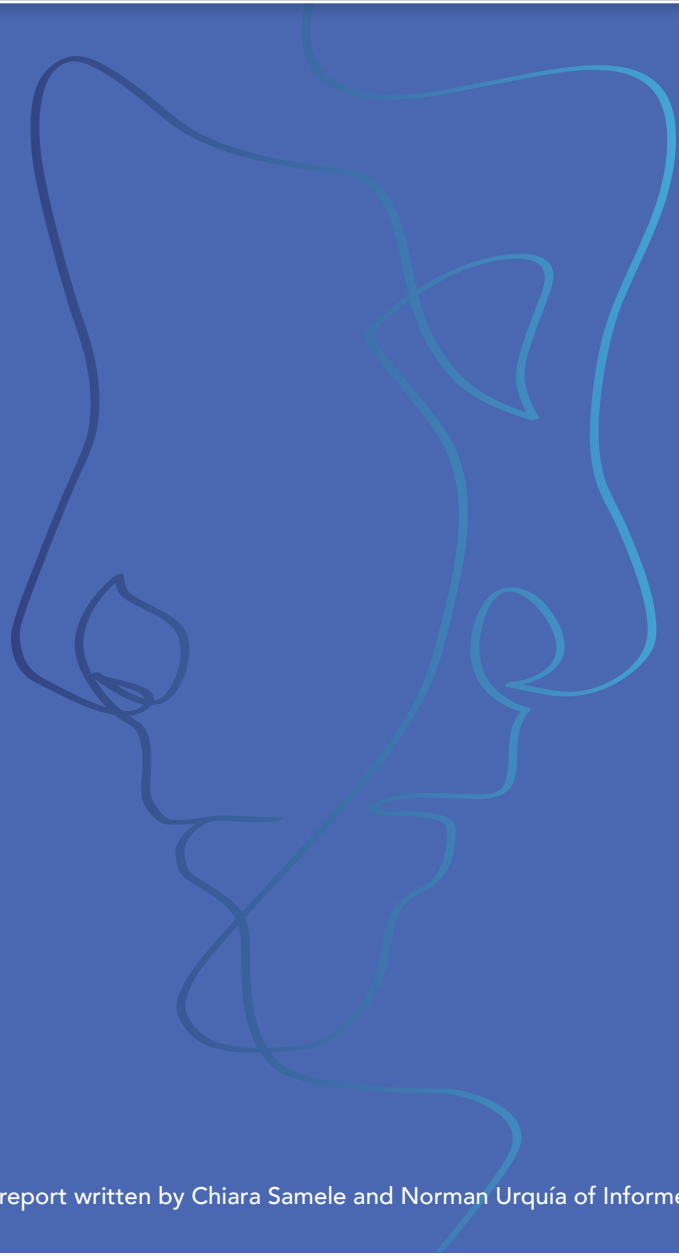
DEVELOPING TRUST AND EFFECTIVE CARE FOR PEOPLE WITH DEPRESSION: PATIENTS AND PSYCHIATRISTS WORKING IN PARTNERSHIP



A JOINT PROJECT BETWEEN GAMIAN-EUROPE
AND THE EUROPEAN PSYCHIATRIC ASSOCIATION

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EUROPEAN PSYCHIATRIC ASSOCIATION

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CONTENT

SUMMARY

The importance of the therapeutic relationship between a patient and their clinician cannot be underestimated. Previous research has shown the positive effects of good therapeutic relationships and improved health outcomes. However, there has been relatively little systematic exploration of the experiences of patients and clinicians together, their interactions and therapeutic relationship to shed light on how these relationships can be improved.

The project represents an important joint partnership between GAMIAN-Europe and the European Psychiatric Association (EPA) and a way to strengthen this through joint working to improve the therapeutic relationship between patients and psychiatrists. The aim was to explore the patient-clinician relationship in a pilot project from the perspective of both the patient and their psychiatrist as individuals; and to explore their 'paired' experience in relation to developing trust, shared-decision making regarding treatment, and positive and negative experiences of their meetings. The main objective was to identify optimal interactions between psychiatrists and patients.

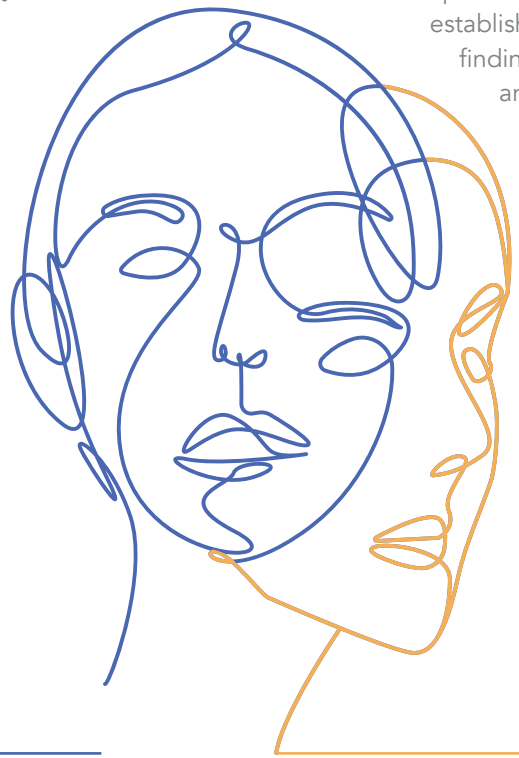
The project was an exploratory pilot using a practical approach to recruiting paired psychiatrists and patients. Semi-structured questionnaires were developed for collecting qualitative data from patients and psychiatrists. Eighteen patient and psychiatrist pairs (a total of 36 individuals) were recruited from across three countries: France, Italy and Romania.

Patients and psychiatrists highlighted the elements they considered important for a good therapeutic relationship. These included a relationship in which both parties listened to each other and from the patients' perspective where a psychiatrist was respectful, empathetic and non-judgemental. Psychiatrists considered it important to explain information clearly to patients and to develop relationships over time, especially if they were difficult to begin with due to hospitalisation.

