Interdisciplinary Differences on a General Hospital Psychiatry Unit

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Abstract: *A questionnaire was distributed to staff members of a 28-bed general hospital psychiatry unit to determine and compare staff perceptions of the value of psychotherapies and the role of the disciplines in conducting treatments. Marked interdisciplinary differences were reported in attitudes toward the use of psychopharmacologic agents, the importance of diagnostic evaluation, the value of psychotherapy in the treatment program, the role of various disciplines in the program, and the therapeutic community approach. Clinical implications of the magnitude of interdisciplinary differences are discussed, and recommendations are made for resolving intergroup conflict.*

During the past several decades, staff members of general hospital inpatient psychiatry programs have witnessed profound changes (1). Examples include revised civil commitment statutes (2–5), continued advancements in psychopharmacology, the impact of federal financial support for community-based programs (6), the establishment of quality-care and peer review standards (7, 8), and the fluctuating influence of therapeutic community approaches in the hospital milieu (9). Subsequent to these changes, the characteristic atmosphere in many general hospital psychiatry units has become one of therapeutic uncertainty, fragmentation, and interdisciplinary competition (10).

Staff responses to this atmosphere of change and conflict have clearly affected both clinical and educational programs. Few investigators, however, have attempted to assess objectively how staff members of general hospital psychiatry units perceive their relative roles and how they feel about such items as psychopharmacologic agents, therapeutic community approaches, individual, group, and family therapies, and decision making among disciplines.

To study these perceptions, the authors conducted a survey among the entire staff of the acute psychiatry inpatient unit at the University of Michigan Medical Center (NPI-4). At the time of the study, nearby Ypsilanti State Hospital was undertaking a marked reduction in patient census, the State of Michigan had adopted a new protective Mental Health Code, and NPI-4 had itself experienced three rapid changes in treatment orientation (from a "long-term psychotherapy-oriented," to a "therapeutic community," to an "acute service" model). Because

The authors wish to acknowledge the assistance of the staff members of The University of Michigan Statistical Research Laboratory.

ISSN 0163-8343/79/020091-07/$02.25

of these changes, which appear also to have occurred in many other similar hospital units throughout the country, NPI-4 seemed an ideal setting in which to conduct an assessment of how staff members currently perceive the treatment program.

Specific objectives of the study were: (a) to determine and compare current staff perceptions about the value of psychiatric treatments and the roles of various disciplines in conducting these treatments, and (b) to identify any interdisciplinary differences in these perceptions which might adversely affect patient care or educational programs.

Method

During October 1975, a 100-item, key-punchable questionnaire was distributed to 47 staff members of the Acute Psychiatry Service, a 28-bed unit at the University of Michigan Medical Center. Because many topics were provocative, the authors emphasized an anonymous, confidential approach, requesting identification only by professional discipline. Most of the 24 items on the form utilized a 5-point Likert scale (11), ranging from strongly agree (No. 1), agree (No. 2), neither agree nor disagree (No. 3), disagree (No. 4), and strongly disagree (No. 5). Forty-one forms were completed, for an 87% total response.

Respondents consisted of four board-certified senior faculty psychiatrists, eight first-year and one third-year psychiatry residents, eight registered nurses (two diploma nurses, five with a Bachelor of Science in Nursing, and one with a Master of Science in Psychiatric Nursing), eight psychiatric care workers, or PCWs (typically, college graduates with interest in psychology or other social sciences and some training in psychiatric principles), four social workers (ACSWs), four activity therapists (three registered occupational therapists and one recreational therapist), and four others (one clinical psychologist, one chaplain, one psychiatric social work student, and one ward clerk, who had extensive daily contact with patients).

Through initial separate analyses of seven subgroups (faculty psychiatrists, residents, nurses, PCWs, ACSWs, activities therapists, and others), it was determined that major differences did not exist between comparable subgroups. For statistical reasons, all respondents were thus combined into three major subgroups: 13 "psychiatric staff" (senior faculty psychiatrists and psychiatry residents), 16 "nursing staff" (nurses and PCWs), and 12 others (ACSWs, activity therapists, and others). Responses of these three subgroups were then compared.

