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A STUDY ON DISAGREEMENTS BETWEEN PATIENTS AND
PSYCHIATRISTS, THEIR NATURE, TYPE,
CONTRIBUTING VARIABLES, AND CONSEQUENCES

by

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Submitted in partial fulfilment
of the requirements for the degree of
Doctor of Philosophy

Faculty of Graduate Studies
The University of Western Ontario
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ABSTRACT

This research identified disagreements between patients and psychiatrists on problems, goals, and methods for treatment. Specifically, their nature, type, contributing variables, and consequences were investigated.

The study was conducted at two provincial psychiatric hospitals in Ontario. Subjects included patients (n=135) diagnosed as depressed, manic, neurotic, or schizophrenic. The attending psychiatrist (n=29) also participated in the study.

Two to five days after admission to hospital, patients were interviewed according to a checklist on problems, goals, and methods for treatment. At the same time, the psychiatrist completed an identical checklist. Patients were observed for discharge against medical advice (AMA) and absent without leave (AWOL) within the first six weeks of hospitalization.

Findings pertaining to disagreements on problems, goals, and methods for treatment, of an environmental and psychological nature, were consistently of the type whereby psychiatrists identified items when their patients did not. In addition, the relationship between patient variables; psychiatrist variables; variables related to both the patient and psychiatrist; and disagreements were examined. Few of these variables, with the exception of

involuntary detainment, were found to be associated with disagreements. There was a strong relationship between involuntary detainment and disagreements on problems, goals, and methods for treatment. Also, a significant relationship was found between disagreements and the likelihood of patient discharge AMA or AWOL.

In summary, disagreements were of the type whereby the psychiatrist identified problems, goals, and methods for treatment, when the patient did not. A consequence of these disagreements was found to be patient discharge AMA or AWOL. The above findings have implications for clinical practice. Awareness of disagreements would enable the psychiatrist to attempt appropriate interventions to prevent or mitigate adverse consequences. This, in turn, would provide for the effective management of psychiatric patients.

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Chapter 1

Introduction

The identification of problems, goals, and methods for treatment is central to the process of patient care. When disagreements arise between a patient and a clinician, both may be working towards different goals. In turn, the patient may express this disagreement by not complying with treatment.

A review of the published research in psychiatry has revealed that disagreements do exist between patients and clinicians. Some investigators identified disagreements on problems, others focussed on either goals or methods for treatment. However, the extent to which disagreements occur during this overall process for treatment has not been well-established. For example, although patients and clinicians may agree on problems, they may not necessarily agree on the goals and methods for treatment.

Some investigators have observed that clinicians tend to focus on patient problems which are of a psychological nature, whereas patients are more concerned with problems related to environmental conditions. However, the nature of these disagreements has not been clearly established. Further, whether disagreements are of the type whereby the patient identifies problems, goals, and preferences for treatment when the clinician does not, or vice versa, has not been clarified.

The need to specify variables which may contribute to disagreements has been identified by investigators, but not pursued. In addition, some investigators have found evidence that disagreements may result in adverse consequences for the patient. However, these outcome studies were conducted with patients in the community rather than in hospital.

The purpose of this investigation was to advance the research on disagreements between hospitalized patients and psychiatrists. Within the context of the treatment process, disagreements on problems, goals, and methods for treatment were identified. Further, disagreements were classified according to their nature (i.e., environmental or psychological). Whether disagreements were of the type whereby patients identified problems, goals, and methods for treatment when psychiatrists did not, or vice versa, was also determined. Finally, the variables contributing to and consequences of disagreements were investigated.

Chapter 2

Review of the Literature

This chapter offers a critical review of the psychiatric research on disagreements between patients and clinicians. A discussion of the limitations of this research will be provided. Finally, a review of the literature will be presented on the nature of disagreements, their type, contributing variables, and consequences.

2.1 Extent and Limitations of the Research on Disagreements

A review of the literature between the years of 1966 to present was conducted using various sources (e.g., MEDLINE search). Fifteen studies were found to examine disagreements between psychiatric patients and clinicians on problems, goals, or methods for treatment. Detailed information about these studies with regard to sample size, diagnosis of patients, professional background of clinicians, and study setting is provided in Tables 1, 2, and 3 (Section 2.2).

Many of the studies on disagreements have serious methodological and analytical weaknesses. For example, small sample sizes may have hindered investigators from generalizing their findings. Caskey, Deher, and Elliot (1984) interviewed 16 patients in the community and their

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therapists. Polak (1978) interviewed 18 patients and clinicians who knew the patient best. Skodol, Plutchik, and Karasu (1980) interviewed 30 patients and their physicians or nurses. Stubbs (1978) interviewed 15 chronic anxiety patients and their physicians.

Many investigators failed to provide basic information of a descriptive nature about patients and clinicians. For example, the diagnosis of patients was not given in a number of the studies (e.g., Dimsdale, 1975; Dimsdale, Shershow, Klerman, & Kennedy, 1978; Dowds & Fontana, 1977; Horenstein, Houston, & Holmes, 1973; Leonard, 1973; Mayer & Rosenblatt, 1974; Skodol et al., 1980; Vale & Mlott, 1983). Some investigators failed to report the number of clinicians who participated in their study (e.g., Dimsdale, Klerman, & Shershow, 1979; Dowds & Fontana, 1977; Polak, 1978; Skodol et al., 1980; Stubbs, 1978; Zaslave, Ungerleider, & Fuller, 1966). Two of the studies (Dimsdale et al., 1979; Vale & Mlott, 1983) did not describe the professional background of the clinicians who participated.

Health professionals vary in the type of training and level of education required. These differences may well be related to the likelihood of disagreements. However, this issue was not addressed in the research. A considerable number of the studies involved clinicians from a wide range of professional backgrounds. For

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example, Polak (1970) requested that the psychiatrist, social worker, or psychiatric technician who knew the patient best, participate in his study. The criteria used to determine which clinician was most familiar with the patient was not presented. Furthermore, often no attempt was made to control for the varying types of professional background of the clinicians (e.g., Caskey et al., 1984; Glick & Gould, 1976; Polak, 1970; Skodol et al., 1980; Vale & Mlott, 1983).

The generalizability of findings from the disagreement studies may also be limited because of bias in the selection of patients. For example, Dimsdale et al. (1978) selected their sample on the basis of who was available for interview. Gould and Glick (1976) excluded from their study those patients who were absent without leave, discharged against medical advice, and hospitalized less than 30 days. Leonard (1973) from a sample of 239 patients had a non-response rate of 68%. Mayer and Rosenblatt (1974), in their study of 288 patients, had 28% of their sample judged as incompetent and 33% discharged before they had an opportunity to interview these patients. Zaslove et al. (1966) excluded from their sample of 128 patients those who were discharged against medical advice and absent without leave. Goldstein, Racy, Dressler, Ciottone, and Willis (1972) interviewed patients prior to their discharge from hospital. The investigators

excluded from their study patients who were highly disturbed, as well as, patients who provided incomplete information on their questionnaire. Further, these investigators excluded patients who were hospitalized less than one week or discharged at an inconvenient time for interview.

Investigators used a variety of methods to gather information from their subjects (e.g., interview and observation). Most investigators provided insufficient information concerning the instrument used for data collection (e.g., Dowds & Fontana, 1971; Horenstein et al., 1973). This lack of information about the instruments makes it difficult to assess the integrity of findings.

Previous research has shown that disagreements between patients and clinicians do exist. However, some of the studies did not specify the frequency of these disagreements but only whether disagreements did exist (e.g., Dowds & Fontana, 1977; Gould & Glick, 1976; Vale & Mlott, 1983). Also, the majority of the reports failed to indicate how disagreements were operationally defined.

When the frequency of disagreements was reported, some researchers compared the two groups of patients and clinicians without acknowledging that the patient and clinician constituted a paired observation (e.g., Dinsdale, 1975; Dinsdale et al., 1978; Dinsdale et al.,

1979; Dowds & Fontana, 1977; Zaslave et al., 1977). This approach, which ignores the matching of a given patient with a particular clinician, does not utilize all information. Also, in many of the studies, the statistical analyses applied to determine when patients and clinicians were in disagreement was described with such brevity that one cannot evaluate their adequacy.

In summary, the limitations of the 15 psychiatric studies reviewed included small sample sizes; biased subject selection; the frequent lack of information about patients (e.g., diagnosis, involuntary status); the frequent lack of information about clinicians (e.g., sample size, professional background); the absence of operational definitions (e.g., disagreement); insufficient documentation about methods (e.g., instruments); and statistics of uncertain adequacy. Despite these limitations, the studies reviewed were generally of an exploratory nature and did provide direction for the development of this research.

2.2 Review of the Literature for Disagreements on Problems, Goals, and Methods for Treatment

The limitations of the studies on disagreements between patients and clinicians have been discussed above. The next section reviews findings from the studies previously outlined.

(a) Problems: (See Table 1.)

Horenstein et al., (1973) reported the correlation between patients and clinicians on their ratings concerning the patient's problems before therapy ($r=.34$) and after therapy ($r=.38$).

Stubbs (1978) had patients and physicians complete a 28-item rating scale about the psychic and somatic aspects of the patient's anxiety. Total agreement (i.e., when both the patient and clinician identified or denied a symptom) was 51% before therapy; and 64% after therapy. The author found that patients and physicians agreed more on the overall level of symptomatology than about the degree of severity of a particular symptom. He concluded that the nature of a symptom rather than its severity is a major determinant of agreement between patients and physicians. Further, disagreements were found to be the greatest when the average level of patient symptomatology was identified to be minimal or severe, and when the relative change in the patient after therapy (as measured by a reduction of symptoms) was the greatest. A final conclusion was that, in general, the patient and physician were not in agreement before therapy. However, after therapy, agreement increased.

(b) Goals: (See Table 2.)

Using an open-ended structured interview, Polak (1978) found that the mean number of goals for treatment

Table 1

Disagreement Research on Problems

Author(s)	Number of patients (n) and their diagnosis	Number of clinicians (n) and their professional background	Study setting
Horenstein, Houston, & Holmes, (1973)	n=41 Diagnosis not given.	n=17 Psychology students.	University affiliated community clinic, Kansas.
Stubbs (1978)	n=15 Chronic anxiety.	n not given Physicians	Inpatients. Study setting not given.

Table 2

Disagreement Research on Goals for Treatment

Author(s)	Number of patients (n) and their diagnosis	Number of clinicians (n) and their professional background	Study setting
Polak (1970)	n=18, 11 from one hospital, 7 from another. Schizophrenic, depressed, alcoholic, neurotic.	n not given Clinicians who knew the patient best: psychiatrist, social worker, psychiatric technician, and referring practitioner, family member, or neighbour.	Two psychiatric hospitals, one rural and one urban, Scotland.
Dimsdale (1975)	Test: n=188 Retest: n=118 Diagnosis not given.	Test: n=87 Retest: n=49 Physicians.	Veterans Administration Hospital, Massachusetts.
Dimsdale, Shershow, Klerman, & Kennedy, (1978)	Test: n=66 Retest: n=36 Diagnosis not given.	n not given Physicians.	Psychiatric unit, Massachusetts General Hospital.
Dimsdale, Klerman, & Shershow, (1979)	Test: n=66 Retest: n=36 Diagnosis not given.	n not given. All staff on the unit & physicians.	Psychiatric unit, Massachusetts General Hospital.

mentioned by patients was 18.3. This information was not provided for clinicians. In comparison, the mean number of goals identified by both patients and clinicians was 3.3. Goals for treatment were identified after the clinician assessed the patient, obtained a social history, and began treatment. At one of the hospitals, only one of the patient-clinician pairs (4%) were in agreement on their rankings of goals for treatment. At another hospital, six pairs (16%) were in agreement.

Dimsdale (1975) had patients and clinicians complete a questionnaire on their goals for treatment. One year later, this questionnaire was readministered to patients who remained in hospital and, as well, to clinicians. Although the responses of patients and clinicians were not matched, the investigator found that patients differed from clinicians in their ranking of the importance of goals for treatment. In addition, this finding persisted during the course of hospitalization (i.e., on both testing occasions, patients and clinicians did not change their ranking of goals for treatment). In a replication study, Dimsdale et al. (1978) reported similar findings.

In a later study, Dimsdale et al. (1979) interviewed all the patients and clinicians on a psychiatric unit for their preferences on goals for treatment. One year later, this testing was repeated on the same unit. Despite a substantial turnover of staff and patients, the results

from the two test periods remained similar. The investigators reported disagreements between patients and clinicians on their ranking of goals for treatment at the beginning and at the end of the study. Clinicians showed a strong preference for insight orientation and a relatively low preference for symptom relief. Patients uniformly devalued insight in favour of 'non-therapy susceptible goals' and 'adaptation'. The authors state that 'non-therapy susceptible goals' refer to goals not amenable to psychotherapeutic intervention. However, no clear definition was given for 'non-therapy susceptible goals' and 'adaptation'.

(c) Treatment Methods: (See Table 3.)

Caskey et al. (1984) had patients and clinicians in a community setting rate the helpfulness of methods for treatment according to a five-point Likert scale. On the average, they agreed on the helpfulness of four out of the six approaches for treatment (33%). Average correlations ranged from 0.17 to 0.45.

Dowds and Fontana (1977) had patients and therapists rate the helpfulness of 14 methods for treatment. Therapists were either first-year psychiatric residents or first-year psychology students. The authors found that patients tended to rate 13 of the 14 methods to be more helpful than did therapists. The one exception was that

Table 3

Disagreement Research on Methods for Treatment

Author(s)	Number of patients (n) and their diagnosis	Number of clinicians (n) and their professional background	Study setting
Caskey, Baker, & Elliot, (1984)	n=16 All diagnoses except psychotic, organic, sociopathic.	n=16 Psychiatrists, residents, psychologists, interns, social workers.	Variety of outpatient settings (not specified), University of California, Los Angeles.
Dowds & Fontana, (1977)	n=54 males. Diagnosis not given.	n not given. First year psychiatric residents, first year psychology trainees.	Psychiatric Unit, Veterans Administration Hospital, Connecticut.
Goldstein, Racy, Dressler, Ciottone, & Willis, (1972)	n=346 females=218 males=118. Discharged organic, schizophrenic, psychotic-depressive, manic, neurotic-depressive, neurotic, character disorder.	n=23 First year psychiatric residents.	University Psychiatric Hospital, New York.
Gould & Glick, (1976)	n=44 Scheduled for discharge: schizophrenic, neurotic, personality disorder.	n=28 Psychiatric residents=2, psychology fellows=2, psychiatric nurses=14, occupational therapists=2.	Clinical Research Ward, Neuropsychiatric Institute, University of San Francisco, California.

Table 3 (continued)

Author(s)	Number of patients (n) and their diagnosis	Number of clinicians (n) and their professional background	Study setting
Leonard (1973)	n=96 Diagnosis not given.	n=14 males=12, females=2. Psychiatric residents.	Neuropsychiatric Institute, University of California, Los Angeles.
Mayer & Rosenblatt (1974)	n=288 Diagnosis not given.	n=199 Psychiatrists=13, psychologists=17, social workers=22, rehabilitation workers=37 nurses=17 attendants=43.	Bronx State Psychiatric Hospital, New York.
Skodol, Plutchik, & Karasu, (1988)	n=38 First & readmissions to study hospital. Diagnosis not given.	n not given Physicians or nurses.	University affiliated hospital, New York State Psychiatric Institute, New York.
Vale & Mlott, (1983)	n=24 males=7 females=17. Diagnosis not specified, ranged from mild neurosis to psychotic.	n=13 Background not provided.	Psychiatric Unit, Medical University of South Carolina.
Zaslave, Ungerleider, & Fuller, (1966)	n=93 Discharged psychotic, neurotic, personality disorder.	n not given Psychiatric residents, head nurses.	Neuropsychiatric Institute, a university & state hospital, University of California, Los Angeles.

therapists rated group therapy as being more helpful than did patients.

