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The Therapeutic System as Viewed by Depressive Inpatients and Outcome: An Expanded Study

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In an expansion of a previous study, we examined in which way depressive inpatients' views of psychiatrists' and significant others' attitudes toward the severity of their illness were related to outcome. Fifty-six patients 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 the psychiatrists' and significant others' attitudes as similar and those who viewed them as dissimilar. Both groups showed substantial and significant improvement during hospital treatment; but the group that viewed the attitudes held by psychiatrists and significant others as dissimilar had significantly fewer depressive symptoms by the end of a 3-month followup period. The findings were consistent with those of the original study, and with the hypothesis as derived from the Mental Research Institute brief therapy principles.

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At the Mental Research Institute (MRI) in Palo Alto, an Ericksonian-based and solution-oriented brief therapy has been developed (Coyne & Segal, 1982; Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974). A central principle of brief therapy is that one evaluates which solutions have so far been attempted for the patient's problem, and then to try a different solution in therapy. That is, one tries solutions that are different from or even the opposite of what has already been tried, for instance, by patient's significant others. Applying this principle to basic attitudes toward a patient's illness, it may be hypothesized that, in therapy, patients should experience an attitude toward their illness that is different from the one they are used to from their significant others. Thus, patients who view their therapists' attitude to their illness as different from their significant others' attitude, should benefit more from therapy than those who view therapists' and significant others' attitudes as similar. In a simplified fashion, this hypothesis, referring to a general principle of MRI brief therapy and not to specific therapeutic interventions, was tested in hospital treatment of depressive patients in a previous study (Priebe, 1989).

Forty-one depressive inpatients were asked a two-part question—"Who regards your illness as being more severe: (a) significant others or you yourself (or is there no difference); and (b) the psychiatrist or you yourself (or is there no difference)?" Two subsamples of patients were identified: 26 patients viewed psychiatrists' and significant others' attitudes toward the illness as similar ("equally structured systems") and 15 patients viewed them as dissimilar ("differently structured systems"). Both groups did not differ in treatment variables that were recorded in the first study. They showed equal and significant improvement during hospital treatment; but the group that viewed attitudes held by psychiatrists and significant others as dissimilar more often reported improvement within a 3- to 4-month followup after discharge. The results from the first study were regarded as being consistent with the hypothesis. However, one had to be cautious about the findings since they were the result of a preliminary study.

We now report an expanded study that was carried out in the same setting, but examined a larger sample and used more established methods to assess outcome after discharge. Like the original study, this expanded study was not intended to investigate effects of properly administered brief therapy, but to analyze therapeutic systems in conventional psychiatry according to principles of brief therapy. We tested whether the structure of the therapeutic system was associated with outcome.

METHOD

All patients were admitted to a moderately sized psychiatric university hospital, and suffered from a depressive syndrome. Inclusion criterion was a score on the Von Zerssen (1986) Depression Scale DS + DS' > 24. Only patients with organic or schizophrenic formal thought disturbances were excluded in order to avoid a priori restrictions on the basis of conventional psychiatric criteria, such as formal diagnosis. Depressive symptoms were assessed at the beginning and end of inpatient treatment. For clinical ratings the Hamilton (1960) Depression Scale (HAMD), for self-ratings the Von Zerssen Depression Scale (DS) and a visual analogue scale (VAS—extreme points: 0 = "my condition is generally good," 100 = "my condition is generally bad") were used. (See Aitkin, 1969, and Bond & Lader, 1974, for studies using the VAS). The same clinical and self-ratings were made 3 months after discharge. This application of standardized rating scales to assess

outcome after the followup phase was different from the method used in the original study. In that study, after followup, patients just made a statement as to whether their condition was generally better than, equal to, or worse than at discharge.

Patients were asked the same two-part question, as in the original study, by an interviewer not otherwise involved in therapy. If required, a short explanation was given. Unlike the original study, patients were asked not on the day after admission, but on the day before discharge. On the day after admission, patients' views of the psychiatrist and his or her attitudes were based upon the experience of only one intensive interview. At discharge, patients had experienced their psychiatrist in many, usually daily, contacts during the entire period of hospital treatment. Therefore, patients' statements at discharge were likely to be more reliable than on the day after admission.