Factors that impeded a positive therapeutic relationship, from the psychiatrists' perspective included, patients not being open to discussion and the advice they gave and not adhering to treatment.

Two main approaches to treatment decision-making were identified – A) psychiatrist alone deciding on treatment and informing the patient and B) the psychiatrist proposing treatment and involving the patient in the decision. Most patients and their psychiatrists shared the decisions made about treatment and to some extent mutually agreed what that would be.

The patients and psychiatrists included in the project had well established relationships and knew each other well. Our findings show interesting insights into what the patient and their psychiatrist consider important in building a trusting and therapeutic relationship; both being crucial for ensuring effective practice, treatment and care.



BACKGROUND TO THE PROJECT

This project represents an important joint partnership between GAMIAN-Europe and the European Psychiatric Association (EPA) and a way to strengthen this was through joint working to improve the therapeutic relationship between patients and their psychiatrists, with a focus on patients diagnosed with depression. The project began in September 2018 as a pilot to explore the therapeutic relationship between a patient and a psychiatrist from their 'paired' perspectives.

INTRODUCTION

The prevalence of depression is more wide-spread than ever, where each year a quarter of the European population experience depression and anxiety; and around 50% of people with major depression do not receive treatment.[1] The reasons for this are complex and include fear, stigma, discrimination and a lack of service capacity.

MISSED APPOINTMENTS

Around 18% of people referred by their primary care physician to see a psychiatrist do not attend this appointment; and this increases to 21% for missed follow-up appointments.[2] Some patients may miss their first appointment because they might not have agreed their referral was necessary or their symptoms have resolved while waiting. Common reasons for missing appointments include patients simply forgetting, oversleeping or getting the date wrong.[3] Missed appointments, however, especially follow-up appointments present a serious problem clinically, which can lead to poorer outcomes. Missed appointments can indicate a deterioration of a patient's symptoms and/or social functioning and so increases their chances of being admitted to hospital.[4]

TREATMENT ADHERENCE

Following the advice given by psychiatrists and adhering to the treatment agreed also presented particular difficulties concerning clinical outcomes. Clinical status, review and management form important elements of consultations, which point to the purpose and nature of the patient-clinician relationship. An effective way to improve adherence to care is to establish a good therapeutic alliance.[5] This alliance can also be a strong predictor of good outcome and should include a clinician involving and partnering with their patient to help identify their treatment goals, any specific triggers for relapse and to anticipate what may happen if a patient does not participate in the treatment plan. Developing a good therapeutic relationship with a patient is said to take up to six months.[6]

FEAR AND MISTRUST

The sense of 'being afraid' can play an important role in shaping the experiences of people who use mental health services, particularly those from Black and Ethnic communities and vulnerable groups.[7] Stigma and discrimination are also linked to fear and have powerful consequences for people experiencing mental health problems in accessing and engaging with mental health services.[8] Some of these consequences include mistrust of mental healthcare staff, reluctance to cooperate, delays in seeking help, avoiding services and feeling unsafe in the community. All of these factors may have a negative impact on therapeutic relationships and engagement with mental health services.[8]

PATIENT-CLINICIAN RELATIONSHIP

The quality of the relationship between a clinician and patient is a critical part of psychiatric care during which diagnoses are made, treatment plans

are decided and interventions are carried out.[9] Terms such as therapeutic relationship or therapeutic alliance are used to describe the patient-clinician relationship. For the purposes of this report we refer to the term therapeutic relationship as to include the collaborative relationship between a clinician and patient, the affective bond (or feelings of attachment) and mutually agreed goal(s).[10]

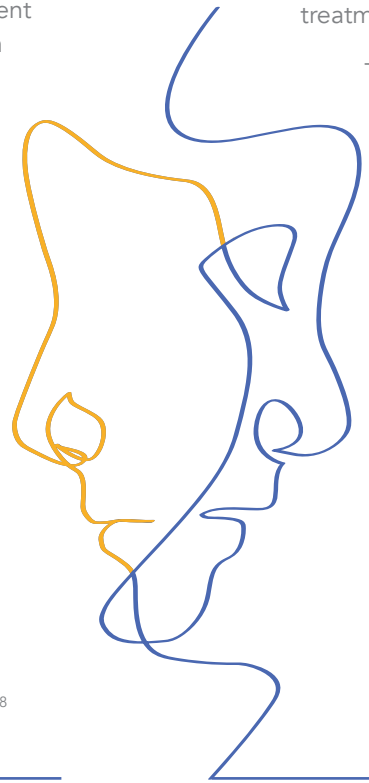
Research has explored the therapeutic relationship in various psychiatric settings, for example in ward, outpatient and community settings. A positive therapeutic relationship contributes to improved clinical outcomes and better patient satisfaction for people receiving outpatient psychiatric services.[12 13 14] The relationship is suggested to be curative in its own right.[11]

A negative therapeutic relationship therefore can have profound consequences. This can include lower patient participation and engagement with treatment and care, including non-adherence to medication, which in turn leads to poorer health outcomes.

