

THE EFFECTS OF PSYCHOTHERAPIES: A STUDY ON PATIENTS' PERCEPTION OF RESULTS IN AN ITALIAN PUBLIC SETTING

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SUMMARY

Enquiries centred on the perspective of users of psychiatric treatments and their families, has become an increasingly widespread method to improve the quality of treatments administered by health services. In this study, in particular, we examine the users' perception of the quality and variability of the effects of psychotherapies, the difficulties met, and the perceived help factors.

The sample consists of 216 users of psychotherapy and 223 patients in psychiatric treatment with psychological support. They are outpatients, managed by the public health service. The questionnaires included closed ended, open-ended questions and scales that were previously tested on a sample of patients. The questionnaire for patients was anonymous and administered by researchers external to the medical staff.

Irrespective of the diagnosis or of a concurrent pharmacological therapy, a high percentage of patients (75%), in both groups, feel improved. Improvement consist of the decrease of symptoms, a sense of feeling better, but also feeling grown up, more mature, having higher self-esteem and feeling more adequate in interpersonal relationships. This last type of result is significantly more frequent in the group of patients in psychotherapy. Besides these patients are faced with more difficulties and play more active a role while they are in treatment.

The main difference between patients in psychotherapy and those in psychiatric management with psychological support is not indeed the identification of different perceived therapeutic factors, but rather the different evaluation of their relative importance.

On the whole, the study seems to show that the effects of real psychotherapies include, beside an improvement of symptoms, the achievement of goals of personal growth and maturity, self-satisfaction and an increase in self-esteem, all in accordance with a conception of health as well-being and self-satisfaction rather than as absence of illness.

INTRODUCTION

One of the main issues involved in outcome evaluation lies in the choice of a perspective enabling us to detect and measure such effects as thoroughly as possible. The choice of one or another measuring tool for the results may at times represent a limit towards a broad-spectrum knowledge of all possible effects of therapy.

THE EFFECTS OF PSYCHOTHERAPY: A STUDY ON PATIENTS' PERCEPTION OF RESULTS IN AN ITALIAN PUBLIC HOSPITAL

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SUMMARY

Empirical studies on the perception of users of psychiatric treatment and their families have not so far widely spread, except for the study of patients hospitalized in mental hospitals. In this study, in particular, we examine the patients' perception of the quality and validity of the effects of psychotherapy. The hypotheses are: first, the patients will feel satisfied.

The sample consists of 218 users of psychotherapy and 223 patients in psychiatric treatment with psychological support. They are outpatients managed by the public health services. The questionnaire included closed-ended, free-ended questions and scales that were previously tested on a sample of patients. The questionnaire was administered and administered by researchers external to the institution.

In a series of 10 dimensions of a conceptual psychotherapeutic therapy, a high percentage of patients (70%) in both groups feel satisfied. Furthermore, 60% of the diseases of symptoms, a sense of being better, but also feeling down, up, down, better, and a sense of being better, and a sense of being better, and a sense of being better. The type of result is not always more frequent in the group of patients in psychotherapy. Besides these scales, we also used with these dimensions and have given a score while they are in treatment.

The main difference between patients in psychotherapy and those in psychiatric treatment with psychological support is not related to the perception of different perceived therapeutic factors, but rather to different evaluation of their relative importance.

Conclusions: the study's aim is to know that the effects of treatment, besides the effects of improvement of symptoms, the satisfaction of goals of cognitive growth and autonomy, self-actualization and the increase in self-esteem, self-acceptance, and a sense of well-being and self-actualization rather than an absence of illness.

INTRODUCTION

One of the main issues involved in outcome evaluation lies in the choice of a perspective to employ in the study and measure such effects as thoroughly as possible. The choice of an objective measure, and the results may in times represent a shift towards a better scientific knowledge of all possible effects of therapy.

Moreover, such choice may influence the conclusions of a study, both by considering as equivalent treatments that are in fact different, and by not taking into account changes because they were not foreseen by the researcher and not recorded by the measuring tools employed.

For this reason some authors, such as Gerin & Dazord (1990), suggested the use of multidimensional measuring systems that would define profiles of change, rather than using a single scale or a general index of result, and this in spite of the bigger complexity such system of survey and data processing might entail. In the same perspective, given the impossibility of giving priority to any of the many criteria of healing, Luborsky suggested another type of measuring tool. This would take into account the variety of criteria used from various points of view to define the results and, implicitly, also the goals of treatments (H.S.R.S. – Health-Sickness Rating Scale – Luborsky, 1962, 1974, 1998).

Seligman, in a work of 1995, criticises the methodological approach of the efficacy studies. He sees this research model as not completely adequate for studying the results of psychotherapeutic treatments, because of the differences between real treatments and treatments administered within the research protocol. In the latter, some specific characteristics of real treatments, such as the mutual choice between patient and therapist, flexibility, duration of treatments and, consequently, the specificity of goals, that are presumably correlated with their efficacy, are generally excluded.

Seligman (1995) proposes to develop, next to the classical efficacy studies, some studies of effectiveness. These would be founded on the systematic survey, on large populations, of opinions and perspective of patients who have experienced treatment. He also sees this method as a “pioneering” system towards knowledge of the broad-spectrum effects of real treatments. Wampold (1997) has subsequently and extensively explored these issues.