Results

Psychopharmacologic Agents

Perhaps the major finding of this study was the striking difference in reported perceptions toward medications among the three subgroups (Table 1, items 18, 20, 59). Although 92% of the 13 psychiatrists felt that drugs for schizophrenia had been rigorously evaluated and proved clinically beneficial, only slightly more than half of the other two subgroups expressed agreement. Similarly, 85% of psychiatric staff agreed that the most effective treatment for schizophrenia depends upon drugs, but fewer than one-quarter of other staff members concurred. Consistent subgroup differences were also noted for a third item on medications, which attempted to assess the relative importance of drug therapy in conjunction with other therapies.

Evaluation

Two items on the questionnaire pertained to evaluation and diagnosis (Table 1, items 13 and 16). More than three-quarters of all respondents believed that it was not essential to know intimate details of a patient's history to conduct beneficial psychotherapy. Only the four senior faculty psychiatrists and the four social workers collectively disagreed with this statement. Indeed, this was one of only three items on which psychiatry faculty and psychiatry residents differed. Residents and senior faculty psychiatrists also differed when asked about the value of diagnoses based on the DSM-II. Three of four faculty members felt nosologic labels were helpful in formulating treatment; most residents and other staff personnel did not.

Psychotherapies

Six statements pertained to utilization of various psychotherapies in hospital psychiatry. Again, subgroup differences were often marked. When asked whether individual sessions conducted by psychiatry residents were valuable, for example, or whether residents should be able to maintain some selected patients in the hospital for psychotherapy, the percentage of physicians in agreement was significantly higher than that of those from other dis-

Table 1. Psychiatric evaluation and treatment, as perceived by staff

Item	Percent of subgroups expressing agreement (1, 2 on 5-point Likert scale)			
	Psychiatric staff (n = 13)	Nurses and PCWs (n = 16)	Social workers, activity therapists, and others (n = 12)	Total (n = 41)
PSYCHOPHARMACOLOGIC AGENTS				
18. Drugs for schizophrenia (e.g., Thorazine, Mellaril) have been rigorously evaluated and proved clinically beneficial[a]	92	63	50	68
20. The most effective treatment for schizophrenia depends upon drugs (e.g., Thorazine, Mellaril)[a]	85	25	17	42
59. On the whole, too great a dependence is placed on drug therapy on inpatient therapeutic units, rather than person-to-person interventions[a]	5	50	50	39
EVALUATION				
13. While it may often be desirable, it is not essential to know intimate details of a patient's psychopathology (e.g., sexual fantasies, dreams) to conduct beneficial psychotherapy	62	94	75	78
16. A diagnosis based on DSM-II (e.g., "paranoid schizophrenia," "phobic neurosis," "hysterical personality") is generally helpful in constructing a treatment plan	46	25	50	39
PSYCHOTHERAPIES				
37. Individual therapy sessions between psychiatry residents and patients are therapeutically valuable (i.e., they alleviate symptoms and reduce psychopathology) on a therapeutic inpatient unit like NPI-4[a]	93	63	50	68
22. Residents should be permitted to maintain some selected patients in the hospital for long periods to learn individual psychotherapy	62	33	33	43
34. Patient care is benefited if psychiatry residents have an office on the inpatient service (e.g., NPI-4)[a]	93	25	50	54
50. If senior medical staff spent more time on NPI-4, the patients would improve more rapidly[a]	31	10	0	17
36. Group therapy (e.g., resident-run groups, family groups, relatives groups, community meetings) should be the primary treatment modalities on an inpatient therapeutic unit (such as NPI-4)[a]	15	50	17	29

(*Continued*)

Table 1. *Continued*

Item	Percent of subgroups expressing agreement (1,2 on 5-point Likert scale)			
	Psychiatric staff (n = 13)	Nurses and PCWs (n = 16)	Social workers, activity therapists, and others (n = 12)	Total (n = 41)
42. Significant family members should be involved in family therapy sessions for all patients on an inpatient therapeutic unit (such as NPI-4)[a]	38	75	75	63
45. Explicit treatment contracts specifying behaviors which the patient and staff agree need changing should be worked out by the team for each patient on a therapeutic inpatient unit (e.g., NPI-4)[a]	39	82	93	71