COMMUNICATION

Less is known about what predicts a positive therapeutic relationship and good health outcomes. Some research has highlighted the importance of communication and that various communication styles to improve outcomes. For example, collaborative communication or using a participatory approach by involving patients in treatment decisions can help improve awareness of their condition and adherence to medication over time. [15 16 17]

Little is known about how patient-clinician communication improves health outcomes exactly. One study has, however, identified seven pathways for improved health outcomes following good patient-clinician communication, including increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment and better management of emotions.[18]



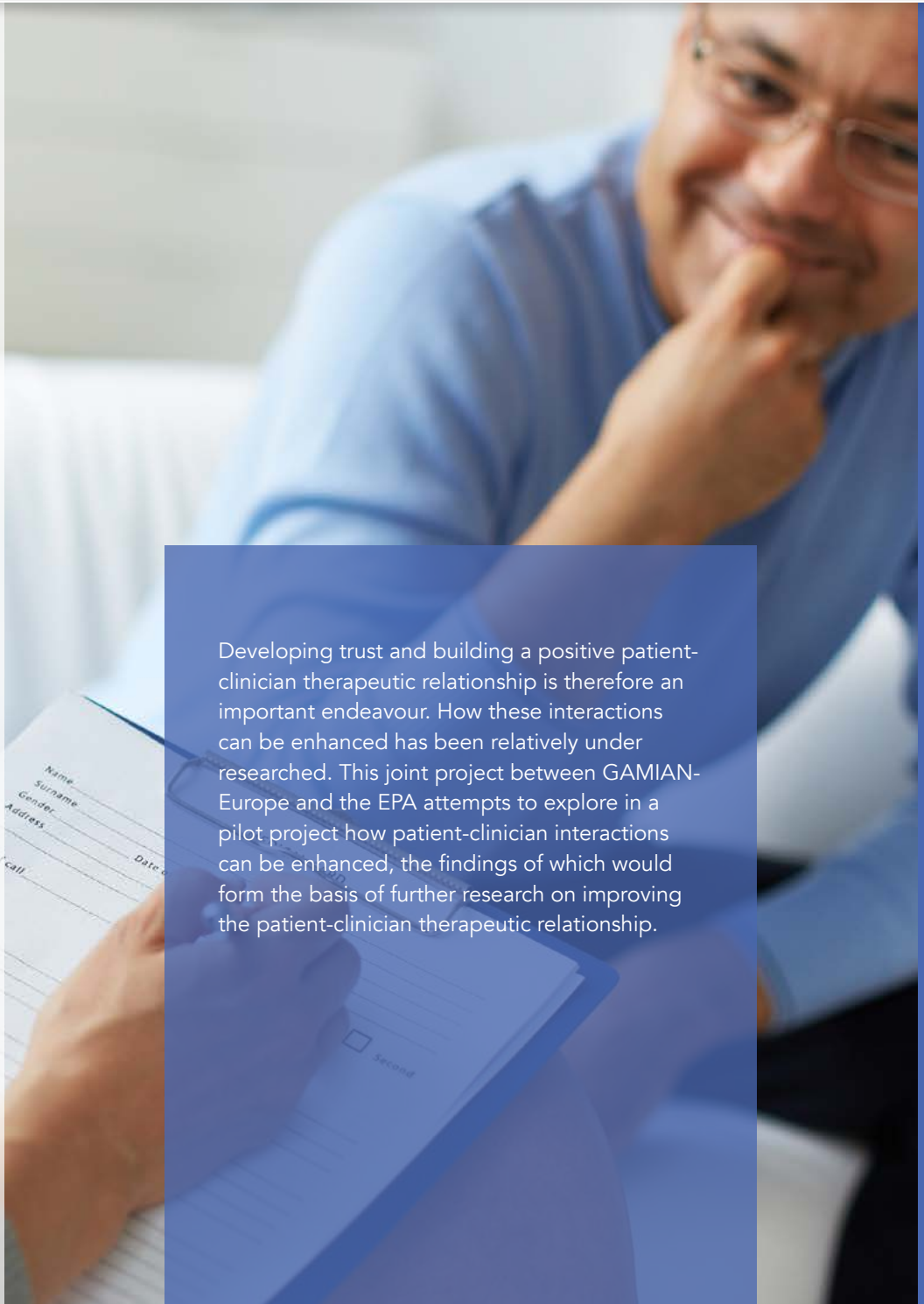
The most immediate impact of a positive patient-clinician interaction often includes better patient understanding, reaching a shared agreement and importantly in building trust.

TRUST

Trust in the clinician is considered an essential element to clinical practice and forms an important basis for effective treatment and patient-centred care.[19 20] Many factors influence the level of trust between a patient and their clinician, including patients' demographic characteristics, such as age and gender. But interpersonal aspects of care also play a role. Trust and confidence in a primary care physician, for example was strongly associated with being taken seriously, being treated with care and concern, involving the patient in treatment decisions and explaining tests and treatments.[21]

There is also research that has looked at the relationship between trust and health outcomes. One review drawing on research carried out in Asia, Europe, North America and Australia found a significant association between trust and positive health outcomes, particularly where patient satisfaction is concerned, and to some extent quality of life and severity of symptoms.

Trust in mental health services, both from the perspective of the user and the public are similarly important, particularly in relation to access and quality of care. Given the huge importance concerning patient-clinician trust and trust in mental health services the EPA have published guidance on how this can be improved. Based on a systematic review of the research literature the EPA proposed five recommendations to:[23]



Prioritise

the rate of mental health service utilisation and patient satisfaction;

Increase

trust by achieving clinical remission, continuity of contact and care with the psychiatrist and avoid negative patient experiences such as coercion, violence and staff ignorance;

Continue

professional development and training for psychiatrists to emphasise their honesty, professionality, empathy, confidentiality and flexibility;

Inform

the general public about the settings and diagnostic/therapeutic processes of mental health care via healthcare providers, non-governmental organisations and psychiatric speciality societies inform the general public;

Improve

the quality of care of mental health systems which promote safety and assure patient dignity.

Developing trust and building a positive patient-clinician therapeutic relationship is therefore an important endeavour. How these interactions can be enhanced has been relatively under researched. This joint project between GAMIAN-Europe and the EPA attempts to explore in a pilot project how patient-clinician interactions can be enhanced, the findings of which would form the basis of further research on improving the patient-clinician therapeutic relationship.

PURPOSE OF THE PROJECT

The aim of this pilot project is to explore the patient-clinician relationship from the perspective of both the patient and their psychiatrist as individuals; and to compare their 'paired' experience in relation to developing trust, shared-decision making regarding treatment, and their meetings in terms of their positive and negative experiences. The main objective is to highlight optimal ways of interaction between psychiatrists and patients.

