

A Study on Therapeutic Teams in Psychoanalytical Hospital Treatment

— Diversity and agreement within the team —

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The author evaluates the group function of therapeutic teams in psychoanalytical inpatient treatment, by examining the association between perception of factors which affect treatment in 4 groups comprising the therapeutic team: the patients, attending physicians, supervisors, and nurses. The survey was conducted prospectively following the course of hospitalization on 98 patients and staff groups using 8 rating scales. The following findings were obtained: 1) The only significant correlation between all 4 groups was in evaluations on treatment progress upon discharge and one item pertaining to collaboration. 2) Among the many factors examined, the patient having clear therapeutic goals and striving for their attainment, difficulty of treatment, and certain negative emotions were the only items for which significant correlation was seen between all 3 staff groups. 3) No evidence was found of splitting in the patient's view of different staff. These findings indicated that disagreement in perception within the therapeutic team may be a phenomenon peculiar to team therapy. As such, the need for open discussion on disparities in perception, difficulty in treatment, and negative emotions among staff, the sharing of clear treatment goals between patients and staff, and recognition of staff and team meetings as therapeutic means were emphasized.

Key words : Psychoanalytical hospital treatment, Therapeutic team, Group work, Therapeutic goal, Team meeting

INTRODUCTION

This study is a prospective corroborative study to clarify the actual state of the team approach in psychoanalytical hospital treatment.

Psychiatric hospitalization applying the principles of psychoanalysis was first captured as an auxiliary method simply to admit patients as a means for carrying out psychoanalytical psychotherapy. Since then, the functional concept of treatment under hospitalization has undergone novel transformation, and today, hospitalization is in itself regarded as having primary significance in both diagnosis and therapy [12, 13]. This is based upon the principle that the patient's internal object relations and their pathology are reenacted via transference-countertransference within the therapeutic relationships with members of the staff.

Therefore, in diagnosing or taking any therapeutic approach, establishing a therapeutic alliance following careful evaluation of the transference-countertransference is believed to be crucial in understanding the patient's internal object relations [12]. As a natural subsequence to such understanding, the therapeutic team itself, comprised of members of diverse occupations, has come to be regarded as having a vital role and function.

This change in concept or methodology is in large part a reflection of the transition in psychoanalytical theory and introduction of the group dynamics theory and general systems theory [14, 15, 19]. However, although there has been extensive research on psychoanalytical inpatient therapy, most have been conceptual accounts delivered as case reports. The extreme complexity of the treatment process involved in hospital treatment has contributed to the difficulty of corroborating

orative research in this area. Systematic and prospective corroborative studies on inpatient treatment and therapy teams focusing upon therapeutic relationship were finally launched in the United States in the latter half of the 1980s. In our country, given the limited number of facilities with the quantity and quality of staff enabling the practice of psychoanalytical inpatient team therapy, research in this area has been practically non-existent. Even in the United States, the studies have been forced into discontinuation once into the 1990s due to economical pressures reducing inpatient psychiatric care to very short stays (1 week to 10 days).

Cohesiveness among staff composing the therapeutic team, i.e., the importance of good teamwork is emphasized in team approach. At the same time, the therapeutic team is a hierarchical organization composed of staff from many occupations and the patient. Therefore, the probability is high that recognition of the elements affecting hospital treatment, and emotional reactions toward the patient should be diverse in many ways. However, even so, a team will normally appear to function as a unified whole. And because of this, in which elements the therapeutic team agrees, and in which elements they disagree become highly intriguing questions.

To date, the Menninger Hospital Treatment Research Project (MHTRP) by Colson, D.B. et al. have contributed largely to corroborative research in this area. Members of the project, Allen, J.G. et al., have demonstrated the quality of therapeutic alliance as being an integral factor in determining therapeutic outcome [1, 2]. In their subsequent study, the Menninger group extracted "collaborative action of the patient", i.e., cooperative attitudes and behavior on the part of the patient in taking active advantage of the therapeutic opportunity to bring about change as an observable phenomenon pertaining to therapeutic alliance, and found this "collaborative action of the patient" to be a prominent marker for assessment of progress in treatment under hospitalization [4, 9].

This study was motivated by such historical background and clinical experience. Therefore, we believe this study can be regarded as being a further step forward based upon the findings from the MHTRP.

In other words, the target of analysis has been displaced from the dimension of a one-on-one therapeutic relationship to that of a therapeutic team as a whole consisting of the patient, attending physician, supervisory doctor, and nurses, or that of a staff group as a whole within a therapeutic team consisting of the attending physician, supervisor, and nurses. The objective of this study was to clarify the agreement and disagreement in recognition of the elements affecting hospital treatment within this group dimension.

SUBJECTS AND METHODS

The following 8 evaluation scales were employed to evaluate the patients' attitude toward therapy, their experience relative to therapeutic relationships, their perception of the degree of treatment progress, and staff recognition of the patients' attitude toward treatment, experience relative to the therapeutic relationship, emotional relationship with the patient, degree of difficulty in treatment, and degree of treatment progress, prospectively, following the course of hospital treatment. All evaluations were made along a 5-point scale (see Appendix for details): 1) Anticipation of therapeutic outcome made upon admission, 2) degree of progress in treatment, 3) degree of progress evaluated at the time of discharge, 4) degree of overall treatment difficulty, 5) evaluation of therapeutic relationship, 6) evaluation of collaboration in the treatment program, 7) evaluation of teamwork, 8) evaluation of emotional responses.

Working definitions of "anticipation of therapeutic outcome" upon admission, "degree of progress in treatment", "degree of progress at the time of discharge", "degree of overall treatment difficulty", "therapeutic relationship", and "collaboration in treatment program", were newly created with reference to the Collaboration Scale [4] and the Hospital Treatment Rating Scale (HTRS) [10] developed by the forerunning Menninger Hospital Treatment Research Project (MHTRP). The definition of "anticipation of therapeutic outcome" upon admission was created combining the working definitions for "degree of progress in treatment" and "therapeutic relationship". "Degree of progress at the time of discharge" was constructed with reference to the working definition of "degree of progress in treatment". In

the MHTRP, evaluation of the degree of collaboration was meant for the patient only, but in this study, the "collaboration in treatment program" scale was also appended for staff. The above working definitions were all qualified in the questionnaires. Regarding "emotional responses", 16 emotional responses staff are likely to have regarding patients in general were extracted by the K-J method to assess the extent to which such reactions are harbored by the staff regarding each patient. The scales were designed with direct association to the treatment the patients were receiving under hospitalization, phrased in straight-forward and easily assessable manner, for ease of understanding and cooperation even for the relatively highly disabled patient.

