Psychiatric Staff Opinion About Patient Etiology and Treatment

Doris A. Wartel
Eastern Michigan University

Alejandro Aragon
Eastern Michigan University

ABSTRACT: This study used Q methodology to assess a psychiatric hospital staff's opinions concerning the relevance of three perspectives (internalism, environmentalism, and a field approach) for patient etiology and treatment. Seven out of 12 staff loaded on two factors. Implications of incongruity between staff opinions and their observed behavior are discussed.

Patient care staff in inpatient psychiatric settings come from a wide variety of educational, training, and experiential backgrounds and consequently may have varying philosophies about patient care. In addition, there appears to be an absence of clearly defined organizational goals and objectives across disciplines beyond custodial routine and paperwork require-

Authors' addresses: *Wartel,* 6346 Orchard Lake Road, Suite 108, West Bloomfield, MI 48322; *Aragon,* APDO 6599-1000, San Jose, Costa Rica.

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ments. Consequently, it is not evident what guides staff in determining their views of etiology and treatment, and whether or not there is a conflict across disciplines.

Knowledge about the implicit assumptions various staff rely on to decide what a patient's problems are and what to do about them, as well as what assumptions they share, might be valuable in formulating procedural objectives that are in agreement with the ideals of the institution. Taking into consideration formal institutional philosophy and procedures actually carried out and comparing these with staffs' opinions could provide useful direction for institutional operations.

This study was conducted to examine staff opinion concerning why patients behave the way they do, and what it is that constitutes the best form of treatment. Thirty statements were designed to reflect three theoretical perspectives covering etiology and treatment: (a) *Internalism,* encompassing the traditional medical disease model, biological reductionism, and mental determinism; (b) *environmentalism,* encompassing mechanistic aspects of behaviorism and social learning theory; and (c) a *field* perspective encompassing integrated field/systems theory and the interbehavioral approach (Ruben & Delprato, 1987). Each of the three perspectives included five statements on etiology and five on treatment.[1]

Twelve staff members of a 30-bed ward of a 900-bed state psychiatric hospital volunteered to participate. The ward is considered to be a "behavioral ward" where behavior modification techniques are officially sanctioned. The ward psychologist is required to have a behavioral degree, but no behavioral training is required for any other staff members. Staff are assigned to patients labeled both mentally retarded (IQ < 70) and mentally ill with severe behavioral problems.

[1] The following are illustrative: "Patients behave the way they do because they have unresolved conflicts from early childhood" (internal, etiology); "The best form of treatment is to bring about any changes in the person's life circumstance that could contribute to therapeutic gain" (field, treatment); "Patients behave the way they do because their family and society taught them to do so" (environmental, etiology). A copy of the $N = 30$ statements and their factor scores is available from the authors.

Subjects were classified by their occupational title and included one registered nurse supervisor (RN), three licensed practical nurses (LPN), one residential care aide supervisor, three residential care aids, one M.S.W. social worker, one M.S. psychologist, one activity therapist, and one housekeeper. The ward psychiatrist was not available to participate in the study.

The 12 staff members were instructed to Q sort the statements from +3 to -3 so as to represent their overall views concerning treatment and etiology, and the resulting data were analyzed using Stricklin's (1987) p.c.q. program. Only the first unrotated factor produced an eigenvalue in excess of 1.00 (see McKeown and Thomas, 1988, for details concerning factor analysis), but as Brown (1980: 42) has said, "the importance of a factor cannot be determined by statistical criteria alone, but must take into account the social and political setting." In this case, the second factor represented the views of the psychologist alone, and inasmuch as this person was the ward's behavioral expert and possessed the required behavioral training, it was of interest to determine which theoretical perspective was represented by her Q sort.