[a] $P < 0.05$ by Chi-square analysis, df = 4.

ciplines. Questions about the value of the physical presence of the psychiatric staff also generated subgroup differences (Table 1, items 34 and 50). Responses toward group therapy as a primary approach were mixed, with little overt support from psychiatrists. Similarly, attitudes toward family therapy and the utilization of explicit treatment contracts were more favorable among the other disciplines than among the psychiatric staff.

Staff Interactions

A variety of differences emerged when respondents were asked about staff interactions (Table 2). Most

Table 2. Staff interactions, as perceived by staff

Item	Percent of subgroups expressing agreement (1, 2 on 5-point Likert scale)			
	Psychiatric staff (n = 13)	Nurses and PCWs (n = 16)	Social workers, activity therapists, and others (n = 12)	Total (n = 41)
21. Nonmedical staff members resent the power of psychiatry residents	77	47	67	63
61. Medical staff, in general, are not aware of the problems encountered by other disciplines[a]	31	69	84	61
38. If there is disagreement among team members about whether a patient should be discharged, the senior staff psychiatrist should make the final decision[a]	67	38	15	50
58. Even if staff do not share the same notion of what is wrong with each patient and what should be done about it, they have an obligation to follow the treatment plan	100	88	75	88
52. Staff members of therapeutic inpatient units should have periodic (e.g., weekly) group meetings to "work through" staff conflicts and disagreements	77	81	83	81

[a] $P < 0.05$ by Chi-square analysis, df = 4.

nurses, for example, felt that medical staff were generally not aware of problems encountered by other disciplines. One item uncovered a potentially significant authority conflict pertaining to the issue of who should make ultimate treatment decisions (Table 2, item 38). Despite the fact that it was operating policy for the faculty psychiatrist to have final decision-making authority, there was clearly little expressed support at the time of this survey for this position; indeed, three of the residents expressed disagreement. If a decision were made, however, staff seemed to agree in principle on an obligation to follow treatment plans. Staff also agreed about using group meetings to resolve conflict (Table 2, items 58 and 52).

Therapeutic Community Approach

Six statements reflected on various aspects of therapeutic communities (Table 3). Despite a 3-year therapeutic community tradition on NPI-4 prior to its becoming an acute service, there was little expressed support for most therapeutic community principles. For example, only about one-third of all the staff felt that patients should share in making treatment plans or that patients were prime personnel in dispensing treatment to each other. Similarly, although therapeutic communities stress individual responsibilities and prompt reintegration into outside life, only the nursing staff seemed to support a standing "open door" policy. An intriguing but unexplained difference was that psychiatrists believed that modeling from staff behaviors was clinically important (Table 3, item 47) and that the ward atmosphere often reflected staff conflicts (Table 3, item 44), but those in other disciplines generally did not agree. Quite consistent with such responses was the reaction to a "summarizing" statement about therapeutic communities (Table 3,

Table 3. Therapeutic community approach, as perceived by staff

Item	Percent of subgroups expressing agreement (1, 2 on 5-point Likert scale)			
	Psychiatric staff (n = 13)	Nurses and PCWs (n = 16)	Social workers, activity therapists, and others (n = 12)	Total (n = 41)
11. Patients and staff should share in making treatment plans for patients on an inpatient therapeutic unit (such as NPI-4)[a]	15	38	42	32
8. Patients are prime "treatment dispensers" for other patients on an inpatient therapeutic unit (such as NPI-4)	25	47	33	35
18. Patients on therapeutic inpatient units (e.g., NPI-4) should be free to come and go at will (i.e., no locked doors)[a]	15	63	36	40
47. Patient modeling from staff behaviors is a major impetus for improvement on a therapeutic inpatient unit (e.g., NPI-4)[a]	85	56	33	59
44. Excessive tension, anger, or frustration among the patients on a therapeutic inpatient unit (e.g., NPI-4) usually means something is wrong among the staff[a]	77	38	42	51
23. A "therapeutic community" (such as described by Maxwell Jones) can work effectively on NPI-4 with its current patient population	23	25	8	20
65. Staff should never disagree with each other in front of patients	0	25	8	12

[a] $P < 0.05$ by Chi-square analysis, df = 4.

item 23), indicating that only 20% of respondents believed that it could work effectively on NPI-4.