The subjects of this study were patients admitted to the psychiatric ward of Tokai University Hospital, and all staff directly involved with the patients. Before going into the methods of implementing this study, the following is a brief summary of the therapeutic structure of this ward. Because the psychiatric ward at Tokai University Hospital is an open ward situated within a general hospital, the proportion of patients with physical complications is high. The number of beds is 37, but patients range from children to the elderly, admitted for a variety of psychiatric disorders including physical complications. Treatment in this ward was being carried out by therapeutic teams, each team consisting of 4 constituent groups including a psychiatrist with more than 10 years of clinical experience acting as the supervisor or team leader, several younger psychiatrists with 1~5 years experience (referred to hereafter as the attending physicians), nurses, and patients. One team was devoted to the treatment of eating disorders. Patients were assigned to each team mostly in order of admittance to the ward. Each team conducted three separate meetings, a doctor-nurse conference (staff meeting), a team meeting (including supervisor, attending physician, nurses, and patient), and a group therapy session (with the supervisor as the central figure), once a week for an hour each. Regarding the ward as a whole, supervisor conferences and ward case conferences were held on a weekly basis to oversee the different teams, in addition to community meetings held each month

attended by all patients and staff. The primary characteristic of inpatient treatment in this ward was that therapy employing these various groups was being carried out within a highly structured setting. The second characteristic was that psychoanalysis was providing direction in the inpatient treatment. Very few psychiatric wards are being operated along such principles and methods in our country. The team supervisors were left to pursue their individual forms of team approach, while holding such basic understanding in common.

The study was carried out prospectively on patients admitted to the psychiatric ward in the 14 months between May 10, 1995, and July 31, 1996, and all staff associated with the patients as the subjects. The survey was carried out upon admission, at 1 month, 3 months, and at discharge, following the course of hospitalization of each patient. The survey was terminated on April 4, 1996. For the patients admitted within this 14-month period, the following two conditions were regarded as exclusion factors. The first was those under 16 years old. Treatment modalities differ for adult patients and child/adolescent patients in the psychiatric ward. Because the objective of this study was the mutual relationship between adult patients and staff, we adopted the standard of 16 and over in defining adults. The second exclusion factor was clear cases of severe cognitive disorders, and severe dementia. This was because of the difficulty or impossibility filling out the survey forms presented for such patients. Patients thus excluded from this survey amounted to 21 among 151 patients admitted in the 14-month period. Thus, the survey was conducted on 130 patients. Among these, the subjects of analysis were 98 patients who completed the admission, 1 month, and discharge surveys, and all staff directly involved with these patients. The 98 patients and staff, and the various staff-patient relationships represented, thus comprise a representative sample of actual treatment being undertaken in the psychiatric ward that is the setting of this survey (i.e., they are a consecutive sample of patients capable of partaking in the survey representing the actual state of treatment being carried out on this ward).

The total of 32 cases lost to the survey included 11 cases discharged within 1

month, so that only the admissions stage survey was available, 20 patients who agreed to take part in the survey but did not or could not fill out the forms (due to severe psychotic symptoms upon admission or aggravation of symptoms under hospitalization), and 1 case which could not be used due to clerical mismanagement. Of the remaining 98 cases, 68 patients remained in hospital for over 3 months, and completed the 3rd month survey. General attributes of these 98 patients are given in Table 1. Thirty-six were male (36.7%), 62 were female (63.3%), mean age was 34.6 years, and mean duration of hospitalization was 136.0 days. At present, the ward in which the survey took place has been converted into a short-term inpatient treatment ward with a mean stay of 30~40 days, but at the time of the survey, longer stays were possible. The high proportion of female patients is believed to be associated with the fact that the ward is a small-scale open ward within a general hospital, without protective isolation. Classifying the 98 cases along of DSM-III-R resulted in 28 different diagnoses. Because this made capturing the overall characteristics difficult, the disorders were reclassified according to classic diagnosis, working with the DSM-III-R diagnoses as reference. The results are given in Table 2. According to this reclassification, the subjects were classified into groups of schizo-

phrenia (n = 6), depression (n = 24), neurosis (n = 12), personality disorders (n = 36), organic mental disorders (n = 4), and eating disorders (n = 16). Generally speaking, schizophrenia is the most common disorder among patients admitted to single department psychiatric institutions, making the large proportion of patients with personality disorders and depression a characteristic of this survey group.

The survey was carried out on the patient, and all staff on the therapeutic team directly involved with the patient in the following manner. Within a few days of a patient's admission, the patient, attending physician, supervisor, and 3 nurses (4 categories, 6 subjects) were asked to evaluate their "anticipation of therapeutic outcome". Regarding the evaluations by the 3 nurses, the most common rating was adopted as the nurses' rating in subsequent analysis. In addition, the attending physician was asked to fill out a form on the basic patient attributes addressing gender, age, profession, and as medical information, the overall condition of the patient together with a tentative diagnosis. At 1 month and 3 months from admission, the attending physician, supervisor, and a nurse (3 staff subjects) were handed questionnaires to evaluate "progress in treatment", "degree of overall treatment difficulty", "therapeutic relationship", "collaboration in

Table 1 Overall patient attributes

Item	Male	Female	Overall
Number (%)	36 (36.7%)	62 (63.3%)	98
Mean age (S. D.)	36.5 (16.8)	33.5 (16.4)	34.6 (16.6)
Mean length of hospitalization in days (S. D.)	124.6 (91.1)	143 (92.9)	136.0 (92.6)

