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Psychiatry Research

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## Factor structure of the autonomy preference index in people with severe mental illness

Kelsey A. Bonfils<sup>a,b,\*</sup>, Erin L. Adams<sup>a,b</sup>, Kim T. Mueser<sup>c</sup>, Jennifer L. Wright-Berryman<sup>d</sup>, Michelle P. Salyers<sup>a,b</sup>

<sup>a</sup> Psychology Department, Indiana University-Purdue University Indianapolis, Indianapolis, IN, United States

<sup>b</sup> Assertive Community Treatment Center, Indianapolis, IN, United States

<sup>c</sup> Center for Psychiatric Rehabilitation, Boston University, Boston, MA, United States

<sup>d</sup> School of Social Work, University of Cincinnati, Cincinnati, OH, United States

### ARTICLE INFO

#### Article history:

Received 18 November 2014

Received in revised form

21 April 2015

Accepted 5 June 2015

#### Keywords:

Autonomy

Decision-making

Patient-centered care

Severe mental illness

Confirmatory factor analysis

### ABSTRACT

People vary in the amount of control they want to exercise over decisions about their healthcare. Given the importance of patient-centered care, accurate measurement of these autonomy preferences is critical. This study aimed to assess the factor structure of the Autonomy Preference Index (API), used widely in general healthcare, in individuals with severe mental illness. Data came from two studies of people with severe mental illness ( $N=293$ ) who were receiving mental health and/or primary care/integrated care services. Autonomy preferences were assessed with the API regarding both psychiatric and primary care services. Confirmatory factor analysis was used to evaluate fit of the hypothesized two-factor structure of the API (decision-making autonomy and information-seeking autonomy). Results indicated the hypothesized structure for the API did not adequately fit the data for either psychiatric or primary care services. Three problematic items were dropped, resulting in adequate fit for both types of treatment. These results suggest that with relatively minor modifications the API has an acceptable factor structure when asking people with severe mental illness about their preferences to be involved in decision-making. The modified API has clinical and research utility for this population in the burgeoning field of autonomy in patient-centered healthcare.

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### 1. Introduction

Autonomous decision-making, or the control a person wants in their treatment choices, has been an area of interest in healthcare research over the past two decades. The importance of patient preferences in this area is clear: a review of the literature on patient preferences for decision-making and information-seeking in healthcare found that the match between patient preferences and how treatment is provided affects both patient satisfaction and healthcare outcomes (Kiesler and Auerbach, 2006). Recently, interest in autonomy preferences has grown to include consumers of mental healthcare (e.g., Hamann et al., 2007a, 2011; O'Neal et al., 2008). However, the measures used to assess autonomy preferences were developed and tested in general or chronic healthcare samples (Ende et al., 1989; Simon et al., 2010), leaving the question of whether the measurement techniques are valid in psychiatric populations.

One widely used self-report measure, the Autonomy Preference Index (API), was developed through a focus group of providers, medical sociologists, and ethicists who identified two key domains for patients' involvement in their own care: engagement in decision making and acquisition of knowledge about one's health (Ende et al., 1989). A confirmatory factor analysis supported the proposed two-factor solution. As the emphasis on shared decision-making and collaborative care increased in medical care, the measure quickly gained acceptance for assessing patient preferences in surgical (Doherty and Doherty, 2005) and primary care settings (Schneider et al., 2006), as well as general patient populations (Thompson et al., 1993) and those with chronic health conditions (Gibson et al., 1995; Adams et al., 2001). Studies using the API have linked autonomy preferences to satisfaction with the patient-doctor relationship and mental health-related quality of life following treatment (Lee and Lin, 2010).

In recent years the API has also been used with psychiatric populations, demonstrating that consumers of mental health services often want to be actively involved in making their own treatment decisions (Hamann et al., 2005, 2011). However, consumers report differing levels of desired autonomy based on setting and personal characteristics (Hamann et al., 2008, 2011).