Many other authors have emphasised the importance of knowing the point of view of users and their families in evaluating the effects of treatments. Among them are Strupp (Strupp & Hadley, 1977), Lazare (Lazare *et al.* 1972, 1975) and, recently, Karasu (Karasu, 1997), who has maintained that the ideal instrument for evaluating treatment effects should include the best characteristics of both the efficacy studies and the effectiveness ones, based on a survey of the patients’ points of view.

Coursey (1991, 1995) examines the literature about the problems concerning the reliability of the patients’ answers or, rather, their ability to formulate “competent” answers, accurate and usable. His conclusions show how patients, even with most severe pathology, are able to express articulate opinions about their own experience, if the research is based on carefully formulated questions and an appropriate methodology. Coursey, in particular, emphasises the importance of using structured response questionnaires, supported by a few unstructured response questions that would allow the researchers to cross-validate the patients’ answers. Moreover, questions must be expressed in clear and specific terms, without using any technical jargon. He also maintains that, in order to avoid compliance effects, interviews must be carried out by people that are not part of the therapy staff. Coursey further stresses the importance, that those who conceive the questionnaires, are specifically competent about the patients’ problems.

Recently, Vourganti *et al.* (1998) working on schizophrenic patients, have come to similar

conclusions: these patients, when they are in a phase of clinical stability, can evaluate and report about their life quality with a high degree of reliability and, consequently, of validity.

Research on patients' perspective certainly bears some similarities with research on users' satisfaction. In planning this study, though, we have taken into account the reserves of Williams & Wilkinson (1995) and, subsequently, of Sitzia & Wood (1997) about the ambiguity and vagueness of the concept of satisfaction, and about the consequent need to study each of its possible determinants separately.

We chose to study the perception of the effects – including qualitative ones – of treatments, the perceived helping factors, and any intervening difficulty. By doing this, we tried to avoid considering user satisfaction uncritically, thus further enhancing some aspects of our previous competence regarding results and on the process-result correlation.

It is worth remembering that the validity of such studies depends on how faithfully the questionnaire answers reflect the actual perceptions of patients. Anonymity, the modality of administration of the questionnaires and the formulation of items have as their main goal as significant as possible a reduction of whatsoever form of conditioning of the patients' freedom of expression.

AIMS

Following Seligman's outline, in this work we intend to analyse the users' perspective in order to know the possible effects of treatments, the quality of the perceived changes, as well as some aspects of the correlation between treatment and outcome.

We have therefore taken into account the perceived results of treatment, evaluated by patients in terms of: perceived wellbeing, changes and goals achieved, quality of the therapist-patient relationship, difficulties met during treatment, interventions perceived as most useful in the achievement of results.

In Italy, as already noticed by others (Minguzzi, 1986) psychotherapeutically oriented therapies administered within the National Health Service can be grouped into two large categories:

- 1) The first category includes treatments administered in a specific setting, different from other therapeutic approaches, and relying on well defined theoretical and practical methods, similar to those of private structures (from now on, we will define this category with the expression "formalised psychotherapy": FT).
- 2) The second category, whose boundaries are not as well defined a priori, includes treatments in which psychiatric management is integrated with forms of psychological support (this will be defined as "non-formalised psychotherapy": NFT).

We have therefore included in our research two groups of patients belonging to these categories. In this sense, our study also aims to outline, based on the patients' perceptions, the existence of a certain degree of specificity which characterises formalised psychotherapy treatments when compared with other forms of psychiatric intervention, also having a dynamic and/or relational element.

METHOD

Research tools and procedure

The study, in all its aspects, has collected three types of data from the psychiatric services: the data concerning the functioning of Mental Health Services, the perception of users, and that of the people directly or indirectly involved in psychotherapeutic treatments.

We used five self-administered questionnaires containing open ended and closed ended questions, and an overall question leaving a range of answers from "definitely much better" to "definitely much worse". The data concerning the user questionnaires are the object of this article. In particular, we will consider the answers to questions B4, B5, B6, B8, B9 e B12.

The simultaneous use of open-ended questions, closed-ended questions and scales, as well as the use of different terminology, was previously tested on representative sample of patients, who were different for education, employment and life experience. By proceeding this way, we obtained complex questionnaire which is suitable for different types of user, expedient (filling in requires approximately thirty minutes), and generalisable (structured response questions). Moreover, the unstructured response questions make it possible to explore and check the internal coherence of the various answers, and to investigate opinions and motivation more in depth.

Following Coursey's suggestion, the questionnaires are anonymous and administered by staff external to the Services.