Table 2 Number of patients classified in terms of classic diagnosis

Group	Number of patients
Schizophrenia	6
Depression	24
Neuroses	12
Personality disorders	36
Organic mental disorders	4
Eating disorders	16
Total	98

treatment program”, “teamwork”, and “emotional responses”, while the patient was asked to evaluate “progress in treatment”, “therapeutic relationship”, and “collaboration in treatment program”. Regarding “therapeutic relationship”, the patient was asked to give separate evaluations for the attending physician, supervisor, and nurses. However, regarding the nurses, because a primary nurse system had not been adopted, the following instructions were given: “Please bring to mind 5 nurses on this ward, and evaluate them individually. Which of the nurses you choose to bring to mind is up to you.” In subsequent analyses, the most common rating among the evaluations of 5 nurses given by the patients was regarded as the patient’s rating of nurses. At the time of discharge, 6 subjects, including the patient, attending physician, supervisor, and 3 nurses, were asked to evaluate “degree of progress at the time of discharge”. Four of the 98 cases were still under hospitalization at the time of termination of the survey. For these long-term cases, evaluations of treatment progress at the time the survey was terminated were regarded as their “degree of progress at the time of discharge”. The supervisor and attending physician made note of the patient’s finalized diagnosis according to DSM-III at 3 months from admission (or at the time of discharge for patients discharged within 3 months).

Survey forms were distributed to staff members on the day of each survey. Completed forms were retrieved in retrieval envelopes within a few days. Regarding the patients, explanations were given and consent to participate in the survey were obtained, both verbally and in writing. Patients were then directly handed the questionnaires in envelopes, which were retrieved in the same envelopes after a few days. The 3 nurses completing the forms were those on duty at the time the survey was conducted following admission of a patient, and were chosen at random from among those on the day shift at the times of the subsequent surveys. Questionnaires from each survey were immediately retrieved and managed collectively, and subsequent evaluations were made independently without reference to previous responses.

The objective of this study was to clarify the actual state of the mutual relationships

between the 98 patients and the attending physicians, supervisors, and nurses comprising the therapeutic team in direct contact with the patient, and between the various members of staff. For this, correlation between evaluations made by a patient group, an attending physician group, a supervisor group, and a nurse group were analyzed regarding “anticipation of therapeutic outcome” upon admission, “progress in treatment”, “degree of overall treatment difficulty”, “therapeutic relationship”, “collaboration in treatment program”, “teamwork”, “emotional responses” and “degree of progress at the time of discharge”.

Statistical analysis was carried out using “HALBAU” software, and Pearson’s correlation coefficients were employed as the index of correlation.

RESULTS

(1) Evaluation of anticipation of therapeutic outcome upon admission

Simple summation of the projections on treatment at the time of admission showed 40.8% of the patient group with optimistic views regarding outcome, 20.4% thinking pessimistically, and 38.8% feeling that making any projection was difficult. On the other hand, the attending physician group held optimistic outlooks regarding the treatment of 31.7% of their patients, pessimistic outlooks for 19.3%, and found it difficult to make projections either way for 49% of the patients. The supervisor group held optimistic views for 36.8% of the patients belonging to their team, pessimistic views for 29.6%, and found it difficult to make projections for 36.8% of their patients. The nurse group held optimistic views for 21.4% of the patients, pessimistic views for 19.4%, and found it difficult to make projections for 59.2% of the patients. In projecting outcome for treatment, the supervisor group was found making more definitive judgments in comparison to the attending physician group or nurse group.

Table 3 is the correlation between evaluations of anticipated therapeutic outcome upon admission given by the 4 groups. The only significant correlation noted was between the supervisor and nurse groups.

(2) Evaluation on degree of progress in treatment

Simple summation of responses regarding

the level of therapeutic progress at one month from admission showed 73.4% of the patient group responding that some degree of progress had been made, i.e., those responding “somewhat improved”, “significantly improved” or “greatly improved” in

terms of the extent to which improvement had been made in terms of everyday life. The attending physician group considered 83.7% of their patients as having improved, the supervisor group saw improvement in 93.8% of the patients belonging to their

Table 3 Correlation between patient and staff groups regarding anticipation of therapeutic outcome at the time of admission

Group	1.	2.	3.	4.
1. Patient	-			
2. Attending physician	0.029	-		
3. Supervisor	0.109	0.152	-	
4. Nurse	0.156	0.186	0.296**	-

**p<0.01

Table 4 Correlation between evaluations of treatment progress by staff and patient groups at one month and upon discharge at one month and upon discharge

Group	1 month from admission				Upon discharge			
	1.	2.	3.	4.	1.	2.	3.	4.
1. Patient	-				-			
2. Attending Physician	0.232*	-			0.367***	-		
3. Supervisor	0.234*	0.193	-		0.401***	0.592***	-	
4. Nurse	0.025	-0.023	-0.079	-	0.430***	0.550***	0.629***	-

*p<0.05, **p<0.01, ***p<0.001

Table 5 Correlation between staff evaluations on degree of overall treatment difficulty

Group	1.	2.	3.
1. Attending physician	-		
2. Supervisor	0.454***	-	
3. Nurse	0.429***	0.291**	-

*p<0.05, **p<0.01, ***p<0.001

Table 6 Correlation between evaluations of the therapeutic relationship by the patient and staff groups

Group	1.	2.	3.	4.
1. Patient	-			
2. Attending physician	0.183	-		
3. Supervisor	0.157	0.175	-	
4. Nurse	0.221*	0.008	-0.043	-

*p<0.05

own team, and the nurse group noted some form of improvement in 85.7% of the patients. Similarly, evaluations on progress made at the time of discharge show some form of improvement being noted by 89.7% of the patient group, in 84.7% of the patients as seen by the attending physician group, in 93.9% as seen by the supervisor group, and in 81.6% of the patients in the eyes of the nurse group.