Goldstein et al. (1972) conducted a study with patients prior to discharge. These patients and first-year psychiatric residents were asked for their perceptions about the benefit of the 24 methods for treatment. Patients viewed all the methods as more helpful than did their residents. On the other hand, there was a high degree of agreement between patients and residents about the extent of benefit gained from each treatment ($r=.83$).

Leonard (1973) mailed questionnaires to patients who were discharged from hospital. Patients and psychiatric residents were asked to rank-order their preferences for 12 methods of treatment. The average rating of the helpfulness of treatment by patients was 71%, with a range of 50% to 84%. For psychiatric residents, their average rating was 68%, with a range of 25% to 79%. Patients and residents agreed that five of the twelve methods were the most helpful. They also agreed that three of the methods were the least helpful.

Mayer and Rosenblatt (1974) administered a 15-item questionnaire on goals for treatment to unmatched patients and clinicians. A ranking of the importance of these goals according to a five-point Likert scale revealed disagreements between patients and staff. In particular,

psychiatrists selected medication as the most important therapy whereas patients tended to consider the hospital milieu (e.g., eating and sleeping) as the most important.

Skodol et al. (1988) found that during an open-ended interview, patients and clinicians (i.e., physicians or nurses) were in agreement on 7 of the 21 methods for treatment. In contrast, they were in disagreement on 14 of the 21 methods (67% disagreement). Eleven disagreements were of the type whereby clinicians identified the item to a greater extent than did patients. Three items were of the type whereby patients identified the item to a greater extent than did clinicians.

Vale and Mlott (1983) investigated the perceptions of patients and clinicians on the helpfulness of 13 methods for treatment. Only those patients who volunteered to participate were included in the study. Patients and clinicians were interviewed five days after the patient's admission and again at discharge. No relationship was found between the ratings of patients and clinicians on the helpfulness of these methods.

Zaslave et al. (1966) sent a questionnaire to discharged patients excluding those who were discharged against medical advice. Patients were asked what treatments were the most helpful during hospitalization. Also, a questionnaire was sent to psychiatrists and nurses asking them what treatments were the most helpful for

their patients. Disagreements were reported for 65% of the patients and psychiatrists, for 48% of the patients and nurses, and for 61% of the nurses and psychiatrists. Of the patients, 32% identified individual psychotherapy as being the most helpful. In contrast, 15% of psychiatrists perceived this method to be the most helpful. Further, 35% of the psychiatrists, as compared to 3% of the patients, identified medication as the treatment which was the most helpful.

Unlike the findings reported by the previous investigators, Gould and Glick (1976) found almost complete agreement between patients and clinicians on a rank-ordering of the helpfulness of 18 methods for treatment.

2.3 Nature of Disagreements

Researchers have not thoroughly investigated the nature of disagreements. However, some investigators have suggested that disagreements occur because clinicians operate from a psychological perspective whereas patients are more concerned with conditions in their environment (e.g., Chesney, Brown, Poe, & Gary, 1983; Dimsdale, 1975; Dimsdale et al., 1978; Eisenthal & Lazare, 1976; Eisenthal, Emery, Lazare, & Udin, 1979; Eisenthal, Koopman, & Lazare, 1983; Evans, 1984; Horenstein et al., 1973; Hurst, Weigel, Thatcher, & Nyman, 1969; Krauskopf, Baumgardner, & Mandracchia, 1981; Lazare, Eisenthal, &

Wasserman, 1975; Polak, 1978; Zaslove et al., 1966). In view of the foregoing research which suggests that clinicians operate from a different perspective than patients, it would be clinically meaningful to examine the nature of disagreements according to psychological and environmental problems, goals, and methods for treatment.

In a previously discussed study, Dimsdale et al. (1979) concluded that their findings reconfirm evidence that patients and clinicians differ in their ideology about goals for therapy. For example, clinicians favoured a goal ideology that encouraged patients to pursue insight into their problems. On the other hand, patients uniformly devalued insight in favour of 'non-therapy susceptible goals' and 'adaptation'. As mentioned previously, no clear definition was given for 'non-therapy susceptible goals' and 'adaptation'. However, these goals are most likely related to the patient being able to live in the community (e.g., manage daily routines).

Polak (1978) found that clinicians usually gave a high ranking for goals of an intrapsychic and symptomatic nature and a low ranking for goals related to social disturbance. Furthermore, clinicians defined problems within the patient whereas patients defined problems within the group of people with whom they lived.

Zaslove et al. (1966) found that physicians tended to view both medications and individual psychotherapy as the

most helpful treatment for patients. In contrast, almost half of the patients did not identify psychotherapy as the most helpful. The majority of patients viewed the hospital milieu of living and interacting with other patients as the treatment which was the most helpful.

2.4 Type of Disagreement

Whether patients or clinicians identify problems, goals, and methods for treatment has been examined in only one of the previously discussed studies (i.e., Skodol et al., 1980). These investigators reported that there was disagreement on 14 of the 21 methods for treatment (67% disagreement). Three of the 14 disagreements (21%) were of the type whereby patients identified the item when their clinicians did not; and 11 (79%) were of the type whereby clinicians identified the item when their patients did not. Given the lack of research that has examined type of disagreement (i.e., for problems and goals), further study would be informative.

2.5 Variables Contributing to Disagreements

Researchers have not investigated variables which may be associated with disagreements. The patient-psychiatrist variables which may contribute to disagreements and are of interest to this research are as follows:

(1) variables related to the patient:

- (a) sex
- (b) age
- (c) educational level
- (d) employment status.
- (e) psychiatric diagnosis
- (f) involuntary status

(2) variables related to the psychiatrist:

- (a) language at birth
- (b) psychiatrist versus resident status
- (c) clinical orientation

(3) variables related to both the patient and psychiatrist:

- (a) sex differences
- (b) at least a 28-year age disparity
- (c) previous psychiatrist contact with the patient

(1) Patient Variables:(a) Sex

and

(b) Age

The relationship between the patient's sex, age, and disagreements has not been investigated. However, a medical study conducted by Prestin, Goldman, and Cecil (1988) determined agreements between patients in an ambulatory care center (n=439) and medical residents of physicians (n not given). The association between agreements and the patient's sex was investigated. The investigators reported that the patient's sex was found to be unrelated to agreement scores. Also, it was found that

increased agreement (i.e., partial to full agreement) was related to the patient being 50 years of age and older. However, it is noted that this study was conducted with patients and residents or physicians in a medical setting.

(c) Educational Level

and

(d) Employment Status

The relationship between educational level, employment status, and disagreements has not been examined in the research reviewed. However, it is plausible that the socio-economic class of patients may be related to the likelihood of disagreements. For example, Burgoyne, Staples, Yamamoto, Wolkon, and Kline (1979) conducted a study at an outpatient clinic. The patients (n=325) at this clinic were from a lower socio-economic class. They were interviewed with respect to the importance of 14 goals for treatment. Also, second-year psychiatric residents (n=22) were asked what they perceived their patients would identify as important goals for treatment. Approximately two-thirds of the patients identified the following goals as being very important: intrapsychic therapy, clarification, and control of feelings. At least one-third of the patients considered 10 of the 14 goals (71%) to be very important. Residents identified 9 of the 14 goals (64%) to be of less importance than did their patients.

In contrast to the study by Burgoyne et al. (1979), Frank, Eisenthal, and Lazare (1978) found virtually no basis for the speculation that patients of various socio-economic classes have different expectations for treatment. These investigators found that patients in a walk-in clinic from a lower socio-economic class ($n=278$) scored high on presumed middle-class requests (e.g., insight therapy and clarification of problems). On the other hand, patients from a middle socio-economic class often endorsed typical lower-class requests (e.g., treatment for medical problems).

(e) Psychiatric Diagnosis

The relationship between a patient's diagnosis and disagreements was found to be examined in only one study (Gould and Glick, 1976). These investigators found that on a rank-ordering of the helpfulness of methods for treatment, greater agreement between patients and clinicians was found with psychotic (Kendall $W=0.59$) than with non-psychotic patients (Kendall $W=0.45$). No explanation was given for this finding.

(f) Involuntary Status

Investigators studied the attitudes of patients who were involuntarily detained. However, the relationship between involuntary detainment and disagreements has not been examined. Jones and Kahn (1964) and Linn (1969) reported that voluntary patients had a more favourable

attitude towards hospitalization than involuntary patients. Shannon (1976) interviewed 100 patients upon admission to a psychiatric hospital in Melbourne, Australia. Involuntary patients and those who felt coerced into hospital had a negative attitude towards their hospitalization. On the other hand, voluntary patients who did not feel coerced into hospital had a positive attitude towards their hospitalization. Bradford, McCann, and Merskey (1986) studied the views of involuntary patients (n=57) towards their involuntary detainment. Many of these patients (58%) considered involuntary detainment as appropriate for them.

(2) Psychiatrist Variables:

(a) Language at Birth

While it has been suggested that cultural differences between patients and clinicians may lead to disagreements (e.g., Caskey et al., 1984), this has not been pursued in the research examined.

(b) Psychiatrist Versus Resident Status

A general medical study by Freidin et al. (1980) investigated the association between the medical training of clinicians (i.e., physician versus resident) and agreements. It was found that the level of medical training was not related to agreement scores. None of the research reviewed examined the extent to which a psychiatrist's level of training (i.e., psychiatrist

versus psychiatric resident status) accounted for disagreements.

(c) Clinical Orientation

In two studies (Rosenthal and Frank, 1958; Brill and Storow, 1960), it was reported that psychiatrists from a psychodynamic orientation considered patients of middle and upper socio-economic classes to be good candidates for psychotherapy; patients from a lower socio-economic class were not. Thus, it seems plausible that the clinical orientation of a psychiatrist (e.g., psychodynamic or biological versus eclectic) may account for disagreements with patients. This possibility has not been examined by previous investigators.

(3) Variables Related to Both the Patient and Psychiatrist:

(a) Sex Differences

Sherman, Koufacos, and Kenworthy (1978) found evidence that male psychiatrists may fail to identify the concerns of female patients because of a lack of knowledge about problems unique to women. A study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) found that clinicians of both sexes were less likely to attribute to women than to men traits which characterized healthy adults. Broadsky and Hare-Mustin (1980) reviewed the related literature on this issue and reported a lesser degree of such stereotyping. Thus, there is evidence to

support the possibility that sex differences between patients and clinicians may be related to disagreements, although this has not been formally investigated.

(b) An Age Disparity of at Least 20 Years

and

(c) Previous Psychiatrist Contact With Patient

There was no evidence in the literature that disagreements were related to an age disparity between the patient and clinician, nor to the clinician having had previous contact with the patient.

2.6 Consequences of Disagreements

Disagreements may be associated with specific consequences. As suggested by previous investigators (e.g., Dimsdale et al., 1979; Hurst et al., 1969; Skodol et al., 1980), it is important to further clarify whether this relationship holds with hospitalized patients. Two consequences of particular interest to this research are patient discharge against medical advice (AMA) and absent without leave (AWOL). Studies which indirectly provide support for the speculation that disagreements may be associated with specific consequences are reported below.

Albonda, Dean, and Starkweather (1964) interviewed patients ($n=328$) who were discharged from a community clinic. Patients were interviewed about problems and treatments which were helpful. The investigators found that when social workers assisted these patients ($n=328$)

early in therapy to formulate their problems, goals for treatment, and the nature of therapy to be received, a significant improvement was noted. Specifically, such patients achieved a higher level of social functioning and required a shorter length of therapy.

Phillips, Goldberg, and O'Connell (1984) conducted a study with outpatients ($n=23$) and clinicians (n not given). The professional background of these clinicians was not provided. The investigators found that congruence between patients and clinicians on problems and preferences for treatment increased a therapist's willingness to initiate therapy.

Hurst et al. (1969) determined the degree of agreement between university students at a counselling center ($n=156$) and counsellors ($n=6$) on seven diagnostic items. A positive relationship between diagnostic agreement and the client's perceptions of the benefit of counselling was found for six out of the seven items (86%).

Epperson, Bushway, and Warman (1983) found that students at a university counselling center ($n=754$) were more likely to self-terminate after one therapy session when recognition of the patient's problem by the counsellor ($n=34$) was absent. When therapists recognized the client's problems after the initial counselling

session, 15% of the clients terminated. On the other hand, when problem recognition was absent, 55% terminated.

In a similar type of study, Krauskopf et al. (1981) asked students at a university counselling clinic to identify their problems as educational, personal, or vocational. The investigators found that students returned for treatment more often when the client and counsellor agreed on the types of problems identified.

Borghi (1968) conducted a study with outpatients (n=29) and their psychiatrist (n=3) or social worker (n=3). The investigator found that 7 out of the 29 patients disagreed with clinicians about their method of treatment (24% disagreement). Patients who remained in treatment voiced expectations for treatment which were congruent with those of clinicians (e.g., for psychotherapy), whereas terminators did not express expectations similar to clinicians.

At a community clinic, Rosenthal and Frank (1958) investigated disagreements between patients and psychiatrists on methods for treatment. The researchers reported that disagreements were associated with patient dropout rates of up to 60%.

Chapter 3

Research Questions

This research addressed the following three questions:

3.1 Research Question #1:

Is the probability that a psychiatrist will identify a given item (regarding problems, goals, and methods for treatment) as being relevant for the patient greater than the probability that the patient will identify the item as being relevant?

3.1(1) Disagreements on Problems, Goals, and Methods for Treatment

Upon entering hospital, patients are assessed by their psychiatrist for problems. The recognition of these problems by both the patient and physician is an essential first step in the process of care (Starfield, Steinwachs, Morris, Bause, Siebert, & Westin, 1979). Based on problems, goals for treatment can then be established and the appropriate methods for treatment prescribed.

When there are disagreements between the patient and psychiatrist on problems, goals, and methods for treatment, there may be no shared basis from which treatment can be established. In contrast, if there are some agreements, this enables the patient and psychiatrist to work towards the resolution of problems by establishing common goals and preferences for treatment. However, because the patient and psychiatrist

identify a problem, it cannot be assumed that they are both of the opinion that this problem should be treated. Therefore, agreements and disagreements needed to be clarified not only for problems but also for goals and methods of treatment.

3.1(2) Nature of Disagreements

Disagreements between patients and psychiatrists were classified according to their nature (i.e., environmental or psychological). As reported in the review of the literature, it has been suggested that disagreements may be such that clinicians focus on psychological problems whereas patients are more concerned with conditions in their environment. Also, it has been postulated that clinicians identify goals and methods for treatment which focus on problems of a psychological nature whereas patients tend to identify treatments for environmental concerns.

3.1(3) Type of Disagreement

If the psychiatrist identifies problems, goals, and methods for treatment that the patient does not, then treatment proposed by the psychiatrist may be resisted by the patient. On the other hand, if the patient identifies problems, goals, and methods for treatment that the psychiatrist does not, the patient's concerns and preferences for treatment may not be addressed. For the

purpose of this research, when disagreements existed between a patient and psychiatrist, their direction was classified as follows:

TYPE 1 DISAGREEMENT - the patient identified a given item when the psychiatrist did not.