On scrutinizing the unstructured response items, in particular B5 and B6, we first considered each patient's answers as they were verbalised. Then, we elaborated on them with as little inference as possible, respecting the original formulation by the patient and the

Table 1
Users questionnaire

PART A: GENERAL INFORMATION
<ul style="list-style-type: none"> • Duration of registration at the Mental Health Service (ITEM A1) • Duration of psychotherapy treatment at the Mental Health Service (ITEM A2) • Frequency of psychotherapy sessions* (ITEM A3) • Number of therapists in charge of the patient (ITEM A4) • Previous psychological treatment (ITEM A5)
PART B: PSYCHOLOGICAL SUPPORT
<ul style="list-style-type: none"> • Help Alliance (<i>Help Alliance Rating Scale</i>, Luborsky 1984) (ITEM B1) • Perception of the type of treatment (ITEM B2) • Reason for requiring treatment (ITEM B3) • Perception of the effect of the treatment (ITEM B4) • Perception of the improvement/worsening (ITEM B5–ITEM B6) • Use of psychotropic drugs and evaluation of their help (ITEM B7) • Perception of therapeutic factors (ITEM B8) • Perception of difficulties during psychotherapy (ITEM B9) • Perception of the changes, due to psychotherapy, in the quality of life (ITEM B9–ITEM B12) • Way to contact the structure (ITEM B10)* • Expectations about psychotherapy (ITEM B11)*
PART C: PERSONAL DETAILS (optional)
Sex (C1) – Age (C2) – Education (C3) – Employment (C4)
Marital Status (C5) – Children (C6) – Composition of the family (C7)

*Item that appeared only in the questionnaire for patients in formalised psychotherapy

'tailored' categories (see Table 2), which were subsequently grouped into more general clusters by affinity and similarity (see Figure 2). The inter-rater reliability was also considered.

Sample characteristics

The sample consist of 216 patients who received formalised psychotherapy and 223 patients who received non-formalised psychotherapy (psychiatric treatment plus psychological support), in 21 different Mental Health Centres.

We adopted a criterion of geographical distribution, using the nine provinces of Regione Lombardia and the city of Milan. For each area, we selected a Mental Health Centre in the city, one in a big center, and a rural or mountain one; for Milan have selected central, semi-suburban and suburban Mental Health Centres.

The initial sample was represented by 26 Mental Health Centres. We only took into account the questionnaires from those Mental Health Centres which proved most reliable in terms of return rate of the questionnaires, which was not to be below 50%.

The patients receiving either form of treatment varied between 10% and 25% of those managed by the structures. This seems to be connected to the workload of the Centres and to the availability of the therapists (Lomazzi *et al.* 1997).

The composition and characteristics of the two groups show prevalence, in the FT group, of female patients, younger and with a higher cultural level than in the nFT group. Diagnoses are also not equally distributed within the two groups, although all category of pathology are present in both.

Anxiety, Somatoform and Dissociative disorders (45.0%) and Personality Disorders (25.9%) are predominant in the first group. Affective Disorders (26.0%) and Psychotic Disorders (24.7%) are, on the other hand, predominant in the second group.

Duration of treatment and frequency of sessions

In our samples, patients in formalised therapy attend the Mental Health Centres more frequently (an average, 3.72 times a month, as compared to 2.66 times measured for patients in psychiatric management), although the average duration of their treatments turns out to be lower. In general, formalised psychotherapy does not seem to have the characteristics of a long-term treatment (84.1% of the cases have been in therapy for less than three years, as compared to 63.3% of patients in non-formalised treatment).

The approximate distribution of the types of treatment administered was obtained from the questionnaires distributed to the therapists. These gave evidence of a clear prevalence of psychoanalytically oriented individual treatments (59.1%). Systemic (9.6%) and cognitive-behavioural approaches (6.7%) are also represented. Other therapeutic approaches (such as, for instance, hypnosis, sexual therapy, etc.) are represented, though in negligible percentages. 9% of the psychotherapists have claimed to be 'eclectic' (Lomazzi *et al.* 1997).

RESULTS

Perception of treatment effects

The perception of treatment effects was investigated in these questionnaires at three different levels:

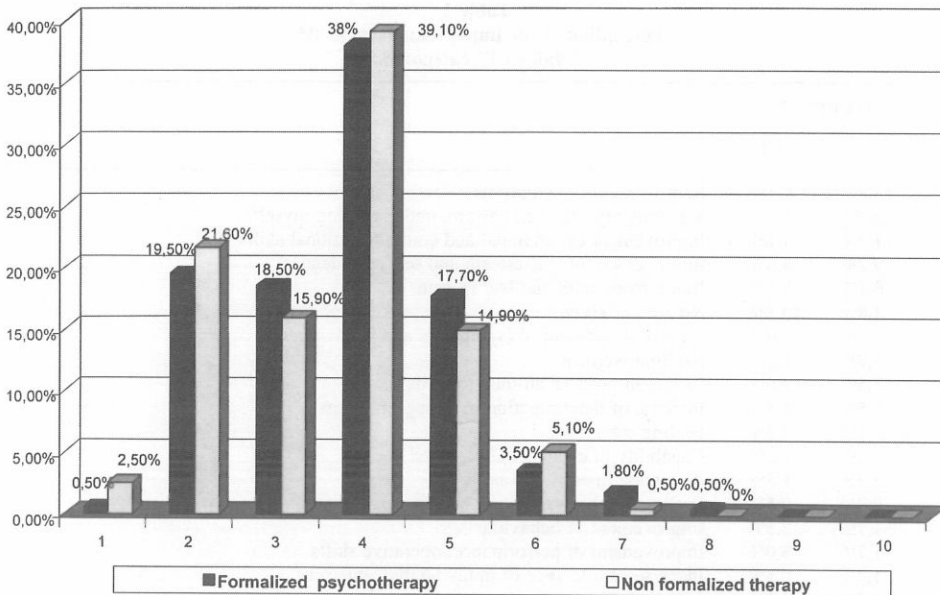


Figure 1. Perception of the effectiveness of treatment (item B4)