According to their 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 psychiatrists 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, regardless of the kind of difference. The first group, therefore, viewed the therapeutic system—consisting of patient, significant others, and psychiatrist—as equally structured; the second group viewed it as differently structured, according to the first study's definition. These two groups were compared in outcome during hospital treatment and after a 3-month followup.

RESULTS

Sample and Psychiatric Treatments

Fifty-six patients (38 females, 18 males), who were treated on six different wards, were examined. Their ages ranged from 21 to 72 years (mean = 46, SD = 14.2). The primary psychiatric diagnoses, made by the clinicians according to ICD-9 classification (1977), were schizophrenia (n = 2), endogenous depression (n = 15), depression in bipolar affective psychosis (n = 4), paranoid syndromes (n = 2), anxiety states (n = 5), neurotic depression (n = 8), other neurotic (n = 3) and personality (n = 4) disorders, alcohol dependence (n = 2), depressive reaction (n = 10), and adjustment disorder (n = 1). In seven patients the secondary diagnosis was drug abuse or dependence.

The patients were hospitalized from 4 to 223 days (mean = 64, SD = 47.6). During this time, 41 patients received antidepressives, 18 received neuroleptics, four received benzodiazepines, and six received lithium; nine patients received no medication. On an average, 1.6 different psycho-tropic drugs per patient were given during hospitalization. Two patients received electroconvulsive therapy. In addition to the ordinary ward program, 19 patients participated in occupational therapy, 11 patients in psychoanalytic group therapy, 13 patients in a group for assertive and concentration training, and 14 patients in music therapy. The type and amount of individual psychotherapeutic activities depended on the nature and extent of the psychiatrist's psychotherapeutic training and on the ward's atmosphere and staff, and were mostly eclectic. During followup, 37 patients were regularly seen by a psychiatrist, 37 also took some psychotropic medication, and 8 were in psychotherapy.

Patients' Views of the Therapeutic System

How patients assessed the attitude of psychiatrists and significant others toward the severity of the illness, as compared with their own attitude, is summarized in Table 1. Table 2 shows how these answers to the two questions were related. According to the definition of the original study, 40 patients viewed the therapeutic system as equally structured, and 16 as differently structured.

Table 1

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

(a) Significant others or yourself?	
Significant others:	12
No difference:	20
Myself	24
(b) Your psychiatrist or yourself?	
Psychiatrist	7
No difference:	23
Myself	26

Table 2

Relation of Different Answers on Two-Part Question: Who Regards Your Illness as More Severe?

(b): Psychiatrist or yourself	(a): Significant others or yourself?		
	Others	No difference	Myself
Psychiatrist:	5*	1**	1**
No difference:	3**	16*	4**
Myself	4**	3**	19*