TYPE 2 DISAGREEMENT - the psychiatrist identified a given item when the patient did not.

3.2 Research Question #2:

To what extent do variables related to the patient, variables related to the psychiatrist, and variables related to both the patient and psychiatrist, explain disagreements?

The patient variables were as follows:

- (a) sex
- (b) age
- (c) educational level
- (d) employment status
- (e) psychiatric diagnosis
- (f) involuntary status

The psychiatrist variables were as follows:

- (a) language at birth
- (b) psychiatrist versus resident status
- (c) clinical orientation

The variables related to both the patient and psychiatrist were as follows:

- (a) sex differences
- (b) at least a 20-year age disparity
- (c) previous psychiatrist contact with the patient

Disagreements between patients and psychiatrists were determined for:

- (a) problems
- (b) goals
- (c) methods for treatment

of the following nature:

- (i) environmental
- (ii) psychological

3.2(1) Patient Variables

In the literature reviewed, previous investigators have speculated that some patients may be more prone than others to disagree with their psychiatrist. Such characteristics of patients which were of interest to this study include (a) sex (b) age, (c) educational level, (d) employment status, (e) psychiatric diagnosis, and (f) involuntary status. For example, male patients are sometimes perceived to be less compliant with treatment than are female patients and thus, may be more inclined to disagree with their psychiatrists. Similarly, younger patients are sometimes thought to be more rebellious than older patients, possibly resulting in a greater likelihood of disagreement between these patients and psychiatrists. Patients of a lower socio-economic class and a lower educational level may lack insight about problems, in particular, problems of a psychological nature. This may lead to the patient and psychiatrist having different perceptions about problems and methods for treatment.

Some diagnostic groups may be inclined to disagree with their psychiatrist more than others. For example, patients diagnosed as schizophrenic often have an inability to perceive reality because of the nature of their illness. This lack of reality may lead to disagreements about problems and preferences for treatment. Also, patients detained involuntarily at admission may become angry and resentful about being hospitalized without their consent. This could inadvertently lead to disagreements between the patient and psychiatrist on goals and methods for treatment.

See table 4, Chapter 4, for a classification of the patient variables discussed previously.

3.2(2) Psychiatrist Variables

As mentioned in the review of the literature, no research examined the extent to which characteristics of the psychiatrist might, in fact, be associated with disagreements. However, characteristics of the psychiatrist such as (a) language at birth, (b) level of training, and (c) clinical orientation may be associated with disagreements. For example, the psychiatrist's language at birth (i.e., English versus non-English) may be related to disagreements. A psychiatrist whose language at birth was English may focus on problems related to the patient's lifestyle and societal stresses to a greater extent than a psychiatrist whose language at

birth was not English. These associated cultural differences may lead to disagreements.

It seems plausible that a physician's status (i.e., psychiatrist versus resident status) may be related to disagreements. Because psychiatric residents are generally less experienced clinically, they may be more prone to agree with patients. Furthermore, the specific clinical orientation of psychiatrists (i.e., psychodynamic, biological, or eclectic) could also lead to disagreements. For example, because of differences in the type of clinical orientation, psychiatrists may differ in their perceptions of the patient's problems and on how these problems could best be treated. Psychiatrists whose focus is psychodynamic may recommend psychotherapy for patients. On the other hand, psychiatrists with a biological orientation may operate from a medical perspective; offering treatments such as chemotherapy.

See Table 7, Chapter 4, for a classification of the characteristics of psychiatrists examined in this research.

3.2(3) Variables Related to Both the Patient and Psychiatrist:

Investigators have postulated that disagreements may be explained by variables associated with both the patient and psychiatrist. Some of these variables include (a) sex differences, (b) at least a 20-year age disparity,

and (c) whether the psychiatrist had previous contact with the patient. For example, the possibility of sex-role stereotyping, as well as, psychiatrists failing to understand the problems of patients who are of the opposite sex could possibly contribute to disagreements. In addition, an age disparity between patients and psychiatrists may result in different attitudes, values, and lifestyles. This, in turn, could lead to different perceptions of problems and goals for treatment, eventually leading to disagreements. Furthermore, familiarity with the patient from a previous hospitalization may enhance the psychiatrist's insight about the patient's problems and whether past treatments were effective. This knowledge may lead to agreements or, on the other hand, possibly disagreements.

See Table 9, Chapter 4, for a classification of the variables related to both the patient and psychiatrist investigated in this research.

3.3 Research Question #3:

To what extent do variables related to the patient and disagreements between a patient and psychiatrist explain patient discharge against medical advice (AMA) or absent without leave (AWOL)?

The patient variables were as follows:

- (a) sex**
- (b) age**
- (c) educational level**
- (d) employment status**
- (e) psychiatric diagnosis**
- (f) involuntary status**

Disagreements between a patient and psychiatrist were determined for:

- (a) problems
- (b) goals
- (c) methods for treatment

3.3(1) Classification of Disagreement Status

As discussed in the review of the literature, there was a lack of information explaining how disagreements were determined. For the purpose of this study, it was thought that requiring complete disagreement on all items was too stringent a definition, given the substantial number of items that a patient and psychiatrist would be asked to identify as relevant. However, there needed to be clear evidence that the patient and psychiatrist were in disagreement. Thus, when classifying a patient and psychiatrist on their disagreement status, at the most, one agreement was allowed. Those patients and psychiatrists who were in agreement on the identification of more than one item were classified as agreeers. It should be noted that when an item was not identified by either the patient or psychiatrist, this item was excluded because there was no agreement or disagreement.

In summary, the criterion for classifying a patient and psychiatrist as a disagreeer or agreeer was as follows:

DISAGREER: For a patient to be classified as a disagreeer it was required that there be disagreement on all items, with the exception of one agreement at most being allowed.

AGREER: For a patient to be classified as an agreeer, it was required that there be agreement at least on two or more items.

This criterion was then applied to determine disagreement status for problems, goals, and methods for treatment as follows:

(1) For Problems:

(a) **Environmental:** To be classified as a disagreeer on problems of an environmental nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(b) **Psychological:** To be classified as a disagreeer on problems of a psychological nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(c) **All Problems:** To be classified as a disagreeer on problems in general (i.e., environmental and psychological), there needed to be disagreement on environmental problems (as defined above) and also disagreement on psychological problems (as defined above).

(2) For Goals:

(a) **Environmental:** To be classified as a disagreeer on goals of an environmental nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(b) **Psychological:** To be classified as a disagreeer on goals of a psychological nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(c) **All Goals:** To be classified as a disagreeer on goals in general (i.e., environmental and psychological), there needed to be disagreement on environmental goals (as defined above) and also disagreement on psychological goals (as defined above).

(3) For Methods:

(a) **Environmental:** To be classified as a disagreeer on methods for treatment of an environmental nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(b) **Psychological:** To be classified as a disagreeer on methods for treatment of a psychological nature, there needed to be disagreement with the exception of one agreement at most being allowed.

(c) **All Methods:** To be classified as a disagreeer on methods for treatment in general (i.e., environmental and psychological), there needed to be disagreement on environmental methods (as defined above) and also disagreement on psychological methods (as defined above).

3.3(2) Consequences of Disagreements

As discussed previously, investigators suggested that disagreements between outpatients and clinicians may lead to adverse outcomes such as a patient's termination from therapy. It seems plausible that patients who are in disagreement with their psychiatrist may also be those patients who resist treatment and discharge themselves against medical advice (AMA) or are absent without leave (AWOL). This research examined the extent to which these outcomes (i.e., patient discharge AMA/AWOL) could be explained by disagreements on (a) problems, (b) goals, and (c) methods for treatment and, as well, by the patient variables (a) sex, (b) age, (c) educational level, (d) employment status, (e) psychiatric diagnosis, and (f) involuntary status.

A six-week time frame was used to observe the outcome variables (i.e., AMA/AWOL status) for two reasons. First,

after this length of hospitalization, the patient becomes a candidate for long-term care. At this time, the patient's problems, as well as, the methods for treatment often change (Glick, Hargreaves, Drues, Showstack, & Katzow, 1977; Herz, Endicott, & Spitzer, 1977). Second, since patient discharge AMA or AWOL generally occurs within the first few weeks of hospitalization, six weeks was considered an adequate length of time to observe these outcomes.

Table 4, Chapter 4, shows the classification of patient variables and AMA/AWOL status. Research Question #2, Section 3.3(1) gives the classification of disagreement status.

Chapter 4

Method

4.1 Study Sample:

The Ontario Ministry of Health operates 10 psychiatric provincial hospitals. These hospitals report directly to the Mental Health Branch of the ministry. Each hospital admits patients from a defined geographic area, with beds for approximately 4,500 inpatients. The patients in this study were admissions from two of these hospitals: the London Psychiatric Hospital (LPH) and the St. Thomas Psychiatric Hospital (STPH). Each hospital has approximately 450 beds serving both rural and urban areas in southern Ontario.

Between the months of mid-October 1986 to mid-January 1987, male and female patients ages 18 to 65 years were included in the study on a sequential basis. Each psychiatrist contributed a maximum of eight patients to the study. Patients with a primary diagnosis of organic or personality disorder were excluded. Thus, only patients with a diagnosis of depression, mania, neurosis, or schizophrenia were selected. Eight patients were unable to be approached for their consent to participate because they were in seclusion on a long-term basis. Five patients refused to participate. This left a final sample size of 135 patients. Of note, for the purpose of the data analysis, patients diagnosed as schizophrenic were

differentiated from patients diagnosed as depressive, manic, and neurotic. The reason for this grouping was that patients with the latter diagnoses tend to be more similar, in a clinical sense, when compared to patients who are schizophrenic. See Table 4 for information about the demographic characteristics and psychiatric background of the patients participating in this study.

Table 5 compares the patients at the LPH and STPH with respect to various demographic characteristics and their psychiatric background. The patients at the two hospitals were similar with regard to their demographic characteristics: sex, age, educational level, and employment status. Also, the patients at the two hospitals were comparable with respect to variables related to their psychiatric background: diagnosis, involuntary status, contact with their psychiatrist on a previous hospitalization, and discharge status within the first six weeks of hospitalization.

Psychiatrists were randomly assigned to patients who were first admissions. Readmissions were assigned to their previous psychiatrist, to the extent that this was possible. Each patient's attending physician agreed to participate in the study. A total of 21 psychiatrists and 8 psychiatric residents participated. For the purpose of discussion, the term 'psychiatrist' will refer to both psychiatrists and psychiatric residents. A distribution

Table 4

**Demographic Characteristics and Psychiatric Background
of Patients (n=135)**

Variable	Classification and coding	n	%
Sex	0 = male	69	51%
	1 = female	66	49%
Age	0 = over 30 years	83	61%
	1 = 30 years or less	52	39%
Educational level	0 = less than Grade 12	89	66%
	1 = Grade 12 or more	46	34%
Employment status	0 = employed	38	28%
	1 = not employed	97	72%
Diagnosis*	0 = depressive/manic disorder*	47	35%
	1 = neurotic disorder*	16	12%
	2 = schizophrenic disorder*	72	53%
Voluntary status at admission	0 = involuntary*	79	58%
	1 = voluntary	56	42%
Previous contact with psychiatrist	0 = no	77	57%
	1 = yes	58	43%
Discharged within first six weeks of hospital stay	0 = AMA*/AWOL*	40	30%
	1 = continued hospitalization/voluntary discharge	95	70%

* See Glossary for definition.

Table 5

Comparison of Patients at the London Psychiatric Hospital (LPH) (n=83) and the St. Thomas Psychiatric Hospital (STPH) (n=52) According to Demographic Characteristics and Psychiatric Background

Variable	Classification ^a and coding	LPH n(%)	STPH n(%)	P- value
Sex	0=male 1=female	41(49%) 42(51%)	28(54%) 24(46%)	.62
Age	0=18-29 years 1=30-39 years 2=40-49 years 3=50-59 years 4=60-69 years	32(39%) 24(29%) 12(14%) 10(12%) 5(6%)	14(27%) 19(36%) 12(23%) 5(10%) 2(4%)	.46
Educational level	0=university 1=community college 2=Grade 12, 13, or trade school 3=Grade 9, 10, or 11 4=Grade 8 or less	6(7%) 2(2%) 25(30%) 32(39%) 18(22%)	2(4%) 2(2%) 9(17%) 20(38%) 19(37%)	.32
Employment status	0=employed 1=not employed	21(25%) 62(75%)	17(33%) 35(67%)	.35
Diagnosis*	0=depressive/manic disorder* 1=neurotic disorder* 2=schizophrenic disorder*	30(36%) 7(9%) 46(55%)	17(33%) 9(17%) 26(50%)	.30
Involuntary status at admission	0=involuntary* 1=voluntary	48(58%) 35(42%)	31(60%) 21(40%)	.84
Previous psychiatrist contact with patient	0=no 1=yes	50(60%) 33(40%)	27(52%) 25(48%)	.34
Discharge status during first six weeks of hospital stay	0=AMA* 1=AWOL* 2=voluntary discharge 3=continued hospitalization	19(23%) 5(6%) 27(33%) 32(38%)	11(21%) 5(10%) 19(37%) 17(32%)	.82

* See Glossary for definition.

Table 6

Number of Patients Per Psychiatrist
and Per Psychiatric Resident

(n=135 patients)

(n=21 psychiatrists)

(n=8 residents)

Psychiatrist number	Number of patients per psychiatrist
1	7
2	6
3	7
4	6
5	6
6	5
7	8
8	4
9	7
10	6
11	7
12	6
13	4
14	6
15	5
16	4
17	5
18	4
19	4
20	2
21	3
Total	111
Mean	5.3

Resident number	Number of patients per resident
1	4
2	3
3	5
4	3
5	2
6	2
7	3
8	1
Total	24
Mean	2.9

of the number of patients each psychiatrist contributed to the study is presented in Table 6. Information on the demographic characteristics and clinical background of the psychiatrists participating in the study is provided in Table 7.

A comparison of the characteristics of the psychiatrists at the LPH and STPH is presented in Table 8. This comparison revealed that the psychiatrists at the STPH were somewhat older and more frequently not of the English language at birth. In addition, most of the psychiatrists at the STPH were male. However, at the LPH, the number of male and female psychiatrists was approximately equal. At the LPH there were seven psychiatric residents whereas at the STPH there was only one resident. Most of the psychiatrists at both the LPH and STPH stated that their clinical orientation was eclectic as opposed to psychodynamic or biological.

Characteristics related to both the patient and psychiatrist were also of interest in this research. See Table 9 for a description of these characteristics.

4.2 Procedure:

Patients who met the criteria for inclusion in the study were approached by this investigator two to four days after admission and asked for their consent to participate. See Appendix A for the letter of explanation about the study and the form used to obtain a

Table 7

**Demographic Characteristics and Psychiatric Background of
Psychiatrists (n=29)**

Variable	Classification and coding	n	%
Sex	0 = male	18	62%
	1 = female	11	38%
Age	0 = 25 to 40	11	38%
	1 = 41 to 65	15	52%
	2 = 66 to 68	3	10%
Language at birth	0 = English	13	45%
	1 = non-English	16	55%
Psychiatrist status*	0 = psychiatrist*	21	72%
	1 = psychiatric resident*	8	28%
Clinical orientation*	0 = psychodynamic*	1	4%
	1 = biological*	4	14%
	2 = eclectic*	24	83%

* See Glossary for definition.