The key research questions included:

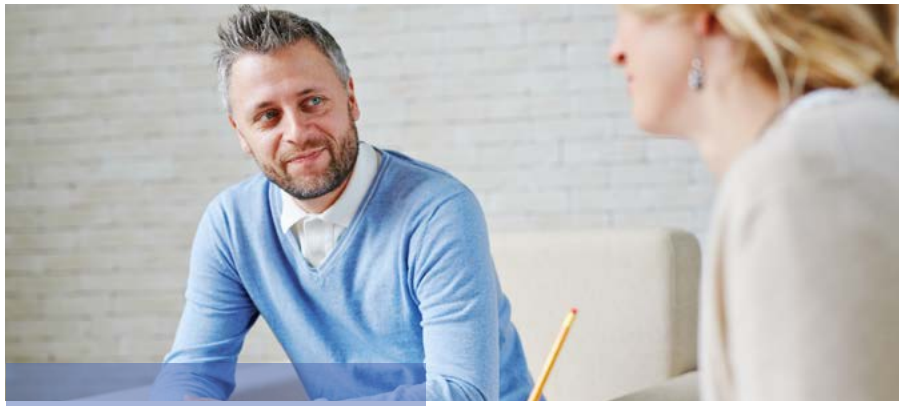
1. What have been good and negative experiences of meetings?
2. Is the interaction between patients and clinicians lacking a foundation of trust, leading to a cycle of disrespect, fear and coercion?
3. What approaches might have facilitated a positive process and support patients to gain optimal benefit from treatment and care?
4. Does psychiatric care have the resources to offer adequate care for patients, or does their absence result in a demoralised workforce?

WHAT WE DID

As part of the partnership working between GAMIAN-Europe and the EPA both organisations invited their members to take part in this pilot project. The project was advertised on the GAMIAN-Europe and EPA's websites so that psychiatrists and their patients could take part. Eligible patients were adults between the ages of 25-70 years with a diagnosis of depression or bipolar disorder. Finland, France, Italy, Romania and the Netherlands were the five countries selected for the pilot project. Details of the methods used can be found in appendix 1 below.

WHAT WE FOUND

A total of 36 people came forward from France, Italy and Romania and participated in the pilot and completed the questionnaires. These participants came from Paris (France), Naples (Italy) and Suceava (Romania). This provided 18 pairs of patients and psychiatrists who answered questions about their therapeutic relationship.



PATIENT PROFILE

Most patients were aged between 45-65 years, with an average age of 52 years. Similar numbers of patients were working or unemployed and three were retired.

Eight patients had a diagnosis of depression and six had bipolar disorder. Three patients had been first diagnosed over 20 years previously. Two patients had been diagnosed within the past year.

Seven patients had a well-established mental health problem spanning at least five years or more. The average length of illness and contact with psychiatric services was seven years, with a minimum of between two and 25 years. Nine patients (9) had seen one or two psychiatrists.

TABLE 1

Patients' demographic and clinical profile – frequencies (n=18)

Gender	n
Male	5
Female	12
not known	1

Age (years)	
25-35	4
35-45	1
45-55	6
55-65	6
65-75	1

Country of residence	
France	8
Italy	7
Romania	3

Employment	
Employed	5
Unemployed	6
Retired	3
Not known	4

Diagnosis	n
Bipolar disorder	6
Depression	8
not known	4

Length of illness (years)	
<1	2
1-5	4
6-10	2
11-15	0
16-20	2
21+	3
not known	5

No. of psychiatrists seen	
1-2	9
3-4	5
5+	1
not known	3

Years in contact with psychiatric services	
median	6.8
min	1
max	30

PSYCHIATRISTS' PROFILE

Table 2 shows the profile of participating psychiatrists. The majority of psychiatrists were male (13) and experienced clinicians with an average of 18 years practice. Psychiatrists saw an average of 18 patients in a typical day.

TABLE 2

Psychiatrists' profile– frequencies and averages (n=18)

Gender	
Male	13
Female	3
not known	2

Years practicing as a psychiatrist	
Median	18.5
Min	5
Max	40

No. of patients seen on a typical day	
Median	18
Min	7.5
Max	30

EXPERIENCES OF OUTPATIENT MEETINGS

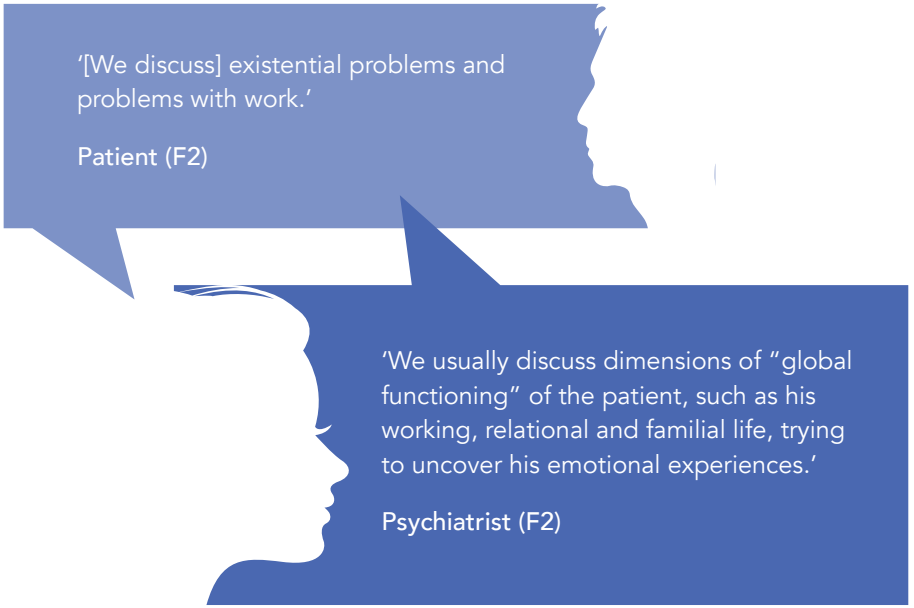
Patients and psychiatrists were asked to describe their outpatient meetings, what they discussed and their experience of it. The majority of patients (8) and psychiatrists (8) described their relationship as 'good'. The following two examples of patient-psychiatrist pairs described what a typical meeting would be. A meeting would usually start with the psychiatrist asking how the patient was feeling, anything of note that had happened in their lives since their last meeting, enquiring about their close relationships and work life if relevant:

'I explain what has happened since our previous meeting. He [the psychiatrist] asks questions to clarify. He notes this with detail. For 5 to 10 minutes, we comment. It's very interactive. Then we move to the treatment, either to its continuation or modification.'

