BELIEF CORRELATES OF PSYCHIATRISTS IN TWO SELECTED SETTINGS

Thesis for the Degree of M. A.

MICHIGAN STATE UNIVERSITY
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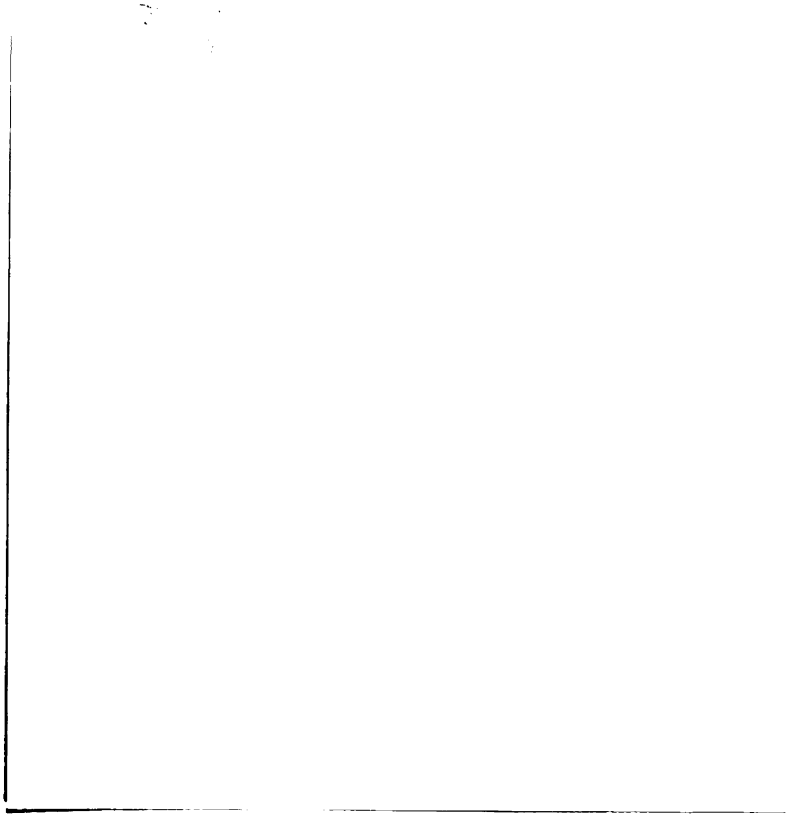
1972



BELIEF CORRELATES OF PSYCHIATRISTS IN TWO SELECTED SETTINGS

By

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A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

Department of Sociology

1972

ACKNOWLEDGMENTS

The author gratefully acknowledges the help and assistance of Dr. Peter Manning, whose critical insight was vital to this thesis. The advice of Dr. Philip Marcus was also greatly appreciated.

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INTRODUCTION

This study concerns itself with the institution of psychiatry in state mental hospitals and its supporting disease ideology. Psychiatry as an institution is an organized prescribed system of differentiated activities set up for the resolution of problems in interpersonal relationships, intrapsychic dynamics, and social role performance. Psychiatry is differentiated into specialized roles (e.g. public and private) with complementary beliefs, attitudes and values. As a speciality of medicine psychiatry has a mandate from society to deal with problems of personality (Hughes 1958). Although psychiatry holds this primary mandate, it has a very tenous claim to exclusive competence and it receives competition from occupations outside medicine (e.g. clinical psychology and counseling) and from within medicine. Also public recognition of competence if problematical due to the nature of the problems, i.e. they are part of everyday living,and the uncertain evidence of success or cure of these problems (Wilensky 1964).

This introduction will attempt to delineate the general nature of an ideology in a profession and then go on to examine ideology in psychiatry with emphasis on the effect that institutional structure has in a professional belief system. Another major consideration will be the particular nature of psychiatry as a scientific profession and the resultant role that an ideology holds in it.

Shils (1968) characterizes an ideology broadly as being highly systematized or integrated around a few pre-eminent values with a high degree of explicitness over a very wide range of objectives with which it deals. There is a consensus and a commitment to it by its adherents with a closure to novel elements and variations. Armor and Klerman (1968) delineate the unique nature of a professional ideology positing it as a coherent system of both existential and evaluative ideas. It is a series of ideas where each idea gains its support primarily by the virtue of the other ideas in the system. The existential ideas for a profession are those embodied in a codified knowledge base. They contain the particular judgement of what is correct and what is not. Evaluative ideas are statements of what ought to be for the profession. They correspond to the general goals such as a code of ethics which are based on normative prescriptions outside the formal knowledge base. It must be emphasized that there is no clear dichotomy between evaluative and existential ideas in a professional ideology. Also in a profession another kind of evaluative idea is possible where the codified knowledge base is incomplete or ambigous about means to attain a professional goal, then the means chosen can have an evaluative basis. Finally, as least some sub-group of the profession as a whole must identify with the ideology. It is importnat to note that this identification may take place for only a small group while the majority will

maintain an eclectic position.