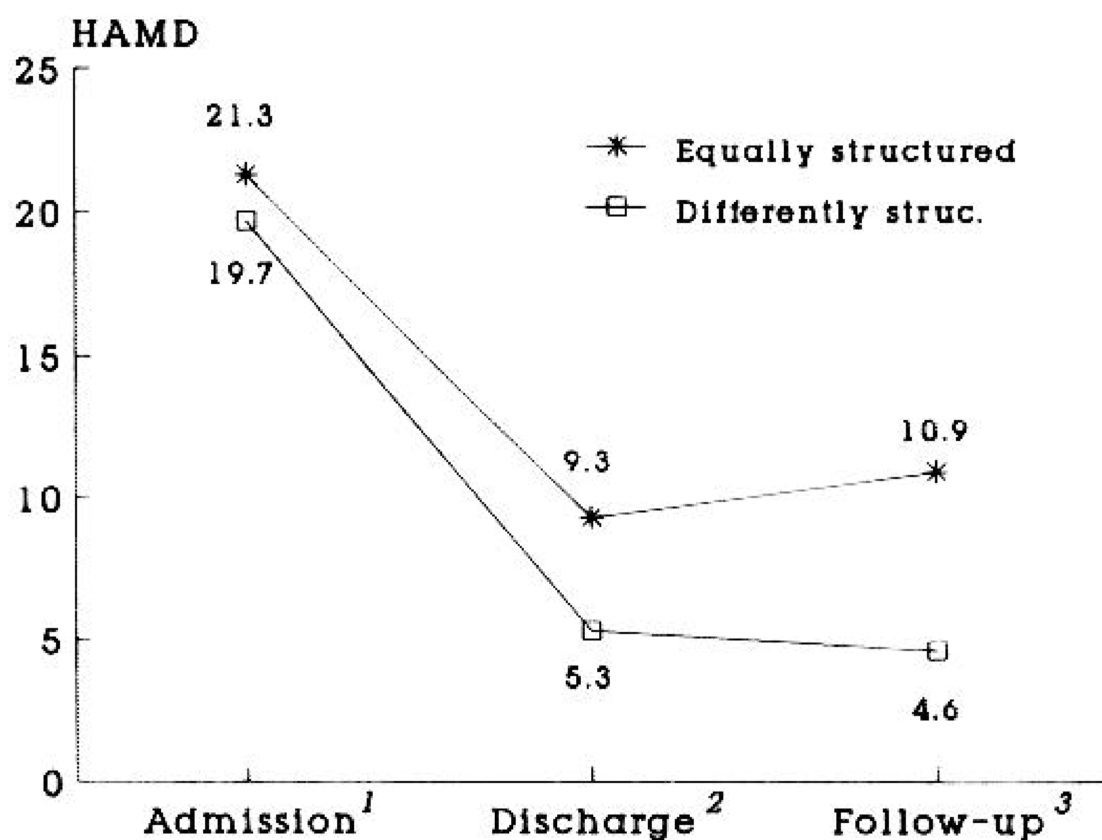
* equally structured systems (n = 40)

** differently structured systems (n = 16)

The two groups did not significantly differ in sociodemographic data (gender, age, marital and occupational status), in psychiatric history (duration of illness and outpatient treatment, frequency of previous hospitalizations, previous psychotherapy), nor in diagnostic classification (depression versus no depression). As for variables of inpatient treatment (ward assignment, length of stay, medication, participation in group therapies) and outpatient care after discharge (regularly seen by psychiatrist, medication, psychotherapy, readmission), there were no significant differences between the two subsamples.

Outcome

