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Case formulation for the psychiatric assessment

Submission date
14/06/2018

Recruitment status
No longer recruiting

Registration date
20/06/2018

Overall study status
Completed

Last Edited
01/07/2020

Condition category
Mental and Behavioural Disorders

[ ] Prospectively registered
[ ] Protocol
[ ] Statistical analysis plan
[X] Results
[ ] Individual participant data

Plain English summary of protocol

Background and study aims
People who seek psychiatric assessment expect to receive an explanation for their symptoms. They also want a good interpersonal relationship with their clinician(s), acknowledgment and assurance they are being listened to, and involvement in and information on clinical decisions. Achieving these patient-centred objectives, a case formulation method was implemented based on dialogical sequence analysis (DSA) at a community mental health centre. By identifying the patient's problematic, recurring psychological action patterns, it helps to improve the psychiatric assessment. This new method may improve the patient-centredness and the validity of the psychiatric assessment for an individual patient. The aim is to achieve better congruence and collaboration between the patient and professionals concerning the tasks and goals of the assessments, and advance the patient's agency in their treatment. The aim of this study is to compare DSA-based and standard psychiatric assessments.

Who can participate?
Patients aged 18–65 with a referral for a psychiatric assessment

What does the study involve?
Patients are randomly allocated to undergo either the DSA-based assessment or a standard psychiatric assessment. Both groups receive psychiatric treatment in accordance with the usual treatment recommendations. The relationship between the patient and the therapist (therapeutic alliance) is assessed at the treatment planning (i.e. final) visit.

What are the possible benefits and risks of participating?
It is already known that the DSA-based assessment is patient-centred and could complement psychiatric assessment in a collaborative way and result in a better joint understanding regarding the patient's problems and needs in a shorter time period than the standard assessment. The study does not involve any risks for the patients.

Where is the study run from?
Päijät-Häme Central Hospital (Finland)

When is the study starting and how long is it expected to run for?
February 2014 to March 2017

Funding of the study?
Competitive State Research Financing of the Expert Responsibility area of Tampere University Hospital (Finland)

Who is the main contact?
Dr Enikö Savander

Contact information

Type(s)
Public

Contact name
Dr Enikö Savander

ORCID ID
https://orcid.org/0000-0003-0249-0587

Contact details
Keskussairaalankatu 7
Lahti
Finland
FI-15850

Additional identifiers

Clinical Trials Information System (CTIS)
Nil known

ClinicalTrials.gov (NCT)
Nil known

Protocol serial number
Q275

Study information

Scientific Title
Case formulation in psychiatry: do we treat symptoms or do we solve obstacles of individual agency? A single-blind randomised controlled trial

Study objectives
By implementing dialogical sequence analysis (DSA) based case formulation for the psychiatric assessment, the clinicians can achieve an individual definition of problems and more effective care for the patients.

Ethics approval required
Old ethics approval format

Ethics approval(s)
Ethics Committee of Tampere University Hospital, 18/09/2014, ref: R 14094

Study design
Single-blind randomised controlled trial

Primary study design
Interventional

Study type(s)
Other

Health condition(s) or problem(s) studied
Psychiatric assessment phase with the patients' diverse symptoms in a community mental health centre

Interventions
The patients were randomised into two groups. The aim was to obtain 40 participants for both study arms. The randomisation was done immediately when the patient’s referral was approved and the assessment phase started. The study protocol was similar in both arms of study. In the first visit, the clinicians informed the patient about the research protocol, provided a written statement, and requested the patient’s consent to participate in the study. Moreover, five randomly selected patients in the AAU group gave their written consent for the assessment process to be audiotaped. In the DSA group, every first visit and some later visits were audiotaped with the patient’s consent.

INTERVENTION: Assessments based on dialogical sequence analysis (DSA group)
In the DSA group, the assessments were carried out by three psychiatrists and three psychologists who participated in a two-year DSA training programme between September 2013 and May 2015. In the DSA group, the patient’s first visit was managed by a psychiatrist-psychologist pair. The visit was divided into two parts. In the first part, the clinicians focused on the patient’s present problem. Here, the clinical interview and the assessment of the patient’s current problem was conducted by the conceptual tools of DSA-based case formulation.
After the initial part of the interview there was a 10–15 minute break, during which the clinicians discussed and shaped a working hypothesis about the patient’s repetitive problematic action patterns that possibly maintained the patient’s distress and symptoms.
In the second part of the first visit the clinicians evaluated the patient’s risk behaviour, possible self-harm, and psychotic symptoms. Similarly, they appraised the patient’s need for other needful clinical interventions, such as medications or laboratory tests and provide statements to allow the patient to receive social security benefits. Finally, the clinicians offered the patient a preliminary formulation of the present problem, which the patient could then reflect on in order to collaborate in advancing the treatment plan. The clinicians and the patient then discussed the content of the subsequent assessment visits and the tentative diagnosis.
Thereafter, the psychologist, the psychiatrist, or both run the following assessment visits depending on the patient’s needs. The purpose was to comprehend in all details the patients’ important life events, problems, symptoms, and relationships with significant others through their narratives. The clinicians observed the patient’s stance on the addressed topic or object by focusing on their gestures, facial expressions, speech prosody, postures, and behaviours.
In the final assessment visit as the treatment-planning session, the clinicians and the patient aimed at clarifying the repetitive external and internal activity patterns that seemed to bring forth and maintain the patient’s present problems. Based on this joint formulation, they shaped

