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Behavior management training in inpatient psychiatric rehabilitation: Impact on ward atmosphere, program operation and outcome

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BEHAVIOR MANAGEMENT TRAINING
IN INPATIENT PSYCHIATRIC REHABILITATION:
IMPACT ON WARD ATMOSPHERE, PROGRAM OPERATION AND OUTCOME

BY

MARK D. VANGEN

A DISSERTATION

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GRADUATE COLLEGE
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BEHAVIOR MANAGEMENT TRAINING IN INPATIENT PSYCHIATRIC REHABILITATION: IMPACT ON WARD ATMOSPHERE, PROGRAM OPERATION AND OUTCOME

Mark D. Vangen, Ph.D.

University of Nebraska, 1990

Advisor: Will Spaulding

The purpose of the present research project was to explore the relative contributions of two characteristics of an inpatient psychiatric rehabilitation program, organization/philosophy and staff training, to program operation. Specifically this study examined the impact of a Behavior Management Inservice Training Program on staff attitudes, behavior and perceptions of the ward. The study was carried out in the context of a treatment/research program where ongoing data collection had been occurring for seven years. A previous study had found that staff attitudes and ward perceptions were influenced by program organizational and philosophical changes. The present study was an extension and an expansion of the previous study. The present study hypothesized that desirable changes in staff behavior can be brought about by inservice training in behavioral therapy skills. This study also examined the differential effects of the inservice training on individual staff members. The results of the study indicate that although training produced some further staff attitude and ward perception changes, the training did not produce desirable staff behavioral changes. It was also found that the response to the training program differs across staff groups and across individuals, and that individual responses can be predicted from initial staff characteristics.

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TABLE OF CONTENTS

	Page
Introduction	1
Current Status of Treatment for the Chronic Mentally Ill	4
Remaining Issues for the Social-Learning Programs	7
Staff Attitudes and Perceptions	9
Opinions About Mental Illness Scale (OMI)	10
Ward Atmosphere Scale (WAS)	12
Other Research on Staff Attitudes and Perceptions	18
Staff Behavior	21
Staff Training	27
Present Study	35
Development of a Study Site	37
Operational Hypotheses	39
Method	41
Subjects	41
Measures	41
Data Collection Procedures	47
Results	51
Univariate Analyses	51
Multivariate Analyses	63
Discussion	68
Experimental Hypotheses	70
Tables	87
Figures	113
References	128

Appendices 137

Appendix A: Student's Workbook 137

Appendix B: Supervisor's Training Workbook 195

Appendix C: Glossary of Behavior Management Terms 208

Appendix D: Inservice Training Quizzes 218

INTRODUCTION

The purpose of this introduction is to set the context of the research study by reviewing major developments in psychosocial treatment of the chronically mentally ill over the past three decades. Particular attention is given to evaluation of treatment programs in terms of conceptual structure, ward ecology, and staff training and attitudes.

With the advent of the Community Mental Health Centers Act (Public Law 88-164), spearheaded by President Kennedy in 1963, a "bold new approach" to mental health was officially initiated and formalized. This law established the community mental health center system and continued the earlier unofficial movement initiated in the latter 50's and early 60's of depopulating state hospitals and of treating the mentally ill in their communities. This phenomenon, which was never awarded a universally accepted definition, has been called "deinstitutionalization" (Bachrach, 1978). The most often quoted definition of deinstitutionalization comes from Bachrach (1978) who defines it as, "a process involving two elements: the eschewal, shunning, or avoidance of traditional institutional settings (particularly state hospitals) for the care of the mentally ill, and concurrent expansion of community-based facilities for the care of these individuals" (p. 573). According to Talbott (1980), the change of location for treatment of the mentally ill from the hospital setting to the community and the resulting decrease of the state hospital population was due to four events:

1. the development of the philosophy that it is better to treat mental patients in the community than in institutions;
2. technological advances, especially the introduction of new psychopharmacological agents;
3. increasing emphasis on patient rights by legal, legislative, and judicial forces;
4. the shift in a substantial part of the economic responsibility for the several million chronic mentally ill patients from the states to the federal government (through SSI, Medicaid, and Medicare funding) as patients were discharged from the state hospitals to nursing homes and board and care homes. (p. 43)

Bloom (1977), in discussing the events which led to the 1963 Act, has indicated that the Joint Commission's 1961 report Action For Mental Health (1961) suggested the following areas of concern for the mental health field:

1. immediate intensive care for the acutely disturbed mental patient and outpatient community mental health clinics;
2. improved care of chronic mental patients in other converted state mental hospitals;
3. improved and expanded aftercare, partial hospitalization and rehabilitation services;
4. expanded mental health education (Bloom, 1977, p. 25).

