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Subjective models of psychological disorders: Mental health professional's perspectives

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ABSTRACT

This exploratory study is an extension of previous studies which have applied personal construct theory (PCP) methodology toward a better understanding of the structure and dynamics of multidisciplinary mental (and physical) health care (Kirkcaldy and Pope, 1992; Kirkcaldy et al., 1993, 2000, 2005; Kirkcaldy and Siefen, 1999). In this study we wanted to use similar cluster statistical analyses, not unlike PCP analysis, to identify the diverse subjective models of psychological ailments such as anxiety, depression, psychosis, mania, obsessive compulsive disorder (OCD), post stress traumatic disorder (PTSD), etc., using not the idiosyncratic constructs generated by individual triadic element comparisons, but by selecting those constructs which have been clearly identified in various psychiatric and psychological rating scales (e.g. somatic preoccupation, social withdrawal, conceptual disorganization, hostility, disinhibition and controlling).

Clinical experts (psychological psychotherapists, and medical psychotherapist and psychiatrist) each with over 25 years of clinical and research experience were required to complete the ratings of each disorder listed in terms of the pre-formulated behavioral, emotional and cognitive concepts. What emerged are several multivariate (grid) analyses based on mental health professionals' perception of diverse elements (disorders) and their interrelationship derived from the similarity of composite profiles of ill-related constructs. Overall, the analyses revealed clear associations between the subjective evaluations of psychological ailments suggesting some uniformity in mental health assessment of such disorders. The implications of these findings are discussed within the theoretical framework of improved mental health care.

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1. Introduction

Contemporary research has challenged some facets of the traditional medical model, emphasizing a biopsychosocial model of disorders instead. One of the interesting questions is who believes most in which models? Furnham and Kirkcaldy (2012) in their review claimed "Clearly many doctors, researchers and medical companies are most comfortable with the medical model. Interestingly many patients favour a psychological model where behavioural and cognitive factors influence the aetiology and progress of illness (Kirkcaldy et al., 2001; Furnham and Kirkcaldy, 1994). It is common sense and an empirical fact that social and psychological factors impact on health. Yet it is by no means universally accepted. Clearly there are economic, epistemological, and political factors involved in the support for the different models. The majority of medical doctors are comfortable with and comforted by the medical model. Psychosocial factors are often multiple and difficult to measure reliably. Some people are interested more in the 'how much' rather than the 'how' question regarding the effects of psychological and social factors on medical diseases."

In an earlier study by Kirkcaldy et al. (2001), they had examined the health-related theoretical concepts (belief and attitudes individuals had regarding their selection of traditional or alternative medical treatment) and then compared profiles of two patient groups, derived from subjective treatment theory. Persons preferring alternative medical treatment were more likely to display scepticism and dissatisfaction with conventional medical treatment, and were more likely to rate diverse illnesses or disorders as psychologically determined as well as being more health conscious in terms of nutritional needs.

Kirkcaldy et al. (2000) have applied Personal Construct Psychology (PCP) methodology to various aspects of health care, such as identifying multidimensional idiosyncratic perceptions of stress among medical practitioners and specialists, and more recently identification of structures of sociometric analyses among

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patients displaying chemical and/or alcohol dependency (Kirkcaldy et al., 2005), as well as sociometric analysis of the structure of multidisciplinary clinical organizations e.g. psychooncology units of a university hospital (Kirkcaldy and Pope, 1992), and a child and adolescent psychiatric clinic (Kirkcaldy et al. (1993), etc.

George Kelly's two volumes on Personal Construct Psychology written in 1955 (Kelly, 1955/1991) were acknowledged by Bruner (1990; p. 163) to be the first attempt to construct a theory of personality from a theory of knowledge and he recognized that Kelly was at the forefront of those concerned with how people make sense of their worlds. His prophetic ideas have spawned a wide range of applications in research, education and clinical practice (Winter, 1992; Pope and Denicolo, 2001; Fransella, 2005). Kelly provided an initial "tool-box", including the repertory grid, which has been used in its traditional form and imaginative variations of it to explore personal construing. He saw limitations in psychometric research. His stance is congruent with current emphasis on qualitative/interpretative methods. These support research, which seeks to encourage participants to reveal personal meaning and use idiographic methods. Kelly identified "diagnostic bias" but saw it not as a problem, rather as something a clinician should become aware of, and realize its' significance within therapeutic practice. One implication of PCP is that clinicians should adopt a reflective and enquiring stance and recognize that how they view people and therapy will have implications within the clinic. As far back as 1955 George Kelly explored the value of describing individual perspectives and indicated that commonly named experiences (such as psychological constructs of emotions and behavior) may not necessarily involve shared meanings.

