

The customer is always right? Subjective target symptoms and treatment preferences in patients with psychosis

Steffen Moritz¹ · Fabrice Berna¹ · Susanne Jaeger² · Stefan Westermann³  · Matthias Nagel^{4,5}

Received: 13 January 2016 / Accepted: 11 April 2016
© Springer-Verlag Berlin Heidelberg 2016

Abstract Clinicians and patients differ concerning the goals of treatment. Eighty individuals with schizophrenia were assessed online about which symptoms they consider the most important for treatment, as well as their experience with different interventions. Treatment of affective and neuropsychological problems was judged as more important than treatment of positive symptoms ($p < 0.005$). While most individuals had experience with Occupational and Sports Therapy, only a minority had received Cognitive-Behavioral Therapy, Family Therapy, and Psychoeducation with family members before. Patients appraised Talk, Psychoanalytic, and Art Therapy as well as Metacognitive Training as the most helpful treatments. Clinicians should carefully take into consideration patients' preferences, as neglect of consumers' views may compromise outcome and adherence to treatment.

Keywords Psychosis · Schizophrenia · Treatment preferences · Treatment gap

✉ Steffen Moritz
moritz@uke.uni-hamburg.de

Stefan Westermann
stefan.westermann@psy.unibe.ch

¹ Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

² Department of Psychiatry and Psychotherapy I, Ulm University, ZfP Südwürttemberg, Ravensburg, Germany

³ Department of Clinical Psychology and Psychotherapy, Institute of Psychology, University of Bern, Bern, Switzerland

⁴ Department of Psychiatry and Psychotherapy, Asklepios Clinic North, Hamburg, Germany

⁵ Department of Psychiatry and Psychotherapy, University Luebeck, Lübeck, Germany

Introduction

Positive symptoms, e.g., delusions and hallucinations, remain the conventional target of treatment of schizophrenia [1–3]. In contrast, affective symptoms have long been neglected in schizophrenia [4, 5]. While there is new hope that affective and negative symptoms can be addressed by novel approaches, particularly Cognitive-Behavioral Therapy (CBT) and “third wave” CBT approaches [6–12], psychological interventions are still rarely applied.

The majority of patients have rather ambivalent attitudes toward the treatment of positive symptoms; only a minority report unequivocal relief if their symptoms were gone [13]. Accordingly, “gain from illness” due to positive symptoms is a frequent motive for non-adherence [14].

There is an emerging literature suggesting that patients have different views than their therapists on a number of treatment aspects [15]. However, patients' views are rarely taken into account [16]. Results from the CATIE trial [17] suggest that the reduction in confusion and improvement in concentration represent the foremost treatment goals for patients, followed by an increase in energy and interest. The reduction in core positive symptoms was only ranked 3 out of 6 domains [17]. Kuhnigk et al. [3] interviewed outpatients with schizophrenia, physicians, relatives, and “payers.” “Improved cognitive abilities” ranked among the top three goals for treatment by patients, physicians, and relatives. Patients laid most emphasis on “fewer depressive thoughts/emotions.” Reduction in “disease-related symptoms” like delusions was ranked first by relatives, second by physicians and payers, but only fifth by patients (see also [18]).

While CBT is recommended as a complementary treatment for schizophrenia by most guidelines, it is in fact

rarely applied [19–22]. Bechdolf and Klingberg indicate that less than 1 % of patients with schizophrenia receive treatment by a licensed outpatient psychotherapist, and even low-threshold interventions like psychoeducation are only offered to a minority of patients [23]. A recent survey in Germany suggests that in 46 % of all psychiatric facilities some kind of psychotherapy is offered to schizophrenia patients [24]. A study on 187 service users with psychosis from a large mental health care trust found that only ten patients (5.3 %) received individual CBT [22]. Only two out of 187 patients received family intervention in the past year despite evidence for its efficacy.