Note:

PERCEPTION OF THE EFFECTIVENESS OF THE INTERVENTION (ITEM B4)

“How are you now? How do you feel now if compared to when you began the therapy”

1. No answer given
2. Definitely better
3. Much better
4. Better
5. Slightly better
6. Unchanged
7. Slightly worse
8. Worse
9. Much worse
10. Definitely much worse

- 1) With the question *“How are you now? How do you feel now if compared to when you began the therapy?”*. It is a structured response question, based on a scale from “definitely much better” to “definitely much worse” (see Figure 1).
- 2) With the open ended questions *“In what do you feel improved?”* (see Figure 2) and *“In what do you feel worse?”*
- 3) Lastly, closed ended questions have explored the changes perceived in various functional areas: dependence on the service and on the therapist, need to take drugs, symptoms, quality of personal relationships, working capability, sex life, interests. These questions allowed for five levels of answer, from ‘increased’ to ‘decreased’ (increased, slightly increased, unchanged, slightly decreased, decreased).

Table 2
Perception of the improvement (item B5)
("tailored" categories)

Treatments		
FT	nFT	
13,7%	22,1%	Improvement of symptoms
13,2%	5,6%	Knowing myself, being aware, understanding myself
11,9%	4,1%	Improvement of relational and communicational skills
9,2%	4,6%	Improvement of self-esteem and self-confidence
6,1%	8,2%	Being more calm and less in pain
4,8%	10,8%	No answer given
4,4%	3,6%	Improved self-control (symptoms and behaviour)
3,9%	1,5%	No improvement
3,5%	4,6%	Increased positive attitude towards life
3,5%	1,5%	Increase of determination in facing problems
3,1%	3,6%	Feeling safer
2,2%	1,0%	Capability to evaluate, choose and decide
2,2%	1,5%	Accepting oneself, as one is
2,2%	0,5%	Feeling one has grown up, become more mature
1,7%	2,5%	Improvement of behaviour
1,7%	3,0%	Improvement of performance, operative skills
1,3%	0,5%	Increase of tolerance of unfavourable situations
1,3%	1,0%	Acceptance of reality
1,3%	0,5%	Being less dependent (on others)
1,3%	2,5%	Having found a point of reference
1,0%	0,0%	Not being afraid of expressing one's emotions, being spontaneous
1,0%	2,0%	Improvement and control over some symptoms, but persistence of other ones
1,0%	0,0%	Understanding others
0,5%	1,0%	Achieving self-realisation and self-assertion
0,5%	0,5%	Accepting one's own fragility
0,5%	1,0%	Understanding myself better, though unable to control myself
0,5%	0,0%	Having got over a loss, a situation of crisis
0,5%	0,0%	Increase of trust in other people
0,5%	0,0%	Increase of trust in psychotherapy work
0,5%	1,0%	Knowing one's illness in depth
0,5%	0,0%	Improvement of one's appearance
0,5%	3,0%	Improvement in everything
0,0%	2,0%	Improvement of behaviour
0,0%	1,0%	Being more interested in things
0,0%	0,5%	Improvement due to the therapist's help, guidance, and advice, which are useful for the whole family
0,0%	0,5%	More at ease with everything
0,0%	1,0%	Feeling more confident
0,0%	1,5%	Seeing things more realistically
0,0%	0,5%	Being less in need of psychological support

In defining the functional area to be investigated, we have been guided by Luborsky's Health-Sickness Rating Scale (H.S.R.S.), here used as a reference for the formulation of questions.

Perception of the effectiveness of treatment – ITEM B4

Patients in formalised therapy feel better or much better in 76.0% of cases, slightly better or unchanged in 21.2% of cases, and worse in 2.3% of cases. Patients in non-formalised