The research described here draws on aspects of PCP. It has at its focus the personal meanings of clinicians in relation to their clinical world. The advantage of the idiographic approach is that each health professional acts as their own control. The regularity in individual responding is analyzed in what amounts to an interpretative and quantitative case study. In this paper we present individual case studies from four mental health professionals working in different therapy contexts and from different therapeutic directions. These illuminate the terms and concepts which these psychotherapists use when viewing their work, in particular the major psychological disorders met in their daily clinical practice, and the relationship between the clinical constructs used to assign disorders to specific mental disorders. Eysenck (1952) had reported of the notorious lack of agreement in the clinical diagnoses among mental health professionals. Some would argue that the level of concordance remains low to the present day, despite, or perhaps because of the overabundance of newly "generated" diagnostic categories.

The key research questions are (a) what meanings do mental health professionals give to their subjective models of psychological disorders, (b) to what extent is there consensus in their implementation of psychiatric and psychological rating scales, and (c) are there similarities in the subjective perception of disorders between health professionals? This study is not unlike repertory grid analysis, but on this occasion we used pre-specified constructs derived from a variety of psychiatric scales, and principal component factor analysis with varimax rotation, coupled with cluster analyses to examine perceptual similarities and differences. The methodology of such a construct grid represents a mean of reaching idiosyncratic parameters, enabling single case estimates of personal factors.

2. Methods

2.1. Participants

Four consultant mental health professionals (two male and two female) working as psychotherapists within private health practices in North Rhine Westfalia, Germany, each with at least 25 years clinical experience, are listed below.

G is a 64 year old psychiatrist and psychotherapist with many years of clinical work in hospitals and outpatient settings He lectures at a university and is especially interested in developmental psychopathology. Furthermore, he teaches at an institute for cognitive behavioral therapy (CBT) but basically has a psychodynamic background. K is a 49 year old MD and specialized in child and adolescent psychiatry as well as in psychotherapy for adults (psychotherapeutic medicine). In the latter field she worked for several years at a university clinic. As a psychotherapist she has been practicing for many years in private practice. She feels herself as a "full-hearted practitioner". Her orientation is psychodynamic. C is a 60 year old clinical psychologist and psychotherapist. After working in a psychiatric hospital, treating inpatient clients as well as outpatients, she is currently working in her private office. Her theoretical background is CBT, and she is also qualified in group therapy. B is a 59 year old clinical psychologist and psychotherapist with postgraduate training in behavior therapy. He has a Ph.D. and is a Visiting Professor in Psychology with some 35 years clinical and research experiences, and serves as a moderator for a health professional quality circle group (physicians, consultants and psychotherapists).

2.2. Procedure

As elements in the grid, each health professional was requested to rate each of 12 frequently used diagnoses (as shown in the data table matrix Fig. 1) in terms of an array of 16 pre-specified constructs derived from psychiatric status rating scales and a consensus of clinical experience. Each specialist rated these psychological disorders ("elements" e.g. phobia, anorexia/bulimia, depression, obsessive compulsive disorder, adult attention deficit hyperactivity disorder, etc.) on a 10-point scale ("10" highest endorsement, "1" lowest) for each of the underlying constructs (e.g. disinhibition, grandiosity, excitement, tension, urgency, withdrawal, etc.).

We selected those psychological and/or psychosomatic disorders, which were most frequently confronted in daily clinical psychotherapy practices. The incidence rates vary in the general population but estimates of 12 month prevalence are provided in parentheses most taken for US health statistics, mania (2.6%),

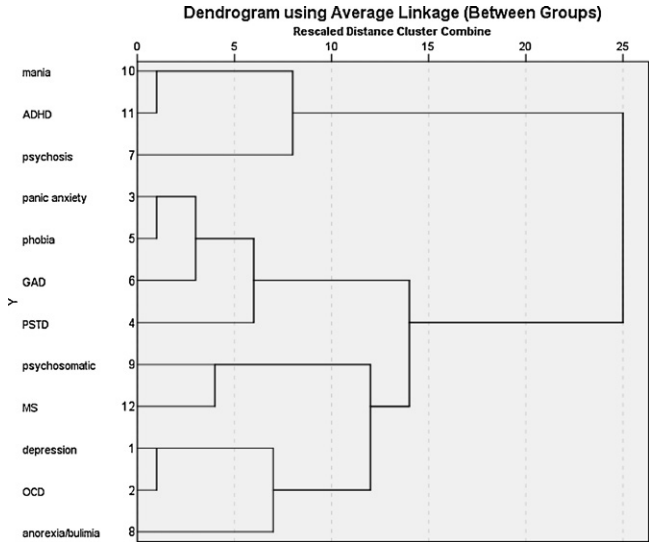

Fig. 1. Cluster analysis representation of psychological disorders. Adult ADHD represents adult attention deficit hyperactivity disorder; GAD is generalised anxiety disorder; PTSD is equivalent of post traumatic stress disorder; MS is multiple sclerosis; OCD is obsessive compulsive disorder.

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