Apart from pessimistic views about outcome, severe workload, time pressure, and the need for specialist staff have all been identified as barriers to implementation of psychotherapy in the treatment of psychosis [25].

The aim of this study was to explore the treatment goals of patients with schizophrenia and to determine patients' treatment preferences. We hypothesized that patients would favor treatment of affective symptoms over treatment of positive symptoms. Individuals were recruited through the Internet. Such a sample was assumed to respond more openly than an inpatient population who may feel less comfortable speaking openly in an interview setting.

Methods

Participants

Invitations to the study were posted in several guided self-help Internet networks dealing with schizophrenia. In addition, we approached former patients of the Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf (Germany) with verified diagnostic status (schizophrenia) via e-mail. Approximately two-thirds of participants were recruited online.

A total of 145 patients accessed the first page. Of these, 65 data sets were deleted because important criteria were violated: no schizophrenia spectrum disorder, premature cancellation, same value entered in psychopathological questionnaire, extreme scores on the psychosis lie scale (see below), and age lower than 18 or higher than 70 years. Diagnostic status was verified mainly by a psychiatrist. Eleven patients were not taking antipsychotic medication at the time of the study.

Design

All posts and e-mails contained a Web link, which directed interested parties to the survey. Participants were informed that the aim of the study was to learn about patients' treatment goals and their experience with and their assessment

Table 1 Appraisal of individual treatments in descending order

Treatment	<i>M</i>	SD
1. Talk Therapy	3.18	0.88
2. Psychoanalytic Therapy	3.08	1.00
3. Art Therapy	2.92	1.04
4. Metacognitive Training (MCT)	2.91	0.95
5. Psychoeducation with Relatives	2.75	0.96
6. Antipsychotic Medication	2.74	0.93
7. Psychoeducation	2.69	0.95
8. Sports/Physical Training	2.67	1.02
9. Relaxation	2.60	0.94
10. Cognitive-Behavioral Therapy	2.56	1.00
11. Occupational Therapy	2.55	0.95
12. Music Therapy	2.50	0.99
13. Social Skills Training	2.47	0.86
14. Dance Therapy	2.46	0.97
15. Cognitive Remediation	2.33	1.00
16. Family Intervention	2.29	1.11
17. Daily Life Competence Training	2.00	1.07
18. Drama Therapy	2.00	n.a.

Means and standard deviations (1 = not helpful at all, 4 = very helpful)

of different treatment options. Participants received a self-help manual as an incentive for participation.

Questionnaires

Participants were first asked whether they had ever received any of the treatments listed in Table 1; multiple endorsements were possible (adapted from [26]). Response options were “no, never,” “yes, more than one year ago,” “yes, within the last year,” and “yes, presently.” Afterward, we asked how helpful the individuals found the respective treatments (see Table 1 and Fig. 2) on a four-point Likert scale: *not helpful at all*, *somewhat helpful*, *helpful*, and *very helpful*. We then asked to what degree participants suffered from the symptoms and problems listed in Fig. 1 and how important they deemed treatment for these symptoms (see figure for response options). The Community Assessment of Psychic Experiences Scale (CAPE) [27] was administered to measure positive, negative, and depressive symptoms. We added a lie scale [14, 28] consisting of items mirroring common misconceptions about psychosis.

Results

Participants were about 40 years old ($M = 40.40$, $SD = 9.43$); most were females ($n = 50$) and had

Fig. 1 Subjective treatment targets in descending order of mean values (in brackets; 1 = treatment not necessary; 4 = treatment urgently needed). The differently shaded bars indicate endorsement of response options in %

