Therapeutic relationship in the context of perceived coercion in a psychiatric population

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ABSTRACT

The relationship between patient and therapist in mental health care is one of the most important treatment factors. It is a reliable predictor of treatment outcome, regardless of diagnosis, setting or of the type of therapy used. On the other hand, influence and coercion occur in patient–physician relationships in psychiatry. We investigated the associations between patients' perceived coercion and the therapeutic relationship.

A total of 116 psychiatric patients, who have been admitted to the Psychiatric University Hospital Zurich, were interviewed using a structured interview. Data were collected by using Scale To Assess the Therapeutic Relationship (STAR) (therapeutic relationship) and Mac Arthur Admission Experience Survey (AES) (perceived coercion). Associations were investigated using bivariate and multivariate methods.

Perceived coercion predicts the patients' appraisal of the therapeutic relationship. We found a moderate relation between the patients' and the clinicians' view of their relationship. Perceived coercion is related to a higher symptom level and a lower level of global functioning at admission, and higher perceived coercion is related to a more negative patient–therapist relationship rated by the patient.

Perceived loss of autonomy goes hand in hand with a more negative relationship between the patient and the clinician. This phenomenon has to be impeded, regarding the unambiguous impact relationship quality has on treatment outcome.

1. Introduction

The relationship between the therapist and the patient, for example, in psychiatric inpatient treatment, is the means through which treatment aspects such as diagnosis, medication and other forms of therapy are mediated (Priebe and McCabe, 2008). Interactions between patient and health-care professionals vary in degree, frequency and duration. Based on these interactions, relationships are being formed. In psychiatric inpatient treatment, the patient does not exclusively interact with the clinician in charge, but also with other staff members. In addition, the treatment period is usually shorter than in outpatient settings, or in newer health-care models such as 'integrative settings' or in 'assertive community treatment' scenarios (Mueser et al., 1998). One might argue that in a complex psychiatric setting, with multidisciplinary therapeutic teams, the therapeutic relationship between the patient and the clinician may not be as central as in

psychotherapy. Yet, increasing empirical evidence indicates its significance also in psychiatric settings (McCabe and Priebe, 2004). Qualitative research repeatedly found that patients consider relationship aspects as the most important components of care (Gilburt et al., 2008; Johansson and Eklund, 2003). McGuire et al. carried out a review identifying six central theories to frame the definitions and methods regarding therapeutic relationship in psychiatry. They list role theory, psychoanalysis, social constructionism, system theory, social psychology and cognitive behaviourism. Further specification and testing of the theories are warranted (McGuire et al., 2001).

As a consequence of the variety of conceptualisations on the therapeutic relationship, a wide range of scales assessing different aspects were developed (Catty et al., 2007; Martin et al., 2000; McCabe and Priebe, 2004). One of them, the Scale To Assess the Therapeutic Relationship (STAR), has been specifically developed for use in the context of severe mental illness (McGuire-Snieckus et al., 2007). In line with previous findings, Martin and others (Martin et al., 2000) concluded that theoretical definitions of the relationship mainly have three aspects in common: (a) the collaborative nature of the patient–therapist relationship, (b) the affective bond between patient and therapist and (c) the patient's and therapist's ability to agree on treatment goals and tasks. From an empirical point of view,

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the therapeutic relationship can be emphasised not only as a consistent predictor for outcome, but also as an outcome criterion in its own right (Gaston et al., 1988; Howgego et al., 2003; Priebe and McCabe, 2008). Different factors seem to have influence on the therapeutic relationship, that is, symptom level (McCabe and Priebe, 2003), level of functioning (Hersoug et al., 2009) and socio-demographic variables (Bjorngaard et al., 2007).

Gilburt et al. found in a qualitative study design an impact of coercion on relationships between patients and the psychiatric staff. They define coercion as a function of the relationship with those who enforced legislation (Gilburt et al., 2008).

The present quantitative research focusses on the potential influence of perceived coercion. Interventions aiming at engagement in or adherence to treatment may include various forms of pressure, formal or informal coercion, which may lead to the patients' perception of being coerced (Gardner et al., 1993). Feeling coerced means perceiving that one does not have influence, control, freedom or choice (Gardner et al., 1993). Even if events are perceived accurately, individuals may come to different judgements about whether they ought to be regarded as coercive. Patients' perceptions of events are of fundamental importance as they indicate how patients view the experience (Hoge et al., 1997).

Influence and coercion are inherent in the patient–physician relationship in the field of psychiatry (Olsen, 2003), and it has been argued to be an inescapable component of any human relationship (McConnell and Gillett, 2006). Measures of perceived coercion have been developed and applied in US samples by the Mac Arthur Research Network (Gardner et al., 1993; Hoge et al., 1997). Perceived coercion has been found to be associated with the use of negative pressures and are inversely related to a patient's sense of procedural justice, that is, that the patient believes she or he has been treated with fairness, concern and respect (Bennett et al., 1993; Lidz et al., 1995; Watson and Angell, 2007).

Both concepts, the therapeutic relationship and the coercion concept, are central to clinical practice and have garnered a lot of attention in clinical literature. The aim of the present study was to investigate the relationship between perceived coercion and the therapeutic relationship. We hypothesised that perceived coercion would negatively influence the therapeutic relationship as rated by the patient, and vice versa. Thus, we did not posit a unidirectional but a reciprocal effect. We further hypothesised perceived coercion to be influenced by legal status, both at admission and in previous hospitalisations.