Table 8

Comparison of Psychiatrists at the London Psychiatric Hospital (LPH) (n=17) and the St. Thomas Psychiatric Hospital (STPH) (n=12) on Demographic and Psychiatric Background Variables

Variable	Classification and coding	LPH n(%)	STPH n(%)	p-value
Sex	0 = male 1 = female	9(53%) 8(47%)	9(75%) 3(25%)	.23
Age	0 = 25 to 40 1 = 41 to 65 2 = 66 to 68	7(41%) 10(59%) 0	4(42%) 5(42%) 3(16%)	.09
Language at birth	0 = English 1 = non-English	10(59%) 7(41%)	3(25%) 9(75%)	.07
Psychiatrist status*	0 = psychiatrist* 1 = resident*	10(59%) 7(41%)	11(92%) 1(8%)	.05
Clinical orientation*	0 = psychodynamic* 1 = biological* 2 = eclectic*	1(6%) 3(18%) 13(76%)	0(0%) 1(8%) 11(92%)	.51

* See Glossary for definition.

Table 9

Characteristics Related to Both the Patient and
Psychiatrist (n=135 Patients)

Variable	Classification and coding	n	%
Differences of sex	0 = patient male, psychiatrist female	24	18%
	1 = patient female, psychiatrist male	37	27%
	2 = patient male, psychiatrist male	45	33%
	3 = patient female, psychiatrist female	29	22%
Age disparity	0 = 20 years or more	35	25%
	1 = less than 20 years	100	75%
Previous psychiatrist contact with patient	0 = no	77	57%
	1 = yes	58	43%

patient's consent. A patient who agreed to participate was then interviewed according to a checklist for problems, goals, and methods for treatment. Appendix B shows this checklist.

Immediately after the patient was interviewed, the attending psychiatrist was approached and asked to participate. See Appendix C for the letter of explanation about the study and the form used to obtain a psychiatrist's consent. In all cases, the attending psychiatrist interviewed the patient prior to identifying, according to the checklist, their patient's problems, goals, and methods for treatment. Refer to Appendix D for the checklist. Psychiatrists were given the option to have the checklist read to them by this investigator or to complete the checklist independently. A psychiatrist who chose the latter option, but failed to return the checklist within a week, was interviewed.

Chart abstractions were completed to collect information about the demographic characteristics and psychiatric background of patients. See Appendix E for the form used to gather this information. Psychiatrists were also asked to provide information about their demographic background and psychiatric training. See Appendix F for the form used to gather this information.

4.3 Instrument

A checklist was developed by this investigator to identify problems experienced by patients admitted to provincial psychiatric hospitals. In relation to these problems, corresponding goals for treatment were identified. The methods for treatment were selected from those offered within the study hospitals. Items for the checklist (i.e., for problems and goals) were drawn from this investigator's clinical experience and from instruments constructed by other researchers. In particular, the following three instruments were reviewed:

- (1) The Patient Request Form (Lazare & Eisenthal, 1977) is an 84-item checklist which elicits the requests of patients in the community with regard to their preferences for treatment.
- (2) The Patient's Self-Perceived Needs Scale (Fitzgibbons, 1972) is a 93-item checklist which elicits the psychiatric and personal needs of patients in the community.
- (3) The Treatment Modalities instrument (Dowds & Fontana, 1977) is a 12-item checklist on methods for treatment. A brief explanation is given for each method.

For the purpose of this study, the checklist items for problems, goals, and methods for treatment were classified according to whether they were predominantly of an environmental or psychological nature. Environmental problems and goals were those items related to difficulties patients experienced within their community.

Psychological problems and goals were items that focussed on difficulties in the patient's mental functioning. As well, methods for treatment were classified according to whether these approaches addressed concerns of an environmental or psychological nature. See Table 10 for a classification of the checklist items.

4.4 Pilot Study

A pilot study was conducted at the LPH during the Fall of 1985. The objectives and findings from this pilot were as follows:

Objective #1:

To test checklist items for their clarity, relevance, and completeness.

After the checklist was developed, 13 patients and 13 psychiatrists at the LPH; and clinical colleagues (i.e., psychiatric nurses and related health professionals) commented on the checklist for its clarity, item relevance, and completeness. Overall, clinicians found the checklist to be relevant and comprehensive. However, they recommended that the wording of some items be simplified for their use with patients.

Objective #2:

To determine the study's feasibility.

Table 18

Classification of Checklist Items*

Checklist Items:		Checklist item number
Type	Nature	
(1) Problems	(a) Environmental	#1 to #7
	(b) Psychological	#8 to #22
(2) Goals for treatment	(a) Environmental	#23 to #29
	(b) Psychological	#30 to #44
(3) Methods for treatment	(a) Environmental	#45 to #49
	(b) Psychological	#50 to #62
All items: (1), (2), & (3) as above		#1 to #62

* See Appendix B or D for checklist items #1 to #62.

The same 13 psychiatrists at the LPH who commented on the checklist for its appropriateness (as described in Objective #1) agreed to also participate in this aspect of the pilot study. For each psychiatrist, one patient was selected to participate. None of the patients or psychiatrists refused to participate. Patients were interviewed according to the checklist for problems, goals, and methods for treatment. The patient's psychiatrist also completed this checklist.

The findings revealed that disagreements ranged from 25% to 77% for problems (mean 46%), from 5% to 75% for goals (mean 45%), and from 23% to 78% for methods (mean 45%). Based on these findings, there was evidence that disagreements do exist.

4.5 Sample Size For the Major Study

The sample size estimate for the study was based on addressing the first research question with sufficient precision. (See Chapter 3, Section 3.1 for Research Question #1.) The sample size of 135 patients and their psychiatrist was thus selected in order to have a reasonably high probability of detecting a difference of 20 percentage points in the rate at which a given item was identified as being relevant in the two groups (i.e., patients and psychiatrists). Setting alpha at .05, two-tailed, this size of sample will provide a 90% chance of detecting such a difference as statistically significant.

(Colton, 1974, p. 168). This calculation was a conservative estimate of the required sample size, since it does not take into account the matching of patients and psychiatrists which would be expected to increase efficiency.

Chapter 5

Data Analysis

A separate data analysis was conducted for each of the three research questions as follows:

5.1 Data Analysis for Research Question #1:

Is the probability that a psychiatrist will identify a given item (regarding problems, goals, and methods for treatment) as being relevant for the patient greater than the probability that the patient will identify the item as being relevant?

For each checklist item and for each psychiatrist, a 2x2 table was constructed as shown below; where b and c were the 'discordant cell frequencies' (i.e., b+c was the number of patients who disagreed with their psychiatrist on the identification of a given item).

		<u>Psychiatrist</u>	
		Identified item	Did not identify item
<u>Patient</u>	Identified item	a	b TYPE 1 DISAGREEMENT
	Did not identify item	c TYPE 2 DISAGREEMENT	d

Fisher's permutation test (Snedecor & Cochran, 1980, pp. 99-102), a nonparametric test, was used to test over all n such tables if the probability that psychiatrists identified a given item as being relevant differed from

the probability that patients identified the item. The rationale for using this test was as follows: Note that $b/(b+c)$ was the proportion of disagreements which were of type 1 (i.e., the patient identified the item when the psychiatrist did not). Under the null hypothesis of equal identification rates, the deviation $d = b/(b+c) - 1/2$ would not be expected to differ significantly from zero over the sample of n tables (i.e., one table for each psychiatrist). The appropriate test statistic is given by $z = \bar{d}\sqrt{n}/\sqrt{\sum d_i^2}$, where \bar{d} is the mean value of d over the n 2×2 tables; and z may be regarded as an approximate standard normal deviate. When $|z| > 1.96$, \bar{d} was significantly different from zero (alpha of .05, two-tailed), and it could then be concluded that the probability of psychiatrists identifying the item was different from the probability of patients identifying the item.

Stated differently, this analysis focussed on the direction of disagreements between psychiatrists and their patients. (See Section 3.1(3) for definition of type 1 and type 2 disagreements.) Thus, the analysis to test the probability that a psychiatrist's identification of a given item differed from the probability that patients identified the item reduced to testing whether type 1 disagreements (the patient identified the item when the psychiatrist did not) were more frequent than type 2

disagreements (the psychiatrist identified the item when the patient did not). This was because the 'concordant cell frequencies' a and d offered no information concerning the null hypothesis of equal identification rates.

For an item to be included in the analysis, it was decided arbitrarily that at least 20 of the 29 psychiatrists showed some disagreement with their patients on that item. This implies that a sample size of at least $n=20$ psychiatrists was required for Fisher's permutation test. Given this criterion, eight checklist items were omitted: 2 of the 22 problems, 1 of the 22 goals, and 5 of the 18 methods for treatment. These items were regarded as not yielding sufficient disagreement to be eligible for analysis. See Tables 11, 12, and 13 for the items which were excluded.

For each checklist item included in the analysis, Fisher's permutation test was performed to determine if the probability that psychiatrists identified an item as being relevant differed from the probability that the patients identified the item as being relevant. The results of these analyses are presented in Tables 11, 12, and 13. The most striking aspect of the results was that, for items included in the analysis, for 18 of the 20 problems, for 19 of the 21 goals, and for 7 of the 13 methods for treatment, there was a significant difference

between the probability of a psychiatrist identifying an item and the probability of a patient identifying the item ($p < .05$, two-tailed). Moreover, almost all of these disagreements were of type 2 (the psychiatrist identified the item when the patient did not) as opposed to type 1 (the patient identified the item when the psychiatrist did not). These results must be interpreted with some caution because of the numerous significance tests that were conducted. However, taken as a whole, they provided consistent evidence that the probability of psychiatrists identifying items was greater than the probability that their patients would identify items. The size of this disagreement effect was quantified for each item using the summary odds ratio formula $OR = \sum c_i / \sum b_i$, as reported in Tables 11, 12, and 13. These results showed that, for items included in the analysis, the summary odds ratio was greater than one for all but 1 of the 26 problems, for all 21 goals, and for all but 1 of the 13 methods for treatment. Furthermore, the values of the summary odds ratios frequently exceeded two, indicating disagreement effects of a fairly substantial magnitude.

Subsequent to this analysis, a multiple linear regression (Kleinbaum & Kupper, 1978, pp. 131-144) was conducted to determine the extent to which the variation in each of the summary odds ratios was explained by the characteristics of the psychiatrist. The independent

Table 11

Disagreements on Problems: Their Direction and Associated
Psychiatrist Variables

Item No.	z-value	Summary odds ratio (OR)	t-value for multiple regression		
			Psychiatrist characteristics:		
			Female versus male	Resident versus psychiatrist	Non-English versus English
(a)	Environmental:				
1	-1.49	1.83	-.34	-.05	-1.16
2	-2.96**	2.87	.48	-1.05	.51
3	-2.57*	2.12	.42	.68	-.96
4	-3.11**	3.60	2.14*	-.70	-.37
5	-3.57***	4.18	1.47	-1.11	.84
6	-2.50*	2.22	-1.00	-.87	-2.53*
7	-3.86***	6.25	-1.91	-.72	.88
(b)	Psychological:				
8	0.26	0.81	-1.43	.50	.36
9	-2.98**	3.82	1.07	-.40	.78
10	-2.33*	2.85	-.49	-1.68	-1.49
11	-3.09**	5.88	-.68	.38	.01
12	-2.52*	2.57	.16	-.07	1.63
13	-4.56***	6.45	-1.01	-.33	-1.88
14					
15					
16	-4.15***	6.33	.33	1.20	.15
17	-2.33*	1.69	-1.08	.18	-.87
18	-2.05*	1.75	.83	.30	-.20
19	-2.25*	2.25	.05	.78	-1.40
20	-3.31***	3.10	1.00	.88	1.10
21	-2.89**	2.38	.58	.21	-.89
22	-2.70*	2.86	1.83	.59	2.52*

Note. Items #14 and #15 were excluded from the analysis.

OR = the odds of a psychiatrist identifying the problem relative to the odds of a patient identifying the item. An odds ratio exceeding 1.0 corresponds to a z-value with a negative sign.

*p<.05
**p<.01
***p<.001

Table 12

Disagreements on Goals: Their Direction and Associated
Psychiatrist Variables

Item No.	z-value	Summary odds ratio (OR)	t-value for multiple regression		
			Psychiatrist characteristics:		
			Female versus male	Resident versus psychiatrist	Non-English versus English
(a)	<u>Environmental:</u>				
23	-1.48	1.93	-.01	-1.04	-1.56
24	-2.32*	2.92	.64	-1.17	-.34
25	-2.38*	2.10	.06	-1.37	-.59
26	-2.73**	3.24	2.36*	-1.78	-.76
27	-3.75***	3.92	-.79	-.54	.41
28	-4.51***	13.33	-1.70	-.34	-.22
29	-2.53*	3.00	-2.73**	-.59	.33
(b)	<u>Psychological:</u>				
30	-2.94**	2.88	-.37	-.03	-1.63
31	-2.88**	3.19	1.19	-.37	.62
32	-3.89***	5.49	.67	-.06	.14
33	-4.61***	6.62	-.17	.07	1.24
34	-3.46***	3.30	-1.32	-.76	.35
35	-4.32***	6.54	-.11	-1.27	-3.47***
36					
37	-1.29	2.22	2.18*	-1.36	-1.85
38	-4.76***	7.81	1.95	.32	-.66
39	-3.11**	2.35	.20	.07	-.49
40	-3.32***	3.56	.97	.02	-.70
41	-2.98**	4.63	-.45	-.33	-.17
42	-3.62***	4.44	.57	1.23	1.63
43	-3.48***	2.64	.55	-.07	-.24
44	-2.07*	1.85	.97	.94	1.77

Note. Item #36 was excluded from the analysis.

OR = the odds of a psychiatrist identifying the goal relative to the odds of a patient identifying the item. An odds ratio exceeding 1.0 corresponds to a z-value with a negative sign.

*p<.05

**p<.01

***p<.001

Table 13

Disagreements on Methods for Treatment: Their Direction and Associated Psychiatrist Variables

Item No.	z-value	Summary odds ratio	t-value for multiple regression		
			Psychiatrist characteristics:		
			Female versus male	Resident versus psychiatrist	Non-English versus English
(a)	Environmental:				
45	-3.00**	3.91	-1.61	.33	-.73
46	-2.88**	2.54	-.61	-.01	.23
47	-1.84	1.72	-.50	.49	-.42
48	-.27	1.59	.43	.40	-.15
49	-2.81**	2.53	2.68*	.22	-.53
(b)	Psychological:				
50					
51					
52	-2.21*	1.71	.11	-.30	.15
53	-1.51	2.00	1.78	.15	-.71
54	-0.61	1.20	2.17	2.33	-.85
55	-1.57	1.43	.47	.31	-1.20
56	-3.96***	3.89	-.92	-1.55	-.34
57					
58	-3.78***	5.85	1.38	-.50	1.52
59	-2.82**	1.92	1.18	-.78	1.53
60					
61	1.03	.67	-.83	2.32*	.69
62					

Note. Items #50, #51, #57, #60 and #62 were excluded from the analysis.

OR = the odds of a psychiatrist identifying the method for treatment relative to the odds of the patient identifying the item. An odds ratio exceeding 1.0 corresponds to a z-value with a negative sign.