Altogether (as indicated in Tables 1, 2, and 3), 13 of 24 items revealed statistically significant differences when the three subgroups were compared (Chi square = $P < 0.05$).

Discussion

The findings of this study may be distressing for psychiatrists in general hospital inpatient units. Despite substantial time and attention to group process work, the actual number, percentage, and magnitude of intergroup differences reported among a representative general hospital psychiatry staff are rather startling. Although exploration of these findings in other settings would be required for generalization, subjective exchanges with units elsewhere reveal that similar patterns exist in many educational settings throughout the country.

From a clinical perspective, the study has implications. The data indicate that as part of the treatment approach for hospitalized patients with schizophrenia, the typical psychiatrist would prescribe and emphasize neuroleptic medications. In contrast, support for neuroleptics from other disciplines would often be firmly withheld, or even opposed. Thus, even in psychopharmacology, a topic area abundantly researched, sharp differences were found among staff. One wonders how such simultaneous conflicting messages conveyed by feuding authority figures in the staff may affect the beleagured patient. Staff disagreements have been shown to contribute to patients' discontinuance of medication (12) and theoretically could precipitate premature departures from the hospital.

As further illustration of potential clinical conflicts, data from this study suggest that most nurses would diligently work to promote patient participation in family therapy sessions and would support group therapy as a primary therapy approach, while the absence of medical staff support for these approaches—if only nonverbal—would generate another staff "split" and another reaction among confused patients trying to decipher conflicting communications.

A further intriguing conflict with both clinical and educational implications is that senior faculty psychiatrists would predictably encourage a thorough evaluation and nosologic formulation for each patient. Based upon their reported perceptions, however, residents and nurses might simultaneously question the usefulness of the diagnostic process, perhaps viewing it as an academic irritant or destructive labeling.

Although many of these conflicts can be attributed to ongoing intergroup "process" conflicts, many others almost certainly stem from the simultaneous interaction of individuals from different professional orientations—some who believe in analytic theory, some who support therapeutic community beliefs, and some who advocate biologic treatments.

Because current hospital approaches to the treatment of patients with psychiatric problems will continue to require interdisciplinary collaboration, an intriguing question is whether our educational system recognizes and attempts to minimize these differences or whether it actually breeds and perpetuates them. If psychiatry residents, nursing students, psychiatric social work students, and occupational therapy students are taught in isolation, as is usually the case, and if teaching approaches typically emphasize one treatment ideology over another, intergroup conflicts are virtually guaranteed in hospital settings and patient care often suffers.

Recommendations

What solutions are available? Although further group process work might be recommended to resolve interdisciplinary conflict, perhaps it is time to promote objectivity rather than subjectivity. Especially in university settings, where interdisciplinary programs exist in close proximity, comparison and coordination of educational approaches seem to be indicated, with a de-emphasis on ideology and a re-emphasis on research evidence and follow-up data. It is currently often difficult to distinguish "scientific" disagreements from process differences prompted by discipline loyalties and ideologic beliefs. If educational programs were structured to reveal and explore differences between disciplines, different treatment approaches for similar clinical problems could be compared and evaluated.

When established principles of scientific methodology do not serve to resolve conflicts, such issues might then be recognized and responded to as process conflicts rather than legitimized by endless scientific debates. If data are unavailable, the awareness of such deficiencies could conceivably promote a beneficial open-mindness about professional limitations. Perhaps more importantly, recognition of knowledge gaps might actually stimu-

late outcome-oriented research. Although process disagreements among various mental health disciplines will never disappear, the process work that would occur in a collaborative research endeavor would probably do more to alleviate staff conflicts than any of the planned approaches currently utilized.

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