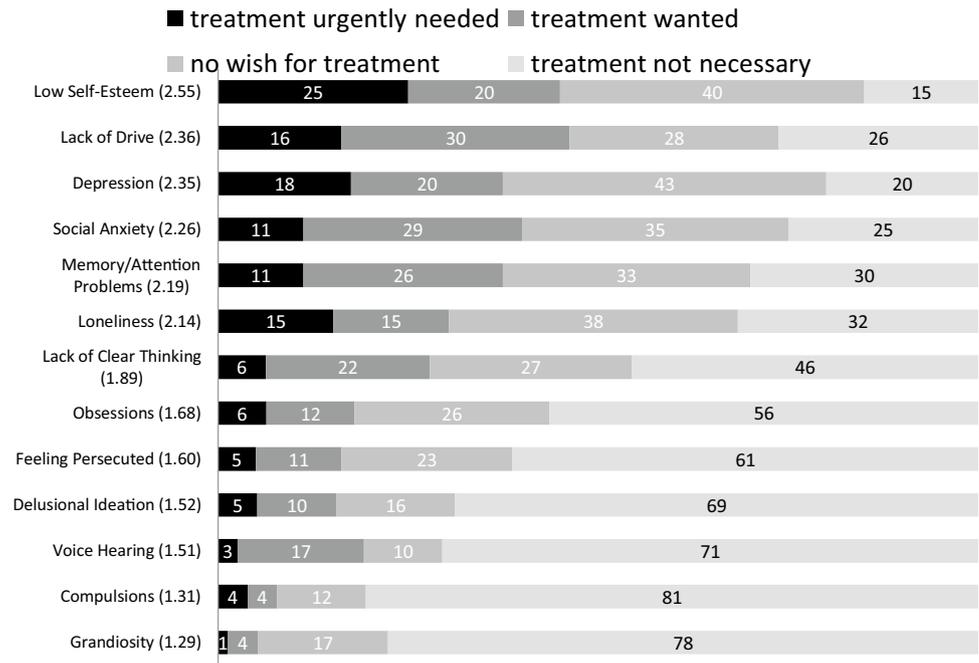
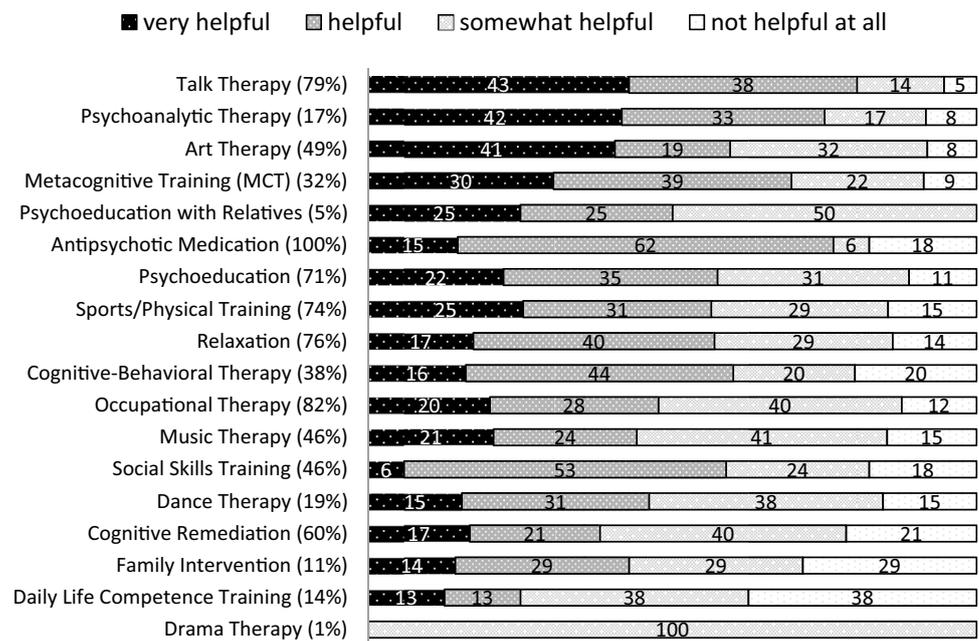


Fig. 2 Experience with non-pharmacological treatments in percent (see brackets). The differently shaded bars indicate endorsement of response options in %



completed high school ($n = 50$). The CAPE positive subscale score was 1.38 ($SD = 0.45$; range: 1–2.90). Approximately two-thirds of participants (80 %) were currently in outpatient treatment.