\* Correspondence to: Psychology Department, Indiana University-Purdue University Indianapolis, 402 N. Blackford St., Room LD120A, Indianapolis, IN 46202, United States. Tel.: +1 317 274 6767.

E-mail address: [kbonfils@iupui.edu](mailto:kbonfils@iupui.edu) (K.A. Bonfils).

For example, one study found that consumers wanted a passive role in primary care encounters, a more collaborative role when making choices about psychiatric medications, and greater autonomy regarding psychosocial treatment decisions (O'Neal et al., 2008). This is consistent with findings in general medical care, showing that autonomy preferences vary based on a number of factors, such as health status and type of decision (Say et al., 2006).

The growing use of the API indicates increased attention to patient preferences and rights in medical settings, but some studies have raised questions about the psychometric properties of the measure when used with persons with severe mental illness (Hamann et al., 2007a; Puschner et al., 2013). Studies in psychiatric populations have reported alphas ranging from 0.88 for the decision-making subscale in a community mental health sample (Hill and Laugharne, 2006), to 0.79 in consumers with depression and 0.59 in consumers with schizophrenia (Hamann et al., 2007a), but the information-seeking subscale is used less often, limiting information on its performance in psychiatric populations. In addition to the paucity of reliability estimates for the API, its factor structure has yet to be tested in those with severe mental illness.

Considering the implications that autonomy preferences can have for satisfaction and outcomes (Hamann et al., 2007b; Kiesler and Auerbach, 2006), it is important to accurately assess preferences in varied populations. The aim of this study was to assess the factor structure and performance of the API in a multi-study sample of individuals with severe mental illness. In keeping with the API's original development (Ende et al., 1989), we hypothesized a two-factor structure and used confirmatory factor analysis (CFA) to test the adequacy of the information and decision-making subscales as two distinct factors. Given the differing nature of primary care and psychiatric healthcare visits, we examined the factor structure of the API with regard to both types of treatment.

## 2. Methods

### 2.1. Participants

Data for this analysis came from two separate studies investigating autonomy preferences of people with severe mental illness (i.e., schizophrenia spectrum, bipolar disorder, or major depression) who were currently receiving outpatient mental health and primary care/integrated care services. Across studies, approval was obtained from the local institutional review boards, and informed consent was obtained from all participants.

The first study was a randomized controlled trial evaluating an adaptation of the Illness Management and Recovery (IMR) program (Mueser and Gingerich, 2002) to incorporate training in the self-management of chronic medical conditions in addition to psychiatric disorders – Integrated IMR (Bartels et al., 2014). Participants were recruited in New Hampshire from late 2006 to early 2009. In addition to having a severe mental illness, inclusion criteria for the study were: age 50 or older; receiving treatment at a community mental health center for at least the last 3 months; diagnosed with a chronic health condition (e.g., diabetes, chronic obstructive pulmonary disease, arthritis, hypertension); and no changes in psychopharmacological treatment over the past 8 weeks. Exclusion criteria were: prior participation in the IMR program; living in a nursing home or psychiatric hospital; diagnosis of dementia; terminal illness with life expectancy of less than 1 year; or moderate to severe cognitive impairment, as indicated by the Mini Mental State Examination. The study had a total of 71 participants; for the purposes of these analyses, additional unpublished pilot data were also included, increasing the total number of participants to 126. Pilot participants were recruited before the main study from a large community mental health system in Chicago.

The second study included baseline data from an investigation of Common-Ground, a program consisting of computerized decision support tools and peer support to enhance shared decision-making with psychiatric providers (Deegan et al., 2008). In addition to having a severe mental illness, inclusion criteria included: willingness to be interviewed 3 times over the course of 18 months and to have three sessions with the psychiatric provider audio-recorded; and ability to pass a short quiz on the content of the informed consent document. Consumers were excluded if they planned to change psychiatric providers during the 18-month study period (Bonfils et al., 2014).