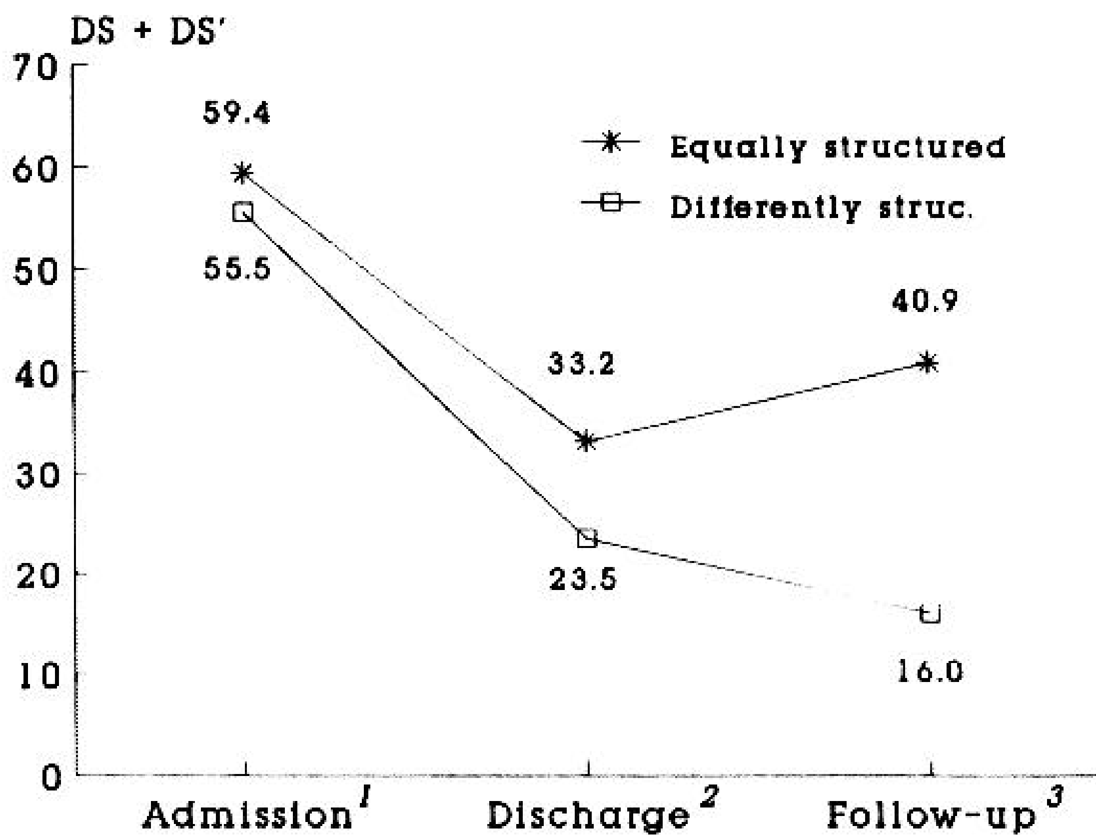
Figure 1, Figure 2, Figure 3 show HAMD-scores and self-ratings on DS and on VAS for the two groups after admission, before discharge, and at 3-month followup. In the total sample, the reduction of symptoms during hospital treatment was significant on each scale (*t*-tests for paired samples ranged from $t = 6.91$ to $t = 11.63$, $p < .001$). During followup, the entire sample did not change significantly. Subsequently, differences between scores on day after admission and those after followup were also significant on each scale ($t = 5.81$ to $t = 9.99$, $p < .001$). Therefore, conventional psychiatric treatment combining various therapeutic approaches led to a marked improvement on average.