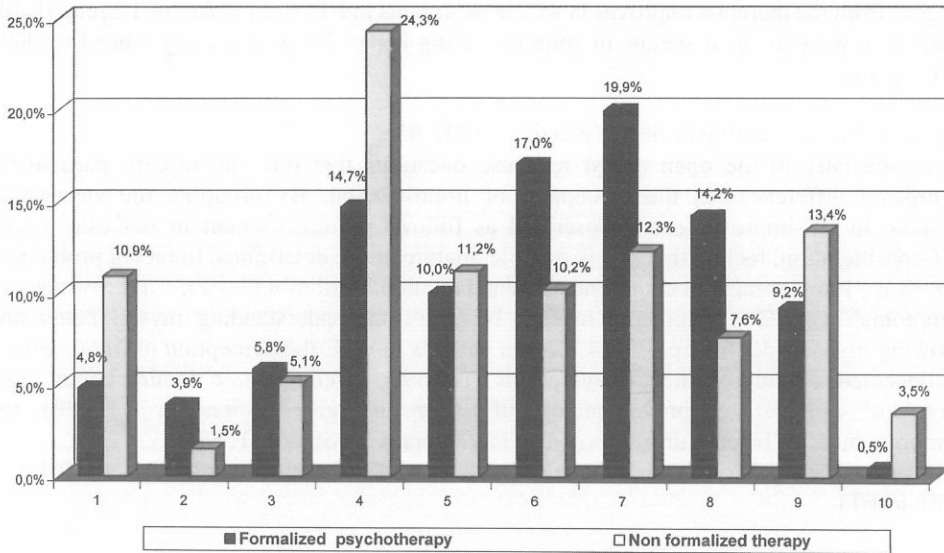


Figure 2. Perception of the quality of improvement (item B5)

Note:

PERCEPTION OF THE QUALITY OF IMPROVEMENT (ITEM B5) (clusters)

“In what do you feel improved? What aspects have improved?”

1. No answer given
2. In nothing
3. Acceptation of reality, of the way one is, of one's own frailty, tolerance of hostile situations and of loss
4. Improvement of symptoms
5. Improvement of behaviours, performance and operative skills
6. Improvement of relational and communicative skills
7. Improvement of self-esteem and self-consideration; feeling one is capable, mature, determination to face problems
8. Knowing myself, being aware, understanding myself better and knowing my illness in depth
9. Being at ease, feeling better, safer
- In everything

therapy feel better or much better in 76.6% of cases, slightly better or unchanged in 20.0% of cases, and worse in 0.5% of cases.

Perception of improvement by symptomatic/functional areas – ITEM B12

As far as functional areas are concerned, the changes perceived with most evidence are in general connected, in both groups, with “the intensity and duration of symptoms” (84.1% for FT vs 81.3% for nFT), and “feeling more at ease and happy” (74.6% for FT vs 69.5% for nFT). In particular, the perception of improvement in the area of re-activation of personal interests is more stressed in FT patients (67.3% for FT vs 57.6% for nFT).

Areas of lowest improvement – ITEM B12

These areas imply a decreased need for medication, which shows improvement in 43.4% of patients in FT and in 43.7% of patients in nFT, while the decrease in the need for help and

support from the therapist improves in 41.7% of patients in FT (vs 51.8% in nFT); remarkable number of patients, as it seems, in spite of feeling better, keep on feeling a need for help and support.

Perception of the quality of improvement – ITEM B5

It is especially in the open ended response questions that one can discern particularly significant differences in the perception of improvement. By grouping the answers in clusters, in FT improvement is described as follows: "Improvement in self-esteem and self-consideration, feeling that one is capable, mature, more determined in facing problems" (19.9%); "Improvement in communication and relational skills" (17.0%); "Improvement of symptoms" (14.7%); "Knowing myself, being aware, understanding myself better and knowing my disorder in depth" (14.2%). In patients in nFT, the perception of improvement is connected to "Improvement of symptoms" (24.3%), "Being at ease, feeling better, more confident" (13.4%), "Improvement of self-esteem and self-consideration" (12.3%), and "Improvement of behaviour, performance and operative skills" (11.2%).

In this second group the percentage of patients who did not answer is higher (10.9% vs 4.8% in FT).

Perception of worsening – ITEM B6

As far as the perception of worsening is concerned, there are no significant differences between the two groups. In both groups we have high percentages of patients who do not express their opinions (30.5% FT vs 41.5% nFT) or who maintain that they do not perceive any sort of worsening (43.8% FT vs 35.8% nFT). The dispersion of the remaining questions is high in both groups of patients. Two other aspects, interesting though based on low percentages, are discernible: the first one concerns patients who identify their worsening in the persistence of some of the symptoms or in the lack of improvement in those symptoms (4.2% for patients in FT and 6.5% for patients in nFT); the second one concerns a percentage of patients in FT who describe worsening as affecting the area of personal relationships with significant people belonging to their milieu (4.9%).

Perception of difficulties during treatment – ITEM B9

An analysis of the answers concerning the difficulties met by patients during treatment shows that those in FT assess that they had difficulties in expressing themselves (20.8%), in accepting reality (13.3%) and in changing (6.2%).

43.0% of the patients in nFT have met no difficulties, against 28.3% of patients in FT. Low percentages of patients mention difficulties in expressing themselves and trusting the therapist. A low percentage of users (4.5% of patients in FT vs 5.6% in nFT) mentions difficulties connected to services' operation (as logistic problems, architectural barriers, date mismatches...). This figure indicates that the quality of treatment is perceived as more important than the structural characteristics of the Centre within which the treatment is administered.

Perception of therapeutic factors – ITEM B8

We formulated a multiple-choice question aiming to investigate patients' perception of what they found most useful to achieve goals of the therapy.