Next, the associations between evaluations on degree of progress from the 4 standpoints at one month from admission, and at the time of discharge were assessed (Table 4). At one month from admission, significant correlation was seen between evaluations made by the patient and attending physician groups, and between the patient and supervisor groups, while no correlation was seen between evaluations made by the patient and nurse groups. Moreover, significant correlation was absent between the 3 staff groups. On the other hand, at the time of discharge, significant correlation was noted between the evaluations made by all 4 groups. In particular, correlation between the evaluations made by the 3 staff groups was of marked significance. Because of this, responses regarding treatment progress at 3 months were also evaluated for the group of patients hospitalized for over 3 months ($n = 68$) and the staff involved, but here again, coefficients of correlation between the evaluations given by the 4 groups were low.

(3) Evaluation of the degree of overall treatment difficulty

Significantly high correlation was observed between the attending physician, supervisor, and nurse groups regarding the degree of overall difficulty in treatment (Table 5), in contrast to the results from progress evaluation at 1 month.

(4) Evaluations of therapeutic relationship

Correlation between evaluations of therapeutic relationship after 1 month of hospitalization was assessed between each of the patient, attending physician, supervisor, and nurse groups (Table 6). Significant correlation was found between evaluations by the patient group and nurse group, although the coefficient of correlation was relatively low. However, correlations of significance were not found between the 3 staff groups, between the patient and attending physician groups, or between the patient and supervi-

sor groups.

(5) Correlation between evaluations on progress in treatment and degree of overall treatment difficulty, and between progress in treatment and therapeutic relationship among the 3 staff groups

Evaluations of the degree of treatment progress through the course of treatment may be regarded as overall judgments on the therapy at the respective times. Hence, the correlation between rating scores for treatment progress at 1 month, and scores for other items (degree of overall treatment difficulty, and progress in treatment) were assessed (Table 7). In the attending physician group, the significant negative correlation between evaluations of treatment progress and overall difficulty in treatment was marked, in addition to there being a significant positive correlation between treatment progress and therapeutic relationship. The supervisor group was characterized by significant negative correlation between the evaluations of treatment progress and overall difficulty, and a highly significant positive correlation between treatment progress and therapeutic relationship. In the nurse group, negative correlation between evaluations of treatment progress and overall difficulty was significant, as was the positive correlation between treatment progress and therapeutic relationship.

(6) Correlation between evaluations of progress in treatment and therapeutic relationship within the patient group, and the correlation between evaluations of therapeutic relationships with the 3 staff groups as seen from the patient

The association between evaluations of degree of treatment progress at 1 month and therapeutic relationship at that point was also verified in the patient group. In the patient group, the only significant correlation was found regarding therapeutic relationship with the attending physician and the evaluation of treatment progress (0.232, $p < 0.05$). Next, the extents of correlation between patient evaluations of therapeutic relationship with the attending physician, supervisor, and nurse groups were assessed. In other words, correlation was sought between evaluation scores for therapeutic relationship with the attending physician, supervisor, and nurse groups, as given by the patients. Evaluations of the 3 therapeutic

Table 7 Correlation between evaluations of treatment progress and degree of overall treatment difficulty, and between evaluations of treatment progress and therapeutic relationship within the 3 staff groups

Attending physician group		Overall difficulty	Therapeutic relationship
	Treatment progress	-0.524***	0.492***
Supervisor group		Overall difficulty	Therapeutic relationship
	Treatment progress	-0.232*	0.584***
Nurse group		Overall difficulty	Therapeutic relationship
	Treatment progress	-0.237*	0.372***

*p<0.05, **p<0.01, ***p<0.001

Table 8 Correlation between patient evaluations of therapeutic relationships with various members of the staff

Relationship with the:	1.	2.	3.
1. attending physician group	-		
2. supervisor group	0.639***	-	
3. nurse group	0.383***	0.359***	-

***p<0.001

Table 9 Correlation between staff members regarding emotional response to patients

	Attending physician— Supervisor	Attending physician— Nurse	Supervisor— Nurse
1. Provoked	0.368***	0.344***	0.334***
2. Irritated	0.417***	0.277**	0.265**
3. Drained	0.309**	0.331**	0.233*
4. Unbearable	0.256*	0.401***	0.371***
5. Schism in team	0.423***	-0.059	0.456***
6. Uncontrollable	0.249*	0.048	0.332***
7. Fear	0.214*	0.307**	0.193
8. Wish to avoid	0.229*	0.398***	0.081
9. Anger	0.177	0.312*	0.254*
10. Ambivalent	0.250*	0.158	0.210*
11. Powerless	0.234*	-0.034	0.043
12. Interest	0.338***	0.014	0.228*
13. Protective	0.426***	0.139	0.088
14. Favorable	0.278**	0.187	0.032
15. Patience in understanding	0.173	0.056	-0.114
16. Wish to do more	0.070	0.166	0.070

*p<0.05, **p<0.01, ***p<0.001

relationships were significantly correlated. In particular, marked significance was seen between the evaluations of therapeutic relationship with the attending physician group and the supervisor group (Table 8).

(7) Evaluation of teamwork

The relationship between evaluations of teamwork within the therapeutic team at 1 month from hospitalization given by the attending physician, supervisor, and nurse groups was evaluated, but coefficients of correlation between the three groups were all low.

(8) Evaluation of degree of collaboration in the treatment program

Association between evaluations of 12 items relative to the degree of collaboration at 1 month was assessed between the patient, attending physician, supervisor, and nurse groups. Significant correlation was noted in all combinations of the 3 staff groups for the following 4 items: “(The patient) has set clear treatment goals” (attending physician—supervisor: 0.216, $p<0.05$; attending physician—nurse: 0.295, $p<0.01$; supervisor—nurse: 0.280, $p<0.01$), “(The patient) is doing his/her best to attain the treatment goals” (attending physician—supervisor: 0.320, $p<0.01$; attending physician—nurse: 0.359, $p<0.001$; supervisor—nurse: 0.249, $p<0.05$), “(The patient) is following his/her treatment plan or program” (attending physician—supervisor: 0.403, $p<0.001$; attending physician—nurse: 0.220, $p<0.05$; supervisor—nurse: 0.258, $p<0.05$), “(The patient) participates actively in the team meetings” (attending physician—supervisor: 0.396, $p<0.001$; attending physician—nurse: 0.270, $p<0.01$; supervisor—nurse: 0.400, $p<0.001$). Among these, the only item for which significant correlation was seen between all combinations of the 4 groups including the patient group was: “(The patient) participates actively in the team meetings” (patient—attending physician: 0.248, $p<0.05$; patient—supervisor: 0.367, $p<0.001$; patient—nurse: 0.294, $p<0.01$).