Ruesch and Bateson (1968) present psychiatry in America today as a cumulative body of knowledge which represents five basic roots: psychoanalysis, psychobiology, experimental and social psychology, state hospital psychiatry and medicine. From these roots they posit five variables which govern psychiatric thinking, structurally organic determinats (e.g. heredity), animalistic forces (e.g. instincts, drives), humanistic features (e.g. emotions, abilities), effector determinants (e.g. emotions, abilities), environmental determinants (e.g. social factors). Psychiatrist have been said to maxmize one or more of these variables in their conception of the etiology and the treatment of mental illness. Thus in modern psychiatry because of the unresolved issues in the etiology of mental illness and the resulting efficacy of treatments (psychotherapy, somatic, etc.) the codified knowledge base is amgibous. This allows a strong belief in one treatment for all illnesses to be interpeted as evaluative. It also allows opposing positions to be taken on etiology, treatment and the resulting relationship between the psychiatrist and the patient. American psychiatry serves then as an example of a profession with conflicting beliefs.

A number of studies have investigated psychiatric attitudes towards treatment and etiology. Hollingshead and Redlich (1958) characterized psychiatrists broadly as either directive-organic or analytic-psychological. In their study of mostly private

practitioners the former type saw mental illness largley the result of chemical and biological factors and offered a direct and explicit explanation of what was wrong with the patient's behavior and what the proper behavior shoudl be while the latter type viewed mental illness as stemming from psychodynamic processes developed in childhood and they offered psychotherapy and psychoanalysis. Sharaf and Levenson (1957), concerned with the mental hospital environment studied the orientations presented in the hospital setting among psychiatric residents, find both psychotherapeutic and sociotherapeutic orientations. The former was similiar to the analytic psychological stance found in the Hollingshead and Redlich study and the latter was seen as an outgrowth of the hospital setting which emphasized the use of the hopsital environment as a device for therapy. The sociotherapeutic orientation also posited mental illness as the result of environmental and situational factors particularily those that were recent. These factors were seen as most important and thus it was the total environment that was manipulated to cure the disease.

Ehrlich and Sabshin (1964) working with data from both private and public mental hospitals, postulated these orientations, somato therapeutic, psychotherapeutic, and sociotherapeutic, as three separate ideologies. Armor and Klerman (1968) accepted the postulate that these three orientations were distinct ideologies. Using data from psychiatrists at fifteen hospitals both public and private they characterized the psychiatrists as somatotherapeutic,

psychotherpaeutic and sociotherapeutic. The somatotherapeutic ideology focuses upon various somatic treatments, such as drugs or electric convulsive therapy. Mental illness is seen as a reflection of organic diseases of the brain and disturbed behavior is determined by altered brain functioning. The most effective treatments are those that effect the physiological functioning of the patient. The psychotherapeutic ideology empashizes psychotherapy including psychoanalysis as the most effective treatment. It holds mental illness as resulting primarily from intra-psychic forces that are determined to a great extent by early childhhod experiences. The sociotherapeutic ideology emphasizes multiple interpersonal and social situational encounters occurring in the patient's treatment setting. Here the manipulation of various environments, the group, the hospital or the community is used for therapeutic purposes. There is the belief that mental illness is caused by social and environmental factors usually of recent occurrence. They found that both the psychotherapeutic and socatotherapeutic ideologies were the most developed and each stressed that this was the best or only therapy for mental patients. The sociotherapeutic orientation lacked both content and commitment, it was less developed and simply was an assertion that social factors are important in treatment. It approved of other therapies and saw forces other than environmental as important in the etiology of mental illness. Sociotherapy was concluded to be too new to have developed a complete ideological status.

It is necessary to consider also the growing literature on the effect of institutional structure on the psychiatrist and his ideology, as a practitioner he exerts himself in particular social settings. Institutional structure is determined by the particular organization (e.g. state of private mental hospital) that the psychiatrist is affiliated with and that he works in. Scott (1966) posits the professional model as one where a free agent, the professional, contracts a service for his client. The professional's first loyalty is to his client. Their theories and practices are formulated for their clients. The professional is thus characterized by antonomous expertise and a service to client ideal. This model of a free professional does not though meet the realties of the professional in the organization. Here there are basic areas of conflict between the professional and the organization that must be resolved. Scott notes four such areas, resistanbeto bureacratic rules, rejection of bureacratic standards, resistance to bureacratic supervision, and conditional loyalty to the organization. These areas are then subject to processes of negotiation, manipulation, and various other exchanges between professional and organization that facilitate the maintance of this particular relationship. Professional ideology is significantly involved in this total relational mix of professional and organizational structure.

Szasz (1961) contends that an ideology of illness serves the psychiatrist in the state mental hospital as a rationalization and defense for the involuntary commitment of mental patients. By presenting mental disorders as disease processes the psychiatrist

expresses an ideology which is in harmony with the structure of state mental hospital.

Subsequently, Szasz (1963) views the goal of psychiatry as helping individual people to gain more power over their lives so that they could best achieve their goals. When psychiatry exists as a social institution serving as a regulator for one of the functional prerequisites of society, it seeks to insure the status quo and promote the prevailing interest of society and enhance its own power and status. Psychiatry, then, no longer places the values of the individual first for the values of the group are preeminent. He thus contends that the social setting that the psychiatrist is in determines his relationship with the patient, the particular action he takes and the aim of his diagnosis.

In particular, the bureaucratic setting forces psychiatry to change so radically that it can no longer be considered the profession of psychiatry because the professional's rights and duties have been redefined by the organization. In the state mental hospital the psychiatrist is the employ of the state, therefore, he functions as an agent for the state. The patient is segregated from society in the institution usually as a result of conflict with social norms. The psychiatrist must then justify both this retention and the subsequent release of the patient. But in private practice the psychiatrist may engage in various forms

of therapy and he justifies this action by concern for helping the patient. While in the mental health clinic the psychiatrist is an employee of the clinic but his alleginace is divided between the patient and the demands of the community. Here he must justify the acceptance or rejection of a particular patient and he engages in various types of psychiatric treatment in accord with the justification for treatment. Thus the methods and the purposes of the psychiatrist differ in these three social settings.