*p<.05
 **p<.01
 ***p<.001

variables were as follows: (a) sex differences, (b) language at birth (non-English versus English), and (c) psychiatrist status (resident versus psychiatrist). See Table 7 for a classification of these variables. The dependent variable was the summary odds ratio defined previously. Given that these odds ratios were not normally distributed, they were transformed to the logarithmic scale (Snedecor & Cochran, 1980, p. 290). Furthermore, a weighted analysis was used to take into account the variable number of patients per psychiatrist. Given the t-values reported in Tables 11, 12, and 13, the results indicated that none of the psychiatrist variables was able to consistently explain variation in the summary odds ratio.

5.2 Data Analysis for Research Question #2:

To what extent do variables related to the patient, variables related to the psychiatrist, and variables related to both the patient and psychiatrist, explain disagreements?

The patient variables were as follows:

- (a) sex
- (b) age
- (c) educational level
- (d) employment status
- (e) psychiatric diagnosis
- (f) involuntary status

The psychiatrist variables were as follows:

- (a) language at birth
- (b) psychiatrist versus resident status
- (c) clinical orientation

The variables related to both the patient and psychiatrist were as follows:

- (a) sex differences
- (b) at least a 25-year age disparity
- (c) psychiatrist having had previous contact with the patient

Disagreements between the patient and psychiatrist were determined for:

- (a) problems
- (b) goals
- (c) methods for treatment

of the following nature:

- (i) environmental
- (ii) psychological

The relationship between patient variables; psychiatrist variables; variables related to both the patient and psychiatrist; and disagreement status was

analyzed using the chi-square test for independence (Colton, 1974, p. 174). Tables 4, 7, and 9 provide a detailed classification of these variables. Section 3.3(1) describes the definition of disagreement status. According to this definition, 16.3% of patients were classified as disagreeers on problems, 17.8% on goals, and 18.4% on methods for treatment.

The relationship between patient variables; psychiatrist variables; variables related to both the patient and psychiatrist; and disagreement status, are reported in Tables 14 to 25. Specifically, the variables which showed some association with disagreement status were as follows: First, the patient with an educational level of less than Grade 12 was associated with disagreements on methods for treatment (Tables 23 and 24). Second, the patient being employed was associated with disagreements on problems (Tables 14 and 16) and on goals (Table 20). Third, the patient being detained involuntarily was found to be associated with disagreements on problems (Tables 14, 15, and 16), goals (Tables 18, 19, and 20), and methods for treatment (Tables 22, 23, and 24). Fourth, the psychiatrist being not of the English language at birth was associated with disagreements on methods for treatment (Table 22). Fifth, the physician being a resident versus psychiatrist was associated with disagreements on problems (Tables 15 and

16) and methods for treatment (Table 22). The statistically significant findings reported above are summarized in Table 17 for problems, Table 21 for goals, and Table 25 for methods of treatment.

While involuntary status was found to be associated with disagreements on problems, goals, and methods for treatment, this relationship must be reported with reservation. It could not be established whether involuntary status preceded or followed the identification of disagreements. For example, involuntary detention at admission may have lead to the patient disagreeing with this decision, resulting in subsequent disagreements on problems, goals, and methods for treatment. However, during the patient's admission, disagreements may have been apparent to the psychiatrist (e.g., because of the patient's lack of insight about problems and resistance towards treatment). The psychiatrist's recognition of these disagreements could have lead to the patient being involuntarily detained. Therefore, in view of this difficulty in ascertaining whether involuntary status preceded or was a consequence of disagreements, this variable was not included in the analysis of disagreement outcomes (i.e., for Research Question #3).

Examination of the percentage of patients who disagreed (as given in the second column of Tables 14 to 16, Tables 18 to 20, and Tables 22 to 24) revealed that

with the exception of involuntary status, there were very few relationships of substantive significance between the variables listed and disagreement status. It should also be remembered that, given the large number of significance tests performed, some of the significant results reported in these tables might well be due to chance. Given this, further analysis was not undertaken to examine the extent to which these variables explained disagreement status.

Table 14

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on Environmental Problems
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	38.2%	.78
female	66	41.4%	
Patient age:			
over 30 years	83	35.7%	.74
30 years or less	52	48.3%	
Educational level:			
less than grade 12	89	48.3%	.72
grade 12 or more	46	38.6%	
Employment status:			
not employed	97	33.3%	.81**
employed	38	56.8%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	41.3%	.75
schizophrenic	72	38.6%	
Involuntary at admission:			
no	56	28.6%	.82*
yes	79	48.1%	
Psychiatrist language at birth:			
English	62	41.8%	.81
non-English	73	38.9%	
Psychiatrist versus resident:			
psychiatrist	112	41.8%	.31
resident	23	38.4%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	44.1%	.56
eclectic	101	38.4%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	38.4%	.74
patient female, psychiatrist male	37	38.9%	
patient male, psychiatrist male	45	42.2%	
patient female, psychiatrist female	29	44.8%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	41.2%	.85
less than 20 years	100	39.4%	
Previous contact between patient and psychiatrist:			
no	77	38.7%	.75
yes	58	41.4%	

*p<.05, **p<.01

Table 15

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on Psychological Problems
(n=135 patients)

Variable	N	% Disagrees	p-Value
Patient sex:			
male	69	17.4%	.34
female	66	24.2%	
Patient age:			
over 30 years	83	26.7%	.55
30 years or less	52	20.0%	
Educational level:			
less than grade 12	89	21.3%	.81
grade 12 or more	46	19.6%	
Employment status:			
not employed	97	17.5%	.14
employed	38	28.9%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	16.9%	.29
schizophrenic	72	24.3%	
Involuntary at admission:			
no	56	7.1%	.001***
yes	79	30.4%	
Psychiatrist language at birth:			
English	62	22.6%	.63
non-English	73	19.2%	
Psychiatrist versus resident:			
psychiatrist	112	24.1%	.03*
resident	23	4.3%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	14.7%	.32
eclectic	101	22.8%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	12.5%	.38
patient female, psychiatrist male	37	29.7%	
patient male, psychiatrist male	45	20.0%	
patient female, psychiatrist female	29	17.2%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	22.9%	.72
less than 20 years	100	20.0%	
Previous contact between patient and psychiatrist:			
no	77	16.9%	.20
yes	58	25.9%	

*p<.05, **p<.01

Table 16
The Relationship Between Patient Variables, Psychiatrist
Variables, Variables Related to Both the Patient and
Psychiatrist, and Disagreements on All Problems
 (n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	13.8%	.38
female	66	19.7%	
Patient age:			
over 38 years	83	28.2%	.68
38 years or less	52	15.8%	
Educational level:			
less than grade 12	89	15.7%	.88
grade 12 or more	46	17.4%	
Employment status:			
not employed	97	12.4%	.85*
employed	38	26.3%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	13.8%	.46
schizophrenic	72	18.6%	
Involuntary at admission:			
no	56	5.4%	.884**
yes	79	24.1%	
Psychiatrist language at birth:			
English	62	19.4%	.38
non-English	73	13.7%	
Psychiatrist versus resident:			
psychiatrist	112	19.6%	.82*
resident	23	8.8%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	11.8%	.41
eclectic	101	17.8%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	12.5%	.22
patient female, psychiatrist male	37	27.8%	
patient male, psychiatrist male	45	13.3%	
patient female, psychiatrist female	29	18.3%	
Age disparity of at least 28 years between patient and psychiatrist:			
28 years or more	35	28.6%	.49
less than 28 years	100	15.8%	
Previous contact between patient and psychiatrist:			
no	77	13.8%	.23
yes	58	28.7%	

*p<.05, **p<.01

Table 17

Summary of the Statistically Significant Findings ($p < .05$)From Tables 14, 15, and 16 on:The Relationship Between Patient Variables; PsychiatristVariables; Variables Related to Both the Patient andPsychiatrist; and Disagreements on Environmental,Psychological, and All Problems (n=135 patients)

Variable	n	% Disagrees on problems		
		Environmental	Psychological	All
Employment status:				
not employed	97	33.3%		12.4%
employed	38	56.8%		26.3%
		$p = .01$		$p = .05$
Involuntary at admission:				
no	56	28.6%	7.1%	5.4%
yes	79	48.1%	30.4%	24.1%
		$p = .02$	$p = .001$	$p = .004$
Psychiatrist versus resident:				
psychiatrist	112		24.1%	19.6%
resident	23		4.3%	0.0%
			$p = .03$	$p = .02$

Table 18

The Relationship Between Effort Variables: Psychiatrist
Variables: Variables Related to Both the Patient and
Psychiatrist, and Disagreements on Environmental Goals

(n=135 patients)

Variable	n	% Disagrees	P-Value
Patient sex:			
male	69	27.5%	.14
female	66	39.4%	
Patient age:			
over 30 years	83	26.7%	.56
30 years or less	52	34.2%	
Educational level:			
less than grade 12	89	33.7%	.98
grade 12 or more	46	32.6%	
Employment status:			
not employed	97	38.9%	.34
employed	38	39.5%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	48.8%	.11
schizophrenic	72	27.1%	
Involuntary at admission:			
no	56	21.4%	.01**
yes	79	41.8%	
Psychiatrist language at birth:			
English	62	24.7%	.18
non-English	73	38.4%	
Psychiatrist versus resident:			
psychiatrist	112	33.9%	.75
resident	23	38.4%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	35.3%	.78
eclectic	101	32.7%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	25.8%	.51
patient female, psychiatrist male	37	48.5%	
patient male, psychiatrist male	45	28.9%	
patient female, psychiatrist female	29	37.9%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	34.3%	.89
less than 20 years	100	33.8%	
Previous contact between patient and psychiatrist:			
no	77	36.4%	.39
yes	58	29.3%	

*p<.05

Table 19

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on Psychological Goals
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	23.2%	.78
female	66	21.2%	
Patient age:			
over 30 years	83	33.3%	.27
30 years or less	52	20.8%	
Educational level:			
less than grade 12	89	22.5%	.92
grade 12 or more	46	21.7%	
Employment status:			
not employed	97	18.6%	.10
employed	38	31.6%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	21.5%	.85
schizophrenic	72	22.9%	
Involuntary at admission:			
no	56	12.5%	.02*
yes	79	29.1%	
Psychiatrist language at birth:			
English	62	22.6%	.92
non-English	73	21.9%	
Psychiatrist versus resident:			
psychiatrist	112	23.2%	.54
resident	23	17.4%	
Psychiatrist clinical orientation:			
psychodynamic or biological	32	17.6%	.46
eclectic	101	23.8%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	20.8%	.98
patient female, psychiatrist male	37	21.6%	
patient male, psychiatrist male	45	24.4%	
patient female, psychiatrist female	29	20.7%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	20.6%	.21
less than 20 years	100	20.8%	
Previous contact between patient and psychiatrist:			
no	77	26.0%	.23
yes	58	17.2%	

*p<.05

Table 28

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on All Goals
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	18.8%	.74
female	66	16.7%	
Patient age:			
over 30 years	83	26.7%	.34
30 years or less	52	16.7%	
Educational level:			
less than grade 12	89	16.9%	.78
grade 12 or more	46	19.6%	
Employment status:			
not employed	97	13.4%	.83*
employed	38	28.9%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	18.5%	.84
schizophrenic	72	17.1%	
Involuntary at admission:			
no	56	7.1%	.887**
yes	79	25.3%	
Psychiatrist language at birth:			
English	62	17.7%	.99
non-English	73	17.8%	
Psychiatrist versus resident:			
psychiatrist	112	18.8%	.51
resident	23	13.8%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	14.7%	.59
eclectic	101	18.8%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	16.7%	.97
patient female, psychiatrist male	37	16.2%	
patient male, psychiatrist male	45	28.8%	
patient female, psychiatrist female	29	17.2%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	22.9%	.36
less than 20 years	100	16.8%	
Previous contact between patient and psychiatrist:			
no	77	19.5%	.55
yes	58	15.5%	

*p<.01

Table 21

Summary of the Statistically Significant Findings (p<.05)

From Tables 18, 19, and 20 on:

The Relationship Between Patient Variables: Psychiatrist Variables: Variables Related to Both the Patient and Psychiatrist: and Disagreements on Environmental, Psychological, and All Goals (n=135 patients)

Variable	n	% Disagrees on goals		
		Environmental	Psychological	All
Employment status:				
not employed	97			13.4%
employed	38			28.9%
				p=.03
Involuntary at admission:				
no	56	21.4%	12.5%	7.1%
yes	79	41.8%	29.1%	25.3%
		p=.01	p=.02	p=.007

Table 22

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on Environmental Methods
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	45.6%	.26
female	66	34.9%	
Patient age:			
over 38 years	83	28.6%	.32
38 years or less	52	42.4%	
Educational level:			
less than grade 12	89	44.3%	.26
grade 12 or more	46	34.1%	
Employment status:			
not employed	97	38.5%	.36
employed	38	47.2%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	47.6%	.13
schizophrenic	72	34.6%	
Involuntary at admission:			
no	56	35.1%	.87
yes	79	47.4%	
Psychiatrist language at birth:			
English	62	15.8%	.001***
non-English	73	54.2%	
Psychiatrist versus resident:			
psychiatrist	112	45.9%	.01**
resident	23	17.4%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	30.3%	.15
eclectic	101	44.4%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	37.5%	.39
patient female, psychiatrist male	37	48.5%	
patient male, psychiatrist male	45	50.8%	
patient female, psychiatrist female	29	29.6%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	50.6%	.21
less than 20 years	100	37.8%	
Previous contact between patient and psychiatrist:			
no	77	39.2%	.65
yes	58	43.1%	

*p<.05, ***p<.001

Table 23

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on Psychological Methods
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	11.6%	.63
female	66	9.1%	
Patient age:			
over 30 years	83	6.7%	.62
30 years or less	52	10.8%	
Educational level:			
less than grade 12	89	14.6%	.82*
grade 12 or more	46	2.2%	
Employment status:			
not employed	97	9.3%	.51
employed	38	13.2%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	9.2%	.68
schizophrenic	72	11.4%	
Involuntary at admission:			
no	56	1.8%	.886**
yes	79	16.5%	
Psychiatrist language at birth:			
English	63	8.1%	.42
non-English	72	12.3%	
Psychiatrist versus resident:			
psychiatrist	112	12.5%	.87
resident	23	8.8%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	8.8%	.73
eclectic	101	18.9%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	8.3%	.86
patient female, psychiatrist male	37	8.1%	
patient male, psychiatrist male	45	13.3%	
patient female, psychiatrist female	29	18.3%	
Age disparity of at least 20 years between patient and psychiatrist:			
20 years or more	35	14.3%	.37
less than 20 years	100	9.8%	
Previous contact between patient and psychiatrist:			
no	77	10.4%	.99
yes	58	18.3%	

*p<.05, **p<.01

Table 24

The Relationship Between Patient Variables, Psychiatrist Variables, Variables Related to Both the Patient and Psychiatrist, and Disagreements on All Methods
(n=135 patients)

Variable	n	% Disagrees	p-Value
Patient sex:			
male	69	11.6%	.63
female	66	9.1%	
Patient age:			
over 38 years	83	6.7%	.62
38 years or less	52	18.8%	
Educational level:			
less than grade 12	89	14.6%	.82*
grade 12 or more	46	2.2%	
Employment status:			
not employed	97	9.3%	.51
employed	38	13.2%	
Psychiatric diagnosis:			
depressed, manic, or neurotic	63	9.2%	.68
schizophrenic	72	11.4%	
Involuntary at admission:			
no	56	1.8%	.886**
yes	79	16.5%	
Psychiatrist language at birth:			
English	62	8.1%	.42
non-English	73	12.3%	
Psychiatrist versus resident:			
psychiatrist	112	12.5%	.87
resident	23	8.8%	
Psychiatrist clinical orientation:			
psychodynamic or biological	34	8.8%	.73
eclectic	101	18.9%	
Sex differences between patient and psychiatrist:			
patient male, psychiatrist female	24	8.3%	.86
patient female, psychiatrist male	37	8.1%	
patient male, psychiatrist male	45	13.3%	
patient female, psychiatrist female	29	18.3%	
Age disparity of at least 28 years between patient and psychiatrist:			
28 years or more	35	14.3%	.37
less than 28 years	100	9.8%	
Previous contact between patient and psychiatrist:			
no	77	18.4%	.99
yes	58	18.3%	

*p<.05, **p<.01

Table 25

Summary of the Statistically Significant Findings (p<.05)From Tables 22, 23, and 24 on:The Relationship Between Patient Variables; PsychiatristVariables; Variables Related to Both the Patient andPsychiatrist; and Disagreements on Environmental,Psychological, and All Methods for Treatment (n=135 patients)

Variable	n	% Disagrees on goals		
		Environmental	Psychological	All
Educational level:				
less than Grade 12	89		14.6%	14.6%
Grade 12 or more	46		2.2%	2.2%
			p=.02	p=.02
Involuntary at admission:				
no	56		1.8%	1.8%
yes	79		16.5%	16.5%
			p=.006	p=.006
Psychiatrist language at birth:				
English	62	15.0%		
non-English	73	54.2%		
		p=.001		
Psychiatrist versus resident:				
psychiatrist	112	45.9%		
resident	23	17.4%		
		p=.01		

5.3 Data Analysis for Research Question #3:

To what extent do variables related to the patient and disagreements between a patient and psychiatrist explain patient discharge against medical advice (AMA) or absent without leave (AWOL)?