Table 3
Perception of difficulty during treatment (item B9)
("tailored" categories)

Treatments		
FT	nFT	
28,3%	43,0%	No difficulty
13,7%	5,1%	Difficulty in expressing myself, in saying everything, being ashamed, fearing judgement
8,0%	18,6%	No answer given
4,9%	1,5%	Difficulty in changing
4,9%	1,5%	Difficulty in accepting "truths" about oneself, increase of self-awareness
3,6%	2,0%	Inhibition, emotional blocks
3,6%	2,0%	Practical difficulty
3,1%	0,5%	Difficulty in starting speech
3,1%	3,6%	Difficulty in letting oneself go
2,2%	1,5%	Feeling problems as too heavy, too serious
2,2%	1,5%	Difficulty in expressing oneself, making oneself understood, understanding oneself
2,2%	0,5%	Difficulty in understanding how the therapy works and what the roles of patient and therapist are
1,8%	0,0%	Difficulty putting into perspective problems
1,8%	0,5%	Difficulty in expressing emotions and understanding the therapist's interpretation
1,3%	0,0%	Difficulty in being honest with oneself
1,3%	0,0%	Difficulty in wanting to change
1,3%	0,0%	Difficulty in remembering the contents of sessions
1,3%	0,5%	Wanting to solve one's problem quickly
0,9%	0,5%	Feeling attacked
0,9%	0,0%	Intolerance, anger, dissatisfaction with the therapist
0,9%	1,0%	Difficulty in trusting the staff
0,9%	2,0%	Difficulty in accepting the pharmacological treatment
0,9%	2,6%	Too short duration and frequency of sessions
0,9%	0,0%	Too many therapist's interventions are perceived and processed but subsequently forgotten
0,9%	0,5%	No more topics to put forth to the therapist
0,9%	0,0%	Accepting to need the therapist
0,9%	0,0%	It is painful to talk about what makes you suffer
0,9%	1,0%	Difficulty in accepting that you are not improving
0,4%	0,5%	Feeling judged, condemned, criticised
0,4%	0,0%	Feeling treated coldly
0,4%	2,6%	Side effects of drugs
0,4%	0,0%	Fear of losing the therapist's trust
0,4%	0,0%	Difficulty in concentrating
0,4%	0,0%	Difficulty in keeping control during family therapy, because of different opinions
0,0%	1,0%	Being regarded as mad by people (social disease)
0,0%	0,5%	Feeling treated with suspicion
0,0%	1,5%	Not feeling at ease with doctors and nurses
0,0%	1,0%	Too much talking about unpleasant subjects
0,0%	0,5%	Being attended only by the psychiatrist
0,0%	0,5%	Periods of lack of confidence
0,0%	1,5%	Fear of not being understood
0,0%	0,5%	Frequent changes of therapist and pharmacological therapy

Table 4
Perception of therapeutic factors (item B8)
(all categories)

Treatments		
FT	nFT	
24,5%	14,7%	Having been helped to understand better myself and the nature of my problems
12,5%	16,1%	Having someone able to listen to me and understand me
11,2%	5,6%	Having been helped to have more self-esteem and self-consideration
6,8%	4,6%	Having been helped to acknowledge my own limits
6,3%	10,4%	No answer given
5,9%	7,2%	Having been able to pour out my feelings
5,0%	10,6%	Having received guidance and advice
4,3%	2,4%	Having learnt different ways of behaving and controlling my symptoms
3,7%	2,5%	Having felt respected
3,4%	2,9%	Having freed myself from guilt and inhibitions
3,1%	2,7%	Having been helped to develop my potential and skills
2,9%	1,5%	Having been helped to give up impossible expectations
2,5%	3,2%	The encounter with the therapist's personality
2,1%	6,5%	Being at ease with the therapist
2,1%	1,7%	Having learnt to control my impulses and aggressiveness
1,6%	0,0%	Other
1,3%	3,9%	I don't know why, but I have felt better
1,3%	1,0%	Acceptation of reality
0,4%	1,3%	The practical help received
0,3%	0,6%	The interventions carried out with my family
0,1%	0,3%	The treatment I am undergoing has not been of help up to date
0,0%	0,3%	Help received by the group of the other patients

Patients had to choose three answers from a wide range of perceived help factors.

The factors selected have been processed by grouping them into seven main clusters.

The percentages reported here are based on the total of the answers.

For patients in formalised therapy (FT), the most frequently mentioned therapeutic factor is "Understanding myself and the nature of my problems better" (24.5%), followed by "Being listened to, understood, feeling close to someone" (20.5%) and "Being helped to achieve a higher self-esteem and self-consideration, being respected" (14.9%), and, lastly, "Acknowledging my own limits, giving up impossible expectations, learning to control impulses and aggression" (11.8%).

In psychiatric treatments with psychological support (nFT), the profile of patients' perceptions of the type of help received is different. The therapeutic factor perceived as most important towards the achievement of goals is "Being listened to, understood, having someone close, letting feelings out" (30.0%), followed by "Understanding myself and the nature of my problems better" (14.7%) and "Receiving directions and concrete help" (12.0%).