Strauss, et al (1964) in their study of two psychiatric hospitals, found that ideologies are associated with institutional locales in that the predominent ideology varies among psychiatric institutions, and particular institutions can be characterized as representing particular ideologies. The researchers also discovered that ideological convictions generated their own morality. The behavior of the professionals was highly charged morally. Treatment procedures was such an area where morality was at issue. The psychotherapeutically oriented people viewed shock therapy as at worst barbarous or midievil and at best crudely expedient. Somaticists frequently accused psychotherapists of exhausting families' financial resources without alleviating patients conditions. Psychotherapists criticized somaticists for turning patients into zombies with drugs who could not be helped with their basic problems. Somaticists felt that pschotherapists were unnecessarily cruel in not diminishing patients' suffering. What the ideology prescribed then defined both improper practice and the framework for judging the efficacy of other treatments.

It is of course natural for an ideology to determine morality for it is a total pervasive belief system. Thus the institution serves the psychiatrist as further evidence to the efficacy of his own orientation because it is in agreement with his ideology.

Finally, there is the example of military psychiatry where bureacratization overwhelms and completely regulates the psychiatrist. Daniels (1969) in an investigation of psychiatry in the military states that ambiguities in psychiatric theory allow the justification for a particular relationship between the psychiatrist and the patient. Here a particular ideology which places the aims of the organization as primary justifies a psychiatrist's actions even though they may be contrary to other norms in the profession. In the case of the military a client is not the first consideration of the psychiatrist. His orientation is to the organization and his ideology serves as a generator for the morality of his particular methods. His professional goals, standards, etc., are those of the military. The psychiatrist makes his psychiatry adjust to fit the military context. Rose (1958) delineates this adjustment procedure in the classification of neuropsychiatric cases during World War II as one where administrative criteria played a significant a role as official psychiatric criteria. Decisions were thus directed by the needs of the organization.

To recapitulate, psychiatry has been presented as a profession that adjusts itself to the organization context that it is part of. Ideology plays a major role in this adjustment by legitmating the operations of the psychiatrists in the social settings. The existence of seemingly conflicting norms in psychiatric practice, treatment, and doctor-patient relationship is the result of differing ideologies which grow out of the ambiguities in psychiatric theory. Specific orientations in psychiatric practice have been noted, but our concern now will be with the disease ideology. The disease model can be seen as a conceptual scheme that is applied to behavior. Its roots are medicine, psychobiology, and state hospital psychiatry.

Szasz (1961) contends that the development of modern public psychiatry has been a function of the development and expansion of the concept of illness. It has become an elastic category capable of including anything a psychiatrist chooses to place in it. He notes that the precipatating factors that made this possible are one, the extension of the concept of illness from a disorder of the body per se to what appears as a disorder of the body but is really a so-called mental disorder, and two, the recognition of the sick role as a sufficient criterion of the existence of an illness. The first factor is the result of the work of Freud who reclassified malingers as patients suffering from the disease, hysteria. This disease had no physiological cause but manifested itself in bodily symptoms. The second factor is the result of society imparting a social status upon an individual by its societal agent (i.e. the psychiatrist) for engaging in abnormal behavior. Psychiatry was able to impute illness to a whole range of individuals who exhibited such behavior by using their societal mandate to equivocate a social status, sick role, as a sufficient criterion of illness.

Scheff and Sundstrom (1970) point out that in a disease framework for mental disorder there is a cause, course, lesion, symptom pattern, and treatment choice. They further note that an unstated but important premise of this framework is the stability of symptomatic behavior overtime. Black (1971)

refutes this unstated premise by detailing the nature of the disease model as allowing for self-terminating disorders. There are disease states that terminate naturally without treatment. He suggests that it is difficult to specify the disease model as widely conceived by practitioners. There have though been some attempts to delineate both the conceptions of disease and some basic tenets for these conceptions. Fabrega (1971) posits three logically distinct conceptions of disease, biologistic, behaviorial and phenomenological. A behaviorial view sees behavior changes as consequences of biological processes. In this conception of disease, types of diseases are categorized by the way an individual's responses to demands are affected. There are then indications or symptons for these various disease types. Psychiatric disorders conceived within a behaviorial disease framework are conceptualized metaphorically as biologistic disease processes. Taber, et al (1969), present four basic components included in the disease model significant to medical practice. They are, nosology, pathology, etiology and treatment. Each of these four components can be transposed to the behavior disease model so that mental disorders are conceived in medical disease terms. Nosology is a classifactory scheme for illness. Each classification is mutually exclusive and the disease is generally considered as being either present or absent. Pathology is the underlying process that occurs in the organism that corresponds to the symptoms that are observable. Etiology is the belief in a pernicious agent as the causal factor in the disease. Therapy holds that treatment will favorably effect.

the condition. Mental disorders conceived within these components emphasize behavior as a consequence of underlying pathology that follows a causal sequence and can be both diagnosed and likely treated.