(9) Evaluation of emotional responses

Association between the 16 items regarding emotional responses to patients at 1 month from hospitalization was evaluated between the attending physician, supervisor, and nurse groups (Table 9). Evaluations for 4 items: “I am emotionally provoked by this patient’s behavior”, “I feel irritated by this

patient”, “I feel drained being with this patient”, and “It is unbearable; putting up with this patient’s behavior is very difficult”, were significantly correlated between all combinations of staff. In contrast, significant correlation could not be seen in any combination of the 3 staff groups regarding the 2 items: “I find myself wanting to take my time in understanding this patient”, and “I feel apologetic, feeling I should be doing more for this patient”.

DISCUSSION

This study is an evaluation of the association between recognition of the factors affecting conflicts experienced by the patient within the course of inpatient treatment and their resolution as perceived by the patients and staff. This was done by designating as the subjects of this study, not only the patients admitted for inpatient care at the Tokai University Hospital psychiatric ward, but all members of the therapeutic team coming in direct contact with the patients, i.e., the attending physicians, supervisors, and nurses as well.

This study was designed fundamentally upon the general systems theory, adopting the methodology of the Menninger Hospital Treatment Research Project (MHTRP). The general systems theory is designed for comprehensive documentation of the phenomena of extremely complex and multidimensional interpersonal relationships within the hospital setting, to enable interpretation of their significance and making use of the analysis in treatment [5, 14, 15, 18, 23]. According to the theory, the effective functioning of a therapeutic system implies that: 1) the primary task is never lost to sight, 2) the leader is functioning appropriately, 3) the boundaries of the system is functioning with flexibility maintaining appropriate permeability, and 4) interrelationships between the subsystems are unfolding dynamically. In other words, the integral elements affecting treatment are: the state of the organizational structure of the wards, treatment goals and plans, division of responsibilities and rights, leadership and distribution of roles. Because of this, the extent to which the staff and patients are able to share in a clear and common understanding of these elements is believed to exert significant effect on treatment [14–16]. Based upon this fundamental

concept, the psychiatric ward at Tokai University Hospital has been operating with constant attention to clarifying staff roles, limits of authority, rights and responsibilities, the purpose and function of the various meetings, and modes for passing on information. Moreover, the MHTRP has demonstrated that staff comprising the therapeutic team display disparate reactions regarding patients or treatment depending upon their occupation [3, 8, 10, 11]. Based upon the above theory and preceding research, this study was carried out dividing the therapeutic team into the 4 subgroups of patients, attending physicians, supervisors, and nurses.

Additionally, in this survey, patients under 16 and those clearly incapable of taking part due to severe cognitive disorders or dementia were excluded. However, apart from these considerations, no selection was made according to disability, and the age range was wide. The decision to include all disorders and age groups regardless of specific characteristics was to obtain as comprehensive a picture as possible regarding the actual state of team treatment through the inclusion of as many adult patients as possible having spent a certain amount of time as an inpatient.

The setting of this survey is a psychiatric ward within a general hospital, in which a relatively large proportion of the patients are cases of depression or personality disorders. This denotes an inherent limitation in extracting generalizations from this survey that are applicable to dedicated, i.e. single-department psychiatric hospitals in which the majority of patients are being treated for schizophrenia. Another limitation is the fact that our therapeutic team is comprised of only doctors and nurses, and does not include clinical psychologists or social workers. However, in our country, there have been no prospective studies dealing with the extremely complex and multidimensional interrelationships entailed in inpatient treatment. Hence, the value of this report is in its focus upon these relationships, captured as the interrelationships between 4 groups of subjects with different roles and functions, i.e. patients, attending physicians, supervisors, and nurses, in this survey.

To date, the series of reports from the MHTRP conducted in the United States have

been the representative studies regarding therapeutic relationship between patients and staff in inpatient treatment [1-4, 8-11]. Although the MHTRP is a comprehensive survey on how the therapeutic relationship between patients and each category of staff or the treatment itself is regarded by patients and staff, the focus is on one-to-one therapeutic relationships. No attempts focusing on the agreement and disparity of how the various elements affecting treatment are regarded between 4 groups, including the patients and 3 staff groups, or even between just the 3 staff groups, as taken up in this study, are seen. In this respect, this report may be taken as a further step forward from the MHTRP studies.

The primary objective of this survey was to clarify the points of agreement and disparity in the perception of elements affecting treatment, not on the level of one-on-one relationships between patient and staff or among staff, but in terms of the group as a whole, regarding the relationships as those between the 3 staff groups or 4 groups including the patient group.

Specifically, it was found that first of all, the only elements for which significant correlation was seen between all 4 groups of patients, attending physicians, supervisors, and nurses, was the evaluation of treatment progress at the time of discharge regarding "the degree to which improvement has been made with regard to *the patient (your)* carrying on with everyday life", and one item in the evaluation of the degree of collaboration, "(The patient) participates actively in the team meetings". It is believed the high correlation between the evaluations by the 4 groups regarding the latter is due to it being behavior which can be captured objectively. With regard to evaluations on progress in treatment, significant correlation was limited to that between patients and attending physicians, and between patients and supervisors at 1 month, and correlation between evaluations by the 3 staff groups were not significant. Looking at each group separately, the majority of patients are rated as having improved in terms of everyday life. In other words, during the course of inpatient treatment, even while the 4 groups, and the 3 staff groups in particular, consider most patients as having improved in terms of everyday life, their evaluations on individual

patients are not in agreement. However, at the time of discharge, not only do each of the 4 groups regard the patients as having improved in terms of everyday life, but a high degree of agreement is seen between the 4 groups, and the 3 staff groups in particular. One way of looking at this is that the 4 groups coming to agreement was the very reason leading to the patient's discharge. However, other possibilities do exist. One is that a patient's discharge denotes separation between patient and staff, or object loss arising from the completion of a job, for which the group dynamics of seeking mutual agreement is operational in defense against the pain accompanying this object loss.