2. Method

2.1. Sample

Between July and December 2009, we recruited a sample of 116 patients admitted to the Psychiatric University Hospital of Zurich. The sample was not preselected by ward clinicians. All patients who met the inclusion criteria were approached by a research assistant and asked to take part in the study. Participants had to fulfil the following criteria: age between 18 and 65 years, sufficient knowledge of the German language and currently no condition resulting in inability to give informed consent. Patients with diagnosis of dementia were excluded. Eligible patients were informed about the purpose and the content of the study and were asked if they were willing to participate. If so, written informed consent was obtained and the participant underwent a semi-structured interview. We offered no reward for participation. Patients ($n=116$) and the admitting clinician were interviewed within an average of 13 days after admission (S.D.$=4.5$). The mean age of the participants was 42.7 years (S.D.$=12.4$), 43.1% of them were female; 27.6% of the participating patients were legally involuntary committed and 50% reported at least one lifetime involuntary admission. The median of foregoing admissions was 3. The mean Brief Psychiatric Rating Scale (BPRS) score was 38.2 (S.D.$=7.8$), and mean Global Assessment of Functioning (GAF) score at admission was 49.5 (S.D.$=13.8$).

Main diagnosis, that is, International Classification of Mental and Behavioural Disorders (ICD-10) diagnosis that determined the current treatment regimen, was recorded (World Health Organization, 1992). Thirty-two per cent had a main diagnosis of mental and behavioural disorder due to psychoactive substance use (F1), followed by mood disorders (F3) in 29%, schizophrenic disorders (F2) in 37%, anxiety and stress disorders (F4) in 8% and personality disorders (F6) in 6%.

The present sample differed from the population of patients admitted to the study site concerning three variables, that is, percentage of involuntary admissions, number of foregoing admissions and percentage of main diagnosis of schizophrenia, which could constitute a selection bias. The statistics of the study site population are as follows: $n=1622$, age 41.3 years, 41.7% female, 37.4% current involuntary admission, one foregoing admission, GAF score at admission 46 and 31% main diagnosis of schizophrenia or delusional disorder. The local ethics committee has confirmed the study in accordance with the Declaration of Helsinki.

2.2. Measures

Socio-demographic data, illness history and self-reported substance abuse were collected.

The therapeutic relationship was assessed by using the Scale To Assess the Therapeutic Relationship (STAR) (McGuire-Snieckus et al., 2007). STAR contains a patient scale (STAR P) and a clinician scale (STAR C) with 12 items each, rated on a 5-point scale ranging from 0 "never" to 4 "always". The patient version contains the three subscales 'positive collaboration', 'positive clinician input' and 'non-supportive clinician input'. The clinician version contains 'positive collaboration', 'positive clinician input' and 'emotional difficulties'.

Perceived coercion during admission and hospital stay was assessed by the Mac Arthur Admission Experience Survey (AES), adapted version (Gardner et al., 1993; Swartz et al., 2002). The AES contains 15 items to be rated on a 5-point-Likert Scale assessing perceived coercion (five items), negative pressure (six items) and process exclusion (four items). This quantitative scale was developed from semi-structured interview schedules. The scale has been shown to have a high internal consistence and validity (Gardner et al., 1993; Hiday et al., 1997).

Symptom severity was assessed by the BPRS consisting of 18 items, rated on a 7-point scale ranging from 1 'not existent' to 7 'extremely severe', leading to a total symptom score with a range from 18 to 126 (Woerner et al., 1988). General functioning was assessed by the GAF score (American Psychiatric Association, 1994). A total score on a scale from 1 to 100 reflects the degree to which an individual's ability to function is impaired by psychiatric reasons (100=highest functioning). Interviewers (psychologists and psychiatrists) were trained in the interview technique and rating of the BPRS and GAF.

2.3. Statistical analyses

Descriptive analyses served to examine the clinical and demographic characteristics of the sample. Bivariate associations between dependent and independent measures were estimated using Pearson's correlation and t-tests. To model simultaneously the relations of clinical and socio-demographic variables with the dependent variables, we used path analysis models. We restricted the analysis to four measures, the STAR, the AES, the BPRS and the GAF. The models were constructed by identifying hypothesised pathways between different variables. The model fit was assessed using χ^2 and root mean square error of approximation (RMSEA) measures.

The data were analysed with SPSS 15.0 for Windows (Statistical Package for the Social Sciences, Lead Technologies, Inc., Chicago, 2006) and with Mplus, Version 5.2 (Muthén & Muthén, Los Angeles, CA, USA).

3. Results

3.1. Descriptive and exploratory analyses

Exploratory data analysis revealed high overall ratings of the therapeutic relationship reflected in high mean scores of patients (mean$=3.05$, S.D.$=0.71$) as well as clinicians (mean$=3.06$, S.D.$=0.53$) (Table 1). Nearly 60% of the patients as well as the clinicians on the average rated the relationship as often or always good. Patients' ratings of perceived coercion indicated that approximately 60% reported little or no coercion. Both, STAR and AES, showed high internal consistency reflected in Cronbach's $\alpha > 0.788$. Sample characteristics and internal consistencies are provided in Table 1.

Concerning normality distribution of raw scores, the Shapiro–Wilk test revealed significant deviation from normality for AES as well as for STAR P mean scores ($P < 0.01$ in both cases). We therefore undertook a careful consideration of the distributions'