This study devised ten tenets of the disasee ideology as delineated by Taber, et al, (1969) (Appendix A). These tenets are both existential and evaluative. They relate to the codified knowledge base regarding the components of nosology, pathology, etiology, and treatment and they also relate to evaluative normative prescriptions regarding responsibility and the total effect of treatment on the individual. Tenet one, qualitatively different states of disorder in the personality exist and can be identified, is an element deduced from the concept of nosology. Tenet two, an underlying condition can be inferred from the observable symptons, is deduced from the concept of pathology. Tenet three, the illness of process persists within the personality over some lenght of time is another element from pathology. Tenet four, personality disorder significantly reduces the responsibility of the individual for his behavior, is an evaluative prescription that derives from the concept of disease. Tenet five, the illness process is the result of a pernicious agent and a particular causal sequence, is an element that comes from the concept of etiology. Tenet six, a single necessary and sufficient cause is present in personality disorders, is another element that is deduced from the concept of etiology. Tenet seven, directed intervention is effective in the correction of personality disability, is

an element derived from the concept of treatment. Tenet eight, directed intervention with drugs is effective in the management of personality disability, is an element derived from the concepts of etiology and treatment. Tenet nine, treatment intervention is not inimical to the organism and thus essential if there is a possibility of illness, is an evaluative prescription of the disease ideology. Finally tenet ten, effective treatment is dependent on the motivation of the individual, is deduced from the concepts of etiology and treatment.

This study is concerned with these ten individual tenets and the degree of consistency of high and low intragroup agreement for public psychiatrists for the three hypothetical cases as compared to the intragroup agreement of a group of private psychiatrists. An ideological system has support in different settings and the support for individual tenets may vary for any psychiatrist in that setting. By comparing these two settings we are able to determine patterns that may exist in either. These will provide insights into both the content of the ideology in either setting and into any evolutionary processes that my be bringing about change in that particular setting.

Ten Tenets Of Disease Ideology

1. Qualitatively different states of disorder in the personality exist and can be identified. *
2. An underlying condition can be inferred from the observable symptons. **
3. The illness process persists within the personality over some length of time. **
4. Personality disorder significantly reduces the responsibility of the individual for his behavior. ***
5. The illness process is the result of a pernicious agent and a particular causal sequence. ****
6. A single necessary and sufficient cause is present in personality disorders. ****
7. Directed intervention is effective in the correction of personality disability. *****
8. Directed intervention with drugs is effective in the management of personality disability. ******
9. Treatment intervention is not inimical to the organism and thus essential if there is a possibility of illness. ***
10. Effective treatment is dependent on the motivation of the individual. ******

* -- inferred from concept of nosology

** -- inferred from concept of pathology

*** -- an evaluative prescription for the ideology

**** -- inferred from concept of etiology

***** -- inferred from concept of treatment

****** -- inferred from concepts of etiology and treatment

METHOD

The primary interest of this study was the differences between private and public psychiatrists along the ten tenets of the disease ideology. We drew a sample of each of these populations. It was assumed that private psychiatrists have no ideological commitment to the disease model of mental disorder. Although they may exhibit certain consistencies with that model, their major concern is with each individual patient.

The subjects consisted of seventy staff psychiatrists at five state mental hospitals in Michigan at Pontiac, Northville, Traverse City, Kalamazoo and Ypsilanti. Their names were chosen from lists of staff psychiatrists at these hospitals secured from the superintendents of each. Except at Kalamazoo, where a list of ten psychiatrists was received, all staff psychiatrists at each hospital received a questionnaire (Appendix C). The ten psychiatrists at Kalamazoo were also sent the questionnaire. A control group of one hundred psychiatrists engaged in private practice in the Detroit Metropolatian area was randomly chosen from a 1970 listing of the active members of the Michigan district branch of the American Psychiatric Association. The questionnaire was mailed twice. Realizing that psychiatrists may regard a mailed questionnaire as both a threat to their institutional domain and an inadequate means of obtaining information (Deutscher 1956) a different questionnaire (Appendix D) was mailed to the five superintendents

of the state mental hospital that were surveyed. This questionnaire allowed for both an administrative view of operational procedures and a check on the congruence between staff and administrative levels. Consequently, it also served as a check on the validity of the responses of the staff psychiatrists.

The questionnaire (Appendix C) mailed to the private and public psychiatrists consisted of three hypothetical cases and a series of eleven questions for each case. A hypothetical case of anxiety, of depression, and of a personality disorder were formulated from the symptoms usually associated with these disorders as detailed in a psychiatric handbook (Hofling 1968). All the psychiatrists received the same three example cases. Certain behavior was reported for each ficitious case.

Ideally, observation of the intake interview, questioning of attending psychiatrists, and analyzing official records would be tactics used to obtain data for this study. However, since this was not possible, hypothetical cases were used. They have been used quite regularily before in the determination of mental health attitudes (Star 1961; Fletcher 1967; Fletcher 1968) and have certain advantages. The fictious cases were structured to isolate critical elements regarding illness and non-illness. They thus stimulate decision-making for the respondent and produce discrimination in responses by precisely detailing components of the particular case. For our purposes fictious cases are "neater" than real life because they are unencumbered with other

intervening variables, though these variables may sometimes be significant.

The series of questions following each case referred to the following: (A) the psychiatric relevance of the behavior (2), (B) what further aspects of the behavior would be important to know (2), (C) the direction that a professional relationship would take (2), (D) what the developmental pattern might have been (1), (E) the responsibility of the individual in his situation (1), (F) what is therapeutically beneficial and situation (1), and (G) what would be crisis and resolution situations for the individuals (2). These questions were designed to bring out the premises that the psychiatrist held underlying both his existential and evaluative conceptions of particular disorder states. These particular examples, anxiety, depression, and personality disorder, were chosen to represent typical disorders.