Patient (F1)

'I generally focus the visit, on his [the patient's] mood, the burden of depressive symptoms and how he manages that, the efficacy of the antidepressant drug I prescribe and the side effects. We try to focus on the difficulties of some specific problems for which we try to find solutions.'

Psychiatrist (F1)

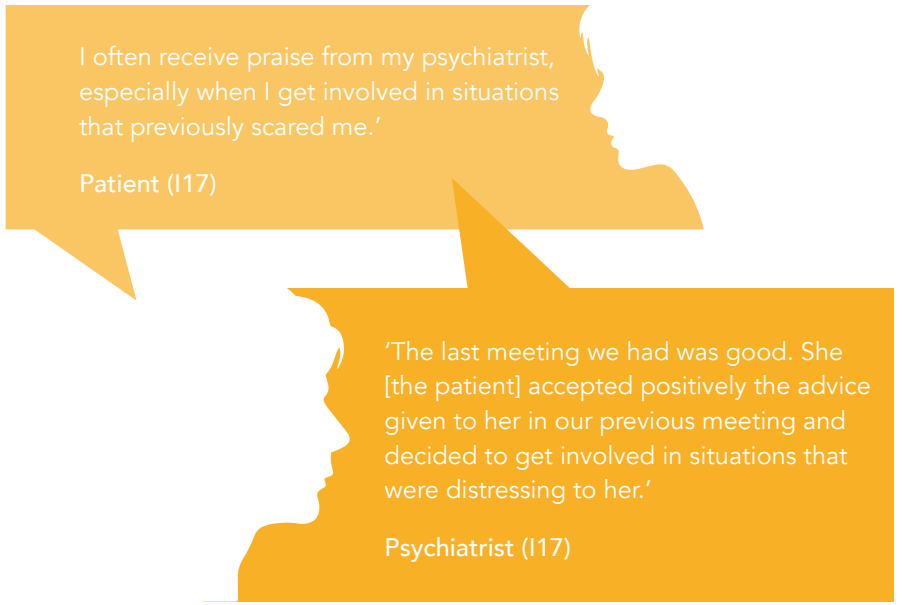


Meetings generally appeared interactive and lasted an average of 22 minutes, in some cases an hour. Only two meetings were reported to be short, lasting 10 minutes (2). Both patients and psychiatrists emphasised the importance of allowing enough time for these meetings. Interestingly, more psychiatrists (7) than patients (4) felt there was not always enough time for their meetings (see Table 3 in Appendix 2). Intuitively this would point to a shortage of capacity, yet only four psychiatrists reported any pressures or challenges due to staff shortages or lack of resources, which could have impacted on the time they were able to spend with patients.

WHEN A MEETING GOES WELL

When asked about the factors which contributed to a good meeting five patients and six psychiatrists highlighted the importance of listening and understanding the problems being described by the patient.

Other important contributors to a good meeting were when the patient followed the psychiatrist's advice and received positive feedback:



Patients and psychiatrists needed to co-operate during a session, this included being open to listening to the patient's issues and being open to follow the psychiatrist's suggestions and advice.

WHEN A MEETING DID NOT GO SO WELL

Meetings that did not go so well were uncommon for participants but on the occasions this did happen they were sometimes related to the patient's condition and how well they were at the time. Patients also acknowledged this:

Patients also acknowledged this:

> 'It depends on my condition, whether I am down, or very anxious, or up.'
>
> Patient (F4)

> 'The patient's beliefs made her more afraid of weight loss than the destabilization of her mood.'
>
> Psychiatrist (F4)

> The first time [I met my psychiatrist] I wanted to cry and I didn't know what was happening to me.'
>
> Patient (R9)

> 'At the beginning and during the admission when he [the patient] was suspicious, reserved and suffering.'
>
> Psychiatrist (R9)

Patients and psychiatrists also gave different reasons for meetings not going so well. In this patient-psychiatrist pair (F6), the psychiatrist noted the lack of agreement concerning medication and this not being taken on a regular basis. For the patient, a meeting would not go well if the psychiatrist was late for their appointment; as this reduced the amount of time they had for discussion. This reiterates the need for sufficient time to discuss issues during meetings.

> 'The doctor was late because of his busy schedule. The appointment was very short and consisted of just making an order.'
>
> Patient (F6)

> 'Discrepancies about the importance and regularity of taking and the therapeutic dose relevance of antidepressant treatment.'
>
> Psychiatrist (F6)

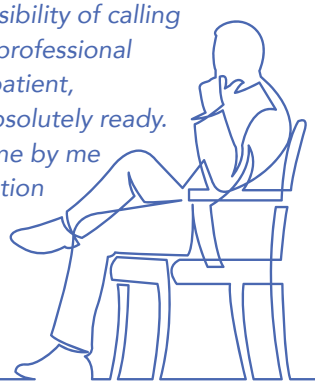
Other reasons given for meetings not going so well included frustration for the psychiatrist if they were unable to find solutions to the problems described by the patient or if the patient was reluctant to take on suggestions or advice.

'It can be frustrating when I do not find a solution for the expressed requests.'

Psychiatrist (F1)

'I approached the question of work, the possibility of calling on day hospitals specialized in [resuming] a professional activity. I saw reluctance on the part of the patient, expressing the fact that she does not feel absolutely ready. This resistance was perceived for the first time by me and I felt a difficulty to come in the continuation of the care; resistance to change that I had not previously identified.'