A total of 293 participants were included in the combined dataset. Participants were predominantly male (54.9%), either White (51.9%) or Black (40.5%), and living independently (56.5%). Most participants had not completed any college (72.3%) and were unemployed (86.0%). The average age of participants was 50.2 years ( $S. D.=11.3$ ). More than half of the sample was diagnosed with a schizophrenia-spectrum disorder ( $N=150, 51.2%$ ); an additional 38.2% ( $N=112$ ) of the sample was diagnosed with a severe mood disorder. Three participants had "other" diagnoses (1.0%), and diagnostic information was unavailable for 28 participants (9.6%).

### 2.2. Measures

The Autonomy Preference Index (API) assesses autonomy preferences in medical decision-making (Ende et al., 1989). The original scale had 23 items: 6 Likert-style items and 9 responses to 3 vignettes (referencing physical illnesses) assessing preference for participation in decision-making, and 8 Likert-style items assessing preference for autonomy in information-seeking. However, many studies of psychiatric populations have excluded the vignette items, in part due to their focus on general medical illnesses (e.g., see Hamann et al., 2007a; O'Neal et al., 2008). Others have adapted these vignettes for psychiatric conditions (Hill and Laugharne, 2006), but adapted items have not been consistently used in psychiatric populations. Thus, only the 14 Likert-style items were tested in this study.

The first sample included in these analyses (Bartels et al., 2014), with a focus on integrated physical and psychiatric care, administered the API twice – once with regard to the psychiatric provider and once with regard to the primary care provider (though pilot participants were not asked about psychiatric providers). The second sample (Bonfils et al., 2014) only asked about autonomy preferences with regard to psychiatric providers, thus the sample sizes are different for psychiatric and primary care providers. A total of 234 participants provided complete autonomy preference data with regard to their psychiatric provider. A total of 123 participants provided complete autonomy preference data with regard to their primary care provider.

### 2.3. Analyses

Confirmatory factor analysis (CFA) was utilized to evaluate the fit of the hypothesized two-factor structure of decision-making autonomy and information-seeking autonomy of the API (Ende et al., 1989). We used a number of fit indices to assess the performance of CFA techniques, including the root mean square error of approximation (RMSEA), the standardized root mean square residual (SRMR), and the comparative fit index (CFI). Although chi-square statistics are reported here, they are heavily influenced by sample size, and so, although we strived for the lowest chi-square values possible, they were of less value in determining adequate fit. As recommended by Brown (2006), the model was considered to have "adequate fit" if the RMSEA and SRMR were less than 0.08, and the CFI was greater than 0.9; "good fit" was indicated by RMSEA and SRMR less than 0.05 and CFI greater than 0.95. CFA models were run for both psychiatric treatment and primary care treatment. In exploring how to improve model fit in the psychiatric care sample, factor loadings for individual items were examined and problematic items were dropped. We also tested this modified model in the primary care sample in order to explore whether a common factor structure could be identified that fit for autonomous treatment decision-making for psychiatric and primary care conditions. All CFA analyses were conducted in LISREL version 8.80.

## 3. Results

See Table 1 for item means and standard deviations. The decision-making subscale means were in the middle of the scale (psychiatric  $M=2.81, S.D.=0.68$ ; primary care  $M=2.85, S. D.=0.73$ ), but the means for the information-seeking subscale were higher (psychiatric  $M=4.21, S.D.=0.47$ ; primary care  $M=4.11, S.D.=0.44$ ).

### 3.1. CFA - psychiatric providers

Fit indices and factor loadings for the CFA of the two-factor structure of the API are provided in Table 1. This model did not meet the criteria for adequate fit for either the SRMR or the RMSEA. Further, factor loadings were low ( $<0.30$ ) for items 4, 6, and 11, indicating poor performance of these items within the two-factor structure. These three items are coded in the reverse direction from all other items on their respective subscales, suggesting that poor fit may be due to method factors. Because the original CFA exhibited inadequate fit to the data, a second CFA

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