Secondly, the factors for which there was significant correlation between all combinations of the 3 staff groups were divisible into the following 3 elements. The first being 3 items pertaining to evaluation of the degree of collaboration, i.e., "The patient has set clear treatment goals", "The patient is doing his/her best to attain the treatment goals", and "The patient is following his/her treatment plan or program". The second was the evaluation regarding difficulty of treatment. And the third was the evaluation of 4 items pertaining to emotional responses to the patient: "I am emotionally provoked by this patient's behavior", "I feel irritated by this patient", "I feel drained being with this patient", and "It is unbearable; putting up with this patient's behavior is very difficult". These 4 emotions are what are generally regarded as negative emotions. On the other hand, no significant correlation was seen between the 3 staff groups regarding evaluations on 2 items generally interpreted as positive emotions, "I find myself wanting to take my time in understanding this patient", and "I feel apologetic, feeling I should be doing more for this patient".

In other words, within the therapeutic team, agreement is seen between the 3 staff groups regarding evaluation on whether the patient has clear treatment goals and is acting in accordance with the treatment plan or program in order to attain those goals. Our ward has been operating with emphasis on the need for not only the staff but the patient as well to have clear treatment goals for successful treatment. Such being the case, perhaps this result was to be expected. However, it was found that the patient group

and the 3 staff groups do not necessarily agree regarding recognition of this point. Additionally, it was also seen that while perception of treatment being difficult and certain negative emotions equally permeated the 3 staff groups, positive emotions regarding the patients were not necessarily being shared between the 3 groups. In other words, it was made clear that when the 3 categories of staff are evaluated as a single staff group, it is only regarding a number of highly limited elements in which agreement is seen in the perception of the overall group.

Such findings enable the extraction of a third result. That is, evaluations on anticipation of therapeutic outcome upon admission, degree of treatment progress, therapeutic relationship, and 8 of 12 items pertaining to the degree of cooperation are disparate for many of the combinations between the 4 patient and staff groups. Similarly, agreement is not seen in evaluations regarding teamwork, and 12 of 16 items pertaining to emotional responses between many combinations within the 3 staff groups. In other words, it was found that when the 3 staff groups, or the 4 groups including the patient group is regarded in terms of a single group, i.e. as a therapeutic team, there is no agreement within the group regarding evaluation of elements affecting inpatient treatment such as the above.

It is necessary to discuss two issues in relation to the phenomenon of such disagreement within the therapeutic team as a group. The first is that regarding whether the 3 subgroups comprising the staff group perceive the elements which affect inpatient treatment differently depending upon their respective occupational roles. Regarding this point, significant correlation is seen within the 3 groups regarding evaluation of the degree of treatment progress, which is a comprehensive judgment on treatment, and therapeutic relationship. Significant negative correlation was seen between degree of therapeutic progress and that of difficulty in treatment among the 3 staff groups, with the association being most marked in the attending physician group. There is a deep association between therapeutic relationship and degree of treatment progress or outcome of inpatient treatment. In one of the studies of the MHTRP, Allen, J.G. et al. concluded that good therapeutic outcome is brought about

through good therapeutic alliance [4]. Another study by Clarkin, J.F. et al. based upon the MHTRP results, conducted on an even larger sample of patients also support Allen, J.G. [7]. In other words, no unique characteristics dependent upon the occupational roles of the 3 staff groups were noted regarding this point. However, such occupational role-dependent characteristics were found regarding the association between the degrees of treatment progress and treatment difficulty. Specifically, it appears to be that the more difficult a patient's treatment, the greater the tendency for the attending physician group, comprised of the younger doctors, to judge that a patient has not improved, in contrast to the supervisor or nurse groups with more experience. Although the analysis of such occupational role-specific characteristics deviate from the objective of this study, it is believed this is an area requiring further clarification in future.

Next, the association between the phenomenon of disagreement within the therapeutic team as a whole is discussed in relation to splitting. This is because ever since the proposal by Kernberg, O.F., such disparity in perception between staff has been regarded as being characteristic in the treatment of borderline patients, brought about by the defense mechanism of splitting [17]. However, no evidence supporting this view of disagreement being peculiar to the treatment of borderline patients was found in the study on inpatient treatment by Allen, J.G. et al. On the contrary, they have limited their interpretation to suggesting that the phenomenon of disagreement is rather associated with the personality disorders in general, and that it probably holds true only from the standpoint of the patient [4]. This point remains to be verified in future, as it has not been possible to draw any conclusions in this regard from this study due to insufficiency in the size of our sample to allow for comparison of difference in perception among staff according to disorder. However, it has been demonstrated that looking at the therapeutic relationship from the standpoint of the patient, that significant correlation was found between the 3 therapeutic relationships with each of the attending physician, supervisor, and nurse groups. This finding is different from that reported by Allen J.G. et al. That is, there is no split-

ting in the patient's viewpoint regarding their therapeutic relationship with different categories of staff.

Then why does disagreement arise within the therapeutic team? Various reasons may be surmised. However, it is believed that the concept of projective identification, i.e., the container-contained model as proposed by Bion, W.R. is the most likely explanation to this disagreement [6]. Gabbard, G.O. and Kano, R. have asserted in separate studies that under the unique environment of hospitalization, powerful projective identification arises between patients and individual members of the staff [12, 14]. In other words, there is a strong tendency for the patient to externalize internal object relationships through the emotional relationships with staff. And furthermore, such patients unconsciously project a certain aspect of their internal representation upon some staff member, and other aspects upon other members of the staff. On the other hand, staff members upon whom such certain aspects of the patient's internal representation is projected come to identify with that particular aspect. It is believed this results in the disparity in staff response to the patient, or the perception of treatment between different members of the staff. Taken in this context, it is probably the case that disagreement in perception or judgment regarding patients between staff members is probably a phenomenon which is widely applicable to hospitalized patients in general, rather than being associated with a specific patient's psychopathology. In other words, it is surmised that disagreement within the therapeutic team as a whole may be a phenomenon peculiar to the team approach in inpatient treatment of any kind.