Psychiatrist (F5)



Having awareness of why a meeting might not go so well provides important insight about how best to approach difficulties concerning adherence to treatment and/or giving advice to help patients progress. This is often easier if the patient and their psychiatrist have a well-established relationship.

RELATIONSHIP AND INTERACTION

The majority of patients (24 or 66.7%) and their psychiatrists described their relationship as positive; either 'good', 'excellent' or 'professional'. Other descriptions included being reassuring, respectful and empathetic.

All patients and their psychiatrists felt comfortable enough to discuss anything they needed to talk about in their meetings. There were some occasions when this did not happen. This patient-psychiatrist pair (F8) touched on openness, honesty, effective follow-up and knowing the patient during stable and difficult times:

'I have no taboo with him [my psychiatrist], unlike my previous psychiatrists with whom I was not always honest, for lack of confidence.'

Patient (F8)

'…effective follow-up for more than one year with knowledge of different periods of life of the patient during periods of difficulty and stability.'

Psychiatrist (F8)

Three patients and nine psychiatrists described having a good connection. Patients and psychiatrists identified what for them contributed towards a good relationship, which included having a mutual understanding. As one patient-psychiatrist pair explained:

'There's an excellent relationship/ rapport... I feel listened to no matter how unpleasant and what the story is and then the psychiatrist understands me.'

Patient (F1)

'It is not a friendly relationship [or like friends], but I think I have a good relationship [with the patient] and that it is mutual.'

Psychiatrist (F1)

Two other psychiatrists described the evolution of the relationship they have with one of their patients which started with difficulties, but over time became a good relationship underpinned by trust during therapeutic sessions:

'There have been difficulties in the past, but I currently consider it a good relationship with strong trust.'

Psychiatrist (I15)

'Trust, built over many years, and to overcome positively difficult moments.'

Psychiatrist (I16)

Patients who described their relationship with their psychiatrist emphasised trust and a range of other important factors, such as empathy, kindness, being benevolent and tact:

'[My psychiatrist is] reassuring, effective, respectful, empathic….It is a relationship that is based on benevolence. It is a relationship of mutual trust. Trust allows you to open to others….When you suffer from depression it is often because there are betrayals, a lack of confidence in yourself or in others…What seems important to me is the use in his speech of the right words, not someone who drowns you with words… What is important, too, is the way of being of the doctor and in this case the softness. Gentleness is necessary in my case, for the type of depression that I suffer. It's a relationship that makes you feel good.'

Patient (F3)

This detailed description provides an insightful view of the multi-dimensional nature of what is needed to build a good relationship with a patient. This highlights the importance of a person-centred relationship, to help the patient build confidence and feel good.

RELATIONSHIP DIFFICULTIES

Difficulties concerning the patient-psychiatrist relationship and obstacles to good relationships included patients feeling judged or that their problems were not taken seriously:

'…if I were in front of a psychiatrist who trivializes my difficulties or does not take into account my personal difficulties that can lead to these mood changes. But it is not the case here.'

Patient (F4)

'His ambivalence to eating disorders sometimes takes him away from his care and changes the therapeutic alliance.'

Psychiatrist (F4)

'When [the psychiatrist] imposes an unverified judgment.'

Patient (I14)

'The fact that he has a low compliance (both in coming to visits and in taking his medications), especially during critical periods of his illness.'

Psychiatrist (I14)

For these two psychiatrists treatment adherence is again mentioned, which for them potentially undermined their therapeutic relationship with the patient. A patient's ambivalence towards their condition could also make it harder to create a good therapeutic relationship. Slow clinical improvement or feeling unable to help the patient could also undermine the relationship:

'At times I [find it] frustrating, due to the slow clinical improvement.'

(Psychiatrist 13)

QUALITIES NEEDED BY A PSYCHIATRIST

Some of the qualities needed by a psychiatrist have already been described by patients, including the importance of and capacity to listen, understand and not to judge. It was also important that psychiatrists could adapt to the patient's needs, be attentive, respectful and to create an environment for the patient to talk freely:

'The doctor has this ability to create a space of freedom that we do not have outside. This freedom is allowed by what the doctor is: his qualities of listening and understanding which I think are natural. We cannot get such a result without actually having someone in front of me who naturally takes care of you in every way.'

Patient (F3)

'The qualities that a psychiatrist must have are listening, patience, tact and adaptability.'

Psychiatrist (F3)

Other qualities deemed necessary for a psychiatrist to help build a good therapeutic relationship included mutual understanding, compassion, empathy, experience and expertise:

> 'We understand each other. We have the same vision of the goal to be achieved: to heal. I do not come here to lounge or to let off steam or whatever. I am also fully aware that I am not his only patient; I'm here to move the process along like him.'
>
> Patient (F1)

> 'Liking to help people who suffer is the most important one. This means compassion, empathy and curiosity and on the top of that of course, a lot of expertise and experience in order to learn what we can do when facing the requests of patients.'
>
> Psychiatrist (F1)

Interestingly, this patient was aware of the importance of their role in achieving the treatment goals and the work they had to do.

TREATMENT DECISION APPROACHES

For patients a key goal or outcome of their treatment was to help prevent, treat, stabilise and/or cure their symptoms to lead a normal life: As these patients explained:

> *'To let me live as normally as possible given my psychological fragility…'*
>
> ***Patient (F2)***
>
> *'I'm waiting to heal someday. The treatment works, but there are still a lot of things that will be solved by speech…'*
>
> ***Patient (F5)***
>
> *I am given this [medication] to stabilize my mood and put my emotions back to their true value and…to calm my anxiety attacks.'*
>
> ***Patient (F4)***

Both patients and psychiatrists were asked how treatment was decided. There were two main treatment decision-making approaches interpreted from the data (see Figure 1), followed by paired examples to describe these.

