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Can Patients' Views of a Therapeutic System Predict Outcome? An Empirical Study with Depressive Patients

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Using the principles of brief therapy as developed at the Mental Research Institute (MRI) in Palo Alto, this study examined how patients viewed psychiatrists' and significant others' attitudes toward the severity of their illness, as compared with their own attitude, and whether these views were related to outcome. Forty-one depressive inpatients were asked a two-part question—Who regards your illness as being more severe: (a) you or your significant others; (b) you or your psychiatrist? Two subsamples of patients were identified: those who viewed psychiatrists' and significant others' attitudes toward the illness as similar (equally structured systems) and those who viewed them as dissimilar (differently structured systems). Both groups showed equal and significant improvement during hospital treatment; but the group that viewed the attitudes held by psychiatrists and significant others as dissimilar reported improvement after discharge.

In the field of psychiatry, empirical research on the concept of systems began with a field study that led to the Department of the double-bind theory of schizophrenia (2). Since then, such research has concentrated mainly on the family. This has been the case in therapeutic studies as well as in field studies. The system that the present study examined was not the family but, rather, a therapeutic system. This system includes not only the patient, his or her family, or a larger social group, but also the therapist, the psychiatric institution, or parts of a health service system (7). The therapeutic system is time-limited and depends on the therapeutic setting.

Our approach to a study of the therapeutic system is based upon brief therapy, as developed by the Mental Research Institute (MRI) in Palo Alto. A principle of brief therapy is that one evaluates which solutions have so far been attempted for the patient's problem, and to try a different one in therapy. That is, one tries solutions that are opposite of what has already been tried, for instance, by the patient's significant others (3, 5, 10, 11). Thus, in a condensed and somewhat simplified fashion, the relationship between patient and therapist should be different in some therapeutically decisive respect from that between the patient and significant others.

In this study, this principle was applied not to specific attempted solutions but, by analogy, to general attitudes toward the patient's problem or illness. Accordingly, the attitudes of both significant others and the therapist should differ in the patient's view. For example, if the patient believes that significant others regard the illness as less severe than he or she does, then the patient should believe that the therapist regards the illness as being equally or more severe than he or she does. Therapeutic systems that are differently structured from the patient's point of view were hypothesized to correlate positively with a better outcome.

To test this hypothesis, we attempted a systems description of an attitude within the therapeutic milieu of a psychiatric hospital, using simple methods, and probing the patterns found in significant relationships with respect to outcome criteria. Only three parts of the therapeutic system were examined: (a) the patient, (b) his or her significant others, and (c) the psychiatrist. The role of the psychiatrist in this setting is as an expert and a representative of the psychiatric institution. The institution is, predominantly, a biologically oriented, moderately sized psychiatric department of a university hospital for mainly acute psychiatric disorders. According to systems theory, features or attitudes of members of a system should be described not in absolute terms (making a comparison only with values from a different system) but, rather, in a relational way by comparisons *within* the system, whereby only differences are relevant (1, 8). Any attitude held by the therapeutic system's members should be described in the same way, that is, not only which attitude is held by the patient, the significant others, and the psychiatrist, but also who holds this attitude to a greater or lesser extent—patient or significant others, patient or psychiatrist. Obviously, one does not know which attitudes are relevant for the therapeutic process and which are not. Different attitudes may be important within different therapeutic systems and at different stages of therapy.

Tentatively, this study concentrates on an attitude that is clinically relevant: the rating of severity of illness. This attitude within the therapeutic system is not described by an observer outside the system but by persons within it. Their views about how that attitude differs among the system's members, their "maps" of the relationship of various attitudes within the therapeutic system, or what they said about their maps in an interview, were examined and related to outcome.

METHOD

The patients were all acutely ill and had been admitted because of severe depression, as rated by the von Zerssen Depression Scale DS + DS' > 24 (9). Only patients with schizophrenic, bipolar affective, or organic disorders were excluded, on the basis that lack of insight and awareness of one's illness are often found in such patients. This wide

inclusion of severely depressed persons necessarily led to a high variability of diagnoses, treatment methods, and course of illness. But, because this study used a new approach, it did not seem useful to make further restrictions beforehand. Thus, in order to describe differences in structures, the criteria for inclusion were restricted to depressive syndromes regardless of formal psychiatric diagnosis.

The patients were interviewed in the afternoon after the day of admission. The regular, intensive psychiatric examination by the psychiatrist had already taken place. An interviewer, not otherwise involved in therapy, asked the patient: "Who regards your illness as being more severe—significant others or you yourself (or is there no difference), and the psychiatrist or you yourself (or is there no difference)?" If required, an identical, short explanation with two examples for each question was given. The psychiatrist was asked the same question, comparing the patient's attitude with his or her own.

Depending on the answers, two subsamples of patients were formed: one group that viewed attitudes of significant others and psychiatrists as being similar, and the other group that did not. In the first group were those patients who stated that both psychiatrist and significant others regarded their illness as being more, equally, or less severe than they did themselves. In the second group were those patients who viewed the attitudes of psychiatrists and significant others as being different than their own, regardless of the kind of difference. The first group, therefore, viewed the therapeutic system as equally structured; the second group viewed it as differently structured. These two groups were compared in outcome.