What then, is the significance of such findings in terms of clinical practice? There are limitations in drawing generalizations from the findings of this study which may be applied to other psychiatric wards in general hospitals or psychiatric institutions. However, it can probably be said that when the therapeutic team is captured as a group in any psychiatric ward or institution, that the phenomenon of there being agreement regarding some elements affecting therapy and disagreement regarding others will be seen within the team. Regarding this assumption, the author believes the follow-

ing 3 points to be of importance.

It has often been pointed out that occupational conflict arising in team medical care is a hotbed of splitting within the team, which exacerbates the patient's pathology [12, 21]. However, Allen, J.G. et al. point out in a study on inpatient treatment of difficult patients that if the discontent and contradictions which arise among staff are expected as a matter of course and accepted as such, not only can they be employed constructively for self-inspection of the treatment plan, but can also be effective in garnering a more comprehensive, deeper understanding of a patient's psychopathology [3]. In other words, the disagreement among staff, certain negative emotions, and pervasion of the sense that treatment is difficult among staff obtained in our study are not entirely negative indications of the treatment course. On the contrary, it is believed staff should keep in mind that such phenomena are peculiar to the team approach, and strive to actively and openly discuss these matters within the team. It is believed such measures will contribute to understanding the patient and development of the therapeutic relationship, as suggested by Allen, J.G. et al. In truth, it is unrealistic to expect flawlessly smooth progression in inpatient treatment. Thus, the belief that disagreement, difficulty, and negative emotions should be expected and discussed. In this context, it is possible that such clinical effort can be an effective means for preventing idle protraction in inpatient treatment.

The next point of importance is for the patient to have set treatment goals and come to strive toward attaining those goals, brought about through open exchange between the patient and staff. Constructing treatment goals and plans, and carrying them out is equally important for both staff and patient. This is because the sense of having clearly defined treatment goals is believed to fortify the patient's motivation to engage in treatment.

As such, the third point of importance is the recognition that team meetings or staff meetings have functions directly connected with therapy. There is a tendency in our country for regarding these meetings simply as administrative or liaison meetings. Metaphorically speaking, it is believed such meetings have a "metabolic function", in that

they serve to metabolize disagreements in perception or raw emotions into more orderly, integrated judgments or emotions. In other words, there is a need for clinical professionals to share further in the recognition that these meetings are treatment measures in themselves.

CONCLUSION

This study was carried out with the objective of evaluating the association regarding perception of the elements which affect treatment in psychiatric inpatient treatment, between a patient group, attending physician group, supervisor group, and nurse group. The questionnaire employed was newly constructed with reference to the Collaboration Scale and Hospital Treatment Rating Scale developed by the Menninger Hospital Treatment Research Project (MHTRP). The survey was conducted prospectively over the course of hospitalization on 98 assessable patients hospitalized for over 1 month, and the attending physicians, supervisors, and nurses directly involved with their treatment and care. In place of dealing with relationships on a one-to-one basis, this study focused upon evaluating agreement and disagreement in perception in terms of the overall group comprised comprisedcomp of 3 staff subgroups or 4 subgroups including the patient. Through this perspective, it was found that agreement in perception within the unit of the therapeutic team was limited to highly specific elements, and that rather, disagreement was the phenomenon of note. In concrete terms, the following new findings were obtained:

- 1) Perception regarding degree of treatment progress upon discharge, and 1 item pertaining to degree of collaboration ("The patient participates actively in the team meetings") were the only aspects for which significant correlation was found between all combinations of the 4 groups.
- 2) Evaluations by the 3 staff groups were in agreement regarding the patient having clear treatment goals, and following the treatment plan or program for attaining those goals. However, the 3 staff groups and the patient group were not in agreement regarding this point.

- 3) Perception of treatment being difficult and certain negative emotions (being emotionally provoked, irritated, drained, or finding a patient unbearable) were found equally pervading the 3 staff groups.
- 4) No significant correlation was found between the evaluation of many elements excepting the above between all combinations of the 3 staff groups or 4 groups including the patient group. Taking the therapeutic team as a group, disagreement in perception was the notable characteristic.
- 5) Individual analysis of evaluations by the 3 staff groups revealed association between good therapeutic relationship and good progress in treatment for the 3 groups of staff. Additionally, significant negative correlation was found between the sense of treatment being difficult and the degree of treatment progress, with this tendency being marked for the attending physician group.
- 6) Looking at the therapeutic relationship between patients and staff from the standpoint of the patient, significant correlation was found between their relationships with all 3 groups of staff. No evidence of splitting in how the patient views various categories of staff were found.

The findings above suggest the possibility of this phenomenon of disagreement within the therapeutic team being a phenomenon peculiar to the team approach as generally seen in inpatient treatment.

In terms of clinical significance of these findings, the importance of anticipating disagreement between staff, difficulty in treatment, and negative emotions from the start, the importance of both staff and patient sharing in clear therapeutic goals, and recognition of staff meetings and team meetings being therapeutic means in themselves were discussed. Moreover, these findings suggest that clinical effort based upon such understanding may be effective for preventing idle protraction of inpatient treatment.

This study has not dealt with disparity in perception or emotional responses arising from the occupational role of various staff. This is one perspective calling for further

clarification in future. Moreover, this study has inherent limitations in discussing team approach in general, as other categories of staff such as clinical psychologists and social workers were not included, owing to the nature of the ward. Thus, it is believed conducting the current survey on therapeutic teams comprising more occupations should yield results capable of further contribution to the study of the team approach as a treatment modality.