Figure 1 shows that affective symptoms (e.g., low self-esteem) and negative symptoms (e.g., lack of drive) were identified by 38–46 % of individuals as preferred targets of treatment, followed by cognitive problems. Only one in five patients identified positive symptoms as important treatment goals.

We then formed three subscales comprising core affective items (depression, loneliness, low self-esteem), core positive items (voice hearing, feeling persecuted, delusional ideation), and cognitive items (memory/attention problems, lack of clear thinking). All pairwise comparisons were significant with respect to treatment preference (at least $p < 0.005$): affective symptoms ($M = 2.32$) > cognitive symptoms ($M = 2.04$) > positive symptoms ($M = 1.56$).

As one may argue that patients with no or few positive symptoms will unlikely name hallucinations or delusions as

targets for treatment (i.e., patients may only wish to treat the most severe symptoms), we performed a subsidiary analysis with participants scoring high on positive symptoms ($n = 41$; median split). Preferences remained essentially the same: depression ($M = 2.76$), avolition ($M = 2.71$), low self-esteem ($M = 2.68$), social anxiety ($M = 2.59$), memory and attention problems ($M = 2.46$), and loneliness ($M = 2.39$). Positive symptoms all scored below 2.

Figure 2 shows that Art Therapy and Occupational Therapy prevailed. Table 1 and Fig. 2 display participants' appraisal for the different treatments. Talk Therapy was deemed the most helpful treatment followed by Psychoanalytic Therapy, Art Therapy and Metacognitive Training. Antipsychotic medication was deemed [very] helpful by 77 % of the participants.

Discussion

Participants with schizophrenia considered the treatment of affective and cognitive problems as more important than the treatment of positive symptoms. This was also true for those with elevated positive symptoms.

A minority of participants had experience with non-pharmacological treatments recommended by most guidelines (e.g., NICE; DGPPN-guidelines in Germany), such as CBT, during their treatment history. Predominant treatment options were Occupational Therapy, Talk Therapy, and physical exercises. Psychoeducation (71 %) and cognitive remediation (60 %) were also very common. Patients appraised Psychoanalytic Therapy, Talk Therapy, Art Therapy, and Metacognitive Training (MCT) as most helpful. Although there is some evidence in favor of these treatments [29], none of them are unequivocally accepted as an evidence-based approach for the treatment of schizophrenia. The German guidelines name Art, Music, Dance, Drama, Movement, and Occupational therapies as potential (complementary) treatments without clear recommendation for application [30].

Some limitations have to be highlighted. We primarily recruited participants through the Internet, many of whom actively searched information about their disorder online; thus, our sample might not be representative of patients with schizophrenia. However, we adopted several measures to ensure the validity and reliability of diagnostic status and to prevent sabotage [28, 31]. While interviews are usually preferred over self-report, they face the disadvantage that participants may pay lip service to the clinician. Also, we had an excess of participants with high school education, and most participants were females, again, limiting the sample representativeness. Another caveat is that the present study only recorded if the treatments were deemed globally helpful and did not specify subdomains (e.g., well-being). Finally, participants may not be aware about the

specific contents of some therapies. For example, CBT may not have been explicitly called as such, prompting false-negative responses.

Although our sample affirmed experience with CBT-oriented treatments more than in prior studies, generic treatments such as Occupational Therapy prevailed. We propose that while such treatments may be beneficial for some patients, treatment time should be devoted to the most effective interventions in order to reduce treatment duration [32]. In view of low [medication] adherence, which is associated with grave consequences such as relapse [33, 34], we should not only seek medications with better side-effect profiles, but also consider patients' preferences with respect to the treatment of symptoms appraised as most bothersome [35]. In light of the present findings, the authors have complemented their Metacognitive Training approach with two modules dealing with (self-) stigma and low self-esteem, in order to reach patients who consider the treatment of affective symptoms as most essential.