The advice in this report went generally unheeded, and consequently the needs of the chronically mentally ill were not emphasized in mental health policy. The "five essential services", as enumerated in the Act of 1963 were inpatient care, outpatient care, emergency services, partial hospitalization, and consultation and education. It was not until 1975 that community mental health centers were mandated to provide aftercare services for deinstitutionalized people (Bloom, 1977).

There is more to deinstitutionalization than simply discharging patients from the hospital to the community. However, a well-developed

method for this process was never devised, and any planning that was done was sporadically implemented. Bassuk and Gerson (1978), in describing the disorganization and lack of priorities in the deinstitutionalization movement, note that "eleven major Federal departments and agencies share the task of administering 135 programs for the mentally disabled" (p. 52). They report that these agencies all differed in their interpretation of deinstitutionalization policy and used different priorities within the agencies. This further explains why the deinstitutionalization movement has failed to accomplish its intended goal.

The question, "What role will hospitalization play in the treatment of the chronically ill" is of vital importance in the process of formulating a strategy to deal with this population. Two disparate philosophies have emerged in the last twenty years. One maintains that state hospitals were and continue to be inhumane and oppressive institutions. This position is supported by numerous mental health professionals, legal rights activists, politicians, and patients' rights groups. They emphasize that any alternative to hospitalization for the chronically mentally ill is a more humane and positive treatment modality (Mendel, 1974; Rappaport, 1977).

At the opposite pole are those who argue that there remains a real need for hospitals for the chronically mentally ill. Many argue that state hospitals provide a necessary facet of treatment because a total lack of appropriate social behaviors often precludes acceptance of chronic patients into the community (Rachlin, 1974; Rieder, 1974).

According to this point of view, failure to acknowledge these realities has contributed to the problems of deinstitutionalization.

More recently a third position has emerged, based on the argument that an "either/or" approach to hospitalization is unacceptable (Group for the Advancement of Psychiatry, 1978; Turner, 1978). It is argued that a more comprehensive model is required, in which treatment is placed on a continuum between the hospital and an independent living situation. Advocates of the comprehensive model proposed that this type of program, accompanied by a revision of the organizational structure of government agencies dealing with the chronic population, would provide a firm base upon which to build more successful deinstitutionalization programs.

Current Status of Treatment for the Chronic Mentally Ill

There is currently a myriad of treatment modalities and settings available to serve the chronically mentally ill (CMI) population. These modalities range from more traditional therapies, e.g., individual psychotherapy, group psychotherapy, medications, to more recent innovations, e.g., social skills training, family treatment/ psychoeducation, and vocational rehabilitation. Other modalities involve behavioral approaches such as token economy programs and social-learning programs. Psychiatric rehabilitation (Anthony, 1980) has become another popular model in treating the CMI.

In addition to the mental health system's large armamentarium of services, therapies, and programs to offer clients, there is a range of

treatment settings in which to provide these services. These settings range from the more restrictive types such as inpatient hospitals and state hospitals, to gradations of hospitalization such as partial hospitalization, day treatment or care programs, and numerous community residential programs -- halfway houses, Fairweather lodges, foster care, and quarter-way houses.

The treatment outcome literature differentiating the effectiveness of community alternatives versus hospital programs for the CMI is inconclusive due to methodological problems in the various studies (Magaro, Talbott, & Glick, 1984; Test & Stein, 1978). Although the outcome data are inconclusive, there are two issues which nevertheless suggest that community alternatives are more desirable for (CMI) clients than inpatient programs. The first issue is the fiscal aspect. Community-based programs have been found to be at least as cost effective as traditional hospital programs (Sharfstein & Clark, 1978). The second issue is the desirability of treating the CMI in the community in the least restrictive, most normalized setting. Independent of treatment outcome issues, these considerations suggest the community-based programs are to be preferred over institutional hospital-based programs.