DISCUSSION AND CONCLUSIONS

Based on the answers to the unstructured question "*In what do you feel improved?*" the perceived effects of formalised and non-formalised treatments, are distributed within a

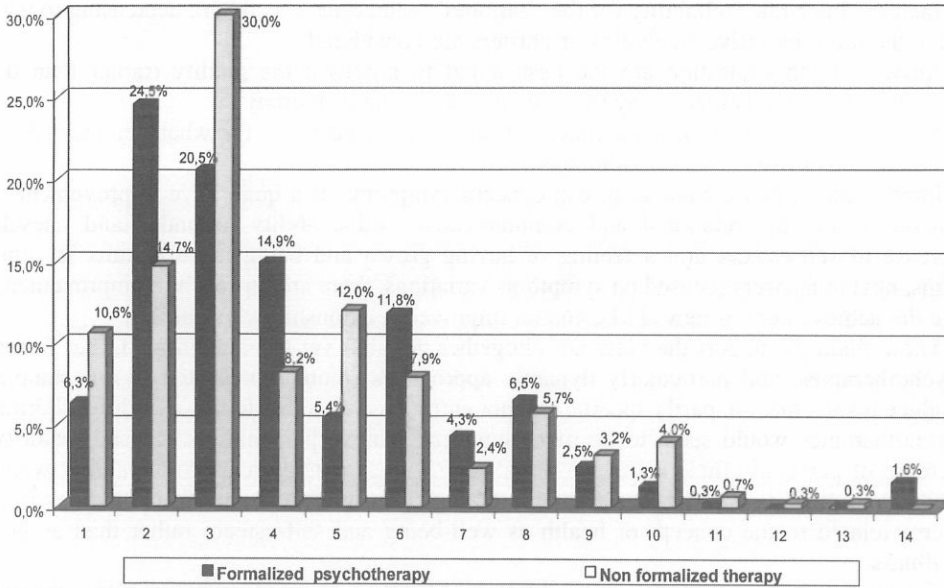


Figure 3. Perception of therapeutic factors (item B8)

Note:

PERCEPTION OF THERAPEUTIC FACTORS (ITEM B8) (clusters)

“About the treatment you have been subject to, what was more helpful?”

1. No answer given
2. Understanding myself and the origin of my problems better
3. Being listened to, understood, having someone close, pouring out my feelings
4. Achieving a higher self-esteem and self-consideration, being respected
5. Receiving guidance and practical help
6. Acknowledging my own limits, giving up impossible expectations, learning to control impulses and aggressiveness
7. Learning new ways of behaving and controlling symptoms
8. Freeing myself from inhibitions, from guilt, being helped to develop my potential and skills
9. The encounter with the therapist's personality
10. I don't know why
11. The interventions carried out with my family
12. The help received by the group of the other patients
13. The psychotherapy I am undergoing has not been of help
14. Other

relatively limited amount of “tailored” categories. These can be subsequently reduced, to facilitate the calculation process, to an even lower amount of more inclusive categories.

Each of the answers has a value by itself, because it represents “the point of view” of a single patient, which differs from the answer of every other patient. Yet, the meaning and content of some answers tend to overlap with little inference by raters. The process to build more inclusive categories implies more inference, with a consequently wider margin of error.

In fact, the inter-rater reliability for the "tailored" categories was 0.866, decreasing to 0.73 when the more inclusive categories or clusters are considered.

Answers to this question are the best suited to highlight the quality (rather than the quantity) of change perceived by the patient as an effect of therapy.

Moreover, the use of an open-ended question leaves no room for whatever bias of the researchers in choosing the possible answers.

Improvement, as we have seen, can concern symptoms or a qualitative improvement of general well-being, relational and communicative skills, ability to understand oneself, increase of self-esteem and a feeling of having grown and being more mature. In other terms, next to answers focused on symptoms variations, there are far reaching improvements like the achievement of new skills, and an improved relationship with oneself.

These findings support the view not altogether new but yet to be confirmed, that formal psychotherapies, and particularly dynamic approaches (more represented in our sample) produce results that are partly specific and not entirely comparable to those of drugs. Formal psychotherapies would seem to be more suited to achieve personal growth and maturity, increase of personal efficiency and overcoming of those conditions of vulnerability which accompany patients well beyond their symptoms. This interpretation of our findings is of course related to the concept of health as well-being and self-esteem rather than as lack of illness.

If we examine the distribution of the answers about the perceived improvements in the two groups, this view seems to be further confirmed. In general, the questions concerning the quantitative aspects of change – as they emerge from the structured questions B4 and B12 (about the degrees of feeling better/worse and about the different functional areas) – do not present particularly significant differences. On the other hand, if we consider the qualitative aspects of change – as they emerge from answers to the unstructured response question B5 – the two groups show remarkable differences. In patients in psychotherapy, the perception of improvement has proved significantly more connected to the perception of an increase in self-esteem (significance with test χ -square $p < 0.001$) and in self-awareness ($p < 0.001$), whereas in patients in psychiatric treatment the perception of improvement is significantly more connected to the perception of a decrease of symptoms and an increase of general well-being ($p < 0.001$). That is to say that formalised psychotherapies show a different profile of change, if we consider the patient's point of view. This difference specifically concerns the aspects of personal growth and maturity rather than general well-being or symptoms' improvement. Variation of the latter, instead, seem to be equivalent in the groups.