The questionnaire (Appendix D) mailed to the hospital superintendents dealt with certain changes that have been reported as occuring in state mental hospitals (Folta and Schatzman 1968). These questions related to the following: (A) the demise of the traditional form of the mental hospital, (B) increases in research and training, (C) redirection of treatment philosophy, and (E) the consequences of the changes for mental patients.

The responses received from the questionnaire mailed to public and private psychiatrists were analyzed for evidence of an affirmation or negation of the ten tenets of the disease model that were proposed (Appendix A). A three point scale was used for each individual tenet, affirmation, negation, and abscence of any information. The affirmation and negation points are delineated in the code (Appendix B) for each tenet. All responses for each case were coded for the ten tenets. Where there was no information for a particular tenet a zero was recorded for the psychiatrists on it. Thus each psychiatrist on each reported case affirmed, negated, or neglected all ten tenets of the disease ideology. The responses received from the superintendents were not subjected to an coding procedure but were analyzed for major themes and trends.

The information received from the analysis was summarized for each group, public and private, in percentage terms. Each tenet for each of the three cases had a percentage score for the three points on the scale for the public psychiatrists and the private psychiatrists. From these percentages a nonmetric measure of dispersion or variability was computed for each tenet and each group on all the cases. This information variable, H, indicates the amount of uncertainity or information expressed (Atteave 1959; Garner 1962). This variable is calculated by means of the formula:

$$H = -\sum_{p=1}^{n} P\ i \log P\ i$$

The set of probability values needed to compute this variable were derived from the percentages computed from the responses for a tenet along the three point scale. An elevated value of H indicates that the responses on a tenet contain a great deal of information, which can also be seen as great hetrogenity in responses. A low H reflects low uncertainity, which indicates that the group has high agreement or homogenity and consensus on that tenet. This measure allows us to compare the homogenity of public psychiatrists along the ten tenets of the disease model with the amount of homogenity of the private psychiatrists along the ten tenets. We have then a means of determining whether an ideological commitment to the disease model exists among psychiatrists in state mental hospitals. There H scores would be significantly lower on almost all of the tenets in relation to the H scores of the private psychiatrists.

HYPOTHESIS

1. Public state hospital psychiatry can be characterized as commited to a disease ideology of mental disorder.
    a. intragroup agreement for staff psychiatrists of state mental hospitals will be greater than intragroup agreement for a control group of private psychiatrists.

RESULTS

The major hypothesis to be tested: (1) that psychiatrists practicing in state mental hospitals have greater commitment to a disease ideology than do psychiatrists engaged in private practice. Private psychiatrist are assumed to have no ideological commitment to the disease model of mental disorders.

Thirteen responses were received from the public psychiatrists and twelve responses from the private psychiatrists, response rates of nineteen percent and twelve percent respectively. All respondents were male with the exception of one female in the public sector. All respondents fell within the thirty to forty-five age grouping.

For the hypothetical case of anxiety the public psychiatrists had lower H scores in eight out of the ten tenets but in most cases these were small. The chi-square test did not produce a significant value. This suggests only a very mild tendency for public psychiatrists to have higher intragroup agreement than private for hypothetical case of anxiety.

Table 1 -- H scores for private and public psychiatrists along ten tenets of the disease ideology for a hypothetical case of anxiety.

TENET #	PRIVATE	PUBLIC
1.	1.04	.88
2.	.44	1.02
3.	1.04	.72
4.	.82	.88
5.	,69	.40
6.	1.04	.96
7.	.92	.82
8.	.98	.82
9.	.99	.96
10.	.92	.70
	N = 12	N = 13

For the fictious case of depression the public psychiatrists again have lower H scores in eight out of the ten tenets. Again these differences are very small and the chi-square value was not significant. So this is then only a slight tendency for public psychiatrists to have high intragroup agreement on this second example case.

Table 2 -- H scores for private and public psychiatrists along ten tenets of the disease ideology for a hypothetical case of depression.

TENET #	PRIVATE	PUBLIC
1.	.80	1.04
2.	.80	.58
3.	.90	.69
4.	1.02	.65
5.	.68	.58
6.	1.08	.58
7.	1.03	.98
8.	.70	.47
9.	.68	.69
10.	.80	.69
	N = 12	N = 13

For the hypothetical case of personality disorder the public psychiatrists have lower H scores on six of the ten tenets. These differences too are all very small and the chi-square test did not produce a significant value. This suggests almost no difference in intragroup agreement between public and private psychiatrists foraficitious case of personality disorder.

Table 3 -- H scores for private and public psychiatrists along ten tenets of the disease ideology for a hypothetical case of personality disorder.

TENET #	PRIVATE	PUBLIC
1.	.66	.70
2.	1.04	.82
3.	.58	.58
4.	.99	.69
5.	.69	.66
6.	.99	1.04
7.	1.04	1.04
8.	.92	.69
9.	1.04	.69
10.	.82	.82
	N = 12	N = 13

It is important also to note the various patterns for each group that may have emerged along the ten tenets for the three cases. For the private psychiatrists low H scores were found for tenets two and five on case one, tenet five on case two, and tenets one, three and five on case three. Only tenet five is consistently low for the private group. For the public group only tenet five is low for the first case, tenets two, five, six and eight for the second case, and tenet five for the third case. Again only tenet five is consistently low for the three cases for the public group. Thus high intragroup agreement for the entire

sample is found only in tenet five which relates to the concept of etiology, positing a causal sequence and a particular agent in a mental disorder. Although this is a tenet of the disease ideology, the belief in a causal sequence and agent is a significant factor in all Western thought. There then seems to be no other discernible pattern of high intragroup agreement among the two groups.

