Author’s response to reviews

Title: Do patients prefer optimistic or cautious psychiatrists? An experimental study with new and long-term patients

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Dear Editor

Re: “Do patients prefer optimistic or cautious psychiatrists? An experimental study with new and long-term patients” (Manuscript # BPSY-D-16-00293)

Thanks for your message 7th December about the above manuscript. I need to apologize that in our first re-submission, we indeed addressed the comments of only one reviewer (reviewer no.2). We had not found and therefore did not respond to the comments of reviewer no.1, which was clearly our fault. So, thank you very much for pointing us to our oversight.

We addressed the comments of reviewer no.1 (which we found helpful and have in our view led to several improvements of the paper) as follows:

The manuscript titled “Do patients prefer optimistic or cautious psychiatrists? An experimental study with new and long-term patients” (Manuscript # BPSY-D-16-00293) provides findings from an experimental study that examined the impact of optimistic or cautious messages delivered by a psychiatrist on patients’ ratings of (a) belief the psychiatrist is a good doctor, (b) trust in the doctor, (c) preference to have doctor as personal psychiatrist, and (d) willingness to start the new treatment with this psychiatrist. The findings partially support the authors’ hypothesis. New patients had more positive ratings to the optimistic message about the treatment
than to the cautious message about treatment. Patients who had been in treatment for a longer period of time did not show a difference in their ratings of the optimistic and cautious messages about new treatment options.

A significant strength of the present study is the use of experimental methods to understand the impact of optimistic and cautious messages about new treatment options. The authors used a counter-balanced design to control for effects of the psychiatrist presenting the information and whether the new treatment involved psychotropic medication or psychotherapy. The authors recruited a large sample with sufficient power to detect a medium effect size.

No response required.

The present study can be improved by adding information about the results of the regression analysis. For example, the authors should present the findings related to the main effects for medication vs. psychotherapy, differences between the 4 psychiatrists, optimistic vs. cautious messages, and old vs. new patients. It is very likely that the results were that the comparison of the medication vs. psychotherapy and the comparison of the ratings for the 4 psychiatrists were not statistically significant. (If they comparisons were significant, the authors would have reported these findings in the results sections.) Nonetheless, for the sake of future investigators (or scholars conducting meta analyses), these nonsignificant effects should be reported.

The authors presented the finding of an interaction between patient group (new vs. longer treatment experience) and message (optimistic vs. cautious), but for completeness, the main effects for group and message should be reported as well.

As requested, we added the findings for the main effects (result section; overall ratings).

We would like to refrain from a comparison of means for each psychiatrist, for three reasons: a) a comparison of specific psychiatrists was not part of the research question; b) more statistical significance testing outside the research question may just raise the issue of multiple testing and the need for adjustments; and c) when we recruited psychiatrists for this study (and similar ones in the past) we always guaranteed that we would not analyze individual results and compare ratings for psychiatrists as a poor rating might potentially be humiliating and undermine the willingness of psychiatrists to expose themselves in such video-clips. Since we have only four psychiatrists in this study, any reporting of differences (although anonymised) would raise questions about the differences and about who specifically was rated better or worse.

As the findings were adjusted for clustering of ratings for psychiatrists, this does not have any impact on the results.

Throughout the Results and Discussion sections, the authors refer differences in patient “preference” as the key outcome for this study. However, patients answered 4 questions for this study, and only one of these questions asked “Would you like to have this doctor to be your
psychiatrist?” Ratings to all 4 questions were summed, and the report that Cronbach’s alpha was 0.95, indicating that all 4 questions were measuring the same construct. However, given that only one of the four questions asked whether the patient “would like start the new treatment with this psychiatrist,” or “would like this doctor to be your psychiatrist?”, it is unclear to this reviewer whether the findings should be described as measuring the patients’ “preference.”

We fully accept the limitations of the term ‘preferences’ as patients just rated a psychiatrist at the time without explicitly being asked to ‘prefer’. Yet, after long discussions among the authors and in the wider research team, we felt that the term ‘preferences’ still describes appropriately what was being studied and has the advantage of being relatively independent of already established psychological theories. Thus, we would like to stick to it. Since the study and actual wordings of the presentations are transparently reported in the paper, the readers can judge for themselves as to how best to describe the patients’ ratings.

Regardless of whether the best descriptor for the outcome is “preference”, it is clear that new patients have a more positive response or reaction to the optimistic message about treatment (regardless of whether the proposed treatment is medication or psychotherapy). When new patients receive a cautious message about the effectiveness of the proposed treatment, their reaction is similar to the reaction of longer-term patients.

Although the authors state that longer-term patients do not respond more positively to the optimistic message about proposed treatment, it does not follow that psychiatrists should provide a more cautious message to these patients. With respect to clinical practice, the current findings suggest that psychiatrists should offer an optimistic (but realistic) message about a proposed treatment. New patients will have a more positive response to this optimistic message, but longer-term patients will not have as positive response to this message. If longer-term patients had responded to the optimistic message with lower ratings (in comparison to longer-term patients receiving the cautious message), the practical advice would be to provide different kinds of messages, depending on how long patients have been in treatment.

We fully agree that for new patients optimistic presentations should be preferred, whilst for long-term patients no preference has been identified. We amended the phrasing in the discussion and hope that we now use an appropriate wording throughout the paper.

The present findings raise a possible question (perhaps to examine in future research). To wit, “what kind of message would elicit a more positive response or rating in patients who have had longer-term treatment or experience with mental health intervention(s)? The authors may want to briefly consider this matter in the Discussion section.

As suggested, we inserted this consideration into the discussion (end of implications).

A possible limitation of this study is that psychiatrists probably phrase their cautious messages differently than the ones used in the present study. For example, when uncertain of the benefits
of a new medication or psychotherapy, psychiatrists are likely to provide a blend of optimistic and cautious statements. (Something such as “I cannot say whether this new [medication or psychotherapy] will be the right one for you, but I think it’s worth a try to see if this one will improve your symptoms.”) In other words, the information is likely to offer an honest appraisal that the recommended treatment may work, but the evidence is inconclusive at this time. Messages that could be described as “cautious optimism” may be more common than the cautious messages used in the present study. (The clearer contrast between the types of messages is both a strength and weakness of the current design. The strength relates to the internal validity of the present study, whereas the tradeoff is the difference from how these messages are worded in clinical practice.

As suggested, we added a longer statement in the discussion (strengths and limitations, limitations) outlining this point, which looks indeed important and had not been sufficiently addressed in the original version of the paper.

We hope that the revised manuscript will be acceptable for publication in BMC Psychiatry.

Kind regards

Stefan Priebe