Factor A was defined by the RN, the three LPNs, the social worker, and the activity therapist. In terms of the Q-sample structure, those statements representing the *field* perspective received the highest positive scores, whereas those representing *internalism* received the highest negative scores. Similarly, factor B -- which, again, represented the views solely of the psychologist -- also emphasized *field* statements and rejected *internalism* statements. What distinguished factor B from A, among other things, was the greater theoretical clarity and consistency characterizing the former's array of factor scores. With respect to the field conception of etiology, for example, the following scores were attained in factors A and B, respectively:

A	B	Statements
−2	+3	Patients behave the way they do because of all things that happened in their lives.

+1 +1 Patients behave the way they do because of the interaction of biological, social, psychological, economic, vocational, educational, domestic, interpersonal, and setting conditions.

+3 +1 Patients behave the way they do because they are continually changing and making functional adaptation to their lives.

Hence, although A and B agree, on balance (i.e., as an average), with the field interpretation of etiology, B's scores are more consistent (i.e., less varied).

Similarly at the negative end of the arrays, A and B both reject internalism treatment strategies, but B does so more consistently:

−2 −3 The best form of treatment is to change their minds.

−3 −2 The best form of treatment is sedation, since they can't be cured and it is necessary to keep them under control.

+1 −1 The best form of treatment is psychotherapy, to help them gain insight into the cause of their problem.

There were six consensus statements across the two factors -- involving both etiology and treatment and all three theoretical perspectives -- but all were in the ±1 range, hence of comparatively little salience for either A or B.

Although the presence of factor A indicates that a number of the staff agree with the field perspective and reject internalism, their behavior on the ward contradicts this. Direct observations indicated that a token economy was carried out on less than 75% of the days, and that time out, seclusion, restraints, and sedation were used "upon a physician's order" for a variety of behaviors. Psychotropic medication was also administered to all patients. In sum, staff behavior could be

categorized as primarily internalistic and to a somewhat lesser extent environmental.

Factor A's reluctance to carry out a token economy could be viewed as acceptance of the field perspective (in agreement with the factor array) and conversely with a rejection of environmentalism; however, there is no strong rejection of environmentalism evidence in the factor scores, nor is there behavioral evidence that field thinking is practiced. Informal observations during a nine-month period, and systematic time sampling methods utilized during a three-month period, did not reveal interdisciplinary staff activity or constructional treatment approaches, both of which might be expected from staff following a field perspective.

Factor B represented the lone psychologist on the staff, and direct observation again indicated incongruency between the perspective adopted in the Q sort (field, with internalism rejected) and behavior on the ward; as with the case of factor A, however, unexplored factors in the system would need to be considered to describe the discrepancy adequately.

Whereas the item choice by perspective for factors A and B appear to follow a somewhat similar patterns, the differences were significant enough to separate the two from one another ($r_{AB} = 0.37$). In part, these differences may reflect the dissimilar educational and training requirements of the psychologist's position.

The fact that five staff did not load significantly on any factor is noteworthy. With the exception of the housekeeper, the staff in question shared the occupational title of resident care aide, and none of the five possessed a vocational or professional degree. As might be expected, their positions are at the lowest end of the pay scale and are the least influential. Conversely, all those with significant loadings had completed vocational or professional training and were in the mid-salary range, and all enjoyed some decision making opportunities in their day-to-day functions. Perhaps the powerlessness inherent in certain positions is reflected in the lack of strong orientation concerning patient etiology and treatment among those members of the lower job classifications. In addition, the relative consensus shared by the paraprofessional and professional staff may result from a contribution of their

training and their opportunity to work together as a team. It is unfortunate that these shared opinions are not developed into a concerted effort to formulate dynamic objectives and procedures.

This study demonstrates the utility of Q methodology in guaging staff opinion, which is an important aspect of the public psychiatric hospital system. The results indicate that more research is warranted to expose the incongruency between staff opinion, staff behavior, and organizational philosophy. An effort to narrow the gap between inharmonious postulates and procedures could provide a more effective public service.

References

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Psychiatrists say that one out of four people is mentally ill. Check three friends. If they're okay, you're it. (Anon.)