The patient variables are as follows:

- (a) sex
- (b) age
- (c) educational level
- (d) employment status
- (e) psychiatric diagnosis

Disagreements between a patient and psychiatrist were determined for:

- (a) problems
- (b) goals
- (c) methods for treatment

The chi-square test for independence (Colton, 1974, p. 174) was used to determine if either patient variables or disagreement status was associated with discharge AMA/AWOL. Table 4 describes the classification of patient variables. This table also provides the classification of AMA/AWOL status. Research Question #2, section 3.3(1) gives the classification of disagreement status.

The results in Table 26 indicate that, with the exception of sex, none of the patient variables including age, educational level, employment status, and diagnosis, were significantly related to AMA/AWOL status. However, in contrast to these findings, the results in Table 27 provide evidence that disagreement status was associated with AMA/AWOL status ($p < .05$). In particular, the

Table 26

The Relationship Between Patient Variables
and AMA/AWOL Status

(n=135 patients)

Patient variable	n	% AMA/AWOL	p-value
Sex:			
male	69	39.1%	.04*
female	66	22.7%	
Age:			
more than 30 years	83	26.5%	.14
30 years or less	52	38.5%	
Education:			
Grade 12 or more	46	26.1%	.36
less than Grade 12	89	33.7%	
Employment:			
employed	38	31.6%	.94
not employed	97	38.9%	
Diagnosis:			
depressed, manic, or neurotic	63	33.3%	.60
schizophrenic	72	29.2%	

*p<.05

Table 27

The Relationship Between Disagreements on Problems, Goals, and Methods for Treatment; and AMA/AWOL Status
(n=135 patients)

Disagreement status	n	% AMA/AWOL	p-value
Environmental problems: agrees disagrees	80 53	26.3% 39.6%	.10
Psychological problems: agrees disagrees	107 28	25.2% 53.6%	.004**
All problems: agrees disagrees	113 22	26.5% 54.5%	.01**
Environmental goals: agrees disagrees	90 45	25.6% 42.2%	.05*
Psychological goals: agrees disagrees	105 30	23.8% 56.7%	.001***
All goals: agrees disagrees	111 24	24.3% 62.4%	.0002***
Environmental methods: agrees disagrees	78 54	21.8% 42.6%	.001***
Psychological methods: agrees disagrees	121 14	27.3% 64.3%	.005**
All methods: agrees disagrees	121 14	27.3% 64.3%	.005**

*p<.05

**p<.01

***p<.001

AMA/AWOL rate was consistently higher among disagreeers than among agreeers.

A multiple logistic regression (Aldrich & Nelson, 1984) was conducted to determine the extent to which disagreement status was associated with AMA/AWOL status after controlling for selected patient variables. These variables, with the exception of involuntary status, were the same as the patient variables used to address Research Question #2 (i.e., patient sex, age, educational level, employment status, and psychiatric diagnosis). The dependent variable was AMA/AWOL status. A separate regression was conducted for problems, goals, and methods for treatment. The results in Tables 28, 29, and 30 show that disagreement status on problems, goals, and methods for treatment were significantly related to AMA/AWOL status ($p < .05$). The adjusted relative odds for disagreement status in these analysis were each above five. This indicated a very substantial relationship between disagreement status and the outcome AMA/AWOL.

To further investigate the relationship between disagreements and AMA/AWOL status, the analyses were extended to explore the modifying effect of patient variables in this relationship. Thus, the following interaction terms were added to the three logistic regressions (i.e., for problems, goals, and methods): sex x disagreement status, age x disagreement status,

Table 28

**The Relationship Between Patient Variables: Disagreements
on Problems; and AMA/ANOL Status**

(n=135 patients)

Variable	Coeff	S.E	t-Value	Adjusted relative odds	p-Value	Confidence interval (95%)	
						Lower	Upper
Sex	.47	.22	2.11*	2.54	.04*	1.07	6.06
Age	-.29	.21	-1.42	.56	.16	.25	1.25
Diagnosis	.20	.21	.99	1.50	.32	.67	3.36
Education	.27	.22	1.20	1.71	.23	.72	4.08
Employment status	.33	.25	1.34	1.95	.18	.73	5.17
Problem Disagreer	.86	.27	3.21**	5.56	.01**	1.96	16.67

*p<.05

***p<.001

Table 29

**The Relationship Between Patient Variables, Disagreements
on Goals, and AMA/ANOL Status**

(n=135 patients)

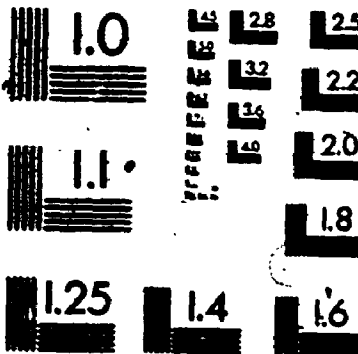
Variable	Coeff	S.E	t-Value	Adjusted relative odds	p-Value	Confidence interval (95%)	
						Lower	Upper
Sex	.42	.22	1.85	2.29	.07	.95	5.54
Age	-.28	.21	-1.33	.57	.18	.25	1.31
Diagnosis	.12	.21	.59	1.28	.56	.56	2.94
Education	.26	.23	1.12	1.67	.26	.68	4.09
Employment status	.36	.26	1.37	2.04	.17	.74	5.62
Goal disagreer	1.05	.27	3.93***	8.06	.0001***	2.86	25.00

***p<.001

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Table 30

The Relationship Between Patient Variables; Disagreements
on Methods for Treatment; and AMA/ANOL Status
(n=135 patients)

Variable	Coeff	S.E	t-Value	Adjusted relative odds	p-Value	Confidence interval (95%)	
						Lower	Upper
Sex	.31	.21	1.45	1.86	.15	.80	4.33
Age	-.33	.21	-1.61	.51	.11	.23	1.15
Diagnosis	.14	.20	.71	1.34	.48	.60	2.96
Education	.10	.22	.47	1.23	.64	.52	2.92
Employment status	.20	.24	.83	1.48	.41	.59	3.76
Treatment method disagreeer	.90	.31	2.83**	6.10	.005**	1.75	20.00

**p<.01

***p<.001

education x disagreement status, employment x disagreement status, and diagnosis x disagreement status.

As shown in Tables 31, 32, and 33, the most striking aspect of these results was that the interaction of sex with disagreement status was statistically significant for problems (Table 31) and methods of treatment (Table 33). The positive sign for this coefficient in these two analysis indicates that the relationship between disagreements and AMA/AWOL status was significantly greater for male patients than for female patients. A second result of interest was the statistically significant interaction of employment with disagreement status for methods of treatment (Table 33). The positive sign for this coefficient indicates that the relationship between disagreements and AMA/AWOL status was significantly greater for employed patients than for unemployed patients.

Table 31

Logistic Regression Analysis of Patient Variables,
Disagreements on Problems, and Interaction Terms, on
AMA/AWOL Status (n=135 patients)

Variable	Coeff	S.E.	t-Value	p-Value
Sex	.25	.23	1.08	.28
Age	-.18	.22	-.82	.41
Education	.24	.24	.97	.33
Employment	.36	.29	1.26	.21
Diagnosis	.18	.22	.82	.41
Problem disagreeer	-9.08	.92	-9.77***	< .001***
Problem disagreeer x sex	8.35	.82	10.20***	< .001***
Problem disagreeer x age	-4.73	14.59	-.32	.75
Problem disagreeer x education	.53	.95	.56	.58
Problem disagreeer x diagnosis	.45	.81	.55	.59

Note. Problem disagreeer x employment status not entered, did not pass tolerance test (i.e., explained insufficient variation in the dependent variable to enter analysis).

Note. The positive coefficient for problem disagreeer x sex indicated that the relationship between disagreement and AMA/AWOL status was significantly greater for male patients than for female patients.

***p<.001

Table 32

Logistic Regression Analysis of Patient Variables,
Disagreements on Goals, and Interaction Terms, on AMA/
ANOL Status (n=135 patients)

Variable	Coeff	S.E.	t-Value	p-Value
Sex	.18	.24	.73	.47
Age	- .15	.23	- .66	.51
Education	.24	.25	.96	.34
Employment	.41	.31	1.31	.19
Diagnosis	.08	.23	.36	.51
Goal disagreeer	-9.27	20.26	- .46	.65
Goal disagreeer x sex	8.55	20.26	.42	.67
Goal disagreeer x age	-4.57	20.27	-.23	.82
Goal disagreeer x education	.51	.94	.54	.59
Goal disagreeer x employment	7.69	20.27	.38	.70
Goal disagreeer x diagnosis	.42	.82	.51	.61

Table 33

**Logistic Regression Analysis of Patient Variables,
Disagreements on Methods for Treatment, and Interaction
Terms, on AMA/AWOL Status (n=135 patients)**

Variable	Coeff	S.E.	t-Value	p-Value
Sex	.23	.23	1.00	.32
Age	-.29	.21	-1.35	.18
Education	.13	.22	.59	.55
Employment	.04	.25	.15	.88
Diagnosis	.12	.22	.56	.57
Method disagreeer	-6.08	.92	-6.63***	< .001***
Method disagreeer x sex	5.01	.80	6.23***	< .001***
Method disagreeer x employment	5.45	.74	7.34***	< .001***
Method disagreeer x diagnosis	.75	.88	.85	.39

Note. Method disagreeer x age and method disagreeer x educational level not entered, did not pass tolerance test (i.e., explained insufficient variation in the dependent variable to enter analysis).

Note. The positive coefficient for method disagreeer x sex indicated that the relationship between disagreement and AMA/AWOL status was significantly greater for male patients than for female patients.

Note. The positive coefficient for method disagreeer x employment indicated that the relationship between disagreement and AMA/AWOL status was significantly greater for employed patients than for unemployed patients.

***p<.001

Chapter 6

Discussion

6.1 Study Findings and Implications

Few investigators examined the important issue of 'disagreements' between patients and clinicians beyond acknowledging that disagreements do exist. This investigation identified disagreements between patients and psychiatrists shortly after the patient's admission. Disagreements were identified for problems, goals, and methods of treatment. Their nature (environmental or psychological) and type (whether the psychiatrist identified an item when the patient did not, or vice versa), was clarified. The relationship between characteristics of the patient, characteristics of the psychiatrist, and disagreements, was also examined. Finally, the consequences of disagreements were observed during the first six weeks of the patient's hospitalization.

The next section summarizes the findings of the study and the relationship of these findings to those of previous investigators. This is followed by a discussion of the implications of these findings for theory, practice, and future research.

6.2 Summary of Findings and Their Relationship to Those of Previous Investigators

This research was conducted with patients and attending psychiatrists at two provincial psychiatric hospitals. The findings presented can only be generalized to patients treated within an institutional setting and with a diagnosis of depression, mania, neurosis, or schizophrenia. The sample size of 135 patients was considerably larger than those reported by previous investigators. Only five patients refused to participate; none of the psychiatrists refused.

Whether psychiatrists identified an item when their patients did not, or vice versa, was examined in only one previous study (Skodol et al., 1980). These investigators, using a relatively small number of patients, examined the type of disagreement between patients and clinicians for methods of treatment. The investigators found that of 14 disagreements between patients and clinicians on methods for treatment, 11 (79%) were of the type whereby clinicians identified the item when their patients did not.

This research reports findings similar to the study by Skodol et al. (1980). In the present study, disagreements on problems, goals, and methods for treatment were consistently of the type whereby psychiatrists identified items when their patients did

not. Further, the odds of psychiatrists identifying an item were twice as great as the odds of patients identifying the item. Some examples of disagreements on problems, goals, and methods for treatment, will be presented in the next section.

During the patient's admission to hospital, the patient is assessed by the attending psychiatrist for problems. Information is obtained through patient self-report, from clinical consultations, medical records, and significant others. Some examples of patient problems were as follows:

Environmental Problem #4: The patient not being able to manage daily living routines when out of hospital.

The chance that a psychiatrist would identify this problem as relevant was three and a half times greater than the chance that the patient would identify it as relevant.

Psychological Problem #2: The patient not being able to control hearing/seeing things that others do not.

The chance that a psychiatrist would identify this problem as relevant was three times greater than the chance that the patient would identify it as relevant.

Once the patient is assessed for problems, goals for treatment are established. Goals provide direction for the overall treatment of the patient. Disagreements on these goals may mean that the patient and psychiatrist differ in their perceptions about the purpose of

hospitalization. Some examples of disagreements on goals were as follows:

Environmental Goal #28: To have established mental health follow-up after discharge.

The chance that a psychiatrist would identify this goal for treatment as relevant was 13 times greater than the chance that the patient would identify it as relevant.

Psychological Goal #41: To have the patient no longer be at risk for harming self/others.

The chance that a psychiatrist would identify this goal for treatment as relevant was four and a half times greater than the chance that the patient would identify it as relevant.

After identifying problems and goals for treatment, the psychiatrist prescribes specific methods for treatment. If the psychiatrist identifies a method for treatment to be helpful when the patient does not, the patient may express this disagreement by not complying with the treatment prescribed by the physician. In fact, it was found in this study that when disagreements occurred, patients eventually were more likely to terminate their hospitalization. Examples of disagreements on methods for treatment were as follows:

Environmental Treatment Method #49: To have the patient be able to live with and talk to other patients.

The chance that a psychiatrist would identify this method for treatment as relevant was two and a half times greater than the chance that the patient would identify it as relevant.

Psychological Treatment Method #56: To have the patient take medications for illness related to mental health.

The chance that a psychiatrist would identify this method for treatment as relevant was almost four times greater than the chance that the patient would identify it as relevant.

