

Persistent Disagreement Between Patients in Psychiatric Hospitals and Therapeutic Recreation Specialists

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INTRODUCTION

In psychiatric hospitals a variety of health team professionals contribute to the provision of services which help patients re-enter and function independently within the community. The therapeutic recreation specialist, as a member of the team, is responsible for addressing the individual's leisure-related needs. To facilitate change, team members employ a defined systematic process consisting of identification of patient problems, establishment of goals for treatment, and selection of methods for treatment.

Disagreement between staff and patients during phases of this process is becoming a subject of discussion among mental health workers. The potential for negative effects has increased interest in the topic and given rise to research concerning its prevalence and effect on patient treatment. Evidence suggests that disagreement exists frequently between patients and staff members, in particular psychiatrists, psychologists, and nurses.

Researchers investigating disagreements have concentrated on specific phases of the systematic treatment process. Some have examined disagreements on *problems* (Friedan, Goldman, and Cecil, 1980; Horenstein, Houston and Holmes, 1973; Starfield et al., 1979, 1981). Others have investigated *goals for treatment* (Dimsdale, 1975; Dimsdale, Klerman and Shershow, 1979; Dimsdale, Shershow, Klerman and Kennedy, 1978; Polok, 1970). And others have studied *methods for treatment* (Dowds and Fontana, 1977; Goldstein, Racer, Dressier, Ciottono and Willis, 1972; Gould and Click, 1976; Leonard, 1973; Mayer and Rosenblatt, 1974; Skodol, Plutchik, and Karasu, 1980; Vale and Mlott, 1983; Zaslove, Ungerleider and Fuller, 1966). These researchers have examined disagreements at the time of the patient's admission or discharge. Because the patient and staff member are likely to disagree during hospitalization, it is disagreements that persist throughout hospitalization, which become the more critical issue. Additionally, consequences associated with disagreement such as patient unwillingness to cooperate with suggested treatment have been studied (Borgi, 1968; Epperson, Bushway and Warman, 1983; Hurst, Weigel, Thatcher and Nyman, 1969; Krauskoph, Baumgardner and Mandracchia, 1981; Starfield et al., 1979, 1981). This research has been conducted in community rather than hospital settings, restricting the applicability of the findings.

The focus of this investigation was to examine the disagreements between therapeutic recreation specialists and patients in psychiatric hospitals on leisure-related problems, goals for treatment, and treatment preferences that were present at admission and still present at discharge. These were said to be persistent disagreements. Consequences associated with the persistence of disagreement were considered. The following research questions were addressed: (1) What is the frequency of persistent disagreement between therapeutic recreation specialists and patients? and (2) What are the consequences associated with this persistent disagreement?

METHOD

The study included 66 patients and 19 therapeutic recreation specialists from two Ontario hospitals: London Psychiatric Hospital and Queen Street Mental Health Centre. Subjects were interviewed according to a checklist developed for this investigation. The checklist

consisted of 45 statements, of which 22 dealt with patient leisure-related problems, 22 focused on goals for treatment, and 1 addressed whether therapeutic recreation would be helpful during hospitalization. A fixed response format (Yes/No) was used.

Immediately following the therapeutic recreation specialist's assessment of a newly admitted patient (usually 7 to 14 days after admission or referral to a unit within the hospital), the patient was interviewed by this researcher using the checklist. At this time, the therapeutic recreation specialist responsible for assessing the patient also completed the checklist. Prior to discharge or after 30 days of hospitalization, the patient was re-interviewed according to the checklist. Once again, his or her therapeutic recreation specialist completed an identical checklist.

Data pertaining to nine consequences (e.g. patient attitude towards treatment programmes) was obtained from the therapeutic recreation specialist after completion of the second checklist.

ANALYSIS

Disagreement was said to exist when the therapeutic recreation specialist and the patient did not respond identically to an item on the checklist. A persistent disagreement existed when a disagreement at the time of the first interview remained a disagreement at the second interview.

Frequency distributions were generated to examine (a) the number of identified problems and goals on which the staff-patient pairs disagreed persistently, and (b) the number of pairs for which persistent disagreement occurred.

A two-factor randomized block analysis of variance was employed to examine the relationship between persistent disagreement for problems and goals for treatment, and the resulting consequences. Factor A was therapeutic recreation specialist (with each specialist forming a block). Therefore, patients were nested within blocks. Factor B was levels of the particular consequence. The dependent variable was the number of items on which the pairs disagreed persistently.

RESULTS

The frequency distributions revealed that persistent disagreement existed between therapeutic recreation specialist-patient pairs on problems, goals for treatment, and therapeutic recreation as a helpful method of treatment.

For problems, a significant association existed between the mean number of items on which the pairs disagreed persistently and three of the nine consequences. First, whether or not the patient was placed in 1:1 treatment programmes with the therapeutic recreation specialist showed a significant variation with the mean number of items on which the pairs persistently disagreed ($F_{1,39}=5.04$; $p=0.03$). When patients were placed in 1:1 treatment programmes with the staff member the mean number of items on which the pairs disagreed persistently was less than when patients were not placed in this type of programme. Second, the patient's attitude toward the treatment programmes was significantly associated with persistent disagreement ($F_{1,28}=13.09$; $p=0.01$). The mean number of items on which the pairs persistently disagreed when the patients' attitudes were positive was less than when attitudes were neutral. And third, significant associations were found between persistent disagreement and the patient's degree of interest in treatment programmes ($F_{1,24}=5.21$; $p=0.03$). When patients were always interested in treatment programmes the mean number of items on which the pairs

disagreed persistently was less than when patients were generally interested in programmes. There were no significant therapeutic recreation specialist effects or interaction effects for these consequences.

Regarding goals for treatment, the same three consequences were significantly associated with persistent disagreement; whether or not the patient was placed in 1:1 treatment programmes with the therapeutic recreation specialist ($F_{139} = 7.42$; $p = 0.01$); attitude towards treatment programmes ($F_{1.28} = 47.12$; $p = 0.02$); and degree of interest in treatment programmes ($F_{1.24} = 5.97$; $p = 0.02$). Examination of cell means for these consequences revealed the same results found above. Similarly, no significant therapeutic recreation specialist effects or interaction effects were found.

DISCUSSION

The findings confirm the existence of persistent disagreement and its impact on the treatment process. Because persistent disagreement can be a deterrent to effective patient care, greater awareness and knowledge of consequences associated with this disagreement is of considerable importance to therapeutic recreation specialists. Such information could be introduced to staff in a training programme or formal education setting. One possible intervention strategy could be a negotiated approach where staff would attempt to elicit and understand the patient's perspective and work towards negotiating a mutually acceptable treatment plan. This strategy has the potential to set the stage for positive change and ultimately enhance the delivery of therapeutic recreation services.

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