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APPENDIX: 5-Point Rating Scales

1) Anticipation of therapeutic outcome (rated by patients and staff on admission; parentheses indicate patient version)

Please give your personal and intuitive anticipation regarding whether you believe *the patient (you)* will be able to take full advantage of the hospital treatment. In doing so, please take into consideration matters such as the extent to which you believe the treatment will be of benefit to *the patient (you)*, and how far you believe *the patient (you)* will be able to adapt to society as a result. However, please disregard any financial aspects.

- 5: I am very optimistic about therapeutic outcome. I am certain *he/she (I)* will take full advantage of the treatment.
- 4: I am pretty optimistic about therapeutic outcome.

- 3: It is very difficult to determine therapeutic outcome.
- 2: I am pessimistic regarding therapeutic outcome, although somewhat favorable results are possible.
- 1: I am very pessimistic regarding therapeutic outcome, and there is little hope for favorable results.

2) Progress in treatment (rated by patients and staff at 1 and 3 months from hospitalization; parentheses indicate patient version)

This is a question regarding progress in the treatment during the past month. Please answer regarding the extent to which you feel *the patient has (you have)* improved in terms of everyday life.

- 5: Greatly improved.
- 4: Significantly improved.
- 3: Somewhat improved.
- 2: Little improvement.
- 1: Worsening rather than improvement.

3) Degree of progress at the time of discharge (rated by patients and staff; parentheses indicate patient version)

This question is concerned with the progress in treatment through the period of hospitalization. Please respond in terms of the degree to which improvement has been made with regard to *the patient (your)* carrying on with everyday life.

- 5: Greatly improved.
- 4: Quite improved.
- 3: Somewhat improved.
- 2: Little improvement.
- 1: Worsened, rather than improved.

4) Degree of overall treatment difficulty (rated by staff at 1 month and 3 months from hospitalization)

Please evaluate the degree of the overall sense of difficulty you have in treating this patient. In doing so, please rate the extent of difficulty in comparison to the other patients in this psychiatric ward.

- 5: This patient has been the most difficult case I have experienced to date.
- 4: Treating this patient is very difficult, but I am used to it having other equally difficult patients.
- 3: Treating this patient is quite difficult; considerably more so than other patients.
- 2: Treating this patient is quite difficult, but not that difficult compared to other patients.
- 1: I have not felt much difficulty with this patient's treatment.

5) Therapeutic relationship (rated by patients and staff at 1 and 3 months from hospitalization; parentheses indicate patient version)

This is a question regarding the quality of your therapeutic relationship with the *patient (staff)* in the past month. As phrased in the descriptions below, please take into consideration the extent to which you think you have been of help to the *patient (staff)*, and the extent to which you have been working together with the *patient (the staff members)* to attain the objectives of treatment.

- 5: Excellent relationship (highly helpful; working highly well together).
- 4: Very good relationship (helpful; working well together).

- 3: Fairly good relationship (somewhat of help; working fairly well together).
- 2: Poor relationship (not helpful; not working together).
- 1: Highly poor relationship (harmful; working against each other).

6) Collaboration in treatment program (rated by patients and staff at 1 and 3 months from hospitalization; parentheses indicate patient version)

Please rate the degree to which *the patient has (you have)* been involved with *his/her (your)* own treatment in the past month. Please consider each item in terms of the following 5 levels:

- 5: Always so.
- 4: Frequently so.
- 3: Sometimes so.
- 2: Rarely so.
- 1: Never.

The patient (I):

- 1) *has set (have set)* clear treatment goals.
- 2) *is (am)* doing *his/her (my)* best to attain the treatment goals.
- 3) *is (am)* trying hard to understand the reasons for *his/her (my)* feelings and actions.
- 4) *is (am)* following *his/her (my)* treatment plan or program.
- 5) participates (participate) actively in the team meetings.
- 6) *is (am)* actively dealing with family problems.
- 7) openly talks about *his/her (talk about my)* problems with the ward staff.
- 8) expresses *his/her (express my)* feelings freely and constructively to staff.
- 9) *is (am)* making good use of the staff's efforts to help *her/him (me)*.
- 10) *is (am)* trying to understand and overcome *his/her (my)* attitudes and feelings which impede progress in treatment.
- 11) *is (am)* making good use of the things gained through treatment in everyday life.
- 12) openly talks about *his/her (talk about my)* problems with the other patients.

7) Teamwork (rated by staff at 1 and 3 months from hospitalization)

Please evaluate the degree of cooperation between staff members in treating the patient over the past month (quality of teamwork). In doing so, please take

into consideration whether there has been open communication regarding the patient's treatment, whether there has been a frank exchange of differences in opinion, whether there has been mutual agreement regarding treatment goals and intervention, and whether there have been instances of members helping each other as a team.

- 5: Excellent teamwork; working very well together.
- 4: Good teamwork; working well together.
- 3: Fair teamwork ; working fairly well together.
- 2: Poor teamwork; not working together.
- 1: Very poor teamwork; working against each other.

8) Emotional responses (rated by staff at 1 and 3 months from hospitalization)

Below is a list of various emotional responses to a patient. Please evaluate the extent to which you feel the following about the patient, in terms of the following strengths of response.

- 1: Not at all.
 - 2: Slightly.
 - 3: Somewhat strongly.
 - 4: Quite strongly.
 - 5: Very strongly.
- 1) I feel irritated by the patient.
 - 2) I feel drained being with this patient.
 - 3) I feel very protective about this patient.
 - 4) I feel helpless in relation to this patient.
 - 5) I feel frightened by this patient.
 - 6) I find myself wanting to take my time in understanding this patient.
 - 7) I feel anger towards this patient.
 - 8) I feel apologetic, feeling I should be doing more for this patient.
 - 9) I am emotionally provoked by this patient's behavior.
 - 10) I am intrigued by this patient.
 - 11) It is unbearable; putting up with this patient's behavior is very difficult.
 - 12) I wish to avoid contact with this patient. I don't want to have anything to do with him/her.
 - 13) I have no control over the circumstances surrounding this patient.
 - 14) I have experienced division among the staff regarding the relationship with this patient.
 - 15) I feel affection for this patient.
 - 16) I am troubled by the ambiguity regarding this patient or the treatment needs.