On the other hand, placement is not treatment; i.e., social/ethical and fiscal reasons for placing CMI in the community are not reasons for providing one type of treatment or another, regardless of the setting. Social-learning programs, behavioral programs, or token economy programs, whether in the community or a hospital setting

have tended to demonstrate more effective outcome data than traditional treatment interventions (Kazdin, 1977; Magaro, Gripp, McDowell & Miller, 1978; Paul & Lentz, 1977).

The Paul and Lentz (1977) study compared three treatment programs for the CMI -- a social-learning program, milieu therapy, and a "traditional" treatment program. The patients in this study were those who had been left in the state hospitals during the deinstitutionalization process and were considered untreatable in the community. The social-learning program emphasized the enhancement of interpersonal skills, instrumental skills, the reduction of bizarre behavior, and the strengthening of the patients community support system. Overall, the ten-year study showed that the treatment of choice for the CMI was clearly a social-learning program.

Patients in the social-learning program achieved greater gains in the areas of instrumental role performance and self-care. Furthermore, by the end of the study, 97.5% of all residents in the social-learning program were successful in maintaining community tenure versus 71.0% and 44.8%, respectively, in the milieu program and hospital comparison group. There were also lower dosages of medication utilized at the end of the study in the social-learning program. Furthermore, the introduction of consultation utilizing social-learning techniques produced beneficial results in the aftercare course for patients who had originally participated in the milieu and social-learning programs.

Remaining Issues for Social-Learning Programs

The studies which most unequivocally show the superiority of behavioral and social-learning approaches were all done at inpatient settings. It does appear that the CMI can be successfully treated in such settings. Today's reality is such that most communities do not have the necessary manpower and other resources to provide those services on an outpatient basis. Until the community mental health system is able to provide the psychosocial, rehabilitative services necessary for the CMI, the state hospital will continue to play an important role in the treatment of the CMI.

Therefore, one remaining issue involves the institutional setting and its continued predominance in research and treatment of the CMI. Seen as a "necessary evil" the institutional setting offers the opportunity to develop, implement, and evaluate specific research/treatment programs. With the ability to do well-controlled research at these settings, researchers have the chance to better understand the interrelationships of the various components involved in the processes of treatment programs. An understanding of these components will provide the information to develop specific programs suitable for their respective settings not only for institutionally-based programs but also for community-based programs.

Another remaining issue centers on the fact that we do not know what specific components of behavior/social-learning programs account for the effectiveness demonstrated in the above studies. Paul and

Lentz (1977) were able to show multiple changes occurring not only in patient behaviors and characteristics, but within the program staff (attitudes and behaviors) and the program itself (increase in programming; decrease in use of seclusion; decrease in violent incidents). Within any developing program there are changes taking place at multiple levels. By being able to measure and account for these changes, one would be better able to understand much more of the process of developing, implementing, and evaluating a research/ treatment program.

Data on multiple levels of program development are clearly necessary for determining the most important characteristics and processes in successful programs. Such a determination is in turn necessary for optimizing the effectiveness of a treatment program. One must be able to tailor various treatment components and stages to specific settings and situations. This is especially true for adapting institutional programs to community settings. In addition to program development and evaluation applications, multi-level data will facilitate analyses of staff and patient behavior, the relationship of patient behavioral changes to the etiology of behavioral disorders, and a fuller understanding of patient treatment outcome data.

Magaro, Gripp, McDowell and Miller (1978) provided a strategy for analyzing different components of behavioral/social-learning programs. Their model is based on data collected after an exhaustive review of the literature on token economy programs (TEP). These authors noted that one of the major failures of those studying TEP programs has been

the neglect "to partial out the relative effects of the various patient and program variables activated by a TEP" (p. 133). Their model for evaluating treatment programs is composed of four categories of importance. These include patient variables (characteristics), program variables (staff training and morale, behavioral techniques, treatment goals, economic principle, staff expectations and attitudes), treatment process behavior (task performance, target behaviors, rating scales, token usage), and outcome variables (rating scales, target behavior, disposition, follow up). Magaro et al. (1978) suggest that all studies done on treatment programs must take into account these domains of variables and the interrelationship of these variables within the process of the treatment program.