In conclusion, clinicians should listen to their patients [36], become more "user-friendly" [37], and meet the needs of their patients [38]. This may not only improve outcome and patient satisfaction, but could also raise adherence to treatment [3]. Ideally, treatment should both be evidence-based and take into consideration patients' preferences. Often, clinicians face the dilemma that what is effective, such as antipsychotics, is not always liked, and what is liked, such as Art Therapy, does not always yield strong effects.

Compliance with ethical standards

Conflict of interest None.

References

- Way BB, Banks S (2001) Clinical factors related to admission and release decisions in psychiatric emergency services. *Psychiatr Serv* 52:214–218
- Addington DE, Beck C, Wang J et al (2010) Predictors of admission in first-episode psychosis: developing a risk adjustment model for service comparisons. *Psychiatr Serv* 61:483–488. doi:10.1176/appi.ps.61.5.483
- Kuhnigk O, Slawik L, Meyer J et al (2012) Valuation and attainment of treatment goals in schizophrenia: perspectives of patients, relatives, physicians, and payers. *J Psychiatr Pract* 18:321–328. doi:10.1097/01.pra.0000419816.75752.65
- Peralta V, Cuesta MJ (2009) Characterization of affective domains within the nonaffective psychotic disorders. *Schizophr Res* 111:61–69. doi:10.1016/j.schres.2009.03.008
- Cotton SM, Lambert M, Schimmelmann BG et al (2012) Depressive symptoms in first episode schizophrenia spectrum disorder. *Schizophr Res* 134:20–26. doi:10.1016/j.schres.2011.08.018
- Moritz S, Cludius B, Hottenrott B et al (2015) Mindfulness and relaxation treatment reduce depressive symptoms