DISCUSSION

These results suggest that public psychiatry as practiced in state mental hospitals operates under no greater commitment to a disease ideology than does private psychiatry as practiced in an entrepreneutrial setting. Further, this limited evidence refutes the past characterization (Szasz 1961, 1963) of public psychiatry as an institution that secures and justifies its position in and to society by means of a disease metaphor applied to the personality system. Thus the evidence suggests that the modern mental hospital has to some extent moved away from an ideological stance of disease implying, also, changes in both operations and techniques.

Let us now reiterate that the literature points out that ideology in psychiatry has changed according to the organizational context that it is in. Ideology in the occupation has been directly affected by social structure. Thus if ideology in the state mental hospital has indeed changed it is the social structure of the mental health system that we will look at to explain that change and the answers received from the state hospital superintendents will be used as insights into the nature of this social structure.

Most significantly the recent period has seen the emergence of the community mental health movement. It is offered that this movement has affected public psychiatry vis-a-vis its role in society and thur altered its psychiatric orientation. This

new mental health organization is characterized as one consisting of a team approach with both professional and non-professional community members on the team (Berlin 1969). There is an emphasis in these mental health centers on providing many services ranging from crisis care to education and prevention (Freeman and Gertner 1969). These centers then are developing new ideas and techniques to handle mental health problems. These new ideas and techniques then have an effect on the rest of the profession including state mental hospital psychiatry. So there is a direct effect from innovations changing the stance of the mental hospital ideology and operational philosophy.

On another level, the community mental health movement is changing the organizational structure of the state mental hospital by redirecting the role of the mental hospital in the mental health network. Folta and Schatzman (1968) contend that the mental hospital no longer exists in its traditional (i.e. long term custodial care) form but increasingly serves as a back-up system to city and community mental health efforts. The state mental health hospital has also become more involved in research and professional training. So there is a movement towards a rational system of community and state services where a commitment is made to reduce overlap in functions and provide an integrated system of mental health services to the public. The state mental hospital has redirected its efforts from its previous basic goal of long term custodial care of major mental illnesses (Strauss and Sabshin 1961) to more diversified

services and operations.

Finally, there is the further contention by Folta and Schatzman (1968) that the community mental health movement in accordance with heightened political consciousness in civil rights and desire for autonomy in decision making has affected the operational philosophy of the state mental hospital. The community mental health organization manifests this community activity and awareness in its operational philosophy and its techniques. These then effect both the profession and the public system of psychiatric service. Specifically, there is an emphasis on personal-social determinism rather than personal-historical determinism with resulting stress on client choice and responsibility. This then leads to a focus on the individuals actions, current situations, capabilities, etc. rather than his history, character, etc.-doing rather than being. These psychiatric concerns are not within a disease ideology of personality disorder but rather are part of some different framework.

The questionnaire mailed to the superintendents of state mental hospital attempted to get a reading of the extent to which their hospitals has indeed been affected by the community mental health movement. The picture that can be drawn from their responses reflects the recurrent themes from all the respondents.

Regarding the state mental hospitals traditional custodial

role all responses indicated movement away from this role. The extent to which their own hospital was removed from the role varied. But even the response that noted the least change from the traditional form remarked, "significant changes are taking place and state mental hospitals are becoming more and more active psychiatric treatment centers with increasing involvement in community mental health programs." All respondents noted that the state mental hospital is becoming increasingly involved in research and professional training. Only the lack of funds has limited these operations and all note that the state mental hospital in the future will most likely become more a center of research and professional training.

As to the effect of heightened political consciousness on operational philosophy, all respondents noted that these activities have certainly influenced the operation of this hospital. One respondent commented, "the state hospital is part of the community and culture and cannot be separated from the present wave or current of change." As might be expected the operational philosophy of personal-social determinism, client responsibility, current actions, etc., is viewed by all as receiving increasing attention in their hospitals. These foci are seen as complementary to the current changes in community awareness. One respondent explained, "increased concern about civil and constitutional rights has been most helpful in breaking down traditional outmoded state hospital practices."

The most recurrent theme from the superintendents is that the state mental hospital is in a stage of transition. They are certainly aware of where they have come from somewhat uncertain of the direction they are to take. One respondent related specific directions that his hospital was moving toward. He said, "we see our own function as that of a regional mental health center, serving as the hub for a cluster of community mental health centers and offering training, research and rehabilitative programs." Regarding operational philosophy this same respondent noted, "our ideal is the model of Maxwell Jones' therapeutic community in which patients and attendents are all seen as co-equal partners of the professional members of the team. We increasingly deemphasize diagnostic labels and past history and focus on an individual treatment plan for each patient which the team constantly reviews and and revises." Although none of the other superintendents were as precise as these statements their answers suggested at least some movement in these directions.