1: n.s. 2: $t = 2.35$; $p < 0.05$ 3: $t = 2.65$; $p < 0.01$

Figure 1.

Hamilton Depression Scale clinical ratings for equally or differently structured patient groups upon admission, before discharge, and at 3-month followup.



1: n.s. 2: n.s. 3: $t = 3.30$; $p < 0.01$

Figure 2.
Von Zerssen Depression Scale self-ratings for equally or differently structured patient groups upon admission, before discharge, and at 3-month followup.

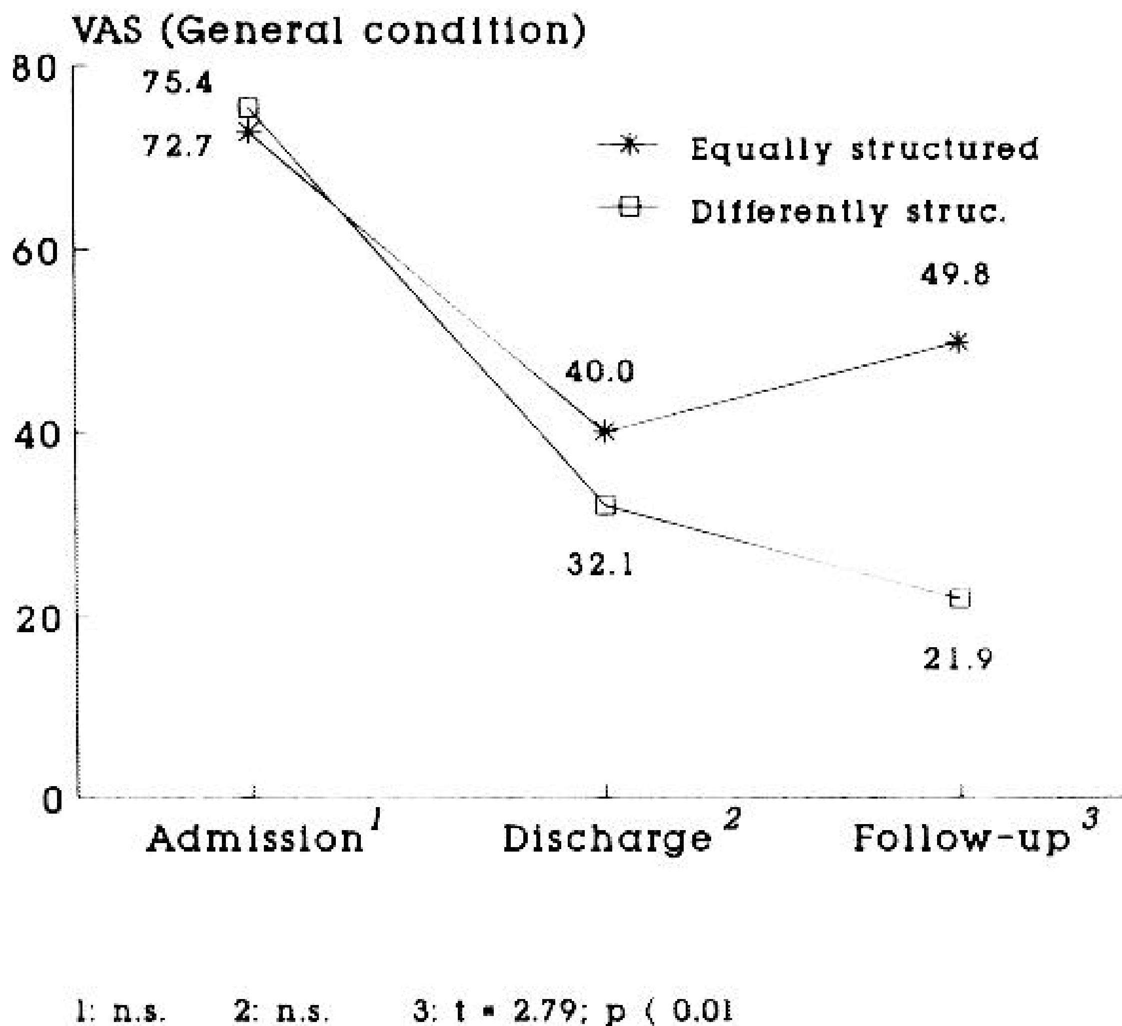


Figure 3.

Visual analogue scale self-ratings by equally or differently structured patient groups upon admission, before discharge, and at 3-month followup.

Between the two groups there were no clear differences after admission in any scale. Before discharge, patients within differently structured systems had significantly lower scores only in the HAMD. Within the followup period, patients who viewed their therapeutic systems as equally structured deteriorated, while those patients who had been in differently structured systems improved on each scale. This opposite tendency in symptom change leads to a substantially increased difference between the two groups at 3 months after discharge, significant at a 1% level in each rating.

Partly during the hospital treatment itself, but particularly within the followup period, patients within differently structured systems show a more positive change in symptoms, so that they evidently had benefited more from hospital treatment as a whole than did patients within equally structured systems. This finding is supported by results of two-factorial analyses of variance the two factors being the structure of the therapeutic system (as viewed by the patient) and point of time (admission, discharge, followup). In these analyses, interactions, group (structure of the therapeutic system) X time, are statistically significant for scores on DS ($F = 3.76$, df = 2, $p < .05$) and on VAS ($F = 3.66$, df = 2, $p < .05$), but failed to reach statistical significance for ratings on HAMD.

Finally, we were interested in whether the less favorable course of symptoms in patients within equally structured systems would be mainly attributable to subgroups within that group. Therefore, we compared (1) patients who stated that both psychiatrist and significant others regarded their illness as being less severe than they themselves did (n = 19 in the lower right of Table 2), (2) those patients who viewed both psychiatrist's and significant others' attitude as similar to their own (n = 16 in the middle of Table 2), and (3) those who believed that psychiatrist and significant others would regard their illness as more severe than they themselves did (n equals; 5 in the upper left of Table 2). The first group of patients tended to have a higher degree of symptoms on each scale and for each point of time. However, the change of symptoms over time

was similar in all three subgroups, and no group showed a significantly worse deterioration after discharge than did the other two groups.