the treatment targets and tasks. Moreover, their intent was to identify a diagnosis and determine the immediate and the long-term targets. The clinicians wrote the treatment plan along with case formulation to the patient's records. After the assessment phase, one of the clinicians continued the treatment according to the treatment plan and schedule.

CONTROL: Assessments as usual (AAU group)
In the AAU group, the assessment team was chosen from a group of seven doctors (psychiatrists and residents), nine psychiatric nurses, and five psychologists who worked and rotated irregularly at the Evaluation Team of the Community Mental Health Care Centre in Lahti. In this group, the patient's clinical assessment and need for treatment were grounded on the standard symptom-oriented and descriptive diagnostic evaluation guidelines of public mental healthcare. A doctor with a nurse or a psychologist conducted the first visit. During the subsequent assessment visits, one of the clinicians continued the evaluation of the patient's clinical condition applying the standard symptom-oriented guidelines. In the treatment planning visit, both clinicians presented and shaped the treatment tasks and objectives, and agreed on the subsequent treatment placement with the patient. In that case, if the duration of the treatment was evaluated to last longer than six months, the patient's treatment was allocated to another Care Team within the same Mental Health Care Centre.

The Working Alliance Inventory (WAI) was used for the self-assessment of the therapeutic alliance in psychotherapy. Both the patient (WAI-P) and therapist (WAI-T) scales consist of 36 items measuring three domains of alliance, namely goals, tasks and bond. In this study, the Finnish version of the Long Form WAI was applied. The Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) was used as the baseline, which was completed during the first visit. This 34-item self-report instrument was applied to evaluate four domains: subjective well-being (CORE-W), psychic symptoms (CORE-P), life functioning (CORE-F), and risk behaviour (CORE-R). The Finnish version of the CORE-OM was approved by the Core System Trust and validated in Finland. Moreover, the number and durations of visits, the lengths of individual assessment periods and the numbers of clinicians who participated in the various phases of assessment were recorded.
During the first visit, every patient in both study groups was requested to complete the CORE-OM form. Furthermore, in the treatment-planning (i.e. final) visit, patients in both groups were asked to complete a WAI-P scale and to put it in an envelope, making the results of this assessment unknown to the clinicians. The clinicians completed a WAI-T scale together after the patient's departure. After every visit, the clinicians in both groups completed an evaluation form.

Intervention Type
Other

Primary outcome(s)
1. Self-assessment of the therapeutic alliance in psychotherapy using the Working Alliance Inventory (WAI) for the patient (WAI-P) and for the clinicians (WAI-T) at the treatment planning (i. e. final) visit. After the first visit, the number of assessment sessions was not known in advance because of the individual assessment process
2. Employee resources: the lengths of individual assessment sessions and periods, the number of and duration of visits and the number of clinicians who were involved in the various phases of assessment

Key secondary outcome(s))
The patient-clinician interaction from the patient-centered approach is investigated using qualitative conversation analysis

Completion date
10/03/2017

Eligibility

Key inclusion criteria
1. Patients with a referral for a psychiatric assessment, sent from primary, occupational, or student healthcare units, or from private practice
2. 18–65 years of age
3. Able to understand the study's purpose and give written informed consent

Participant type(s)
Patient

Healthy volunteers allowed
No

Age group
Adult

Lower age limit
18 years

Sex
All

Total final enrolment
80

Key exclusion criteria
1. Subjects whose referral suggested any psychotic or neuropsychiatric disorders, such as attention deficit disorders and autism, or any cognitive disabilities
2. A referral for an emergency or urgent assessment (i.e. within 7 days)
3. The patient's native language had to be Finnish

Date of first enrolment
13/01/2015

Date of final enrolment
30/08/2016

Locations

Countries of recruitment
Finland

Study participating centre

Päijät -Häme Central Hospital
Keskussairaalankatu 7
Lahti
Finland
FI-15850

Sponsor information

Organisation
Päijät-Häme Central Hospital

ROR
https://ror.org/02v92t976

Funder(s)

Funder type
Hospital/treatment centre

Funder Name
Competitive State Research Financing of the Expert Responsibility area of Tampere University Hospital, Finland

Results and Publications

Individual participant data (IPD) sharing plan
The data sharing plans for the current study are unknown and will be made available at a later date.

IPD sharing plan summary
Data sharing statement to be made available at a later date

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Results article	results	10/12/2019	01/07/2020	Yes	No
Participant information sheet	Participant information sheet	11/11/2025	11/11/2025	No	Yes