A **Psychiatrist**

Psychiatrist alone decides and informs the patient

B **Psychiatrist and patient**

Psychiatrist proposes treatment and involves the patient

Figure 1: The two main treatment decision-making approaches used

A – PSYCHIATRIST ALONE DECIDES AND INFORMS THE PATIENT

Five patient-psychiatrist pairs reported this type of treatment decision-making. Here the psychiatrist predominantly makes the treatment decision, but would provide information about the medication and why it was being prescribed. The patient would then accept this decision:

> 'I have had information regarding the typical medication that I am taking. I had to ask for more information than that given.'
>
> Patient (I13)

> 'I think I have correctly and clearly explained the purpose and the reason why each drug was prescribed. It was not a shared decision-making process, but I am available to modify the therapy, listening to any future requests.'
>
> Psychiatrist (I13)

> 'My psychiatrist decided on treatment alone.'
>
> Patient (F6)

> 'Depending on the symptoms put forward by the patient, treatments are explained to the patient… the information is therefore shared but not necessarily understood [by the patient].'
>
> Psychiatrist (F6)

This paired example showed how again trust lay at the heart of this treatment decision approach:

> I am happy with how my therapy was decided: I was told what each drug is for…'
>
> Patient (I12)

> 'I evaluated the clinical picture [and] proposed treatment to the patient, explaining the reasons it has been prescribed. I found the patient had great trust, but he was not involved [in the treatment decision].'
>
> Psychiatrist (I12)

Psychiatrists using this approach were mostly aware that it did not include any patient involvement, although no reasons were given for this.

B – PSYCHIATRIST PROPOSES TREATMENT AND INVOLVES THE PATIENT

The majority of participants preferred using a shared decision-making approach, with ten participating patient-psychiatrist pairs describing this. The approach started with the psychiatrist proposing a treatment(s), providing an explanation of their effects, including side effects and then involving the patient in a discussion to ask their opinion or point of view:

> 'I had my say in the choice of treatment.'
>
> Patient (F5)

> '…I explained why I was proposing [an alternative medication] - fewer side effects, better tolerance profile, etc. I said that we would start at the minimum effective dose and that a regular and joint reassessment will make it possible to verify that this treatment was suitable for him.'
>
> Psychiatrist (F5)

The following patient-psychiatrist examples suggested this approach involved more than one conversation about the treatment options available:

> 'My current therapy was decided after various discussions. I was able to express my opinion regarding this [medication]…'
>
> Patient (I16)

> The treatment was set up through a shared process, as I do usually.'
>
> (I16 Psychiatrist)

> '[Deciding the medication] has always been very interactive: I do not know anything about it, but it was explained to me that there are several families of medications, that each family could have different effects…'
>
> Patient (F1)

> 'Shared decision-making is my motto, so I always decide the treatment with the patients, but to be frank, the patient has had a lot of different treatments, so the last strategies were more coming from my side…'
>
> Psychiatrist (F1)

The shared decision-making approach was also used to help review the patient's medication at different time intervals.

DIFFERENCES IN HOW TREATMENT DECISIONS WERE MADE

Not all treatment decisions, however, were based on the two main approaches identified above. There were exceptions where patient-psychiatrist pairs differed in their perceptions of how treatment was decided. In the example below the patient described that their treatment was mutually agreed with their psychiatrist, but the psychiatrist noted the patient had refused the medication they proposed and made a unilateral decision about this:

> My care was decided by mutual agreement with the psychiatrist.'
>
> Patient (F3)

> 'This treatment was, in a sense, imposed by the patient who interrupted or refused all the proposed drug prescriptions.'
>
> Psychiatrist (F3)

A similar difference of perception can be found in this pair (F8) where the patient explained they had no say in their treatment but the psychiatrist says this was jointly decided with the patient:

> I was offered this treatment during my hospitalization 3 years ago. I did not have a say but did not refuse.'
>
> Patient (F8)

> '[It was a] joint decision after the first two consultations… Comprehensive explanation of the expected benefits and potential complications associated with the choice of this medication [was given].'
>
> Psychiatrist (F8)

It is difficult to say for certain what accounts for these perceived differences but the paired examples listed in this section show how treatment decisions vary depending on the circumstances (e.g. during admission to hospital or in an outpatient meeting), how much information the patient is given, how this is used and understood by the patient and the psychiatrist's preferred approached.

DISCUSSION

In recruiting patient and psychiatrist pairs our project found varying perspectives and insights about their therapeutic relationship. Patients and psychiatrists reported what they considered to be important elements of positive and negative relationships. Many of these are familiar, for example, a psychiatrist listening to what a patient had to say, being understanding and empathetic. Having enough time to discuss issues was important it is encouraging that many patients and their psychiatrists felt they did have sufficient time for their meetings. It was also important for patients to cooperate, listen and be open to the advice given by psychiatrists.

Few psychiatrists reported any institutional pressures or challenges, such as staff shortages or lack of resources. However, it is likely that a high workload, for example having to see up to 30 outpatients a day, would limit the amount of time a patient would have with their psychiatrist.

Both patients and psychiatrists acknowledged that patient symptoms could negatively affect the success of a meeting and they recognised the importance of overcoming difficulties, at least during the first few meetings when a relationship was being established or if the patient was experiencing a crisis. Developing a good therapeutic relationship therefore required time and allowing for this helped to create a trusting relationship.

Patients highlighted other qualities a psychiatrist needed to help build a positive therapeutic relationship. These included psychiatrists that were attentive, adaptable, respectful and non-judgemental. A key factor for a promoting good relationship for psychiatrist included being able to clearly explain the problem to the patient.

The association between adherence to medication and patient-clinician relationships has been an important focus of attention in previous research. Issues with medication emerged on a few occasions as to what factors could impede a good therapeutic relationship.

This was mainly mentioned by psychiatrists who noted the lack of adherence or reluctance to taking the medication they prescribed as a factor, although one patient noted the importance of their own role in aiding progress towards treatment goals.