DISCUSSION

The findings of this expanded study are similar to those of the original study, and consistent with the hypothesis as derived from MRI brief therapy principles. In contrast to the first study, the course of symptoms within the followup period was now assessed by more exact, standardized, and well-established methods. Thus, the results, that patients who view the therapeutic system as being differently structured benefit more from treatment by the end of the followup period, seem to be more reliable than those of the first study. It remains an open question whether clearer differences would have been found had shorter or longer followup periods been studied. However, it should be taken into account that patients' views of the therapeutic system were again assessed by only one question. More detailed variables of interactions within the therapeutic system were not assessed. In the second study, we did try to validate patient's statements about their views of attitudes within the therapeutic system and to relate them to specific "attempted solutions" by the psychiatrist and by significant others (Priebe & Haug, 1992; Priebe, Saupe, & Kuhn, 1991). Therefore, we asked patients standardized, open questions as to what solutions psychiatrists and significant others had tried and what specific recommendations they had made. However, patients' statements about attempted solutions and recommendations varied from very vague to extremely specific. Because these statements could not be sufficiently categorized, a satisfactory formation of subgroups (similar versus different solutions attempted) and further analysis were not possible. It remains unclear which actual interactions in the family and in therapy affected the patients' views, as assessed in this study, and how those views develop and change over time.

Patients within equally or within differently structured systems did not differ in basic clinical and treatment data. In future studies, more detailed variables about the patients' history, about their interaction with significant others, and about the therapeutic relationship should be obtained in order to get a notion of what different views of a therapeutic system are based on, and how they may be related to other treatment variables. So far, one can only speculate as to which therapeutic factors are associated with the patients' views of the therapeutic system, and which might account for the difference in outcome.

The present study seems to provide support for some assumptions made in discussion of the results of the original study. First, the attitude toward the severity of a patient's illness is 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—patient, psychiatrist, and significant others—are considered. In interpretation of the results, we suggested an explanation in accord with MRI brief therapy principles: while living with significant others, patients were exposed to a certain attitude toward their illness. It is this interaction with significant others in which the disorder had developed and in which admission to a hospital was thought necessary. During hospital treatment, some patients, those within differently structured systems, experience a new attitude toward their illness. This new attitude is presented by a specialist and is unlike the attitude they were used to. This new experience may change the perception and evaluation of their own and significant others'attitudes, and influence patients' view of interactions between significant others and themselves. When patients have returned to living with their significant others after discharge, that changed view might result in altered interactions and lead to different behavior, better adaptation, and improvement. It is possible that, for this group of patients, their psychiatrists may have successfully applied principles of MRI brief therapy without being aware of it. Other patients who do not perceive a new attitude toward their illness by their psychiatrists also benefit markedly from conventional hospital treatment, but they deteriorate when factors of inpatient treatment—such as institutional protection, activation by staff, frequent contacts with fellow-patients and psychiatrists—are not effective any more, and when they experience the same interaction with their significant others as before admission. At followup, the difference between the two groups is of clinical relevance. Mean followup scores in patients having been in equally structured systems (HAMD-score > 10) usually indicate a need of further psychiatric treatment, while—on the average and despite mild remaining symptoms—treatment success may be regarded as satisfactory in the other group.

Of course, alternative models of explanation cannot be ruled out yet. For example, the patients' perceptions of any difference between other people's attitudes toward their illness might indicate a cognitive flexibility as a pre-condition for a better outcome of therapy. Since the present study has been done in the same setting as the original one, the findings might depend on factors in the specific setting and cannot easily be generalized to other treatment settings as yet.

CONCLUSIONS

In both studies the simplification of MRI brief therapy principles and the categorization of patients' views into two subgroups, based on a two-part question, may be seen as inadequate to reflect the real complexity of human interactions. Simplification and categorization were applied to allow an operationalized approach for investigation. This approach is intended to produce empirical support for a hypothesis derived from systemic thinking, and—to some extent—to follow the rules of conventional, psychiatric empirical research in order to improve the reputation of approaches based on systems

theory in psychiatry (Priebe & Haug, 1992; Priebe, Saupe, & Kuhn, 1991). That goal requires definition of hypotheses as well as invention, and further development of special and adequate methods for assessment. Although the results might be interpreted as providing some empirical evidence of MRI brief therapy principles, the therapeutic consequences are limited. It still remains open as to how far therapeutic decisions and interventions can influence patients' views, as tested in these studies and as found to be associated with outcome.

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