CONCLUSION

It is offered, as suggested by the limited empirical evidence gathered by this study on both the staff and superintendant levels, that psychiatry as practiced in the state mental hospital can no longer be characterized as operating within a disease framework for mental disorders. Folta and Schatzman (1968) contend that public psychiatry now has no acceptable ideology which is related to the new institutional operations and vocabulary. As the disease medical model has justified retention of the mentally ill so to will this new ideology, support and justify the techhiques and goals of public psychiatry. This new framework is being developed and modified by the organizational structure emerging in mental health on both the community and state level, technological advances in chemoterapy (e.g. anti-psychotic drugs) and social change in the awareness and concern of individual citizens regarding mental health. Neither the content or structure of this emerging ideology, are clearly delineated. What is clear is that the changing patterns of public psychiatry have begun to incorporate conceptions of quality humane treatment, individual responsibility and choice, and uniqueness and complexity of each individual's problem. Certainly, full realization in all public psychiatric sectors of these conceptions has not been achieved but if the disease ideology has begun to fall then a significant impediment to such realizations is being removed.

On a professional level these tentative results have some important implications for psychiatry in the future. First, the results suggests a breakdown of the relationship between psychiatry and medicine. The psychiatrist in the state mental hospital seems to no longer embody in his work a traditional medical model, the process of disease. Ben-David and Collins (1969) note that the growth of a new paradiagm occurs when and where persons become interested in the new ideas not only as intellectual content but as a potential means for establishing a new intellectual identity. Psychiatry then as a profession serving the public sector may now be seeking out a new societal mandate that will replace the present mandate that it has as a medical speciality. Psychiatry might then move out of medicine and a new merging of the social sciences with psychiatry may take place producing professionals with no medical identities. Such changes now in developmental stages would be nurtured by the increase of awareness in the occupational responsibility that public psychiatry has in a changing society. These responsibilities are, of course, manifested to public psychiatry by the allocation of financial resources for operations. As resources become increasingly allocated to community mental health projects there would seem greater liklihood of a break between medicine and psychiatry.

It is offered that organizational structure in the future will increasingly influence the ideological system that public psychiatry will use to justify its methods and techniques. Further, the nature of the profession itself will be progressively influenced by the context of the social structure as public psychiatry seeks and maintains a new mandate that is not subsumed from medicine. Some broad prospects for this new profession are delineated by Levinson and Klerman (1967) and central to these new role tasks for the psychiatrist is an awareness of the social system of the organization that he is a part of and its societal contxt. Most basically, psychiatry is moving toward a more reflexive and adaptive stance vis-a-vis its society.

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APPENDICES

APPENDIX A

Ten tenets of disease ideology.

1. Qualitatively different states of disorder in the personality exist and can be identified.
2. An underlying condition can be inferred from the observable symptoms.
3. The illness process persists within the personality over some length of time.
4. Personality disorder significantly reduces the responsibility of the individual for his behavior.
5. The illness process is the result of a pernicious agent and a particular causal sequence.
6. A single necessary and sufficient cause is present in personality disorders.
7. Directed intervention is effective in the correction of personality disability.
8. Directed intervention with drugs is effective in the management of personality disability.
9. Treatment intervention is not inimicale to the organism and thus essential if there is a possibility of illness.
10. Effective treatment is dependent on the motivation of the individual.

APPENDIX B

Coding procedure for each tenet of the disease ideology.

1. The use of psychiatric categories affirm the tenet. Evidence of the use of subjective intrapersonal affect and interpersonal relationship disturbances negate the tenet.
2. An explanation that symptoms are manifestations of an underlying disturbance of disorder process affirms the tenet. A focus for the observable symptoms as the substance of significant concern negates the tenet.
3. An emphasis on past experiences as being most important affirms the tenet. An emphasis on the most recent life situations and present state of the individual negates the tenet.
4. A response that the individual has little or no control over his actions affirm the tenet. A response that suggests that the individual is still responsible to interact in relationships in a mature fashion negates the tenet.
5. A response that indicates particular causes in a particular sequential fashion affirms the tenet. A response that is concerned with the present life situation and disregards a causal sequence negates the tenet.
6. There is an emphasis on a single sufficient cause with no sense of interaction between causes affirms the tenet. An emphasis on the interaction of particular causes negates the tenet.
7. Therapy directed at curing or resolving the disorder affirms the tenet. Directed intervention has no value in resolving the disorder but may provide insight into the problem allowing the individual to know himself negates the tenet. Also intervention whose sole goal is support negates the tenet.

8. Therapy such as drugs and tranquilizing agents recommended to ease the individual in life situations and crisis encounters affirms the tenet. Viewing management of life situations as not a goal of psychiatry but these situations must be handled by individual himself negates the tenet.
9. Emphasis on hospitalization, therapeutic mileus, etc. as taken for granted in present analysis affirms the tenet. Evidence that professional relationship exists in non-treatment or insight-type fashion with patient on an equal level with doctor negates the tenet.
10. Emphasis on the motivation of the individual to get well affirms the tenet. Emphasis on the patient's own ability to handle life situations with no concern for his motivation for treatment negates the tenet.

APPENDIX C

Questionnaire mailed to public and private psychiatrists.

PHYSICIAN QUESTIONS

Instructions

1. This questionnaire should take twenty to thirty minutes.
2. Write a brief answer for each question of each example case.
3. There are no right answers, we are interested in your responses as a psychiatrist.
4. Please return the questionnaire in the self-addressed envelope.