- in individuals with psychosis. *Eur Psychiatry*. doi:[10.1016/j.eurpsy.2015.05.002](https://doi.org/10.1016/j.eurpsy.2015.05.002)
7. Van der Valk R, Van de Waerd S, Meijer CJ et al (2013) Feasibility of mindfulness-based therapy in patients recovering from a first psychotic episode: a pilot study. *Early Interv Psychiatry* 7:64–70. doi:[10.1111/j.1751-7893.2012.00356.x](https://doi.org/10.1111/j.1751-7893.2012.00356.x)
 8. Chadwick P (2014) Mindfulness for psychosis. *Br J Psychiatry* 204:333–334. doi:[10.1192/bjp.bp.113.136044](https://doi.org/10.1192/bjp.bp.113.136044)
 9. Khoury B, Lecomte T, Fortin G et al (2013) Mindfulness-based therapy: a comprehensive meta-analysis. *Clin Psychol Rev* 33:763–771. doi:[10.1016/j.cpr.2013.05.005](https://doi.org/10.1016/j.cpr.2013.05.005)
 10. Hasson-Ohayon I, Kravetz S, Levy I, Roe D (2009) Metacognitive and interpersonal interventions for persons with severe mental illness: theory and practice. *Isr J Psychiatry Relat Sci* 46:141–148
 11. White R, Gumley A, McTaggart J et al (2011) A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. *Behav Res Ther* 49:901–907. doi:[10.1016/j.brat.2011.09.003](https://doi.org/10.1016/j.brat.2011.09.003)
 12. Johnson DP, Penn DL, Fredrickson BL et al (2009) Loving-kindness meditation to enhance recovery from negative symptoms of schizophrenia. *J Clin Psychol* 65:499–509. doi:[10.1002/jclp.20591](https://doi.org/10.1002/jclp.20591)
 13. Moritz S, Rietschel L, Veckenstedt R, Bohn F, Schneider BC, Lincoln TM, Karow A (2015) The other side of “madness”: frequencies of positive and ambivalent attitudes towards prominent positive symptoms in psychosis. *Psychosis* 7:14–24. doi:[10.1080/17522439.2013.865137](https://doi.org/10.1080/17522439.2013.865137)
 14. Moritz S, Favrod J, Andreou C et al (2013) Beyond the usual suspects: positive attitudes towards positive symptoms is associated with medication noncompliance in psychosis. *Schizophr Bull* 39:917–922. doi:[10.1093/schbul/sbs005](https://doi.org/10.1093/schbul/sbs005)
 15. Lasalvia A, Boggian I, Bonetto C et al (2012) Multiple perspectives on mental health outcome: needs for care and service satisfaction assessed by staff, patients and family members. *Soc Psychiatry Psychiatr Epidemiol* 47:1035–1045. doi:[10.1007/s00127-011-0418-0](https://doi.org/10.1007/s00127-011-0418-0)
 16. Hamann J, Mendel R, Cohen R et al (2009) Psychiatrists’ use of shared decision making in the treatment of schizophrenia: patient characteristics and decision topics. *Psychiatr Serv* 60:1107–1112. doi:[10.1176/appi.ps.60.8.1107](https://doi.org/10.1176/appi.ps.60.8.1107)
 17. Rosenheck R, Stroup S, Keefe RSE et al (2005) Measuring outcome priorities and preferences in people with schizophrenia. *Br J Psychiatry* 187:529–534. doi:[10.1192/bjp.187.6.529](https://doi.org/10.1192/bjp.187.6.529)
 18. Byrne R, Davies L, Morrison AP (2010) Priorities and preferences for the outcomes of treatment of psychosis: a service user perspective. *Psychosis* 2:210–217. doi:[10.1080/17522430903456913](https://doi.org/10.1080/17522430903456913)
 19. Berry K, Haddock G (2008) The implementation of the NICE guidelines for schizophrenia: barriers to the implementation of psychological interventions and recommendations for the future. *Psychol Psychother* 81:419–436. doi:[10.1348/147608308X329540](https://doi.org/10.1348/147608308X329540)
 20. Bechdolf A, Klingberg S (2014) Psychotherapie bei schizophrenen Störungen: kein Evidenz-, sondern ein Implementierungsproblem [Psychotherapy of schizophrenia: Not a problem of evidence, but a problem of implementation]. *Psychiatr Prax* 41:8–10. doi:[10.1055/s-0033-1359957](https://doi.org/10.1055/s-0033-1359957)
 21. Puschner B, Vauth R, Jacobi F, Becker T (2006) Bedeutung von Psychotherapie in der Versorgung von Menschen mit schizophrenen Störungen in Deutschland: wie evidenzbasiert ist die Praxis? [Importance of psychotherapy in the health care of individuals with schizophrenia in Germany]. *Nervenarzt* 77:1301–1309. doi:[10.1007/s00115-006-2102-2](https://doi.org/10.1007/s00115-006-2102-2)