Some investigators suggested that disagreements tend to be of the type whereby psychiatrists identify problems and goals of a psychological nature, while patients focus on conditions in their environment. Similarly, investigators speculated that psychiatrists identify methods for treatment to deal with psychological problems and goals, whereas patients prefer treatments related to environmental concerns. In contrast, the findings of this research did not support these speculations. Regardless of whether a problem, goal, or method for treatment was of an environmental or psychological nature, disagreements occurred because psychiatrists identified the item when their patients did not.

The present study also examined patient variables contributing to disagreements. These variables included sex, age, educational level, employment status, diagnosis, and involuntary status. The findings failed to confirm the speculation that patients who are in disagreement with psychiatrists tend more frequently to be male, younger, and diagnosed as schizophrenic. Patients who were in disagreement with their psychiatrist on methods for treatment tended to be less well-educated than patients

not in disagreement. Also, employed patients were more frequently in disagreement on all problems, goals, and methods for treatment than were unemployed patients. Finally, a strong relationship was evident between involuntary detainment and disagreements on all problems, goals, and methods for treatment. However, it could not be ascertained whether the psychiatrist's decision to involuntarily detain the patient contributed to or was a consequence of disagreements. Therefore, the interpretation of this latter finding was difficult.

It had been speculated that certain characteristics of the psychiatrist may lead to disagreements. These characteristics included the psychiatrist not being of the English language at birth, resident versus psychiatrist status, and a clinical orientation that was psychodynamic or biological versus eclectic. Only one of these characteristics, resident status, was associated with disagreement status on all problems.

Finally, it had been suggested that characteristics related to both the patient and psychiatrist may account for disagreements. These characteristics included sex differences, an age disparity of at least 20 years, and whether psychiatrists had previous contact with the patient. None of these variables was found to be related to disagreements on problems, goals, or methods for treatment.

A few of the patient-psychiatrist variables were found to be significantly related to disagreement status. These variables were the patient being employed, less than Grade 12 education, and involuntary at admission; the psychiatrist being of a non-English language at birth and resident status. Since the interpretation of these results must take into account the numerous characteristics of patients and psychiatrists that were investigated, as well as, a large number of checklist items that were used to determine disagreements (i.e., 22 items for problems, 22 items for goals, and 18 items for methods), little emphasis can be placed on the findings. However, it would be worthwhile for future investigators to attempt to confirm this in other psychiatric populations.

The final stage of this research investigated the consequences of disagreements. There was evidence in the literature that disagreements resulted in adverse outcomes such as patients withdrawing from therapy. However, these outcome studies were conducted with psychiatric patients in the community rather than with hospitalized patients.

A significant relationship was found between disagreement status and the likelihood of patient discharge AMA/AWOL. When controlling for selected patient variables including sex, age, educational level, employment status, and diagnosis, the odds of a patient

disagreer discharged AMA/AWOL relative to an agreeer discharged AMA/AWOL were consistently found to be over five. For disagreement status with respect to problems and methods for treatment, it was found that the corresponding relative odds for males were significantly higher than for females (i.e., there was a statistically significant interaction between sex and disagreement status). Finally, there was a statistically significant interaction for employment status with disagreement status on methods for treatment. In particular, the association between disagreement status with respect to methods for treatment and patient discharge AMA/AWOL was significantly stronger for employed patients than for unemployed patients. Thus, the interaction results suggest that there is a greater likelihood for male and employed patients that disagreements may lead to patient discharge AMA/AWOL.

While it is important to acknowledge that there are sources of bias in any study, it is difficult to determine how bias may have affected the results reported here. The definition of disagreement status was adopted on an a priori basis before the data was inspected. When classifying a patient and psychiatrist as disagreeers on problems, goals, and methods for treatment, only one agreement was allowed for environmental items and one disagreement for psychological items. As a result,

patients and psychiatrists who were classified as disagreeers were definitely at the extreme end of the agreement-disagreement continuum. The purpose of using this fairly stringent definition was to establish a group of patients who could be clearly characterized as being in disagreement with psychiatrists. It is possible, however, that a less stringent definition of disagreement status could have resulted in findings different from those reported in this study.

It is recognized that disagreements between patients and psychiatrists were determined at a single point in time. Disagreements on problems, goals, and methods for treatment were identified three to five days after the patient's admission. Patients were observed for discharge AMA/AWOL during the first six weeks of hospitalization. Thus, it is possible that after the determination of disagreement status between the patient and psychiatrist, other factors may have affected patient discharge AMA/AWOL (e.g., nurse-patient disagreements).

This research did not examine the extent to which disagreements between patients, and other clinical staff such as nurses, could have also lead to adverse consequences. The nurse may have felt that the patient not being in control of inappropriate behaviour was a problem. In turn, specific interventions may have been used by the nurse to assist the patient to deal with such

behaviour, for example, one-to-one therapy, medications, or seclusion. Given that these methods for treatment were performed in accordance with those prescribed by the attending psychiatrist, it seems likely that the nurse and psychiatrist were in agreement about the interventions. However, it is also conceivable that the patient, psychiatrist, and nurse were all in disagreement.

Only one study (Zaslove et al., 1966) was conducted with patients discharged from a university state hospital ($n=93$). Disagreements between patients, psychiatric residents, and head nurses, regarding what had been the most helpful treatment for the patient, were investigated. It was found that the highest rate of agreement occurred between nurses and patients (53%); the lowest rate between physicians and patients (35%). The patient, nurse, and physician agreed about what had been the most helpful treatment in only 25% of the cases. It is also noteworthy that physicians disagreed with nurses almost as frequently as they did with patients (i.e., 61% nurse-physician disagreement; 65% patient-physician disagreement). However, given that this research was conducted more than twenty years ago, these findings should be updated.

Patients included in the present study were diagnosed as schizophrenic, manic, depressive, or neurotic. Studies on the accuracy of the DSM-III diagnosis have shown that the reliability of the diagnosis for schizophrenic

disorders achieved a kappa of .81 while for affective disorders (i.e., mania, depression, and neurosis), kappas were in the order of .69 to .83 (Diagnostic and Statistical Manual III, 1980, p. 470). Because of the diagnostic requirements at the study hospitals, the diagnoses of patients were consistently made by the attending psychiatrist, in accordance with the International Classification of Diseases (ICD-9, World Health Organization, 1979), and with consultation from other psychiatrists and the interdisciplinary team. In addition, a sizeable number of patients in the study were known to the psychiatrists from previous contact (43%). It is reasonable to assume that this could only enhance reliability of diagnosis. However, some misclassification of diagnosis was clearly possible.

This research focussed on the relationship between a patient's primary diagnosis, disagreement status, and consequences. Thus, there was the possibility that patients with a specific secondary diagnosis were in greater disagreement with psychiatrists than patients without this additional diagnosis. For example, patients with a secondary diagnosis of personality disorder may have been more prone to disagree with psychiatrists than patients without such a secondary diagnosis. In the present study, 22 patients were classified as being in disagreement with psychiatrists on problems, 24 as

disagreeing on goals, and 14 as disagreeing on methods for treatment. Thus, small numbers of patients were classified as disagreeers in each of the diagnostic categories (schizophrenia, depression, mania, and neurosis). Furthermore, not all patients had a secondary diagnosis. Therefore, categorizing patients according to both primary and secondary diagnosis would not have yielded sufficient numbers to permit a meaningful analysis.

Although there was the risk of classification error for patient diagnosis, there was little or no possibility for misclassification on the other patient-psychiatrist variables which were mostly of a demographic nature. For the purpose of analysis, these variables were dichotomized on an a priori basis into clinically relevant categories. It is unlikely that this process of dichotomizing variables could have introduced bias into the results.

6.3 Implications for Theory

This research provided a conceptual framework from which disagreements could be examined comprehensively. Disagreements were determined in relation to the process of treatment, that is, for problems, goals, and methods for treatment. Items were classified according to their nature (environmental and psychological). Disagreement type (whether psychiatrists identified items when patients did not), contributing variables (patient-psychiatrist

characteristics), and adverse consequences, completes the conceptualization.

6.4 Implications for Practice

This research demonstrated that disagreements between patients and psychiatrists in the present study exist on a wide range of problems, goals, and methods for treatment. In particular, when psychiatrists were of the opinion that problems existed and that these problems could best be treated with a specific approach, patients did not always share the same perception. Disagreements were consistently of the type whereby psychiatrists identified items when their patients did not. This suggests that patients are being treated for more problems than they themselves identify. This may have implications in that patients may resist treatment for problems they do not perceive to exist.

The odds of psychiatrists identifying an item were estimated to be at least twice as great as the odds of patients identifying the item. Moreover, these findings could not be explained by the following psychiatrist characteristics: sex, resident versus psychiatrist status, and language at birth. Given that psychiatrists identify both environmental and psychological problems, goals, and methods for treatment, it also suggests that psychiatrists are concerned not only about the patient's

psychological functioning, but also are concerned about the patient's functioning in the community, as well.

This research has found that patients do not always share the same concerns as psychiatrists. With this knowledge, psychiatrists could attempt to minimize or mitigate disagreements by implementing specific interventions. One strategy could be a negotiated approach whereby the psychiatrist attempts to elicit the patient's perspective about problems, goals, and preferences for treatment. Then, the psychiatrist could assist the patient to develop insight into problems, gain an understanding about goals, and attempt a mutually acceptable plan for treatment.

It was found that relatively few patient-psychiatrist variables were significantly related to disagreement status. This suggests that psychiatrists will not often prevent or mitigate disagreements by altering certain conditions (e.g., treating patients of the same sex) and thus, may need to examine other methods for reducing disagreements. Further, it follows that the recruitment of psychiatrists of varied ages, sex, or origin, need not be constrained by these considerations.

The final phase of this study reported a significant relationship between disagreement status and the likelihood of patient discharge AMA/AWOL. When controlling for sex, age, educational level, employment

status, and diagnosis, it was found that patients classified as disagreeers were discharged AMA/AWOL five times more often than patients not classified as disagreeers. This finding has serious implications. Once disagreements are identified, immediate intervention could be implemented to perhaps prevent these patients from discharge AMA/AWOL. For male and employed patients, there is an even greater likelihood that disagreements may lead to discharge AMA/AWOL. This knowledge might be used by psychiatrists when treating patients. That is, if the patient is male and employed, the clinician could use this information to intervene and perhaps prevent adverse consequences.

6.5 Implications for Future Research

This study was conducted with psychiatrists and patients at two provincial psychiatric hospitals. Patients with a diagnosis of personality or organic disorder were excluded. Therefore, as discussed previously, the findings can only be generalized to patients in similar settings. Farther, the findings are strictly limited to patients who have a diagnosis of depression, mania, neurosis, or schizophrenia. It might therefore be useful to replicate this study with patients who are diagnosed as having a personality or organic disorder. The research could also be replicated in alternative settings, for example, with patients from general or private

hospitals. Also, given that this research focussed on psychiatrists, similar studies are needed that include clinicians from other professional disciplines (e.g., nurses).

Relatively few characteristics of the patient and psychiatrist were related to disagreement status. Given that involuntary detention was consistently related to disagreement status on problems, goals, and methods for treatment, a study designed specifically to clarify the association between involuntary detention, disagreements, and consequences, would be informative. For example, at the time of admission, both patients and psychiatrists could identify problems, goals, and methods for treatment, that is, prior to psychiatrists informing patients of their involuntary detainment. However, the timing of informing the patient of this involuntary detainment would depend on the particular jurisdiction of the hospital where the study might be undertaken (i.e., the legal requirements of when and how patients are to be informed). Then, patient perceptions could, once again, be ascertained to determine if awareness of involuntary detainment resulted in a change of identified problems, goals, and methods for treatment. If disagreements could be identified before the patient's involuntary status was determined, then the relationship between involuntary

status and adverse outcomes such as discharge AMA/AWOL could be investigated.

It is also possible that some of the variables not included in this study could be related to disagreement status. For example, whether the patient was a first admission or readmission and, if so, the number of previous admissions may be a relevant variables not investigated. Another potentially important variable is the patient's secondary diagnosis. If the patient's secondary diagnosis is a personality disorder accompanied by alcohol or drug abuse, this additional diagnosis may clarify the relationship between diagnosis and disagreement status.

The persistence of disagreements is an issue that warrants further investigation. While this study examined disagreements at one point in time, specifically, within two to five days after the patient's admission, it was not determined whether disagreements persisted during the course of hospitalization. Since disagreements may be inevitable early in treatment, the failure to resolve these differences over time could be problematic. Therefore, research is needed to address the issue of persistent disagreements, as well as, variables associated with this persistence and related outcomes. Determining whether the same disagreements persisted from one hospitalization to the next would be meaningful in that

unresolved disagreements may prevent successful treatment outcomes in not only the present but also future hospitalizations.

This study showed that disagreements may be identified as early as two to five days after the patient's admission. However, if disagreements could be ascertained at the time of a patient's admission, such early identification would allow for more immediate intervention and perhaps prevention of patient discharge AMA/AWOL. It is recognized that this suggestion is merely speculation. An intervention study is required to ascertain whether, in fact, specific strategies (e.g., the negotiation approach) could minimize disagreements and ultimately prevent any adverse consequences.

While one of the consequences of disagreements was an increased rate of patient AMA/AWOL status, it would be important to examine other consequences. One example would be to determine if the extent to which patients who are in disagreement with psychiatrists are also those patients who do not comply with treatment (e.g., refusing medications). It would also be clinically relevant to investigate whether these patients have repeated admissions and, in particular, if readmissions occur shortly after the patient's discharge.

6.6 Summary

The identification of problems, goals, and methods for treatment by both the patient and clinician gives direction to the planning and delivery of patient care. If disagreements are to be resolved during the process of treatment, then both the patient and clinician must state their perceptions of problems, goals, and methods for treatment. In turn, the patient and clinician become active participants in the treatment process. Also, awareness of disagreements and attempts to prevent or mitigate adverse consequences may lead to more effective patient care and favourable outcomes.

Glossary of Terms

AMA (discharge against medical advice) - An unauthorized discharge from the hospital (Mental Health Act, Section 14.1(a), 1985, p. 7).

AWOL (absent without leave) - An unauthorized absence from the hospital (Mental Health Act, Section 22.1(a), 1985, p. 11).

CLINICAL ORIENTATION OF THE PSYCHIATRIST - The clinical orientation of the psychiatrist was classified as follows:

- (1) **PSYCHODYNAMIC** - The psychiatrist investigates the patient's psychological functioning, the affective components influencing behaviour, and motivations. The focus for treatment is from a psychodynamic orientation (e.g., psychotherapy).
- (2) **BIOLOGICAL** - The psychiatrist investigates the patient's biological functioning. The focus for treatment is from a biological orientation (e.g., chemotherapy).
- (3) **ECLECTIC** - The psychiatrist investigates the patient's functioning from a **PSYCHODYNAMIC** and **BIOLOGICAL** perspective. The focus for treatment is from a **PSYCHODYNAMIC** and **BIOLOGICAL** orientation (as above).

DIAGNOSIS - The diagnosis applied to the patients in the study according to the International Classification of Mental Disorders (ICD-9, World Health Organization, 1979) are listed below.