How patients and their psychiatrists reached decisions about treatment varied but two main approaches were identified; where the psychiatrist alone decided the treatment or the psychiatrist aimed to involve the patient to reach a shared decision. For most patient-psychiatrist pairs (10 in total) the treatment decision process was mutually agreed. No doubt this occurred because most patients and psychiatrists in the project had very well-established relationships which were built on open communication and trust.

CONCLUSIONS

This simple analysis demonstrates and touches on the complex interactions, thoughts and feelings that pairs of patients and psychiatrists have when they meet, and their expectations about what they wish to achieve (for example, fewer symptoms, a better quality of life and so forth). One of the unique strengths of this project has been to bring together the insights of pairs of patients and their psychiatrists.

The patients and psychiatrists included in the project knew each other well. Many patients had been in contact with psychiatric services for a long period of time, and for some this was in excess of 15 years. The sample therefore appeared skewed towards patients and psychiatrists with very good therapeutic relationships. Despite this, our findings show some very interesting insights into what patients and their psychiatrists consider important to building a trusting and therapeutic relationship. This is crucial for ensuring effective practice, treatment and care. More detailed research to explore this relationship is needed to unearth more of the complexity and how good therapeutic relationships are developed and sustained to create improved health outcomes.

APPENDICES

APPENDIX 1 - METHODS

Scoping survey

Prior to recruiting participants a scoping survey was carried out to identify the key issues and areas of focus for the two semi-structured questionnaires to be used. We conducted an initial online survey with members from GAMIAN-Europe and the EPA.

The scoping survey contained six open-ended questions for individual patients and psychiatrists. These scoping questions were uploaded into an online survey, Survey Monkey and sent to selected GAMIAN-Europe and EPA members. Between October to November 2018, a total of 29 responses were received via the online survey – 21 from patients and 8 from psychiatrists. These responses provided data to help formulate questions for the main semi-structured questionnaires.

Semi-structured questionnaires

Based on responses from the scoping online survey two semi-structured questionnaires were developed for the main pilot project. The patient questionnaire included questions concerning their diagnosis, contact with mental health services, current treatment, meetings with their psychiatrist, their relationship with them, involvement of friends and family in their care and anything that could improve their relationship with their psychiatrist. Similar areas were included in the questionnaire for psychiatrists, with the exception of questions asking about any pressures or challenges they experience in their practice (e.g. staff shortages, lack of resources, etc).

Sample and inclusion criteria

Patients between the ages of 25-70 years with a diagnosis of major depression or bipolar disorder were included in the project. Patients with comorbid conditions were eligible for inclusion provided their primary diagnosis was

depression. Five countries were selected from which to recruit participants. These included: Finland, France, Italy, Romania and the Netherlands. However, responses were received from three of these countries: France, Italy and Romania.

The aim was to recruit a convenience sample of 20 pairs of patients and psychiatrists (a total of 40 participants) who met the inclusion criteria.

Recruitment and consent

Recruitment of patients and psychiatrists commenced in March 2019 with adverts placed on the GAMIAN-Europe and EPA websites. These provided a brief description of the project and contact details of the lead researcher for further information. Key members of each organisation involved in the project were also asked to approach members they worked with who might be interested in participating.

Invitation letters and information sheets were sent to any individuals wishing to take part in the project. If they agreed, informed consent was obtained by representatives given the task of coordinating and collecting data from their team/organisation within their country.

Data collection

Data were collected between March to December 2019. Completed questionnaires were received from France (Paris), Italy (Naples) and Romania (Suceava District). Each country's responses were processed by a country representative from France was a clinical research nurse, in Italy a trainee psychiatrist and in Romania a hospital manager. Questionnaires were transcribed and/or translated into English by each country representative or the researchers using online translation software, Google translate.

Psychiatrists were asked to approach patients they thought would be willing to take part. Patients could approach their psychiatrist to take part if they wished to be involved.

Data analysis

Responses to the semi-structured questionnaires were entered into MS Excel and organised by country and patient-psychiatrist pairs, so that responses from patients and their respective psychiatrists could be compared where questions overlapped (for example, how treatment was decided). No personal data were collected and patients and psychiatrists were anonymised to maintain confidentiality.

Responses to the questionnaire were coded separately by two researchers (CS and NU). A first round of coding summarised the responses into short labels which briefly described the responses. The MS Excel pivot table function was used to generate frequency tables for each of these initial codes.

Data were then entered into NVIVO (version 10) - a qualitative software package to analyse qualitative data - for a second round of coding and data analysis. The analysis was guided by the research questions to look specifically at, for example positive and negative experiences of meetings and what promoted a good therapeutic relationship. A further round of coding was carried out to identify themes and patterns in the patient-psychiatrist paired data. The themes identified were checked for appropriateness and alternative interpretations through subsequent iterations of coding and recoding.

APPENDIX 2 – ADDITIONAL TABLE

Meeting time reported by patients and psychiatrists; whether this was enough time for them and if there was agreement on this.

	MEETING TIME IN MINUTES		RESPONSES ON WHETHER ENOUGH TIME		AGREEMENT BETWEEN PATIENT AND PSYCHIATRIST PAIR
ID	PATIENT	PSYCHIATRIST	PATIENT	PSYCHIATRIST	
F1	20	30	Enough		
F2	20	30	Not always enough		
F3	30		Enough		
F4	25	30	Enough	A little short	No
F5	30	30	More needed	Enough	No
F6	10	30	Not always enough	Not always enough enough	Yes
F7	30	45	Enough	Enough	Yes
F8		37	Enough	Enough	Yes
R8					
R10	10	10		Not always enough	
R11	7			Not enough	
I12	30	30	Enough	Enough	Yes
I13	20	20	Not enough	Not enough	Yes
I14		50	Enough	Not enough	No
I15		25	Enough	Enough	Yes
I16	10	30	Enough	Not enough	No
I17	60	60	Enough	Enough	Yes
I18	60	60	Enough	Enough	Yes

Table 3 – Responses from patient and psychiatrist pairs in relation to meeting time and whether this was enough

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