficult to conceive that those changes themselves had a major impact and were effective components of the intervention. We rather assume that the meeting itself and the fact that patients' wishes were specifically noted and taken more seriously than the patients had been used to so far made the difference. Patients might have expressed similar wishes before, with their case managers arguing against them. In this trial, their wishes were just accepted and not questioned, and the formal and somewhat ritualized features of the intervention might have enhanced its effectiveness. The intervention redefined the therapeutic relationship and put the patients in a more active role than they were in previously. As a result of the intervention, some patients might have regarded themselves as active partners in therapy and not as passive objects of a treatment that they did not like. This interpretation is underscored by one of the patients who did not state any wish for change but expressed a high degree of satisfaction with his treatment afterward and improved markedly.

The present trial lasted only 2 weeks, and we do not know whether the improvement seen in the intervention group can be sustained over a longer period of time. Repeated or additional interventions might be necessary to maintain or to build on the initial positive effect.

Conclusions

Future studies might investigate the effects in bigger samples and other settings and lead to a further development and standardization of interventions. Interventions as tested in this study, however, challenge the flexibility of a given treatment program. They have to be designed and carried out so that the treatment of other patients in the same program, who believe in the appropriateness of their treatment and who have a favorable prognosis, is not negatively affected.

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Fig. 1

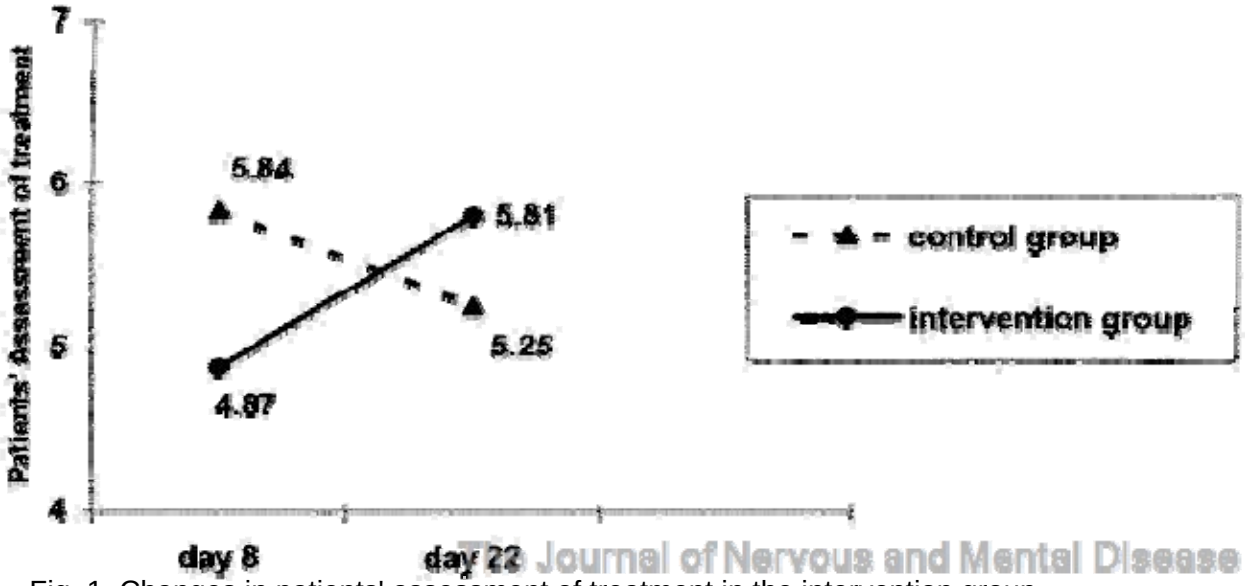

Fig. 1. Changes in patients' assessment of treatment in the intervention group and in the control group (each N = 9).

Fig. 2

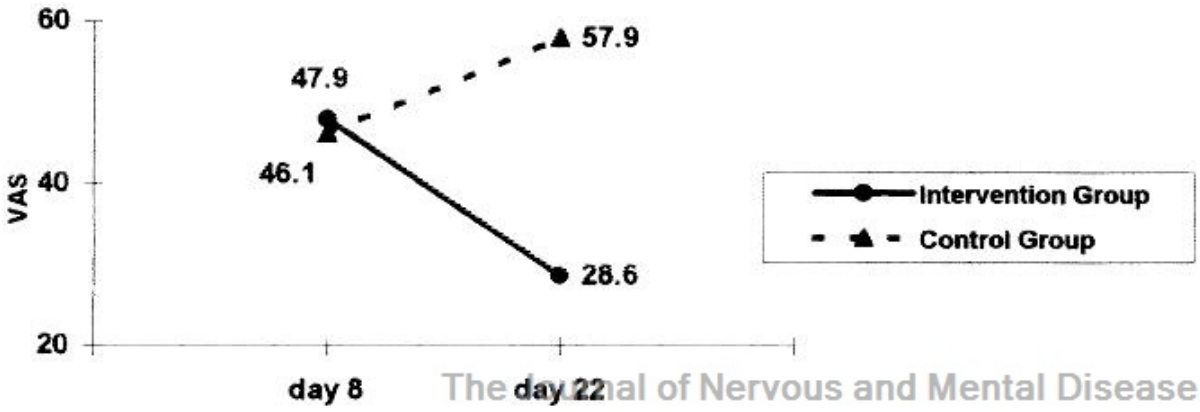

Fig. 2. Changes in self-rated general condition (VAS) in the intervention group and in the control group (each N = 9).

Fig. 3

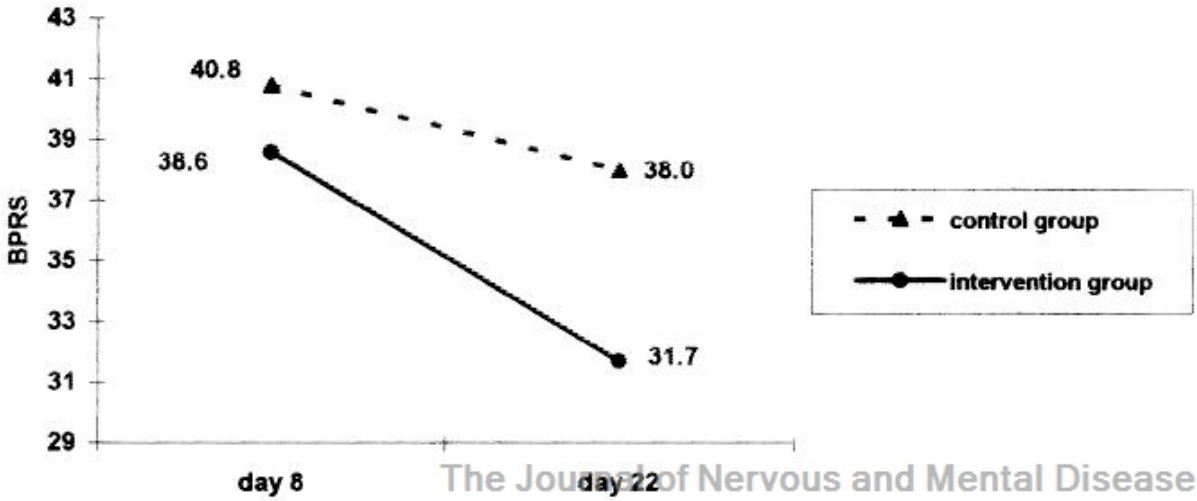

Fig. 3. Changes in BPRS total score in the intervention group and in the control group (each N = 9).