The depressive symptoms were assessed by a self-rating scale, the von Zerssen Depression Scale (9), and by the Hamilton Depression Scale (6) at the beginning and end of inpatient treatment. The Hamilton Scale was rated by the primary psychiatrist. In order to assess the effect of the hospital treatment as a whole, a combination of simple, objective and subjective criteria was applied. Three to 4 months after discharge, all patients were asked whether they had been admitted to a psychiatric hospital in the meantime and, if not, whether their condition was generally better than, equal to, or worse than it had been at the time of their discharge. These criteria can by no means be regarded as sufficient for a comprehensive assessment, but they are certainly one possible route to allow an empirical approach (7).

Characteristics of Patients and Psychiatric Treatments

Nearly all patients who were admitted within a given period of time and met the inclusion criteria could be included in the study. The few exceptions were due to organizational problems. Forty-one patients (30 females, 11 males), who were treated on five different wards by 12 psychiatrists, were examined. Their ages ranged from 21 to 81 (mean = 50, SD = 12.8). The primary psychiatric diagnoses, according to ICD-9 classification (12), were endogenous depression (n = 16), neurotic (n = 16) and personality (n = 1) disorders, depressive reaction (n = 3), alcohol dependence (n = 3), isolated hypochondriac delusion (n = 1), and a depressive condition without clarification (n = 1). In 5 patients, the secondary diagnosis was drug abuse or dependence. Among the 41 patients, significant others were reported as spouses (n = 19), other family members (n = 8), and persons outside the family (n = 14). Until the follow-up, information could be obtained about all patients who had originally entered the study.

The patients were hospitalized from 3 to 223 days (mean = 58, SD = 36). During this time, 32 patients received antidepressives, 12 received neuroleptics, 4 received benzodiazepines, and 3 received lithium; 6 patients received no medication. On an average, 2.1 different psychotropic drugs per patient were given during hospitalization. Two patients received electroconvulsive therapy. In addition to the ordinary ward program, 12 patients participated in occupational therapy. The type and amount of psychotherapeutic activities depended on the nature and extent of the psychiatrist's psychotherapeutic training and on the ward's atmosphere and staff. The therapeutic activities included group therapy for some patients and, for one patient, music therapy.

RESULTS

There was no positive correlation between patients' and psychiatrists' judgments as to which one of them regarded the patient's disorder as being more severe (Kendall's tau = -.05, ns). This means that patients and psychiatrists describe different maps of that attitude within their relationship, although their judgments were based upon the experience of the same interactions that had occurred between them. How a patient assessed the attitude of the psychiatrist and significant others toward the severity of the illness, as compared with his or her own attitude, is summarized in Table 1.

Table 1

Two-Part Question to Patients: Who Regards Your Illness as More Severe?

Part 1: Significant others or yourself?	
Significant others:	6
No difference:	6
Myself (patient):	29

Part 2: Your psychiatrist or yourself?	
Psychiatrist:	8
No difference:	5
Myself (patient):	28

Table 2 shows how these answers to the two questions were related. More than half the patients (22 in the lower right of Table 2) said that they themselves would regard the illness as being more severe than did both the psychiatrist and significant others. In other words, the patients believed that neither significant others nor the psychiatrist could see how severely ill they really were. Therefore, according to this study's definition, 26 patients were in an equally structured system (from their point of view), and 15 were in a differently structured system.

Table 2

Relation of Different Attitudes on Two-Part Question

	Part 1: Significant others or yourself?		
	Others	**No difference**	**Myself**
Part 2: Psychiatrist or yourself?			
Psychiatrist:	3*	1**	4**
No difference:	1**	1*	3**
Myself:	2**	4**	22*

* equally structured systems (26 patients)

** differently structured systems (15 patients)

Table 3 shows the sex, age, and length of stay for patients within equally and differently structured systems. Only the difference in age is statistically significant (*t*-test for independent samples, $t = 2.55$, $p < .05$). Table 4 indicates that both groups did not differ in their depressive symptoms at the beginning or the end of the hospital treatment. None of the differences between the two groups is statistically significant, but the reduction of symptoms for each scale and each group is highly significant (*t*-tests for paired samples ranged from $t = 4.73$ to $t = 7.45$, $p < .001$). As far as the single components of the psychiatric treatment were recorded, there were no apparent differences between the two groups, nor did they clearly differ in diagnoses or ward assignment.

Table 3

Characteristics Patients within Equally and Differently Structured Systems

	Equally Structured	**Differntly Structured**
Sex (female/male)	17 / 9	13 / 2
Age (mean years)	53.8	42.7
Days hospitalized (mean)	59.9	53.6

Table 4

Mean Depression Scores at Beginning and End of Hospitalization

	Equally Structured Systems	**Differently Structured Systems**
At beginning:		
von Zerssen Scale	51.0	50.4
Hamilton Scale	18.1	19.4
At end:		
von Zerssen Scale	28.2	26.0
Hamilton Scale	6.4	6.5

In Table 5, some features of the treatment during the follow-up phase are summarized. No difference is statistically significant.