STAFF ATTITUDES AND PERCEPTIONS

One area of research suggested by Magaro et al. (1978) and others (Paul & Lentz, 1977; Reppucci & Saunders, 1982) focuses on staff variables and the relationship of these variables (staff attitudes and behavior, staff training issues) to one another as well as to the overall process of an ongoing research/treatment program. In spite of these authors' emphasis on the importance of the staff domain, there has not been much research done in better understanding the interrelationship of variables within this domain and the relationship of this domain to treatment outcome. Magaro et al. (1978) stated: "research on staff variables has not been plentiful, especially as they relate to TEP effectiveness, and assertions concerning them are largely anecdotal and speculative" (p. 107).

Reppucci and Saunders (1982) also point out the lack of data gathered within this domain: "It seems paradoxical that in the human services, with their emphasis on human relationships and the usual lack of clear-cut criteria of success, there has been practically no attention paid to staff attitude and behavior" (p. 172).

Working within a more ecological model, Reppucci and Saunders (1982) assess the effects of programmatic changes on staff morale, attitudes, and behavior over the course of a newly implemented behavioral program for adolescents. They found that the staff working on a behaviorally-oriented treatment ward scored in a more positive manner on attitude, morale, and job satisfaction than their counterparts working within a more traditional program.

There have been numerous studies that have researched the attitudes and "ward perceptions" of staff. This literature includes two major types of studies. The early attitudinal work by Cohen and Struening (1962, 1963, 1965) utilizing the Opinions About Mental Illness Scale (OMI) and the work of Moos (1974) in the development and evaluation of social climate scales, specifically the Ward Atmosphere Scale (WAS) have contributed the majority of research related to staff attitudes and ward perceptions.

Opinions About Mental Illness Scale (OMI)

Cohen and Struening (1962, 1963, 1965) have probably conducted the most extensive research related to mental health professionals and their attitudes towards the CMI. The OMI developed by Cohen and Struening in

Restrictiveness scores are associated with lower level and less well-trained staff. Higher Mental Health Ideology scores were associated with higher level employees and better trained staff.

In addition to studies suggesting that specific attitudinal configurations are related to discipline and professional status, there has been research on the effects of classroom training and practical experience on attitudinal change. Rabkin (1972) identifies two types of research related to practical experience. One is related to the personal experience of a worker with hospital patients and the other involves inservice training programs for staff. She found that through these two types of training attitude modification is possible for various mental health workers, especially nurses and aides. The research also demonstrates that direct contact with patients leaves the workers having a more tolerant attitude and a better understanding about mental illness. Rabkin (1972) also points out that academic instruction has been found to be influential in effecting attitudinal change in mental health workers.

Ward Atmosphere Scale (WAS):

In a related area of research, Moos (1974) has developed a number of social climate scales with which to measure the "atmosphere" of various treatment settings. Moos (1974) suggests that the measurement of social climate is one of the best ways in which treatment environments may be described and characterized. He views environments as having their own unique "personalities" as people do. Utilizing the

1962, has proved to be one of the most popular instruments utilized to assess staff attitudes. This instrument was developed by borrowing items from the Custodial Mental Illness Ideology Scale developed by Gilbert and Levinson (1956), the Brunswick F Scale and several earlier scales. The OMI originally used a 60-item Likert-type format, which yielded five factor scores labeled Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness and Interpersonal Etiology. In 1974 Paul and McInnes added nine more items producing a sixth factor defined as Social Learning Ideology. This was included to measure the "nondisease model" that has become more prevalent in the past two decades.

In further investigations utilizing in the OMI, Cohen and Struening (1965) found that the "atmosphere" of a ward is largely determined by the attitudes of mental health workers, especially the nurses and aides. Cohen and Struening (1964) also report that wards whose mental health workers scored high on the Authoritarianism and Social Restrictiveness subscales were not particularly effective in discharging patients to the community.

In a brief review on the use of the OMI in analyzing attitudes, Edelson and Paul (1976) made several discoveries. They found that a number of studies have shown that more effective hospital units tend to be characterized by low scores on Authoritarianism and Social Restrictiveness scales and high scores on the Mental Hygiene Ideology scale, which is defined as having a positive orientation toward psychiatric patients. They detected that higher Authoritarianism and