Example Case #1

Individual is a female, thirty years old. She expresses sustained tension and being constantly on edge. She has difficulty in sleeping. She reports being preoccupied with worry over mental and physical conditions and complains of many minor aches and pains. Her husband complains of her chronic irritability, suspiciousness regarding his activities when he is away from her and her lack of cooperation in his attempting to help her. The individual also complains of headaches, shortness of breath, inability to concentrate and sharp twitches of pain in her chest. She reports a negative attitude toward her doctor and her medical care complaining that he is not listening to her and that she cannot talk to him. Finally, she reports of a general unhappiness regarding herself and her life. She faces the day uneasy and has no explanation for it. She cannot pinpoint when it all started but it is recent and both the intensity and extensiveness of this uneasiness is increasing for her.

Questions

1. Is this reported behavior significant to you, as a psychiatrist? If so in what way(s)?

2. Does this behavior signify to you a particular mode of action of personal organization of this individual? If so, what is that?

3. Are there any further aspects of this individual's behavior or his interpretations of events that would be important to know? If, briefly list them.

4. Recognizing that a psychiatrist has many options after an initial interview assume you have the facts here, what would you do if you saw this individual as a patient?

5. After taking a medical history, what are some of the important questions (e.g., psychosexual development, mental state, etc.) you would ask this individual?

6. What circumstances would maximize the development of a professional relationship between the individual and you?

7. What would you expect the developmental pattern to have been in this reported behavior?

8. What is the responsibility of this individual?

9. What type of therapeutic environment do you see as beneficial for this patient.

10. What would you consider a crisis situation for this individual?

11. What would be a resolution in this behavior?

Example Case #2

Individual is a female thirty years old. She expresses a general hopelessness in her life. Her husband reports that she cries at anything and that his efforts os settling her have little effect. She complains of headaches, many minor aches and pains, fatigue, and insomnia. She reports that she no longer desires to meet friends and go out on the town for the night. She has begun to neglect both her housework and the management of her household. She reports to having things too good all her life and being dissatisfied with

herself for not being able to enjoy her life. She places little value on physical luxuries of life and also reports dissatisfaction with any of her own achievements.

Questions

1. Is this reported behavior significant to you, as a psychiatrist? If so in what way(s)?
2. Does this behavior signify to you a particular mode of action of personal organization of this individual? If so, what is that?
3. Are there any further aspects of this individual's behavior of his interpretations of events that would be important to know? If so, briefly list them.
4. Recognizing that a psychiatrist has many options after an initial interview assume you have the facts here, what would you do if you saw this individual as a patient?
5. After taking a medical history, what are some of the important questions (e.g., psychosexual development, mental state, etc.) you would ask this individual?
6. What circumstances would maximize the development of a professional relationship between the individual and you?
7. What would you expect the developmental pattern to have been in this reported behavior?
8. What is the responsibility of this individual?
9. What type of therapeutic environment do you see as beneficial for this patient?
10. What would you consider a crisis situation for this individual?
11. What would be a resolution in this behavior?

Example Case #3

Individual is a male, thirty years old. He reports a general sense of lineliness but expresses no desire for progressive involvement in social relationships. He guards his interactions

even with people whom he has learned to trust. He enters social relationships with a minimum of commitment so that he can exit quickly if he feels it necessary. He reports common stomach upsets and minor headaches. There is also an increasing sense of jumpiness and he experiences uneasiness at the slightest provocation in social relationships. He is aware of people watching him, following him, and, attempting to interfere with his activities. He also reports a desire for constant travel and expresses high regard for the total freedom that would allow him to pick up and take off at anytime.

Questions

1. Is this reported behavior significant to you, as a psychiatrist? If so in what way(s)?
2. Does this behavior signify to you a particular mode of action of personal organization of this individual? If so, what is that.
3. Are there any further aspects of this individual's behavior or his interpretations of events that would be important to know? If so, briefly list them.
4. Recognizing that a psychiatrist has many options after an initial interview assume you have the facts here, what would you do if you saw this individual as a patient?
5. After taking a medical history, what are some of the important questions (e.g., psychosexual development, mental state, etc.) you would ask this individual?
6. What circumstances would maximize the development of a professional relationship between the individual and you?
7. What would you expect the developmental pattern to have been in this reported behavior?
8. What is the responsibility of this individual?
9. What type of therapeutic environment do you see as beneficial for this patient?
10. What would you consider a crisis situation for this individual?
11. What would be a resolution in this behavior?

APPENDIX D

Questionnaire mailed to five superintendents of the state mental hospitals.

1. It has been said that the State Mental Hospital no longer exists in its traditional form (i.e. long term "custodial" care) but increasingly it serves as a back-up system to city or community mental health efforts. To what extent would you agree with that, and where would you differ?
2. The State Mental Hospital is said to be increasingly involved in research and professional training in addition to custody and treatment. Is this a trend you have observed? Can you offer any predictions on future directions that state mental hospitals might take.
3. Psychiatric treatment philosophy of public institutions is sometimes characterized as oriented toward prevention and crisis care. Enabling crises to be handled when and where they are discovered and clients to be educated in their capabilities, roles, resources, etc. To what extent is this philosophy evident in state mental hospitals?
4. Heightened political activity and awareness, manifested in such notions as civil rights for all and autonomy in decision making, has served to underscore the plurality of our society. Have these kinds of developments affected the operational philosophy of the state mental hospital?

5. It has been suggested that a concept of personal-social determinism has supplanted an older personal-historical determinism in psychiatry, resulting in stress on client choice and responsibility. Is this evident to you in state mental hospital psychiatry? If so, to what extent?
6. It has been further suggested that there is a focus on the individual's actions, current situations, capabilities, etc. rather than what he is, his history, his character, etc. is - doing rather than being. To what extent do you see emphasis on this in the state mental hospital?