 22. Haddock G, Eisner E, Boone C et al (2014) An investigation of the implementation of NICE-recommended CBT interventions for people with schizophrenia. *J Ment Health* 23:162–165. doi:[10.3109/09638237.2013.869571](https://doi.org/10.3109/09638237.2013.869571)
 23. Rummel-Kluge C, Pitschel-Walz G, Bäuml J, Kissling W (2006) Psychoeducation in schizophrenia—results of a survey of all psychiatric institutions in Germany, Austria, and Switzerland. *Schizophr Bull* 32:765–775. doi:[10.1093/schbul/sbl006](https://doi.org/10.1093/schbul/sbl006)
 24. Bundespsychotherapeutenkammer [Chamber of German Psychotherapists] (2014) BPTK-Studie zur stationären Versorgung psychisch kranker Menschen. Ergebnisse einer Befragung der in Krankenhäusern angestellten Psychotherapeuten [Study of the German chamber of psychotherapists about inpatient care in people with psychological disorders]. Bundespsychotherapeutenkammer, Berlin (Germany)
 25. Prytys M, Garety PA, Jolley S et al (2011) Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: a qualitative analysis of the attitudes of CMHT staff. *Clin Psychol Psychother* 18:48–59. doi:[10.1002/cpp.691](https://doi.org/10.1002/cpp.691)
 26. Jaeger S, Wachter C, Steiner T (2014) Nicht-medikamentöse therapeutische Maßnahmen bei Schizophrenie—Was kennen Patienten? Was finden sie hilfreich? [Non-pharmacological therapeutic measures in schizophrenia—what do patients know? What do they judge as helpful?] DGPPN Kongress 2014
 27. Stefanis NC, Hanssen M, Smiris NK et al (2002) Evidence that three dimensions of psychosis have a distribution in the general population. *Psychol Med* 32:347–358. doi:[10.1017/S0033291701005141](https://doi.org/10.1017/S0033291701005141)
 28. Moritz S, Van Quaquebeke N, Lincoln TM et al (2013) Can we trust the internet to measure psychotic symptoms? *Schizophr Res Treat* 2013:457010. doi:[10.1155/2013/457010](https://doi.org/10.1155/2013/457010)
 29. Montag C, Haase L, Seidel D et al (2014) A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: feasibility, impact on symptoms and mentalising capacity. *PLoS ONE* 9:e112348. doi:[10.1371/journal.pone.0112348](https://doi.org/10.1371/journal.pone.0112348)
 30. Deutsche Gesellschaft für Psychiatrie P und N (DGPPN) (eds) (2006) S3 Praxisleitlinien. Band 1 Behandlungsleitlinie Schizophrenie [S3 guidelines. Volume 1. Treatment guideline for schizophrenia]. Steinkopff, Darmstadt
 31. Gosling SD, Vazire S, Srivastava S, John OP (2004) Should we trust web-based studies? A comparative analysis of six preconceptions about internet questionnaires. *Am Psychol* 59:93–104. doi:[10.1037/0003-066X.59.2.93](https://doi.org/10.1037/0003-066X.59.2.93)
 32. Schneider F, Falkai P, Maier W (2012) *Psychiatrie 2020. Perspektiven, Chancen und Herausforderungen* [Psychiatry 2020. Perspectives, chance and challenges]. Springer, Heidelberg
 33. Sun SX, Liu GG, Christensen DB, Fu AZ (2007) Review and analysis of hospitalization costs associated with antipsychotic nonadherence in the treatment of schizophrenia in the United States. *Curr Med Res Opin* 23:2305–2312. doi:[10.1185/030079907X226050](https://doi.org/10.1185/030079907X226050)
 34. Emsley R, Chiliza B, Asmal L, Harvey BH (2013) The nature of relapse in schizophrenia. *BMC Psychiatry* 13:50. doi:[10.1186/1471-244X-13-50](https://doi.org/10.1186/1471-244X-13-50)
 35. Eiring Ø, Landmark BF, Aas E et al (2015) What matters to patients? A systematic review of preferences for medication-associated outcomes in mental disorders. *BMJ Open* 5:e007848. doi:[10.1136/bmjopen-2015-007848](https://doi.org/10.1136/bmjopen-2015-007848)
 36. Naber D, Lambert M (2013) Should we listen and talk more to our patients? *World Psychiatry* 12:237–238. doi:[10.1002/wps.20066](https://doi.org/10.1002/wps.20066)
 37. Suzuki T, Uchida H, Takeuchi H et al (2014) A review on schizophrenia and relapse—a quest for user-friendly psychopharmacotherapy. *Hum Psychopharmacol* 29:414–426. doi:[10.1002/hup.2421](https://doi.org/10.1002/hup.2421)
 38. Westermann S, Cavelti M, Heibach E, Caspar F (2015) Motive-oriented therapeutic relationship building for patients diagnosed with schizophrenia. *Front Psychol* 6:1294. doi:[10.3389/fpsyg.2015.01294](https://doi.org/10.3389/fpsyg.2015.01294)