(1) **DEPRESSIVE DISORDER**

- 296.1 Manic-depressive psychosis, depressed type
- 296.2 Manic-depressive psychosis, circular type but currently manic
- 296.6 Manic-depressive psychosis, other and unspecified
- 296.9 Unspecified
- 298.0 Depressive type psychosis
- 309.0 Brief depressive reaction
- 311.0 Depressive disorder not elsewhere classified

(2) **NEUROTIC DISORDER**

- 300.4 Neurotic depression
- 300.9 Unspecified neurosis

(3) **SCHIZOPHRENIC DISORDER**

- 295.3 Paranoid type schizophrenia
- 295.6 Residual schizophrenia
- 295.7 Schizo-affective type schizophrenia
- 295.9 Unspecified schizophrenia

INVOLUNTARY STATUS - a patient who is detained in a hospital under an APPLICATION FOR PSYCHIATRIC ASSESSMENT (Mental Health Act, Section 9(1), 1985, p. 4) or under a CERTIFICATE OF INVOLUNTARY ADMISSION (Mental Health Act, Section 14.1(a)(b)(c), 1985, p.7). The criteria for determining involuntary status are as follows:

- (1) has threatened, attempted, or is threatening to cause bodily harm to self, or
- (2) has behaved or is behaving violently towards another person, or has caused or is causing another person to fear bodily harm, or
- (3) has shown or is showing a lack of competence to care for self.

PSYCHIATRIST - The physician to whom the responsibility for observation, care, and treatment of the patient has been assigned (Mental Health Act, Section 1(q), 1985, p. 2).

- (1) **PSYCHIATRIST** - A physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada, or a physician who has demonstrated equivalent qualifications to the Minister.
- (2) **PSYCHIATRIC RESIDENT** - A physician who is completing recognized training to specialize in psychiatry.

Appendix A

Letter of Explanation to Patient

Dear Patient:

I am doing a study about patient problems, goals, and preferences for treatment.

I would like to request your participation in this research in the following way:

I would like to ask you some questions about your problems, goals, and treatment preferences. This will take about 10 to 15 minutes.

I am hopeful that this research will provide a better understanding about patient problems and identify methods for treatment which are most helpful.

In no way will your name be mentioned in this study. What you tell me will only be reported with the answers of 130 other patients.

Your responses will be kept confidential. Your doctor and the nurses will not be told your answers.

You may decline to participate in this research. Should you agree to be interviewed by myself, you may refuse to answer any questions, stop the interview, or withdraw from the study at any time. If you decide not to participate or withdraw, your right to do so will be fully honoured without any detriment to your present or future treatment.

You may ask me questions about this study.

Sincerely,

Patricia Petryshen

Patricia Petryshen

Graduate Student
University of Western Ontario
London, Ontario

Honorary Research Worker
London Psychiatric Hospital (Local Ext. #417)
St. Thomas Hospital (Local Ext. #253)

Patient Consent Form

I have read the attached information sheet on the explanation of this study.

The nature of the study and my involvement has been discussed.

I understand that my participation is entirely voluntary and that I may refuse to answer questions or withdraw at any point in time.

I realize that this research may have no direct benefit to me, however it may provide a better understanding about patient problems and treatment preferences.

I understand that my answers will be kept confidential and that in no way will my name be mentioned.

I understand that not agreeing to be interviewed or withdrawing from the study will in no way affect my present or future treatment.

Patient's Signature: _____

Date: _____

APPENDIX B

PATIENT CHECKLIST

Patient Number:

Date:
D / M / Y

PROBLEMS:

IS THIS A PROBLEM FOR YOU DURING THIS HOSPITALIZATION?	YES	NO
1. not being able to find suitable living arrangements when out of hospital?	Y	N
2. not being able to work at a job/attend school when out of hospital?	Y	N
3. not being able to budget for living expenses when out of hospital?	Y	N
4. not being able to manage daily living routines when out of hospital?	Y	N
5. not being able to use free time when out of hospital?	Y	N
6. not being able to have someone to talk with about problems when out of hospital?	Y	N
7. not being able to take medication when in the community for illness related to mental health?	Y	N
8. not being able to express feelings?	Y	N
9. not being able to make and/or follow through on decisions?	Y	N
10. not being able to put aside the past in order to plan for the future?	Y	N
11. not being able to maintain relationship(s)?	Y	N
12. not being able to take medication while in hospital for illness related to mental health?	Y	N

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PROBLEMS (continued)	YES	NO
13. not being able to control inappropriate and/or undesirable behavior?	Y	N
14. not being able to control the use of street drugs when out of hospital?	Y	N
15. not being able to control the use of prescription drugs when out of hospital?	Y	N
16. not being able to control the use of alcohol when out of hospital?	Y	N
17. not being able to control suspicious and/or upsetting thoughts?	Y	N
18. not being able to gain relief from feelings such as loneliness, sadness, and depression?	Y	N
19. not being able to control thoughts of harming self/others?	Y	N
20. not being able to control hearing/seeing things that others do not?	Y	N
21. not being able to be in touch with reality?	Y	N
22. not being able to motivate self to become healthy and leave hospital?	Y	N

GOALS FOR TREATMENT:

IS THIS A GOAL FOR YOUR TREATMENT DURING THIS HOSPITALIZATION?	YES	NO
23. to find suitable living arrangements when out of hospital?	Y	N
24. to learn skills to help with finding work/attend school when out of hospital?	Y	N
25. to learn budgeting for living expenses when out of hospital?	Y	N
26. to learn to manage daily living routines when out of hospital?	Y	N
27. to develop recreational skills to use during free time when out of hospital?	Y	N
28. to have established mental health follow-up after discharge?	Y	N
29. to have a medication plan while in hospital for illness related to mental health?	Y	N
30. to express feelings in a acceptable manner?	Y	N
31. to make and/or follow-through on decisions?	Y	N
32. to make plans for the future rather than to focus on the past?	Y	N
33. to cope in relationship(s)?	Y	N
34. to have a medication program while in hospital for illness related to mental health?	Y	N
35. to gain control over inappropriate and/or unacceptable behaviour?	Y	N
36. to gain control over the use of street drugs?	Y	N

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GOALS. (continued)	YES	NO
36. to gain control over the use of street drugs?	Y	N
37. to gain control over the use of prescription drugs?	Y	N
38. to gain control over the use of alcohol?	Y	N
39. to gain control over suspicious and/or upsetting thoughts?	Y	N
40. to gain relief from feelings such as loneliness, sadness, and depression?	Y	N
41. to no longer be at risk for harming self/others?	Y	N
42. to gain control over hearing/seeing things that others do not?	Y	N
43. to gain touch with reality?	Y	N
44. to develop the motivation to become healthy and leave hospital?	Y	N

METHODS FOR TREATMENT:

WOULD THIS TREATMENT BE HELPFUL?	YES	NO
45. occupational therapy?	Y	N
46. recreational therapy?	Y	N
47. vocational therapy (career counselling)?	Y	N
48. industrial therapy?	Y	N
49. being able to live with and talk to other patients?	Y	N
50. one-to-one supportive/psychotherapy with hospital psychiatrist?	Y	N
51. one-to-one therapy with nurses?	Y	N
52. one-to-one therapy with social worker?	Y	N
53. group therapy (e.g., orientation group, problem-solving group, cognitive group, psychotherapy group, outpatient group)?	Y	N
54. behaviour therapy (e.g., behaviour modification, assertiveness group, remotivation group, relaxation group)?	Y	N
55. marital/family therapy?	Y	N
56. medications for illness related to mental health?	Y	N
57. electroconvulsive therapy (ECT)?	Y	N
58. treatment for alcohol and/or drug abuse (e.g., Alcoholics Anonymous)?	Y	N
59. involuntary detainment (e.g., an inability to leave hospital at your own will because of certification)?	Y	N
60. seclusion (i.e., time-out room)?	Y	N
61. one-to-one close observation?	Y	N
62. outpatient care (e.g., outpatient group, psychiatric follow-up)?	Y	N

Appendix C

Letter of Explanation to Psychiatrist

Dear Dr. .

I am doing a study about patient problems, goals, and preferences for treatment.

I would like to request your participation in this research as follows:

To complete a checklist (as attached) on your perceptions of patient problems, goals, and methods for treatment, for approximately five of your patients shortly after their admission. Each checklist would take, at the most, five minutes to complete. If you prefer that I interview you, (i.e., as opposed to completing the checklist yourself), this can be arranged at your convenience. Thus, over the next month or two, participating in this research may require five to ten minutes of your time per week.

I will independently select the patients for this study. You will have no responsibilities other than to complete the checklists for your patients.

Also, I would like to ask you some questions about yourself (e.g., demographic information). This will take, at the most, five minutes.

I am hopeful that this research will provide a better understanding of the range of patient problems you treat and methods for treatment which you perceive to be most helpful.

In no way will your name be mentioned in this study. What you tell me will only be reported with the answers of 29 other psychiatrists.

Your responses will be kept confidential. Your patients and the nurses will not be told your answers.

You may decline to participate in this research. However, should you agree to participate, you may refuse to answer any questions or withdraw from the study at any time. If you decide to not participate or withdraw, your right to do so will be fully honoured.

You may ask me questions about this study.

Sincerely,

Patricia Petryshen

Patricia Petryshen
Graduate Student
University of Western Ontario

Honorary Research Worker
London Psychiatric Hospital (Local Ext. #417)
St. Thomas Hospital (Local Ext. #370)

Psychiatrist Consent

I have read the attached information sheet on the explanation of this study.

The nature of the study and my involvement has been discussed.

I understand that my participation is entirely voluntary and that I may refuse to answer questions or withdraw at any point in time.

I realize that this research may have no direct benefit to me, however it may provide a better understanding about patient problems, goals, and preferences for treatment.

I understand that my answers will be kept confidential and that in no way will my name be mentioned.

Physician's Signature: _____

Date: _____

APPENDIX D

PSYCHIATRIST CHECKLIST

Psychiatrist Identification Number:

Patient Identification Number:

Date:
D / M / Y

PROBLEMS:

IS THIS A PROBLEM FOR YOUR PATIENT DURING THIS HOSPITALIZATION?	YES	NO
1. not being able to find suitable living arrangements when out of hospital?	Y	N
2. not being able to work at a job/attend school when out of hospital?	Y	N
3. not being able to budget for living expenses when out of hospital?	Y	N
4. not being able to manage daily living routines when out of hospital?	Y	N
5. not being able to use free time when out of hospital?	Y	N
6. not being able to have someone to talk with about problems when out of hospital?	Y	N
7. not being able to take medication when out of hospital for illness related to mental health?	Y	N
8. not being able to express feelings?	Y	N
9. not being able to make and/or follow through on decisions?	Y	N
10. not being able to put aside the past in order to plan for the future?	Y	N
11. not being able to maintain relationship(s)?	Y	N

Page 2

PROBLEMS (continued)

YES NO

- | | | |
|---|---|---|
| 12. not being able to take medication while in hospital for illness related to mental health? | Y | N |
| 13. not being able to control inappropriate and/or undesirable behavior? | Y | N |
| 14. not being able to control the use of street drugs when out of hospital? | Y | N |
| 15. not being able to control the use of prescription drugs when out of hospital? | Y | N |
| 16. not being able to control the use of alcohol when out of hospital? | Y | N |
| 17. not being able to control suspicious and/or upsetting thoughts? | Y | N |
| 18. not being able to gain relief from feelings such as loneliness, sadness, and depression? | Y | N |
| 19. not being able to control thoughts of harming self/others? | Y | N |
| 20. not being able to control hearing/seeing things that others do not? | Y | N |
| 21. not being able to be in touch with reality? | Y | N |
| 22. not being able to motivate self to become healthy and leave hospital? | Y | N |

TREATMENT GOALS:

IS THIS A GOAL FOR YOUR PATIENT'S TREATMENT?	YES	NO
23. to find suitable living arrangements when out of hospital?	Y	N
24. to learn skills to help with finding work/attend school when out of hospital?	Y	N
25. to learn budgeting for living expenses when out of hospital?	Y	N
26. to learn to manage daily living routines when out of hospital?	Y	N
27. to develop recreational skills to use during free time when out of hospital?	Y	N
28. to have established mental health follow-up after discharge?	Y	N
29. to have a medication plan when out of hospital for illness related to mental health?	Y	N
30. to express feelings in a acceptable manner?	Y	N
31. to make and/or follow-through on decisions?	Y	N
32. to make plans for the future rather than to focus on the past?	Y	N
33. to cope in relationship(s)?	Y	N
34. to have a medication program while in hospital for illness related to mental health?	Y	N
35. to gain control over inappropriate and/or unacceptable behaviour?	Y	N
36. to gain control over the use of street drugs?	Y	N

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GOALS (continued)

	YES	NO
37. to gain control over the use of prescription drugs?	Y	N
38. to gain control over the use of alcohol?	Y	N
39. to gain control over suspicious and/or upsetting thoughts?	Y	N
40. to gain relief from feelings such as loneliness, sadness, and depression?	Y	N
41. to no longer be at risk for harming self/others?	Y	N
42. to gain control over hearing/seeing things that others do not?	Y	N
43. to gain touch with reality?	Y	N
44. to develop the motivation to become healthy and leave hospital?	Y	N

TREATMENT METHODS:

WOULD THIS METHOD OF TREATMENT BE HELPFUL FOR YOUR PATIENT?	YES	NO
45. occupational therapy?	Y	N
46. recreational therapy?	Y	N
47. vocational therapy (career counselling)?	Y	N
48. industrial therapy?	Y	N
49. being able to live with and talk to other patients?	Y	N
50. one-to-one supportive/psychotherapy with hospital psychiatrist?	Y	N
51. one-to-one therapy with nurses?	Y	N
52. one-to-one therapy with social worker?	Y	N
53. group therapy (e.g., orientation group, problem-solving group, cognitive group, psychotherapy group, outpatient group)?	Y	N
54. behaviour therapy (e.g., behaviour modification, assertiveness) group, remotivation group, relaxation group)?	Y	N
55. marital/family therapy?	Y	N
56. medications for illness related to mental health?	Y	N
57. electroconvulsive therapy (ECT)?	Y	N
58. treatment for alcohol and/or drug abuse (e.g., Alcoholics Anonymous)?	Y	N
59. involuntary detainment (e.g., an inability to leave hospital at your own will because of certification)?	Y	N
60. seclusion (i.e., time-out room)?	Y	N
61. one-to-one close observation?	Y	N
62. outpatient care (e.g., outpatient group, psychiatric follow-up)?	Y	N

APPENDIX E

Chart Abstraction

Patient Demographic and Psychiatric Background:

Patient's Identification Number:

1. What is the patient's gender?

0 male
1 female

2. What is the patient's age?

years

3. What is the patient's highest educational level achieved?

0 university (completed & uncompleted)
1 community college (completed & uncompleted)
2 Grade 12, 13, or trade school (completed)
3 Grade 9, 10, or 11 (completed)
4 Grade 8 or less

4. Is the patient employed?

0 no
1 yes

5. Date admitted to hospital?

D / M / Y

6. Diagnosis of the patient according to ICD-9 classification number?

-

(Continue with Page 2.)

7. Involuntary status at admission?

0 no
1 yes

8. Readmission to study hospital?

0 no
1 yes

9. Discharge status within the first six weeks of hospitalization?

0 AMA
1 AWOL
2 voluntary discharge
3 continued hospitalization

10. Did the psychiatrist know the patient from a previous hospitalization?

0 no
1 yes

APPENDIX F

Psychiatrist Demographic and Psychiatric Background

Psychiatrist No.

1. Gender?

- 0 male
1 female

2. What is your age?

years

3. What was your language at birth?

- 0 English
1 non-English

4. Physician status?

- 0 psychiatrist
1 psychiatric resident

5. What is your clinical orientation?

- 0 psychodynamic
1 biological
2 eclectic

6. Hospital?

- 0 LPH
1 STPH

THANK YOU FOR YOUR ASSISTANCE.

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