Dodo's judgement, described by Luborsky, is thus confirmed for quantitative data, but it is not if we take into account data concerning the type or quality of the perceived change. Such data would further support the hypothesis that the apparent equality of results might be connected with methodological faults, and in particular to the choice of measuring tools that do not allow to detect the variability of the effects of psychotherapies (Wampold, 1997), (Fava *et al.* 1997).

We wondered whether the distribution we found might be a by-product of the different distribution of diagnoses in the two groups. We therefore calculated the distribution of answers by diagnostic category. The differences detected in the two groups of patients do not give evidence of any connection with the diagnoses. In a cross-examination the figures about diagnostic categories and those about perceived improvements, difficulties and therapeutic

factors, the distribution of answers for each category has not shown any significant difference from the whole sample.

Aspects of the process-result relation

The answers to the questionnaire also seem to suggest some interesting considerations about the relation between process and result in formal psychotherapies. Here we will take into account the questions concerning difficulties met during treatment and the question about the perception of therapeutic factors, that is the perception of what the patient has felt to be most helpful. The answers must not be seen in the perspective of a direct validation of specific techniques, since user questionnaires are not a tool apt to answer technical questions (Coursey, 1995). They must on the contrary be regarded as indicators of aspects of the process-result interaction, filtered by the interpretation given by the patient about his treatment experience.

If compared to patients in formalised therapy, patients in non-formalised therapy claim that they had no difficulties in a higher percentage of cases, these difficulties having to do with the ability to express oneself and to trust the therapist. Patients in formalised therapy declare more frequently that they had difficulties, and such difficulties concern the ability to express oneself freely, to change and to accept truths that are hard to accept. Psychotherapies are therefore also perceived as difficult and painful experiences that imply a personal effort in the overcoming of obstacles and in finding solutions. This seems to match with the patient's perception of a stronger personal commitment on his/her part. These considerations coincide with the results of studies on predictive factors, which emphasise the role of a specific motivation for treatment and of the patient's willingness to face situations that might represent a source of anxiety (Garfield, 1994).

Perception of therapeutic factors

The main difference between patients in formalised psychotherapy and those in nFT is not indeed the identification of different perceived therapeutic factors, but, rather, the different evaluation of their relative importance (Figure 3).

The possibility of giving a multiple choice answer to the question about therapeutic factors allowed the interviewees to locate the perception of the help received at various levels, thus establishing a hierarchy between the levels. The most helpful therapeutic factors, formulated as "Having someone close, being listened to and understood", are frequent in both groups, but are significantly more present in the group of psychiatric patients, where they also have the highest absolute value. Moreover, in this group also some directive attitudes of the therapist, such as giving "guidance and actual help" ($p < 0.001$), are seen as factors of help in a higher number of cases.

"Being helped to understand myself and the nature of my problems better", "Being respected and helped to achieve a higher self-esteem and self-consideration" and "Acknowledging one's limits, giving up impossible expectations and learning to control oneself" are significantly ($p < 0.001$) more frequent in psychotherapies, where help towards self-understanding is also the answer with the highest frequency. It seems relevant to notice how the increase in self-esteem, which appears both as a therapeutic effect and as a therapeutic factor and which represents the most frequently perceived result in absolute terms among the psychotherapy patients, highlights a specific need, particularly felt by the patients belonging to this group.

Support, perceived as closeness and listening, improved self-awareness and the help to achieve a higher self-esteem are, in this order, the therapeutic factors perceived as most important in the whole sample. Yet, the psychological impact, if we consider the cases individually, seems to be articulated into specific and not interchangeable forms in every single case. Someone, for instance, linked his own feeling better to the relationship with the therapist, felt as close and welcoming. This was accompanied by a reduction of symptoms due to pharmacological therapy, and using the therapist as a sort of prosthesis for his own functional and relational deficit. Answers concerning the perceived role of drugs are discussed in another work (Fava *et al.* 1996). Some other patients, on the other hand, use self-awareness, though painful, to foster personal growth.

If we consider the answers individually, case by case, a therapeutic factor that seems to stand out is related to the flexibility of psychotherapy in adjusting to different needs, both in formalised treatments and as an unconventional element within the psychiatric intervention.

Although the self-knowledge factor corresponds to the best results, the aim of this study is not to judge whether a specific combination of therapeutic factors can be considered more effective than any other, because of the initial inequalities of the sample. This was, however, necessary if we want to study psychotherapies, where patient and therapist can choose each other and choose the path they are going to follow. In this case, therefore, results do not only depend on the way treatment is administered, but also on this initial choice. In this respect, the answers to the questionnaires seem to point at the variability of the possible paths.

Seligman (1995) had noticed that patients who had not chosen therapist and therapy had worse results than the others. The study shows, however, that different combinations of perceived therapeutic factors can give results that are perceived as comparable, specially if quantitative variations (B4 and B12) are considered.

Another limit that we shall point out is that this research does not take into account the point of view of those patients who dropped out during treatment. Such occurrence turns out to be frequent in the literature, and also in the questionnaires filled by the therapists. Knowing the point of view of this group of patients should be regarded as a necessary completion of our work: the interruption of treatment could indicate the existence of negative aspects of the therapy process that our study was not able to detect and that might be considerably relevant clinically.

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