Three to 4 months after discharge, 5 patients had been readmitted to a psychiatric hospital. All of them had been in

equally structured systems during inpatient treatment. Of the remaining 36 patients, 12 judged their present condition unchanged, 7 judged it to be worse than at the time of discharge, 17 reported further improvement. Patients with and without further improvement did not significantly differ either in diagnoses, sex, age, length of stay, ward assignment, and treatment variables during and after hospitalization.

Table 5

Some Features of Treatment during 3-4 Months Follow-up Phase

	Equally Structured Systems	**Differently Structured Systems**
Regularly seen by psychiatrist (yes/no):	10 / 16	3 / 12
Medication (yes/no):	16/10	11 / 4
Psychotherapy (yes/no):	4 / 22	2 / 13

Table 6 shows that improvement is reported significantly more in patients who had been in differently structured therapeutic systems. As an example of the relation shown in this table, 4 patients (also see upper right in Table 2), who had stated that their significant others regarded their illness as being less severe than they did themselves, now said that their psychiatrist would regard their illness as being more severe than they did themselves. Presumably, these patients supposed that significant others believed they would fabricate or exaggerate their symptoms, and that they did not suffer as much as they claimed they did. Now they were being treated by a specialist who supposedly thought they were worse off and more severely ill than they believed. This constellation is often sought after in MRI brief therapy. All of those 4 patients reported improvement since their discharge.

Table 6

Relation of Therapeutic System Structure to Reported Further Improvement in 3-4 Months Follow- Up Phase

	Equally Structured Systems	**Differently Structured Systems**
Further improvement	6	11
No further improvement	20	4
$\chi^2 = 9.92$, df = 1, $p < .01$		

DISCUSSION

Patients who view the therapeutic system as being differently structured in terms of attitude toward the severity of their illness significantly more often show a further improvement during the follow-up phase, an improvement that is independent of specific therapeutic measures, and which occurs although both groups had already experienced substantial and equal improvement during inpatient treatment. In explaining the results, it should be taken into account that many factors have not been considered, a case in point being the structures of therapeutic systems in which the patients had been treated as outpatients previous to or following hospitalization. To account for the result, at least three assumptions may be made. First, the attitude toward the severity of a patient's illness seems to be a relevant feature of many therapeutic systems. Second, to some extent, it is possible to analyze the therapeutic system even when only three basic components of it are considered. Third, as the results indicate, the patient's description, his or her map of the system, is an important criterion in determining the outcome of the patient's condition. These maps exist on a cognitive level. The lack of agreement between patients and psychiatrists in their judgment about who regarded the illness as more severe indicates that different observers of the same "objective" interaction may have different maps, at least when they are participants in that interaction.

Looking for a model to explain this, one could speculate that patients, while living with significant others, were exposed to a certain attitude toward their illness, which may be viewed as in accord with the "attempted solution" of MRI brief therapy. It is this system in which their disorder had developed and in which their admission to a hospital was thought necessary or useful. Inpatient treatment in a psychiatric hospital takes place in a complex situation with many different and interdependent processes. These processes, which are not the subject of examination in this study, eventually result in a marked improvement for both groups. During this time, patients live on the ward and have their most frequent and important contacts with nurses, doctors, and other patients. The actual interaction with significant others is rarer and probably less relevant than before and after hospital treatment. During treatment, some patients—those with differently structured systems—experience a qualitatively new attitude toward their illness, unlike the one they were used to. They no longer gain the impression that their significant others' attitude is the only possible one. The differently structured system may influence and change the perception and evaluation of their own and significant others' attitudes. When patients return to their usual environment, this different perception of their illness and of the attitudes within the system in which they are again living may lead to different behavior, better adaptation, and further improvement. This result is in accord with the

results found in differently designed systemic brief therapies—that there is further improvement after termination of treatment (4).

Although there is no satisfactory explanation for the fact that patients within differently structured systems are significantly younger, age cannot account for the difference in improvement after discharge because patients with and without further improvement show no significant age difference. Finally, the exact value to be attached to and the reliability of the global answers patients gave in the interview after the follow-up phase are unclear, although patients' statements about whether they feel better are a valid and common criterion for psychiatric evaluation of outcome.

CONCLUSIONS

Although the attitude about the severity of patients' illness is in itself not a problem-related solution but, rather, a basic attitude in therapy, the (hypothesized) relationship found between the structure of the therapeutic system and outcome can be considered as consistent with MRI brief therapy principles. The examination of patients' maps of how attitudes toward the severity of their illness varied within the therapeutic system allows one to predict at least one relevant outcome criterion. It remains open yet as to how far therapeutic decisions and interventions within the consistent framework of a psychiatric hospital setting can influence these "attitude maps." Granted that the methods used were simple, tentatively applied, and bore a high degree of uncertainty, they did yield results. One should be cautious about the findings until replication studies have been carried out in similar settings. That positive correlations were found under such conditions should encourage empirical research and field testing of systemic ideas in psychiatry. This study has shown that examination of a therapeutic system's structure may be helpful in such attempts.

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